2024 Plan Document Handbook

EPO Plans

EPO 80 Plan
High Option EPO Plan

CDHPs

Consumer-Directed Health Plan 20 (CDHP-20)

Benefits effective as of January 1, 2024

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Introduction

This is not an insured benefit plan. Plan benefits are self-insured by The Episcopal Church Medical Trust and self-funded through The Episcopal Church Clergy and Employees' Benefit Trust, which is responsible for their payment. Kaiser Permanente Insurance Company provides only administrative services on behalf of the Plan and does not insure the Plan benefits.

The Episcopal Church Medical Trust (the "Medical Trust" or the "Plan Sponsor") maintains a series of benefit Plans (each a "Plan" and collectively, the "Plans") for the Eligible Individuals (and their Eligible Dependents) of The Episcopal Church. Since 1978, the Plans sponsored by the Medical Trust have served the dioceses, parishes, schools, missionary districts, seminaries, and other institutions subject to the authority of The Episcopal Church. The Medical Trust serves thousands of active Employees, retirees, and their Eligible Dependents. The Plans are intended to qualify as "church plans" within the meaning of Section 414(e) of the Internal Revenue Code, and are exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The Medical Trust funds certain of its benefit Plans through a trust fund known as The Episcopal Church Clergy and Employees' Benefit Trust (the "ECCEBT"). The ECCEBT is intended to qualify as a Voluntary Employees' Beneficiary Association (a "VEBA") under Section 501(c)(9) of the Internal Revenue Code. The purpose of the ECCEBT is to provide benefits to eligible employees, former employees, and their dependents in the event of illness or expenses for various types of medical care and treatment.

The mission of the Medical Trust is to administer a comprehensive benefit plan while balancing compassion with financial stewardship. This is a unique mission in the world of healthcare benefits, and we believe that our experience and mission to serve The Episcopal Church offers a level of expertise that is unparalleled. If you have questions about any of our Plans, please don't hesitate to contact us. We're looking forward to serving you.

For more information, please visit our website at *cpg.org* or call Client Services at 800-480-9967.

The Plan covers and pays for the benefits described in this Plan Document Handbook. Kaiser Permanente Insurance Company (KPIC) provides administrative services for the Plan but is not an insurer of the Plan or financially liable for Plan benefits. The Plans are self-insured. The Medical Trust offers both an EPO (Exclusive Provider Organization) and CDHP (Consumer Directed Health Plan) medical plan through Kaiser.

The Plan is an Exclusive Provider Organization (EPO) plan. Therefore, you must receive all Covered Services from Network Providers, except you can receive covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care from Non-Network Providers as described in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers" section.

When you enroll in the Plan, your care will be provided in one of the following Kaiser Permanente Regions: Northern and Southern California, Colorado, Georgia, Mid-Atlantic States, and Northwest Regions. Each Region has its own Service Area, but you can receive Covered Services in any Region's Service Area.

Benefits described in this Plan Document Handbook are effective as of January 1, 2024. Please note that capitalized terms used in this section but not defined here have the meanings ascribed to such terms in the body of the Plan Document Handbook below.

The Plan reserves the right to amend, reduce, suspend, or terminate any of the material terms of the plan or coverage. When required by law a Notice of Material Modifications will be sent to enrollees not later than 60 days prior to the date on which such modification will become effective.

Language Assistance

SPANISH (Español): Para obtener asistencia en Español, llame al 866-213-3062
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-213-3062
CHINESE (中文): 如果需要中文的帮助,请拨打这个号码 **866-213-3062**
NAVAJO (Diné): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-213-3062

Schedule of Benefits

This section summarizes Cost Sharing and benefit limits such as day limits, visit limits, and benefit maximums. It does not describe all the details of your benefits. To learn what is covered for each benefit (including exclusions and limitations), please refer to the identical heading in the "Benefits and Cost Sharing" section and to the "General Exclusions, General Limitations, Coordination of Benefits, and Reductions" section of this Plan Document Handbook.

The Episcopal Church Medical Trust

EPO 80 Plan National Benefit Summary

Effective Date: 01/01/2024

KP Use only: Plan IDs : ES8CD, ES8NW, ES8GA, ES8MA, ES8NC, ES8SC, ES8WA

This is a Benefit Summary for your Kaiser Permanente Deductible EPO Plan

OVERALL PLAN FEATURES

Plan Accumulation Type	**Calendar Year**
Plan Deductible Individual Family	 **$500** **$1,000**
Embedded Generally, the Member must pay all of the costs from providers up to the deductible amount before the plan begins to pay. If there are other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by the family members meets the overall family deductible.	
Plan Deductible Accumulates to Out-of-Pocket (OOP) Maximum	**Yes**
Deductible Carryover	**No**
Annual Out-of-Pocket Maximum Individual Family	 **$3,500** **$7,000**
Embedded The out-of-pocket limit is the most the Member could pay in a year for Covered Services. If the Member has other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.	
Out of Pocket Maximum Carry Over	**No**
Copays: One Copay per provider is charged per day.	
Visits: If multiple visits occur on the same day, each visit counts toward the applicable benefit limit.	

ROUTINE PREVENTIVE EXAMS AND SERVICES

See Preventive Exams and Services for a comprehensive list of Preventive Services. Preventive Lab and X-ray screenings not specifically listed within the Preventive Exams and Services section are treated the same as non-preventive Lab and X-ray Services. Frequency and Age Limits managed by Network Provider except where noted.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Wellness Exams – Adults (Including *Well Woman*)	$0	No	No
Wellness Exams – Children	$0	No	No
Preventive Screenings	$0	No	No
Immunizations (Preventive) Adults and Children	$0	No	No
Health Education and Self-Management Classes	$0	No	No

OUTPUTPATIENT SERVICES (Office or Outpatient Facility / Clinics, any Non-inpatient setting)

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
UV Light Treatment Medically Necessary Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if the equipment has been approved for you through the Plan's prior authorization process.			
UV Light Therapy (in the Office) Office Visit Cost Share may apply			
Primary Care	$25	No	Yes
Specialty Care	$35	No	Yes
UV Light Therapy Box (for Home Use)	20%	No	Yes
Vision Exam	Not Covered	N/A	N/A
NOTE: Medical care for eye illness or injury is covered under the medical benefit by provider specialty.			
Orthoptics Treatment/Therapy			
Specialty Care	$35	No	Yes

HOSPITAL / SURGERY SERVICES

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Inpatient Hospital Includes room and board for private and semi-private rooms, ICU/CCU, Inpatient Professional Services, Medically Necessary Ancillary Services, and Supplies.			
Per admission	20%	Yes	Yes
Ambulance			
Emergency Ground and Air Ambulance	20%	Yes	Yes
Scheduled Ground and Air Ambulance	20%	Yes	Yes
Non-Network or Network Hospital to Network Hospital	No charge	No	Yes
Emergency Services Accident and Illness	20%	Yes	Yes
Urgent and After Hours Care Urgent Care and After Hours settings	$50	No	Yes
Outpatient Surgery Performed in Outpatient Hospital or Ambulatory Surgery Center.	20%	Yes	Yes
Abortion Elective, Medically Necessary			
Outpatient Surgery	20%	Yes	Yes
Inpatient Hospital per admission	20%	Yes	Yes
Bariatric Surgery			
Outpatient Surgery	20%	Yes	Yes
Inpatient Hospital per admission	20%	Yes	Yes
Benefit Lifetime Maximum	Unlimited	N/A	N/A
Gender Affirming Surgery Covered upper and lower body gender confirming surgeries			
Outpatient Surgery	20%	Yes	Yes
Inpatient Hospital per admission	20%	Yes	Yes
Temporomandibular Surgery (TMD/TMJ)			
Outpatient Surgery	20%	Yes	Yes
Inpatient Hospital per admission	20%	Yes	Yes

MATERNITY Includes most Routine Pre-Natal and Post-Partum care. Delivery charges and Non-routine Maternity Care and Routine Care not included under Preventive Care would be covered at the appropriate Cost Share.			
Benefit Type	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
Routine Pre-Natal and Post-Partum Care Pre-natal and post-partum visits	$0	No	No
Hospital Inpatient Includes contracted Birthing Center if available. Per admission (facility) Includes Well Baby facility fees when billed with mother.	20%	Yes	Yes
Well Newborn	20%	Yes	Yes

DIAGNOSTIC TESTS & PROCEDURES Includes Preventive Lab and X-ray screenings not specifically listed under Preventive Screenings: These Services are treated the same as Lab and X-ray Services in this section.			
Benefit Type	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
Diagnostic Lab & X-ray	20%	Yes	Yes
High Tech/Advanced Radiology – CT, MRI, Nuclear Medicine, and PET	20%	Yes	Yes

FERTILITY SERVICES Services for Fertility include those related to or part of Artificial Insemination, Surgery, ZIFT/IVF, and Fertility Drugs. Services to rule out the underlying medical causes of infertility and Iatrogenic fertility preservation are part of the medical benefit. Fertility drugs – see Pharmacy section			
Benefit Type	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
Hospital Charges Per admission	20%	Yes	Yes
Office Visit	$35	No	Yes
Diagnostic Lab & X-ray	20%	Yes	Yes
Outpatient Hospital or Ambulatory Surgery Center	20%	Yes	Yes
Artificial Insemination	20%	Yes	Yes
Assisted Reproductive Technology: IVF/ZIFT	20%	Yes	Yes
Fertility Preservation Elective for medical and non-medical reasons or Iatrogenic and short-term cryopreservation storage of eggs and sperm retrieved.	20%	Yes	Yes
Benefit Lifetime Maximum Medical – All Fertility Services and shared with Outpatient Prescription Drug Service	$50,000	N/A	N/A

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES			
Benefit Type	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
Mental Health – Inpatient (Including Residential treatment Services) Per admission	20%	Yes	Yes
Partial Hospitalization Per day	20%	Yes	Yes
Mental Health – Intensive Outpatient, per day Includes all Services provided during the day.	$25	No	Yes
Mental Health – Outpatient/Office Individual Visit Cost Share	$25	No	Yes
Group Visit Cost Share	$12	No	Yes
Substance Use Disorder Services – Inpatient (Including Residential treatment Services) Detox covered under medical benefits. Per admission	20%	Yes	Yes

Substance Use Disorder Services – Partial Hospitalization Per day	20%	Yes	Yes
Substance Use Disorder Services – Intensive Outpatient, per day Includes all Services provided during the day.	$25	No	Yes
Substance Use Disorder Services – Outpatient/Office Individual Visit Cost Share Group Visit Cost Share	 $25 $12	 No No	 Yes Yes

PHYSICAL, OCCUPATIONAL & SPEECH THERAPIES

Outpatient Cost Share for Rehabilitative and Habilitative therapies is applied as one Copay per provider per day. Visits are counted on a "per visit" basis.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Physical Therapy Primary Care Visit Maximum	 $25 60 visits per calendar year (not combined)	 No N/A	 Yes N/A
Occupational Therapy Primary Care Visit Maximum	 $25 60 visits per calendar year (not combined)	 No N/A	 Yes N/A
Speech Therapy Primary Care Visit Maximum	 $25 60 visits per calendar year (not combined)	 No N/A	 Yes N/A

SKILLED CARE

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Home Health Care Nurse visits (2 hrs), Aide visits (4 hours), therapy visits, supplies associated with a visit	$0	No	Yes
Visit Maximum Private Duty Nursing (4 hours = 1 visit) to the 210 visit per calendar year maximum. 16 hour maximum per day.	210 visits per calendar year	N/A	N/A
Hospice Respite Care for Home Hospice Respite Care Maximum	 $0 Up to five consecutive days for each approved admission	 No N/A	 Yes N/A
Skilled Nursing Facility Per day Day Maximum	 20% 60 days per calendar year combined with acute rehab, rehabilitation hospital and sub-acute facility	 Yes N/A	 Yes N/A

OTHER Services

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Acupuncture Self referred Primary Care Visit Maximum	 $25 20 visits per calendar year Unlimited visits for Smoking Cessation	 No N/A	 Yes N/A
Chiropractic Care Self referred			

Primary Care Visit Maximum	$25 20 visits per calendar year	No N/A	Yes N/A
Accidental Injury to Teeth Repair of sound and natural teeth directly related to an accidental injury. Outpatient Surgery Inpatient Hospital per day Benefit Maximum Time limit on benefit	 20% 20% Unlimited Treatment must be started within 12 months of the date of injury	 Yes Yes N/A N/A	 Yes Yes N/A N/A
Autism A diagnosis of ASD is required for benefits to apply Applied Behavioral Analysis Primary Care Age Limit	 $25 Up to age 19	 No N/A	 Yes N/A
Physical/Occupational/Speech Therapy Primary Care Age Limit Visit maximum	 $25 Up to age 19 Unlimited	 No N/A	 Yes N/A
Durable Medical Equipment Including certain diabetic testing supplies and equipment	20%	No	Yes
Glucometers, Peak Flow Meters	$0	No	No
Prosthetics and Orthotics Includes Medically Necessary eyewear for diagnoses of aniridia and aphakia; colostomy/ostomy and urological supplies.	20%	No	Yes
Prosthetics – Wigs and Toupees To replace hair lost due to cancer or anemia, up to a maximum of $700 per calendar year	$0	No	Yes
Hearing Aids Includes tests to determine appropriate model, fitting, counseling, adjustment, cleaning, and inspection after warranty is exhausted. Flat Allowance Allowance frequency	 $3,000 every 36 months	 N/A N/A	 N/A N/A
Medical Foods Amino acid–modified products	$0	No	Yes
Vision Hardware – Contact Lenses **Vision Hardware –** Frames and Eyeglass Lens	Not Covered Not Covered	N/A N/A	N/A N/A

OUTPATIENT PRESCRIPTION DRUGS Obtained from Network Pharmacies and on the KP formulary (list of approved drugs), unless otherwise specified. Note: Member will pay their copay or the full cost of the medication, whichever is less.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to Plan OOP
4 Tier – Generic			
California	$5 up to 30 days supply, $10 31–60 days supply, $15 61–100 days supply	No	Yes
Regions Outside California	$5 up to 30 days supply, $10 31–60 days supply, $15 61–90 days supply	No	Yes
Community/Network pharmacy (GA first fill only and MAS)	$5 up to 30 days supply, $10 31–60 days supply, $15 61–90 days supply	No	Yes
Brand			
California	$30 up to 30 days supply, $60 31–60 days supply, $90 61–100 days supply	No	Yes

Regions Outside California	$30 up to 30 days supply, $60 31–60 days supply, $90 61–90 days supply	No	Yes
Community/Network pharmacy (GA first fill only and MAS)	$30 up to 30 days supply, $60 31–60 days supply, $90 61–90 days supply	No	Yes
Non-Formulary Brand			
California	$70 up to 30 days supply, $140 31–60 days supply, $210 61–100 days supply	No	Yes
Regions Outside California	$70 up to 30 days supply, $140 31–60 days supply, $210 61–90 days supply	No	Yes
Community/Network pharmacy (GA first fill only and MAS)	$70 up to 30 days supply, $140 31–60 days supply, $210 61–90 days supply	No	Yes
Specialty Tier			
California	$90 up to 30 days supply	No	Yes
Regions Outside California	$90 up to 30 days supply	No	Yes
Community/Network pharmacy (GA first fill only and MAS)	$90 up to 30 days supply	No	Yes
Note: Certain medications may be limited to 30-day supply.			

Mail Order Drugs *4 Tier Mail Order – Generic*			
California	$5 up to 30 days supply and $10 from 31 up to 100 days supply	No	Yes
Regions Outside California	$5 up to 30 days supply and $10 from 31 up to 90 days supply	No	Yes
Brand			
California	$30 up to 30 days supply and $60 from 31 up to 100 days supply	No	Yes
Regions Outside California	$30 up to 30 days supply and $60 from 31 up to 90 days supply	No	Yes
Non-Formulary Brand			
California	$70 up to 30 days supply and $140 from 31 up to 100 days supply	No	Yes
Regions Outside California	$70 up to 30 days supply and $140 from 31 up to 90 days supply	No	Yes
Specialty Tier Mail Order			
California	$180 up to 100 days supply	No	Yes
Regions Outside California	$90 up to 30 days supply and $180 from 31 up to 90 days supply	No	Yes
Note: Certain medications (other than Specialty) may be limited to 30-day supply. Not all medications are available via Mail Order.			
Blood Factors	$0	No	Yes
Diabetic Coverage Some diabetic supplies may be covered under Durable Medical Equipment.			
Oral medications and Insulin	=Generic/Brand Cost Share	No	Yes
Diabetic testing supplies (meters, test strips)	=Generic/Brand Cost Share	No	Yes
Diabetic administration devices (syringes)	=Generic/Brand Cost Share	No	Yes
Fertility Drug Coverage	=Generic/Brand Cost Share	No	Yes
Fertility Preservation drugs	=Generic/Brand Cost Share	No	Yes
Lifetime Maximum Shared with Fertility Medical Service	$50,000	N/A	N/A
Growth Hormone	=Generic/Brand Cost Share	No	Yes
Sexual Dysfunction	=Generic/Brand Cost Share	No	Yes
Quantity limits apply	N/A	N/A	N/A
Weight Loss	=Generic/Brand Cost Share	No	Yes
Supplemental Preventive Drugs Includes formulary drugs for asthma, cholesterol, diabetes, hypertension, osteoporosis, and stroke.	=Generic/Brand Cost Share	No	Yes
ACA Mandated Drugs* (see Preventive Services for more information)			
Contraceptive Devices (diaphragms, cervical caps, etc.) **and Contraceptive Drugs**	$0	No	No
Emergency Contraception	$0	No	No
Preventive Breast Cancer Drugs	$0	No	No
Smoking Cessation	$0	No	No
Statins (Cholesterol Lowering Agents)	$0	No	No
PrEP for HIV Prevention	$0	No	No

Preventive Over the Counter Products Preventive Over the Counter products are covered at a network pharmacy when prescribed by your provider for certain conditions.			
Aspirin	$0	No	No
Oral Fluoride	$0	No	No
Folic Acid	$0	No	No
Iron Supplements	$0	No	No
Female Contraceptives (spermicides, male and female condoms, emergency contraceptives, and sponges)	$0	No	No
Bowel Prep	$0	No	No
COVID-19 Test Kits Limited to 4 test kits per month per member	$0	No	No

* With prescription, no Cost Share. Without prescription, Member pays retail cost.

Refer to the Outpatient Prescription Drug section later in this document for coupon information.

For items or injections dispensed by Pharmacy and requiring skilled administration in the Physician's Office (Implantable contraceptives, administered meds, etc.). Office Visit Cost Share for administration may apply.

Travel and Lodging

For reasonable transportation and lodging that is primarily for and essential to receipt of an Organ Transplant or Gender Affirming Surgery where (1) the covered individual is unable to locate a Network provider in the State where the covered individual resides and (2) the covered individual must travel more than 50 miles to receive the Covered Service.

Kaiser coordinated travel for Organ Transplants and Gender Affirming Surgery Only Organ Transplants include recipient, caregiver and donor. Gender Affirming Surgery includes patient and companion			
Transportation Limits Includes round trip transportation and lodging for the patient and one adult companion • Travel in a personal car, at the current IRS standard milage rate • Economy class air or train fare • Public transportation, taxis, Lyft, Uber, or similar services (Limos, luxury or upgraded vehicles will not be reimbursed) • Parking and tolls	Unlimited	N/A	N/A
Lodging Limits Hotel or similar accommodations if an overnight stay is required prior to or following a covered procedure. Reimbursement is limited to the charge for a single (double occupancy) room, including taxes, not to exceed $50/night, per person up to 2 people for 1 or 2 nights as required, unless a longer stay was recommended by a physician. (Hotel movies, entertainment, meals, and other services will not be reimbursed.)	$50 per night, $100 per night if accompanied by a companion	N/A	N/A
Daily Expense Includes incidental expenses such as meals and other personal expenses	Not covered	N/A	N/A
Benefit Lifetime Maximum for Travel and Lodging related to Organ Transplants	$10,000	N/A	N/A
Benefit Lifetime Maximum for Travel and Lodging related to Gender Affirming Surgery	$10,000	N/A	N/A

Reimbursement for reasonable transportation and lodging expenses actually incurred by you and a companion in the course of obtaining the covered service. Services must be received at the most reasonable provider for the service provided.

The Episcopal Church Medical Trust

High Option EPO Plan National Benefit Summary

KP Use only: Plan IDs : ESCDH, ESNWH, ESGAH, ESMAH, ESNCH, ESSCH, ESWAH

Effective Date: 01/01/2024

This is a Benefit Summary for your Kaiser Permanente High Option EPO Plan

OVERALL PLAN FEATURES

Plan Accumulation Type	**Calendar Year**
Annual Out-of-Pocket Maximum Individual Family	 **$1,750** **$3,500**
Embedded The out-of-pocket limit is the most the Member could pay in a year for Covered Services. If the Member has other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.	
Out of Pocket Maximum Carry Over:	**No**
Copays: One Copay per provider is charged per day.	
Visits: If multiple visits occur on the same day, each visit counts toward the applicable benefit limit.	

ROUTINE PREVENTIVE EXAMS AND SERVICES

See Preventive Exams and Services for a comprehensive list of Preventive Services. Preventive Lab and X-ray screenings not specifically listed within the Preventive Exams and Services section are treated the same as non-preventive Lab and X-ray Services. Frequency and Age Limits managed by Network Provider except where noted.

Benefit Type	You Pay and/or Maximums	Applies to OOP
Wellness Exams – Adults (Including *Well Woman*)	$0	No
Wellness Exams – Children	$0	No
Preventive Screenings	$0	No
Immunizations (Preventive) Adults and Children	$0	No
Health Education and Self Management Classes	$0	No

OUTPATIENT SERVICES (Office or Outpatient Facility / Clinics, any Non-inpatient setting)

Primary Care Cost Share will be charged for Family Practice, General Internal Medicine, and General Pediatrics specialties. Specialty Care Cost Share will be charged for visits with all other medical specialties, except Mental Health providers are considered to be Primary Care providers for the purposes of determining Member Cost Share. **Note: Nurse Practitioner and Physician Assistant may be treated as primary or specialty based on their supervising physician status.**

Benefit Type	You Pay and/or Maximums	Applies to OOP
Office Visits Including House Calls	$25	Yes
Referred Hospital Clinic Visits Facility Clinic Charges	$25 $50	Yes Yes
Telemedicine Telephone, Video, or Chat/Online Communications	$0	Yes
Allergy Office Visit Cost Share may apply Injection Testing Serum only	 $25 $25 $0	 Yes Yes Yes
Biofeedback Services Medical and Mental Health Services	Not Covered	N/A
Cardiac Rehab	$25	Yes
Chemotherapy Services	$0	Yes
Dialysis Services **Home Dialysis**	$25 $0	Yes Yes
Hearing Exam Audiometry exam	$25	Yes
Infusion Services Requires skilled or medical administration. Office Cost Share may apply. Infusion **Home Infusion** Infusion materials, drugs, and supplies	 $25 $0	 Yes Yes

Injections and Immunizations Non-routine. Office Visit Cost Share may apply. Injection	$25	Yes
Travel Immunizations Office Visit Cost Share may apply Injection	$25	Yes
Male Sterilization Outpatient Surgery	$100	Yes
Nutrition Visits Visit Limits	$25 Up to six visits per year Unlimited visits with diagnosis of diabetes.	Yes N/A
Radiation Therapy	$25	Yes
Respiratory Therapy	$25	Yes
Pulmonary Therapy	$25	Yes
UV Light Treatment Medically Necessary Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if the equipment has been approved for you through the Plan's prior authorization process. UV Light Therapy (in the Office) Office Visit Cost Share may apply. UV Light Therapy Box (for Home Use)	**$25** **$0**	Yes Yes
Vision Exam	Not Covered	NA
NOTE: Medical care for eye illness or injury is covered under the medical benefit by provider specialty.		
Orthoptics Treatment/Therapy	$25	Yes

HOSPITAL / SURGERY SERVICES

Benefit Type	You Pay and/or Maximums	Applies to OOP
Inpatient Hospital Includes room and board for private and semi-private rooms, ICU/CCU, Inpatient Professional Services, Medically Necessary Ancillary Services, and Supplies. Per day up to a maximum of $600	$100	Yes
Ambulance Emergency Ground and Air Ambulance Scheduled Ground and Air Ambulance Non-Network or Network Hospital to Network Hospital	$0 $0 No charge	Yes Yes Yes
Emergency Services Accident and Illness Copay waived if admitted	$100 Yes	Yes N/A
Urgent and After Hours Care Urgent Care and After Hours settings	$50	Yes
Outpatient Surgery Performed in Outpatient Hospital or Ambulatory Surgery Center	$100	Yes
Abortion Elective, Medically Necessary Outpatient Surgery Inpatient Hospital per day up to a maximum of $600	$100 $100	Yes Yes
Bariatric Surgery Outpatient Surgery Inpatient Hospital per day up to a maximum of $600 Benefit Lifetime Maximum	$100 $100 Unlimited	Yes Yes N/A
Gender Affirming Surgery Covered upper and lower body gender confirming surgeries Outpatient Surgery Inpatient Hospital per day up to a maximum of $600	$100 $100	Yes Yes
Temporomandibular Surgery (TMD/TMJ) Outpatient Surgery Inpatient Hospital per day up to a maximum of $600	$100 $100	Yes Yes

MATERNITY Includes most Routine Pre-Natal and Post-Partum care. Delivery charges and Non-routine Maternity Care and Routine Care not included under Preventive Care would be covered at the appropriate Cost Share.		
Benefit Type	**You Pay and/or Maximums**	**Applies to OOP**
Routine Pre-Natal and Post-Partum Care Pre-natal and post-partum visits	$0	No
Hospital Inpatient Includes contracted Birthing Center if available. Per day Cost Share up to a maximum of $600 Well Newborn	$100 $100	Yes Yes
DIAGNOSTIC TESTS & PROCEDURES Includes Preventive Lab and X-ray screenings not specifically listed under Preventive Screenings. These Services are treated the same as Lab and X-ray Services in this section.		
Benefit Type	**You Pay and/or Maximums**	**Applies to OOP**
Diagnostic Lab & X-ray **High Tech/Advanced Radiology – CT, MRI, Nuclear Medicine and PET**	$50 $50	Yes Yes
FERTILITY SERVICES Services for Fertility include those related to or part of Artificial Insemination, Surgery, ZIFT/IVF and Fertility Drugs. Services to rule out the underlying medical causes of infertility and Iatrogenic fertility preservation are part of the medical benefit. Fertility drugs – see Pharmacy section		
Benefit Type	**You Pay and/or Maximums**	**Applies to OOP**
Hospital Charges Per day Cost Share up to a maximum of $600	$100	Yes
Office Visit **Diagnostic Lab & X-ray** **Outpatient Hospital or Ambulatory Surgery Center**	$25 $50 $100	Yes Yes Yes
Artificial Insemination	Cost Share same as other Services	Yes
Assisted Reproductive Technology: IVF/ZIFT **Fertility Preservation** Elective for medical and non-medical reasons or Iatrogenic and short-term cryopreservation storage of eggs and sperm retrieved.	Cost Share same as other Services $50	Yes Yes
Benefit Lifetime Maximum Medical – All Fertility Services and shared with Outpatient Prescription Drug Services	$50,000	N/A
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Benefit Type	**You Pay and/or Maximums**	**Applies to OOP**
Mental Health – Inpatient (Including Residential treatment Services) Per day Cost Share up to a maximum of $600	$100	Yes
Partial Hospitalization Per day	$25	Yes
Mental Health – Intensive Outpatient, per day Includes all Services provided during the day.	$25	Yes
Mental Health – Outpatient/Office Individual Visit Cost Share Group Visit Cost Share	$25 $12	Yes Yes
Substance Use Disorder Services – Inpatient (Including Residential treatment Services) Detox covered under medical benefits. Per day Cost Share up to a maximum of $600	$100	Yes
Substance Use Disorder Services – Partial Hospitalization Per day	$25	Yes

Substance Use Disorder Services – Intensive Outpatient, per day Includes all Services provided during the day.	$25	Yes
Substance Use Disorder Services – Outpatient/Office		
Individual Visit Cost Share	$25	Yes
Group Visit Cost Share	$12	Yes

PHYSICAL, OCCUPATIONAL & SPEECH THERAPIES

Outpatient Cost Share for Rehabilitative and Habilitative therapies is applied as one Copay per provider per day. Visits are counted on a 'per visit' basis.

Benefit Type	You Pay and/or Maximums	Applies to OOP
Physical Therapy	$25	Yes
Visit Maximum	60 visits per calendar year (not combined)	N/A
Occupational Therapy	$25	Yes
Visit Maximum	60 visits per calendar year (not combined)	N/A
Speech Therapy	$25	Yes
Visit Maximum	60 visits per calendar year (not combined)	N/A

SKILLED CARE

Benefit Type	You Pay and/or Maximums	Applies to OOP
Home Health Care Nurse visits (2 hrs), Aide visits (4 hours), therapy visits, supplies associated with a visit	$0	Yes
Visit Maximum Private Duty Nursing (4 hours = 1 visit) to the 210 visit per calendar year maximum. 16 hour maximum per day.	210 visits per calendar year	N/A
Hospice	$0	Yes
Respite Care for Home Hospice	$0	Yes
Respite Care Maximum	Up to five consecutive days for each approved admission	N/A
Skilled Nursing Facility		
Per admission	$0	Yes
Day Maximum	60 days per calendar year combined with acute rehab, rehabilitation hospital and sub-acute facility	N/A

OTHER Services

Benefit Type	You Pay and/or Maximums	Applies to OOP
Acupuncture Self referred	$25	Yes
Visit Maximum	20 visits per calendar year Unlimited visits for Smoking Cessation	N/A
Chiropractic Care Self referred	$25	Yes
Visit Maximum	20 visits per calendar year	N/A
Accidental Injury to Teeth Repair of sound and natural teeth directly related to an accidental injury.		
Outpatient Surgery	$100	Yes
Inpatient Hospital Per day Cost Share up to a maximum of $600	$100	Yes
Benefit Maximum	Unlimited	N/A
Time limit on benefit	Treatment must be started within 12 months of the date of injury	N/A
Autism A diagnosis of ASD is required for benefits to apply.		
Applied Behavioral Analysis	$25	Yes
Age Limit	Up to age 19	N/A
Physical/Occupational/Speech Therapy	$25	Yes
Age Limit	Up to age 19	N/A

Visit maximum	Unlimited	N/A
Durable Medical Equipment Including certain diabetic testing supplies and equipment Glucometers, Peak Flow Meters **Prosthetics and Orthotics** Includes Medically Necessary eyewear for diagnoses of aniridia and aphakia; colostomy/ostomy and urological supplies.	$0 $0 $0	Yes No Yes
Prosthetics – Wigs and Toupees To replace hair lost due to cancer or anemia, up to a maximum of $700 per calendar year.	$0	Yes
Hearing Aids Includes tests to determine appropriate model, fitting, counseling, adjustment, cleaning and inspection after warranty is exhausted. Flat Allowance Allowance frequency	 $3,000 every 36 months	 N/A N/A
Medical Foods Amino acid modified products	$0	Yes
Vision Hardware – Contact Lenses **Vision Hardware – Frames and Eyeglass Lenses**	Not Covered Not Covered	N/A N/A

OUTPATIENT PRESCRIPTION DRUGS Obtained from Network Pharmacies and on the KP formulary (list of approved drugs), unless otherwise specified**.** Note: Member will pay their copay or the full cost of the medication, whichever is less.

Benefit Type	You Pay and/or Maximums	Applies to Plan OOP
4 Tier – Generic		
California	$5 up to 30 days supply, $10 31–60 days supply, $15 61–100 days supply	Yes
Regions Outside California	$5 up to 30 days supply, $10 31–60 days supply, $15 61–90 days supply	Yes
Community/Network pharmacy (GA first fill and MAS)	$5 up to 30 days supply, $10 31–60 days supply, $15 61–90 days supply	Yes
Brand		
California	$30 up to 30 days supply, $60 31–60 days supply, $90 61–100 days supply	Yes
Regions Outside California	$30 up to 30 days supply, $60 31–60 days supply, $90 61–90 days supply	Yes
Community/Network pharmacy (GA first fill and MAS)	$30 up to 30 days supply, $60 31–60 days supply, $90 61–90 days supply	Yes
Non-Formulary Brand		
California	$70 up to 30 days supply, $140 31–60 days supply, $210 61–100 days supply	Yes
Regions Outside California	$70 up to 30 days supply, $140 31–60 days supply, $210 61–90 days supply	Yes
Community/Network pharmacy (GA first fill only and MAS)	$70 up to 30 days supply,	Yes

	$140 31–60 days supply, $210 61–90 days supply	
Specialty Tier		
California	$90 up to 30 days supply	Yes
Regions Outside California	$90 up to 30 days supply	Yes
Community/Network pharmacy (GA first fill only and MAS)	$90 up to 30 days supply	Yes
Note: Certain medications may be limited to 30-day supply.		
Mail Order Drugs – *4 Tier Mail Order*		
Generic		
California	$5 up to 30 days supply and $10 from 31 up to 100 days supply	Yes
Regions Outside California	$5 up to 30 days supply and $10 from 31 up to 90 days supply	Yes
Brand		
California	$30 up to 30 days supply and $60 from 31 up to 100 days supply	Yes
Regions Outside California	$30 up to 30 days supply and $60 from 31 up to 90 days supply	Yes
Non-Formulary Brand		
California	$70 up to 30 days supply and $140 from 31 up to 100 days supply	Yes
Regions Outside California	$70 up to 30 days supply and $140 from 31 up to 90 days supply	Yes
Specialty Tier Mail Order		Yes
California	$180 up to 100 days supply	Yes
Regions Outside California	$90 up to 30 days supply and $180 from 31 up to 90 days supply	Yes
Note: Certain medications may be limited to 30-day supply. Not all medications are available via Mail Order.		
Blood Factors	$0	Yes
Diabetic Coverage Some diabetic supplies may be covered under Durable Medical Equipment.		
Oral medications and Insulin	=Generic/Brand Cost Share	Yes
Diabetic testing supplies (meters, test strips)	=Generic/Brand Cost Share	Yes
Diabetic administration devices (syringes)	=Generic/Brand Cost Share	Yes
Fertility Drug Coverage	=Generic/Brand Cost Share	Yes
Fertility Preservation drugs	=Generic/Brand Cost Share	Yes
Lifetime Maximum shared with Fertility Medical Services	$50,000	Yes
Growth Hormone	=Generic/Brand Cost Share	Yes
Sexual Dysfunction	=Generic/Brand Cost Share	Yes
Quantity limits apply	N/A	N/A
Weight Loss	=Generic/Brand Cost Share	Yes
Supplemental Preventive Drugs Includes formulary drugs for asthma, cholesterol, diabetes, hypertension, osteoporosis, and stroke.	=Generic/Brand Cost Share	Yes

ACA Mandated Drugs* (see Preventive Services for more information)		
Contraceptive Devices (diaphragms, cervical caps, etc.) **and Contraceptive Drugs**	$0	No
Emergency Contraception	$0	No
Preventive Breast Cancer Drugs	$0	No
Smoking Cessation	$0	No
Statins (Cholesterol Lowering Agents)	$0	No
PrEP for HIV Prevention	$0	No
Preventive Over-the-Counter Products Preventive Over-the-Counter products are covered at a network pharmacy when prescribed by your provider for certain conditions.		
Aspirin	$0	No
Oral Fluoride	$0	No
Folic Acid	$0	No
Iron Supplements	$0	No
Female Contraceptives (spermicides, male and female condoms, emergency contraceptives, and sponges)	$0	No
Bowel Prep	$0	No
COVID-19 Test Kits Limited to 4 test kits per month per member	$0	No
* With prescription, no Cost Share. Without prescription, Member pays retail cost.		
Refer to the Outpatient Prescription Drug section later in this document for coupon information.		
For items or injections dispensed by Pharmacy and requiring skilled administration in the Physician's Office (Implantable contraceptives, administered meds, etc.) Office Visit Cost Share for administration may apply.		

TRAVEL AND LODGING For reasonable transportation and lodging that is primarily for and essential to receipt of an Organ Transplant or Gender Affirming Surgery where (1) the covered individual is unable to locate a Network provider in the State where the covered individual resides and (2) the covered individual must travel more than 50 miles to receive the Covered Service.		
Kaiser coordinated travel for Organ Transplants and Gender Affirming Surgery Only Organ Transplants include recipient, caregiver and donor. Gender Affirming Surgery includes patient and companion		
Transportation Limits Includes round trip transportation and lodging for the patient and one adult companion • Travel in a personal car, at the current IRS standard milage rate • Economy class air or train fare • Public transportation, taxis, Lyft, Uber, or similar services (Limos, luxury or upgraded vehicles will not be reimbursed) • Parking and tolls	Unlimited	N/A
Lodging Limits Hotel or similar accommodations if an overnight stay is required prior to or following a covered procedure. Reimbursement is limited to the charge for a single (double occupancy) room, including taxes, not to exceed $50/night, per person up to 2 people for 1 or 2 nights as required, unless a longer stay was recommended by a physician. (Hotel movies, entertainment, meals, and other services will not be reimbursed.)	$50 per night, $100 per night if accompanied by a companion	N/A
Daily Expense Includes incidental expenses such as meals and other personal expenses.	Not covered	N/A
Benefit Lifetime Maximum for Travel and Lodging related to Organ Transplants	$10,000	N/A
Benefit Lifetime Maximum for Travel and Lodging related to Gender Affirming Surgery	$10,000	N/A
Reimbursement for reasonable transportation and lodging expenses actually incurred by you and a companion in the course of obtaining the covered service. Services must be received at the most reasonable provider for the service provided.		

The Episcopal Church Medical Trust

CDHP/HSA Plan National Benefit Summary

KP Use only: Plan IDs: H0145, H0148, H0149, H0150, H0151, H0152, H0247

Effective Date: 01/01/2024

This is a Benefit Summary for your Kaiser Permanente CDHP/HSA Plan

OVERALL PLAN FEATURES

Plan Accumulation Type	**Calendar Year**
Plan Deductible Individual Family	 **$3,200** **$5,450**
Embedded Generally, the Member must pay all of the costs from providers up to the deductible amount before the plan begins to pay. If there are other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by the family members meets the overall family deductible.	
Plan Deductible Accumulates to Out-of-Pocket (OOP) Maximum	**Yes**
Deductible Carryover	**No**
Annual Out-of-Pocket Maximum Individual Family	 **$4,200** **$8,450**
Embedded The out-of-pocket limit is the most the Member could pay in a year for Covered Services. If the Member has other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.	
Out of Pocket Maximum Carry Over	**No**
Copays: One Copay per provider is charged per day.	
Visits: If multiple visits occur on the same day, each visit counts toward the applicable benefit limit.	

ROUTINE PREVENTIVE EXAMS AND SERVICES

See Preventive Exams and Services for a comprehensive list of Preventive Services. Preventive Lab and X-ray screenings not specifically listed within the Preventive Exams and Services section are treated the same as non-preventive Lab and X-ray Services. Frequency and Age Limits managed by Network Provider except where noted.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Wellness Exams – Adults (Including *Well Woman*)	$0	No	No
Wellness Exams – Children	$0	No	No
Preventive Screenings	$0	No	No
Immunizations (Preventive) Adults and Children	$0	No	No
Health Education and Self-Management Classes	$0	No	No

OUTPATIENT SERVICES (Office or Outpatient Facility / Clinics, any Non-inpatient setting)

Primary Care Cost Share will be charged for Family Practice, General Internal Medicine and General Pediatrics specialties. Specialty Care Cost Share will be charged for visits with all other medical specialties, except Mental Health providers are considered to be Primary Care providers for the purposes of determining Member Cost Share. **Note: Nurse Practitioner and Physician Assistant may be treated as primary or specialty based on their supervising physician status.**

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Office Visits Including House Calls	20%	Yes	Yes
Referred Hospital Clinic Visits			
Provider	20%	Yes	Yes
Facility Clinic Charges	20%	Yes	Yes
Telemedicine Telephone, Video, or Chat / Online Communications	$0	No	Yes
Allergy Office Visit Cost Share may apply			
Injection	20%	Yes	Yes

Testing Serum only	20% $0	Yes Yes	Yes Yes
Biofeedback Services Medical and Mental Health Services	Not Covered	N/A	N/A
Cardiac Rehab	20%	Yes	Yes
Chemotherapy Services	20%	Yes	Yes
Dialysis Services **Home Dialysis**	20% $0	Yes Yes	Yes Yes
Hearing Exam Audiometry exam	20%	Yes	Yes
Infusion Services Requires skilled or medical administration. Office Visit Cost Share may apply. Infusion only **Home Infusion** Infusion materials, drugs, and supplies	 20% $0	 Yes Yes	 Yes Yes
Injections and Immunizations Non-routine. Office visits Cost Share may apply Injection	 20%	 Yes	 Yes
Travel Immunizations Office Visit Cost Share may apply Injection	 20%	 Yes	 Yes
Male Sterilization Outpatient Surgery	 20%	 Yes	 Yes
Nutrition Visits Visit Limits	20% Up to six visits per year Unlimited visits with diagnosis of diabetes.	Yes NA	Yes NA
Radiation Therapy	20%	Yes	Yes
Respiratory Therapy	20%	Yes	Yes
Pulmonary Therapy	20%	Yes	Yes
UV Light Treatment Medically Necessary Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if the equipment has been approved for you through the Plan's prior authorization process. UV Light Therapy (in the Office) Office Visit Cost Share may apply) UV Light Therapy Box (for Home Use)	 **20%** **20%**	 **Yes** **Yes**	 **Yes** **Yes**
Vision Exam	Not Covered	NA	NA
NOTE: Medical care for eye illness or injury is covered under the medical benefit by provider specialty.			
Orthoptics Treatment/Therapy	20%	Yes	Yes

HOSPITAL / SURGERY SERVICES

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Inpatient Hospital Includes room and board for private and semi-private rooms, ICU/CCU, Inpatient Professional Services, Medically Necessary Ancillary Services, and Supplies. Per admission	 20%	 Yes	 Yes
Ambulance Emergency Ground and Air Ambulance Scheduled Ground and Air Ambulance Non-Network or Network Hospital to Network Hospital	 20% 20% No charge	 Yes Yes No	 Yes Yes Yes
Benefit Type	**You Pay and/or Maximums**	**Subject to Deductible**	**Applies to OOP**
Emergency Services Accident and Illness	20%	Yes	Yes
Urgent and After Hours Care Urgent Care and After Hours settings	20%	Yes	Yes
Outpatient Surgery Performed in Outpatient Hospital or Ambulatory Surgery Center.	20%	Yes	Yes

Abortion Elective, Medically Necessary			
Outpatient Surgery	20%	Yes	Yes
Inpatient Hospital per admission	20%	Yes	Yes
Bariatric Surgery			
Outpatient Surgery	20%	Yes	Yes
Inpatient Hospital per admission	20%	Yes	Yes
Benefit Lifetime Maximum	Unlimited	N/A	N/A
Gender Affirming Surgery Covered upper and lower body gender confirming surgeries			
Outpatient Surgery	20%	Yes	Yes
Inpatient Hospital per admission	20%	Yes	Yes
Temporomandibular Surgery (TMD/TMJ)			
Outpatient Surgery	20%	Yes	Yes
Inpatient Hospital per admission	20%	Yes	Yes

MATERNITY

Includes most Routine Pre-Natal and Post-Partum care. Delivery charges and Non-routine Maternity Care and Routine Care not included under Preventive Care would be covered at the appropriate Cost Share.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Routine Pre-Natal and Post-Partum Care			
Pre-natal and post-partum visits	$0	No	No
Hospital Inpatient Includes contracted Birthing Center if available.			
Per admission (facility). Includes Well Baby facility fees when billed with mother.	20%	Yes	Yes
Well Newborn	20%	Yes	Yes

DIAGNOSTIC TESTS & PROCEDURES

Includes Preventive Lab and X-ray screenings not specifically listed under Preventive Screenings. These Services are treated the same as Lab and X-ray Services in this section.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Diagnostic Lab & X-ray	20%	Yes	Yes
High Tech/Advanced Radiology – CT, MRI, Nuclear Medicine and PET	20%	Yes	Yes

FERTILITY SERVICES

Services for Fertility include those related to or part of Artificial Insemination, Surgery, ZIFT/IVF and Fertility Drugs. Services to rule out the underlying medical causes of infertility and Iatrogenic fertility preservation are part of the medical benefit. Fertility drugs – see Pharmacy section.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Hospital Charges			
Per admission	20%	Yes	Yes
Office Visit	20%	Yes	Yes
Diagnostic Lab & X-ray	20%	Yes	Yes
Outpatient Hospital or Ambulatory Surgery Center	20%	Yes	Yes
Artificial Insemination	20%	Yes	Yes
Assisted Reproductive Technology: IVF/ZIFT	20%	Yes	Yes
Fertility Preservation Elective for medical and non-medical reasons or Iatrogenic and short term cryopreservation storage of eggs and sperm retrieved.	20%	Yes	Yes
Benefit Lifetime Maximum Medical – All Fertility Services and shared with Outpatient Prescription Drug Services	$50,000	N/A	N/A

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Mental Health – Inpatient (Including Residential treatment Services) Per admission	20%	Yes	Yes
Partial Hospitalization Per day	20%	Yes	Yes
Mental Health – Intensive Outpatient Per day	20%	Yes	Yes
Mental Health – Outpatient/Office Individual Visit Cost Share Group Visit Cost Share	 20% 20%	 Yes Yes	 Yes Yes
Substance Use Disorder Services – Inpatient (Including Residential treatment Services) Detox covered under medical benefits Per admission	20%	Yes	Yes
Substance Use Disorder Services – Partial Hospitalization Per day	20%	Yes	Yes
Substance Use Disorder Services – Intensive Outpatient Per day	20% 20%	Yes Yes	Yes Yes
Substance Use Disorder Services – Outpatient/Office Individual Visit Cost Share Group Visit Cost Share	 20% 20%	 Yes Yes	 Yes Yes

PHYSICAL, OCCUPATIONAL & SPEECH THERAPIES

Outpatient Cost Share for Rehabilitative and Habilitative therapies is applied as one Copay per provider per day. Visits are counted on a 'per visit' basis.

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Physical Therapy Visit Maximum	20% 60 visits per calendar year (not combined)	Yes N/A	Yes N/A
Occupational Therapy Visit Maximum	20% 60 visits per calendar year (not combined)	Yes N/A	Yes N/A
Speech Therapy Visit Maximum	20% 60 visits per calendar year (not combined)	Yes N/A	Yes N/A

SKILLED CARE

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Home Healthcare Nurse visits (2 hrs), Aide visits (4 hours), therapy visits, supplies associated with a visit Visit Maximum Private Duty Nursing (4 hours = 1 visit) to the 210 visit per calendar year maximum. 16 hour maximum per day.	$0 210 visits per calendar year	Yes N/A	Yes N/A
Hospice Respite Care for Home Hospice Respite Care Maximum	$0 $0 Up to five consecutive days for each approved admission	Yes Yes N/A	Yes Yes N/A
Skilled Nursing Facility Per day	20%	Yes	Yes

Day Maximum	60 days per calendar year combined with acute rehab, rehabilitation hospital and sub-acute facility	N/A	N/A

OTHER Services

Benefit Type	You Pay and/or Maximums	Subject to Deductible	Applies to OOP
Acupuncture Self referred	20%	Yes	Yes
Visit Maximum	20 visits per calendar year Unlimited visits for Smoking Cessation	N/A	N/A
Chiropractic Care Self referred	20%	Yes	Yes
Visit Maximum	20 visits per calendar year	N/A	N/A
Accidental Injury to Teeth Repair of sound and natural teeth directly related to an accidental injury.			
Outpatient Surgery	20%	Yes	Yes
Inpatient Hospital per admission	20%	Yes	Yes
Benefit Maximum	Unlimited	N/A	N/A
Time limit on benefit	Treatment must be started within 12 months of the date of injury	N/A	N/A
Autism A diagnosis of ASD is required for benefits to apply			
Applied Behavioral Analysis	20%	Yes	Yes
Age Limit	Up to age 19	N/A	N/A
Physical/Occupational/Speech Therapy	20%	Yes	Yes
Age Limit	Up to age 19	N/A	N/A
Visit maximum	Unlimited	N/A	N/A
Durable Medical Equipment Including certain Diabetic testing supplies and equipment	20%	Yes	Yes
Glucometers, Peak Flow Meters	$0	No	No
Prosthetics and Orthotics Includes Medically Necessary eyewear for diagnoses of aniridia and aphakia; colostomy/ostomy and urological supplies	20%	Yes	Yes
Prosthetics – Wigs and Toupees To replace hair lost due to cancer or anemia up to a maximum of $700 per calendar year.	$0	Yes	Yes
Hearing Aids Includes tests to determine appropriate model, fitting, counseling, adjustment, cleaning and inspection after warranty is exhausted.			
Flat Allowance	$3,000	N/A	N/A
Allowance frequency	every 36 months	N/A	N/A
Medical Foods Amino acid modified products	$0	Yes	Yes
Vision Hardware – Contact Lenses	Not Covered	N/A	N/A
Vision Hardware – Frames and Eyeglass Lenses	Not Covered	N/A	N/A

OUTPATIENT PRESCRIPTION DRUGS

Obtained from Network Pharmacies and on the KP formulary (list of approved drugs), unless otherwise specified. Note: Member will pay their copay or the full cost of the medication, whichever is less.

Benefit Type	You Pay and/or Maximums	Subject to Plan Deductible	Applies to Plan OOP
4 Tier – Generic			
California	15% up to 30 days supply, 15% up to 100 days supply	Yes	Yes

Regions Outside California	15% up to 30 days supply, 15% up to 90 days supply	Yes	Yes
Community/Network pharmacy (GA first fill only and MAS)	15% up to 30 days supply 15% up to 90 days supply	Yes	Yes
Brand			
California	25% up to 30 days supply, 25% up to 100 days supply	Yes	Yes
Regions Outside California	25% up to 30 days supply, 25% up to 90 days supply	Yes	Yes
Community/Network pharmacy (GA first fill only and MAS)	25% up to 30 days supply 25% up to 90 days supply	Yes	Yes
Non-Formulary Brand			
California	50% up to 30 days supply, 50% up to 100 days supply	Yes	Yes
Regions Outside California	50% up to 30 days supply, 50% up to 90 days supply	Yes	Yes
Community/Network pharmacy (GA first fill only and MAS)	50% up to 30 days supply 50% up to 90 days supply	Yes	Yes
Specialty Tier			
California	50% up to 100 days supply	Yes	Yes
Regions Outside California	50% up to 30 days supply	Yes	Yes
Community/Network pharmacy (GA first fill only and MAS)	50% up to 30 days supply	Yes	Yes
Note: Certain medications may be limited to 30-day supply.			
Mail Order Drugs – *4 Tier Mail Order*			
Generic California Regions Outside California	 15% up to 100 days 15% up to 90 days	 Yes Yes	 Yes Yes
Brand California Regions Outside California	 25% up to 100 days 25% up to 90 days	 Yes Yes	 Yes Yes
Non-Formulary Brand			
California Regions Outside California	50% up to 100 days supply 50% up to 90 days supply	Yes Yes	Yes Yes
Specialty Tier			
California Regions Outside California	50% up to 100 days supply 50% up to 90 days supply	Yes Yes	Yes Yes
Note: Certain medications may be limited to 30-day supply. Not all medications are available via Mail Order.			
Blood Factors	$0	Yes	Yes
Diabetic Coverage Some diabetic supplies may be covered under Durable Medical Equipment. Oral medications and Insulin	=Generic/Brand Cost Share	No	Yes

Diabetic testing supplies (meters, test strips) Diabetic administration devices (syringes)	=Generic/Brand Cost Share =Generic/Brand Cost Share	No No	Yes Yes
Fertility Drug Coverage Fertility Preservation drugs Lifetime Maximum Shared with Fertility Medical Services	=Generic/Brand Cost Share =Generic/Brand Cost Share $50,000	Yes Yes Yes	Yes Yes Yes
Sexual Dysfunction **Quantity limits apply**	=Generic/Brand Cost Share N/A	Yes N/A	Yes N/A
Growth Hormone	=Generic/Brand Cost Share	Yes	Yes
Weight Loss	=Generic/Brand Cost Share	Yes	Yes
Supplemental Preventive Drugs Includes formulary drugs for asthma, cholesterol, diabetes, hypertension, osteoporosis, and stroke.	=Generic/Brand Cost Share	Yes	Yes
ACA Mandated Drugs* (see Preventive Services for more information)			
Contraceptive Devices (diaphragms, cervical caps, etc.) **and Contraceptive Drugs**	$0	No	No
Emergency Contraception	$0	No	No
Preventive Breast Cancer Drugs	$0	No	No
Smoking Cessation	$0	No	No
Statins (Cholesterol Lowering Agents)	$0	No	No
PrEP for HIV Prevention	$0	No	No
Preventive Over the Counter Products Preventive Over the Counter products are covered at a network pharmacy when prescribed by your provider for certain conditions.			
Aspirin	$0	No	No
Oral Fluoride	$0	No	No
Folic Acid	$0	No	No
Iron Supplements	$0	No	No
Female Contraceptives (spermicides, male and female condoms, emergency contraceptives and sponges)	$0	No	No
Bowel Prep	$0	No	No
COVID-19 Test Kits Limited to 4 test kits per month per member	$0	Yes	Yes
* With prescription, no Cost Share. Without prescription, Member pays retail cost.			
Refer to the Outpatient Prescription Drug section later in this document for coupon information.			
For items or injections dispensed by Pharmacy and requiring skilled administration in the Physician's Office (Implantable contraceptives, administered meds, etc.) Office Visit Cost Share for administration may apply.			

TRAVEL AND LODGING For reasonable transportation and lodging that is primarily for and essential to the receipt of an Organ Transplant or Gender Affirming Surgery where (1) the covered individual is unable to locate a Network provider in the State where the covered individual resides and (2) the covered individual must travel more than 50 miles to receive the Covered Service.			
Kaiser coordinated travel for Organ Transplants and Gender Affirming Surgery Only Organ Transplants include recipient, caregiver and donor. Gender Affirming Surgery includes patient and companion Transportation Limits Includes round trip transportation and lodging for the patient and one adult companion • Travel in a personal car, at the current IRS standard milage rate • Economy class air or train fare • Public transportation, taxis, Lyft, Uber, or similar services (Limos, luxury or upgraded vehicles will not be reimbursed)	Unlimited	Yes	Yes

• Parking and tolls			
Lodging Limits Hotel or similar accommodations if an overnight stay is required prior to or following a covered procedure. Reimbursement is limited to the charge for a single (double occupancy) room, including taxes, not to exceed $50/night, per person up to 2 people for 1 or 2 nights as required, unless a longer stay was recommended by a physician. (Hotel movies, entertainment, meals, and other services will not be reimbursed.)	$50 per night, $100 per night if accompanied by a companion	Yes	Yes
Daily Expense Includes incidental expenses such as meals and other personal expenses.	Not covered	N/A	N/A
Benefit Lifetime Maximum for Travel and Lodging related to Organ Transplants	$10,000	N/A	N/A
Benefit Lifetime Maximum for Travel and Lodging related to Gender Affirming Surgery	$10,000	N/A	N/A

Reimbursement for reasonable transportation and lodging expenses actually incurred by you and a companion in the course of obtaining the covered service. Services must be received at the most reasonable provider for the service provided.

Definitions

The following terms, when capitalized and used in any part of this Plan Document Handbook, mean:

Adverse Benefit Determination:

- A denial, reduction, or termination of a benefit by the Plan, or a failure of the Plan to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of your, or your beneficiary's, eligibility to participate in the Plan.
- A denial, reduction, or termination of a benefit by the Plan, or a failure of the Plan to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review; and a failure of the Plan to cover an item or Service for which benefits are otherwise provided because such item or Service is determined to be Experimental or Investigational or not Medically Necessary or appropriate.
- The Plan's determination of whether a participant or beneficiary is entitled to a reasonable alternative standard for reward under a wellness program.
- The Plan's determination as to whether the Plan is complying with the non-quantitative treatment limitation parity provision of the Mental Health Parity and Addiction Equity Act.

Allowable Amount: The amount the provider has contracted to accept for Services rendered. This amount is based on a case rate for bundled professional and facility Services, a contract rate, or a network fee schedule. In the case of pharmaceuticals, the Allowable Amount is an amount based on the average wholesale price plus a dispensing fee.

Allowance: A dollar amount the Plan will pay for benefits for a Service during a specified period. Amounts more than the Allowance are your responsibility to pay and do not apply toward your Out-of-Pocket Maximum.

Ancillary Service: 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 Network provider who can furnish such item or Service at such facility
- items or Services furnished because of unforeseen, urgent medical needs that arise at the time an item or Service is furnished, regardless of whether the Non-Network Provider satisfies the notice and consent requirements under federal law

Annual Enrollment: The annual period of time during which Eligible Individuals may elect and/or change Plans for the following Plan Year for themselves and their Eligible Dependents.

Benefits: Your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations, and exclusions of the Plan, including this Plan Document Handbook, the Summary of Benefits and Coverage, and any applicable amendments.

Billed Group: A Participating Group or one of its congregations, schools or other bodies that is billed by the Plan and responsible for paying monthly contributions. Also sometimes called a "List Bill," or, in My Admin Portal (MAP), a "Billing Account."

Cafeteria Plan:[1]
A Cafeteria Plan, also known as a Section 125 plan, is a separate written plan, maintained by an employer, that offers employees a choice between receiving their compensation in cash or as part of an employee benefit. If taken as a benefit, the employee generally receives two tax advantages: (1) employee contributions toward Cafeteria Plan benefits are made on a pre-tax basis, and (2) employer contributions toward an employee's Cafeteria Plan benefits are not taxed. An employee's elections under a Cafeteria Plan are generally irrevocable until the beginning of the next plan year, although a Cafeteria Plan may permit an employee to revoke an election and make a new one mid-year following the occurrence of a Significant Life Event.

Claims Administrator: The Kaiser Permanente Insurance Company (KPIC) self-funded claims administrator. You can find the Claims Administrator's address in the "Customer Service Phone Numbers" section and on your Kaiser Permanente ID card.

Clinically Stable: You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accord with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during, or because of, the discharge or transfer.

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1985.

Coinsurance: A percentage of Eligible Charges that you must pay for certain Covered Services as described in the "Schedule of Benefits" section.

Community Pharmacy: A retail pharmacy under contract with Kaiser Permanente.

Copayment (aka Copay): A specified dollar amount that you must pay for certain Covered Services as described in the "Schedule of Benefits" section.

Cost Sharing/Share: Copayments, Coinsurance, and Deductibles.

Coverage Tier: Coverage Tiers represent coverage classifications based on the number of Members covered. Contribution rates correspond to the Coverage Tier type (Single, Eligible Individual + Spouse / Domestic Partner, Eligible Individual + Child, Eligible Individual + Children, Family).

Covered Service: Services that meet the requirements described in this Plan Document Handbook.

Custodial Care – Any Service, procedure or supply that is provided primarily:

- For ongoing maintenance of a person's condition, not for therapeutic value, in the treatment of an illness or injury
- To assist a person in meeting activities of daily living for example, assistance in walking, bathing, dressing, eating and preparation of special diets and supervision over self-administration of medication not requiring the constant attention of trained medical personnel

Such Services and supplies are regarded as Custodial Care without regard to the following:

- Who prescribes the Service and supplies
- Who recommends the Service and supplies

[1] A Cafeteria Plan must meet certain legal requirements, so we recommend that you consult with your own legal advisor in order to ensure compliance. The Medical Trust does not maintain a Cafeteria Plan for the purposes of receiving employer and employee contributions; Participating Groups or employers must maintain their own separate Cafeteria Plan in order to benefit from the tax advantages described above.

- Who performs the Service or the method in which such Services are performed

Deductible: A specific dollar amount you are required to pay for certain types of Covered Services annually before benefits will be paid. The Deductible is calculated after the Eligible Charges are determined and prior to any Coinsurance or Copayment.

Dental Services: Items and Services provided in connection with the care, treatment, filling or removal, or replacement of teeth or structures directly supporting the teeth. (Structures supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth and alveolar process.)

Dependent: A Spouse, Domestic Partner, or Child of an Eligible Individual. A "Surviving Dependent" means a Surviving Child, Surviving Domestic Partner, or Surviving Spouse, as applicable.

Child(ren)
An Eligible Individual's, Eligible Individual's Spouse's, or, if Domestic Partner benefits are provided by the Participating Group, a Domestic Partner's biological child, stepchild, legal ward,[2] foster child,[3] or legally adopted child, or a child who has been placed for adoption with the Eligible Individual, Eligible Individual's Spouse, or, if applicable, Domestic Partner. A child will be considered to be "placed for adoption" on the date when the Eligible Individual becomes legally obligated to support that child prior to that child's adoption.

Domestic Partners
Two adults who have chosen to share one another's lives in a mutually exclusive partnership that resembles marriage. The Plan requires completion of the Domestic Partnership Affidavit to confirm that the requirements of the Plan are met. See the Appendix of the Administrative Policy Manual for the affidavit. A "Domestic Partnership" refers to the partnership between two Domestic Partners.

Spouse
An Eligible Individual's lawfully married partner evidenced by a marriage certificate or, in the case of a common-law spouse, evidenced by a written court order.

Surviving Child
A Child of an Eligible Individual who meets the qualifications listed in the Eligibility section and is *enrolled in the Plan* at the time of the Eligible Individual's death. A Surviving Child shall also include a Child of an Eligible Individual born or adopted within 12 months of the Eligible Individual's death.

Surviving Domestic Partner
A Domestic Partner of an Eligible Individual who meets the qualifications listed in the Eligibility section and is *enrolled in the Plan* at the time of the Eligible Individual's death.

Surviving Spouse
A Spouse of an Eligible Individual who meets the qualifications listed in the Eligibility section and is *enrolled in the Plan* at the time of the Eligible Individual's death.

Disabled Child: An eligible Child who has been determined by the Medical Trust (or its delegate) to have

[2] A legal ward is a minor placed under the care of a guardian by an authority of law.

[3] A foster child is an individual who is placed with the Eligible Individual by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

become totally and permanently impaired physically or mentally prior to age 25, to the extent that they are incapable of self-support, and such impairment continues without interruption up to the time of the Eligible Individual's death and continues without interruption thereafter up to the time of such individual's death. The Medical Trust (or its delegate) may, in its sole discretion, require periodic certification of an individual's continuing disability.

Durable Medical Equipment (DME): Durable Medical Equipment (DME) is a device or instrument of a durable nature that meets all of the following requirements:

- It can withstand repeated use.
- It is primarily and customarily used to serve a medical purpose.
- It is generally not useful to a person in the absence of illness or injury.
- It is appropriate for use in your home.

Eligible Charges:

- For Services provided by Kaiser Permanente, this is the charge in the relevant Kaiser Foundation Health Plan's schedule of Kaiser Permanente charges for Services provided to participants.
- For Services that Network Providers (other than Kaiser Permanente) provide under a contract with Kaiser Permanente, this is the amount that the provider has agreed to accept as payment in full under that contract.
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, this is the amount the pharmacy would charge you for the item if your benefits did not cover the item. This amount is an estimate of: the cost of acquiring, storing, and dispensing drugs and other items, the direct and indirect costs of providing Kaiser Permanente pharmacy Services, and the pharmacy program's contribution to the net revenue requirements of the relevant Kaiser Foundation Health Plan.
- For all other Services, these are the amounts that the Plan pays for the Services or, if the Plan subtracts Cost Sharing from its payment, the amount the Plan would have paid if it did not subtract Cost Sharing.

Eligible Charges Non-Network Providers:

- For Emergency Services and scheduled Services at a Network Hospital or ambulatory surgical center rendered by Non-Network Providers, the plan's Qualifying Payment Amount (QPA) – which is the median contracted rate (the middle amount in an ascending or descending list of contracted rates), adjusted for market consumer price index in urban areas (CPIU). The Cost Share will be based on the Recognized Amount (RA) which is lower of the QPA or the provider billed charges for a given Service. The QPA is based on contracted rates for the same or similar insurance market (individual, large group, small group, self-insured employer); geography, based on MSAs (Metropolitan Statistical Area - a geographical region with a relatively high population density at its core and close economic ties throughout the area) and the non-MSA areas in a state; and Service provided in the same or similar specialty or type of facility. The contracted rates must reflect the total provider reimbursement amount contractually agreed, including cost-sharing, whether it's under a direct or indirect contract with the plan.

- To determine the QPA when there is no contracted rate KPIC will use the lower of an underlying fee schedule or the derived amount from Kaiser claims history.

- In the alternative KPIC may attempt to contract with the provider on a patient-by-patient basis.

- Should a provider dispute the QPA they may enter into an Independent Dispute Resolution (IDR) process after a 30-day negotiation period. A certified IDR entity will select between the provider and KPIC's offer of payment. The non-prevailing party will pay all fees charged by the IDR entity.

Eligible Dependent: This definition can be found in the Eligibility for the Episcopal Health Plan (EHP) section of this manual.

Eligible Individual: This definition can be found in the Eligibility for the Episcopal Health Plan (EHP) section of this manual.

Eligible Small Employer: An employer that (1) is eligible to participate in the Medical Trust plans, (2) does not employ 20 or more employees in 20 or more calendar weeks in the current or preceding calendar year, and (3) has met the requirements established by the Centers for Medicare and Medicaid Services (CMS) to qualify as a small employer under the Medicare Secondary Payer Rules.

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

- placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- 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 themselves 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 the following with respect to an Emergency Medical Condition:

- A medical screening examination (as required under the federal Emergency Medical Treatment and Active Labor Act (EMTALA)) that is within the capability of the emergency department of a hospital or Independent Freestanding Emergency Department, including professional, ancillary Services routinely available to the emergency department to evaluate the Emergency Medical Condition, Post-Stabilization Services and outpatient observation during the same "visit" unless the provider/facility:

  (1) determines you may travel using nonmedical or nonemergency medical transportation; and

  (2) has obtained informed consent from you for such items/Services (Consent by may not be obtained when Services are unforeseen and urgent. Ancillary providers may never seek consent to bill the enrollee). In addition, if you (or your authorized representative) consent to the provision of Services by a Non-Network Provider, then KPIC will not pay for such Services and the amount you pay will not count toward satisfaction of the Annual Deductible, if any, or the Out-of-Pocket Maximum(s). The notice must include: (i) that the provider or facility is Non-Network with respect to the Plan; (ii) a good faith estimated amount that the provider or facility may charge including a notification that the provision of the estimate or the consent to be treated does not constitute a contract with respect to those estimated charges; (iii) a list of any Network providers at the facility who are able to furnish the items and Services involved and you may be referred, at your option, to that provider; and (iv) information about whether prior authorization or other care management limitations may be required in advance of receiving the items or Services at the facility.

- Note: Once your condition is Clinically Stable, covered Services that you receive are Post-Stabilization Care and not Emergency Services EXCEPT when you receive Emergency Services

from Non-Network Providers AND federal law requires coverage of your Post-Stabilization Care as Emergency Services. Post-Stabilization Care is subject to all of the terms and conditions of this Plan Document Handbook including but not limited to Prior Authorization requirements unless federal law applies and defines such Post-Stabilization Care as Emergency Services.

EMTALA: The Emergency Medical Treatment and Labor Act (EMTALA) is a United States Congressional Act passed as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

Employee: An individual employed by a Participating Group, including individuals on an approved leave of absence, short-term disability, or long-term disability. In no event will an independent contractor be considered to be an Employee.

Seasonal Employee
An Employee who normally performs work during certain seasons or periods of the year, whose compensated employment is scheduled to last less than six (6) months in a year.

Temporary Employee
An Employee who is scheduled to be employed for a limited time or whose work is contemplated or intended for a particular project or need, usually of a short duration such as three (3) months.

The Episcopal Church Clergy and Employees' Benefit Trust (the ECCEBT):
The Plan funds certain of its benefit plans through this trust that is intended to qualify as a voluntary employees' beneficiary association (VEBA) under Section 501(c)(9) of the Internal Revenue Code. The main purpose of the ECCEBT is to provide health benefits to eligible employees, eligible former employees, and/or their eligible dependents.

Experimental or Investigational Services: Kaiser Permanente determines that a Service is Experimental or Investigational if it meets one of the following criteria:

- 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 Service is to be provided;
- it has not been approved by the US Food and Drug Administration (FDA) and, lacking such approval, cannot be legally performed or marketed in the United States;
- it is the subject of a current new drug or device application on file with the FDA;
- it has not been approved or granted by the FDA, excluding off-label use of FDA-approved drugs and devices;
- it 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;
- it is subject to approval or review of an Institutional Review Board or other body that approves or reviews research;
- it is provided pursuant to informed consent documents that describe the Services as experimental or investigational, or indicate that the Services are being evaluated for their safety, toxicity, or efficacy;
- the prevailing opinion among experts 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 Service; or
- it is provided for Non-referred Services in connection with an approved clinical trial and/or Services in connection with a non-approved clinical trial.

Services related to clinical trials are considered Experimental and Investigational when:

- Items and Services are provided solely to satisfy data collection and analytical needs of a clinical trial and are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);
- Items and Services are customarily provided by the research sponsors free of charge for any enrollee in the trial; and
- Items or Services are needed for reasonable and necessary care arising from the provision of an Experimental or Investigational item or Service--in particular, for the diagnosis or treatment of complications.

Family: A Member and all of their eligible Dependents.

Former Employee

Pre-65 Former Employee
A former Employee of a Participating Group of the EHP who is less than 65 years of age and not otherwise eligible for the EHP or SEE Plan as an Employee:

(a) who at the time of separation from active employment was either participating in the EHP or eligible to participate in the EHP as an Employee who was normally scheduled to work and was compensated for 1,000 or more hours per year; and

(b) at the time of separation from employment with The Episcopal Church, was at least 55 years of age, or, if younger, was eligible for a disability retirement benefit under a pension plan sponsored by The Church Pension Fund or its affiliates prior to December 31, 2017; and

(c) if a Lay Employee, has a minimum of five years of service with The Episcopal Church OR if a cleric, has earned a minimum of five years of Credited Service under The Church Pension Fund Clergy Pension Plan.

Post-65 Former Employee
Clergy:
A former Employee who:

(a) is age 65 or older, and

(b) has earned a minimum of five years of Credited Service under The Church Pension Fund Clergy Pension Plan.

Lay:
A former Employee who:

(a) is age 65 or older, and

(b) who at the time of separation from active employment was normally scheduled to work and was compensated for 1,000 or more hours per year, and

(c) either (1) participated in a pension plan sponsored by The Church Pension Fund for a minimum of 5 years OR (2) was a former Employee of a Participating Group of the EHP for a minimum of five years.

Member of Religious Order who:

(a) is age 65 or older, and

(b) either (1) meets the definition of Post-65 Former Employee Clergy above OR (2) is a former Member of a Religious Order that is a Participating Group of the EHP.

Group Administrator: The individual authorized by the Participating Group to administer its employee benefits program.

Hearing Aid: An electronic device you wear for amplifying sound and assisting the physiologic process of hearing, including an ear mold if necessary.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): The Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued thereunder. HIPAA is a federal law that, among other things, provides rights and protections for participants and beneficiaries in group health plans by regulating the portability and continuity of group health coverage. HIPAA limits exclusions based on preexisting conditions, prohibits discrimination based on health status factors, and gives individuals a special opportunity to enroll in a group health plan in certain circumstances. The Administrative Simplification Provisions of HIPAA address the privacy and security of certain health information.

Home Health Care: Care, by a licensed program or Provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching, and nursing Services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency: A Provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching, and nursing Services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Hospice: A specialized form of interdisciplinary healthcare designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts you may experience during the last phases of life due to a terminal illness. It also provides support to your primary caregiver and your family.

Independent Freestanding Emergency Department: A healthcare facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and that provides Emergency Services.

Kaiser Permanente: A Network of Providers that operate through eight Regions, each of which has a Service Area. For each Kaiser Permanente Region, Kaiser Permanente consists of Kaiser Foundation Hospitals (a California nonprofit corporation) and the Medical Group for that Region:

- Kaiser Foundation Health Plan, Inc., for the Northern California Region, the Southern California Region, and the Hawaii Region
- Kaiser Foundation Health Plan of Colorado for the Colorado Region
- Kaiser Foundation Health Plan of Georgia, Inc., for the Georgia Region
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., for the Mid-Atlantic States Region
- Kaiser Foundation Health Plan of the Northwest for the Northwest Region
- Kaiser Foundation Health Plan of Washington for the Washington Region

KPIC: Kaiser Permanente Insurance Company, which provides claims administrative services for the Plan.

Material Modification: Per Section 102 of the Employee Retirement Income Security Act of 1974 (ERISA), a material modification includes

- any coverage modification that alone or combined with other changes made at the same time would be considered by "an average participant" to be "an important change in covered benefits or other terms of coverage under the plan or policy"
- an enhancement of covered benefits, services or other more general, plan or policy terms—for example, coverage of previously excluded benefits or reduced cost-sharing
- a "material reduction in covered services or benefits" or more strict requirements for "receipt of benefits," including:
  - changes or modifications that reduce or eliminate benefits
  - increases in Cost Sharing
  - imposing a new referral requirement

Medical Board: The Medical Board of The Church Pension Fund, as may be appointed by the Chief Executive Officer and President of The Church Pension Fund or their delegate from time to time. As of January 1, 2024, the Medical Board is American Family Life Assurance Company of New York (Aflac).

Medically Necessary: A Service is Medically Necessary if, in the judgment of a Kaiser Permanente health professional on behalf of the Plan, it meets all the following requirements:

- it is required for the prevention, diagnosis, or treatment of your medical condition;
- omission of the Service would adversely affect your condition;
- it is provided in the least costly medically appropriate setting; and
- it is in accord with generally accepted professional standards of practice that is consistent with a standard of care in the medical community.

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

Medicare Secondary Payer (MSP): The term used when Medicare pays secondary to an active plan covering a Medicare beneficiary.

Medicare Secondary Payer (MSP) – Small Employer Exception (SEE): An exception to the MSP rules that applies to an Eligible Small Employer. For Eligible Small Employers who enroll Members in the SEE Plan, Medicare becomes the primary payer and the Medical Trust will become the secondary payer for claims by Members enrolled in the SEE Plan.

Medicaid: A state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Member: An enrolled Eligible Individual or enrolled Eligible Dependent. As used throughout this Plan Document Handbook, "you" and "your" refer to a Member, unless otherwise clearly required by context (for example, if context indicates that "you" are not enrolled in the Plan).

Member of a Religious Order: A postulant, novice, or professed member of Episcopal Religious Orders, as defined in Title III, Canon 14.1[4] (a "Religious Order") and verified by the House of Bishops' Committee on Religious Communities, who has been accepted or received by the Religious Order.

Mental Health Residential Treatment Center: An institution which specializes in the treatment of psychological and social disturbances that are the result of mental health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of physicians; provides 24-hour

[4] The Constitution and Canons of the Episcopal Church, 2018

care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

My Admin Portal (MAP): My Admin Portal (MAP) is CPG's online application used by benefits administrators throughout The Episcopal Church to manage employment assignments related to retirement and benefits enrollments.

MyCPG Accounts: MyCPG Accounts is a web-based tool designed to allow Members to quickly, conveniently, and safely view benefits information, update contact information, and complete Annual Enrollment.

Network Provider: A Network Hospital, Physician, Pharmacy, Skilled Nursing Facility, Medical Group, or any other healthcare provider under contract with Kaiser Permanente to provide Covered Services. Network Providers are subject to change at any time without notice. For current locations of Network facilities please call Customer Service at the number listed in the "Customer Service Phone Numbers" section. To find a Kaiser Pharmacy, visit *kp.org*—select the *Locate Our Services* tab, select your region, and then select the *Facilities* tab.

Network Facility: Any facility listed on *kp.org*. Note: Facilities are subject to change at any time. For the current locations, call Customer Service.

Network Hospital: A licensed hospital owned and operated by Kaiser Foundation Hospitals or another hospital which contracts with Kaiser Foundation Hospitals to provide Covered Services.

Network Optical Sales Office: An optical sales office owned and operated (or designated) by Kaiser Permanente. Please refer to *kp.org* for a list of Plan Optical Sales Offices in your area. Plan Optical Sales Offices are subject to change at any time without notice. For the current locations of Plan Optical Sales Offices, please go to *kp.org* or call the Customer Service phone number listed in the "Customer Service Phone Numbers" section.

Network Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that Kaiser Permanente designates.

Network Physician: A licensed physician who is a partner, shareholder, or employee of the Medical Group, or another licensed physician who contracts with the Medical Group to provide Covered Services.

Network Ancillary Providers: Non-MD providers such as Psychologists; MFCCs; LCSWs; Optometrists; Physical, Speech, and Occupational Therapists. Such providers will be subject to the primary care Cost Share; however, verify referral requirements in the How to Obtain Services section.

Network Primary Care Provider: Family Practice, Internal Medicine, and Pediatrics. Note: Physician Assistants and Nurse Practitioners may be treated as Primary Care Providers or Specialists based on the supervising physicians' provider status.

Network Specialist: Medical Doctor with a specialty not considered primary care. Note: Physician Assistants and Nurse Practitioners may be treated as Primary Care Providers or Specialists based on the supervising physicians' provider status.

Medical Group: The following medical groups for the following Kaiser Permanente Regions:
- The Permanente Medical Group for the Northern California Region
- The Southern California Permanente Medical Group for the Southern California Region
- Colorado Permanente Medical Group, P.C., for the Colorado Region

- The Southeast Permanente Medical Group, Inc., for the Georgia Region
- Hawaii Permanente Medical Group, Inc., for the Hawaii Region
- Mid-Atlantic Permanente Medical Group, P.C., for the Mid-Atlantic States Region
- Northwest Permanente, P.C., Physicians & Surgeons, for the Northwest Region
- Washington Permanente Medical Group, P.C., for the Washington Region

Network Skilled Nursing Facility: A licensed facility that provides inpatient skilled nursing care, rehabilitation Services, or other related health Services that contracts with Kaiser Permanente to provide Covered Services. The facility's primary business is the provision of 24-hour-a-day 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 if it continues to meet the definition.

Non-Network Provider or Out-of-Network Provider: Any healthcare provider that is not a Network Provider.

Out-of-Pocket Maximum: The maximum dollar amount you can be required to pay for certain Covered Services you receive annually. This amount includes Cost Sharing and Deductible amounts.

Participating Group: A diocese, congregation, agency, school, organization, or other body subject to the authority of and/or associated or affiliated with The Episcopal Church, which has elected to participate in the Plan. Also known in My Admin Portal (MAP) as a "Benefits Group."

Pay or Play Rules: The employer shared responsibility provisions under the Affordable Care Act, which require certain employers (called "applicable large employers" or ALEs) to either offer minimum essential coverage that is "affordable" and that provides "minimum value" to their full-time employees (and their dependents), or potentially make an employer shared responsibility payment to the IRS. The employer shared responsibility provisions are sometimes referred to as "the employer mandate" or "the pay or play provisions."

Plan: The medical and dental plans (i.e., health plans) maintained by the Medical Trust for the benefit of Members. The Plan is intended to qualify as a "church plan" as defined by Section 414(e) of the Internal Revenue Code, and is exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Episcopal Health Plan (EHP)
A program of medical and dental plans through which Members are provided health benefits. Benefits are provided through the Medical Trust.

Small Employer Exception (SEE) Plan
A program of medical plans through which Members are provided health benefits. Benefits are provided through the Medical Trust.

This plan is applicable only to those small employers and individuals enrolled in Medicare who apply and are certified by the Centers for Medicare & Medicaid Services (CMS) as meeting the criteria to participate as a result of meeting the small employer definition and the benefits coordinating with Medicare. This plan is not available through Kaiser.

Plan Sponsor: The plan sponsor is The Episcopal Church Medical Trust.

Plan Year: The date span beginning January 1 and ending December 31.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable. Post-Stabilization Care is covered only when (1) it is considered to be Emergency Services under federal law (without Prior Authorization) or, (2) KPIC determines such Services are Medically Necessary pursuant to a request for Prior Authorization for the Service.

Primary Care: Care provided by a Network Provider who specializes in internal medicine, pediatrics or family practice Services.

Prior Authorization: Medical Necessity approval obtained in advance which is required for certain Services to be Covered Services under the Plan. Authorization is not a guarantee of payment and will not result in payment for Services that do not meet the conditions for payment by the Plan.

Prosthetics and Orthotics: An external prosthetic device is a device that is located outside of the body which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part. Internally implanted prosthetic devices are devices placed inside the body through a surgical incision which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part. Orthotics are rigid or semi-rigid external devices that are used for the purpose of supporting a weak or deformed body part, improving the function of moveable parts, or for restricting or eliminating motion in a diseased or injured part of the body.

Reconstructive Surgery: Surgery to improve function and, under certain conditions, to restore normal appearance after significant disfigurement.

Region: A geographic area serviced by Kaiser Permanente. See “Kaiser Permanente” in this Definitions section.

Seminarian: A full-time student, as defined by the seminary, enrolled at a participating seminary of the Association of Episcopal Seminaries.

Service(s): Healthcare, including mental health care and behavioral health treatment to treat pervasive developmental disorders or autism, services, and items.

Service Area: A smaller geographic area of a Kaiser Permanente Region.

Significant Life Event (SLE): An event, as described in the Plan Election and Enrollment Guidelines section, where as a result of the event, the Eligible Individual is eligible to make certain mid-year election changes.

Specialty Care: Care provided by a Network Provider who provides Services other than Primary Care Services.

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

State of Emergency: During a national or regional state of emergency, patient care may be handled in a variety of new and unusual locations (e.g., drive-up testing in parking lots, overflow inpatient care in convention centers, floating military hospitals, and reopened previously closed facilities). Reimbursement for Services rendered by licensed providers will be based on provider licensure rather than place of Service.

Substance Use Disorders (SUDs): Treatable, chronic diseases characterized by a problematic pattern of use of a substance or substances leading to impairments in health, social function, and control over substance use.

Surprise Billing: Unexpected billing by a Non-Network Provider (except when you have consented) for 1) Emergency Services, 2) certain other Services performed by a Non-Network provider at a Network facility, and 3) air ambulance Services from a Non-Network Provider that is prohibited under federal law. When Surprise Billing occurs, you are only required to pay the Network Cost-Sharing amount. Your Cost-Sharing amount is calculated based upon the "Recognized Amount" for a Non-Network Provider/facility, and for Emergency Services and Ancillary Services, the Recognized Amount is the All Payer Model Agreement amount, if applicable, or the amount calculated pursuant to a specified state law if applicable, or the Qualifying Payment Amount (QPA).

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

Eligibility, Enrollment, and Effective Date

Plan Eligibility Requirements

You must meet the Plan's eligibility requirements listed below:

Service Area Eligibility Requirement

The Member must live or work in a Kaiser Service Area at the time of enrollment. The Service Area cities are listed in the back of this Plan Document Handbook. You cannot enroll or continue enrollment as a Member if you cease to live or work within the cities listed.

Note: You may receive Urgent and Emergent care outside a Kaiser Service Area; see the Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non-Network Providers section for more information.

Additional Eligibility Requirements

The Medical Trust determines the minimum eligibility for the Plans. The employer or Participating Group is responsible for determining whether the Employee is eligible for any employer contributions toward coverage, confirming that Members meet the eligibility criteria described below, and for maintaining documentation related to the Members' enrollment and elections. The Medical Trust may request a copy of required documentation at any time.

The terms "Eligible Individual" and "Eligible Dependent," as defined below, are used throughout this document and identified with capital letters.

Eligible Individuals and their Eligible Dependents described below must be part of a Participating Group that is participating in the EHP.

Eligibility for the Episcopal Health Plan (EHP)

The Medical Trust determines the minimum eligibility for the Plans. The employer or Participating Group is responsible for determining whether the Employee is eligible for any employer contributions toward coverage, confirming that Members meet the eligibility criteria described below and for maintaining documentation related to the Members' enrollment and elections. The Medical Trust may request a copy of required documentation at any time.

Eligible Individuals and their Eligible Dependents described below must be part of a Participating Group that is participating in the EHP.

Eligible Individuals

- An Employee normally scheduled to work 1,000 or more compensated hours per Plan Year or who is treated as a full-time Employee under the Employer Shared Responsibility Provisions under the Affordable Care Act (Pay or Play Rules), but only for the applicable stability period
- An Employee who is on a paid leave of absence or on a legally mandated unpaid leave (provided they met the eligibility criteria described in the first bullet and were a Member immediately preceding such leave)
- A Seminarian who is a full-time student enrolled at a participating seminary of the Association of Episcopal Seminaries
- A Member of a Religious Order

- A Pre-65 Former Employee, not eligible for Medicare, as long as their former employer is participating in the EHP
- A cleric, not eligible for Medicare, who is eligible for benefits under The Church Pension Fund Clergy Short-Term Disability Plan, or The Church Pension Fund Clergy Long-Term Disability Plan who was (i) enrolled in the EHP or SEE Plan as of the date of their disability or (ii) who was eligible for enrollment in the EHP or SEE Plan as of the date of their disability and who subsequently experiences a Significant Life Event that entitles them to subsidized medical coverage under The Church Pension Fund Clergy Long-Term Disability Plan

Eligible Dependents

- A Spouse of an Eligible Individual enrolled in a Plan sponsored by the Medical Trust*
- A Domestic Partner of an Eligible Individual enrolled in a Plan sponsored by the Medical Trust, if Domestic Partner benefits are elected by the Participating Group
- A Child of an Eligible Individual enrolled in a Plan sponsored by the Medical Trust, who is 30 years of age or younger on December 31 of the Plan Year**
- A Disabled Child of an Eligible Individual enrolled in a Plan sponsored by the Medical Trust, who is older than 30 years of age on December 31 of the Plan Year, provided the disability began before the age of 25**
- A pre-65 Dependent, not eligible for Medicare, of a Post-65 Former Employee enrolled in the Group Medicare Advantage Plan (the "GMAP")***
- A pre-65 Surviving Dependent, not eligible for Medicare, of a deceased Post-65 Former Employee or Pre-65 Former Employee who, in each case, was enrolled in a Plan sponsored by the Medical Trust at the time of their death***
- A pre-65 Dependent, of a Pre-65 Former Employee enrolled in the GMAP****

**For information on the eligibility of a former Spouse refer to the Termination of Individual Coverage section, under Divorce.*

***The Dependent must be enrolled under the Eligible Individual's Plan.*

****The Dependent will be enrolled as a "subscriber" (i.e., as if they were themselves an Eligible Individual); however, eligibility is based on the Post-65 Former Employee's status.*

*****The Dependent will be enrolled as a "subscriber" (i.e., as if they were themselves an Eligible Individual); however, eligibility is based on the Pre-65 Former Employee's status.*

Ineligible Individuals

Individuals described below are **not** eligible to enroll in the EHP.

- A part-time Employee who is scheduled to work and be compensated for less than 1,000 hours per Plan Year unless such Employee is required to be treated as a full-time Employee under the Pay or Play Rules
- A Temporary Employee unless such Employee is required to be treated as a full-time Employee under the Pay or Play Rules
- A Seasonal Employee unless such Employee is required to be treated as a full-time Employee under the Pay or Play Rules
- A Seminarian who is not a full-time student or not enrolled at a participating seminary of the Association of Episcopal Seminaries
- A parent or other relative of an Eligible Individual, including grandchildren and in-laws, not listed in the Eligible Dependents section above
- A Post-65 Former Employee or Pre-65 Former Employee (or Spouse/Domestic Partner) eligible for Medicare, regardless of whether they are actually enrolled in Medicare
- A volunteer
- Any Employee who does not meet local jurisdiction's employment requirements (e.g., age requirements or work visa requirements)
- A person who would otherwise be an Eligible Individual or Eligible Dependent who refuses to provide a Social Security or Individual Taxpayer Identification Number
- A Dependent's dependent who is not a legal ward of, a foster child of, legally adopted by, or placed for adoption with, in each case, the Eligible Individual, Eligible Individual's Spouse, or, if Domestic Partner benefits are provided by the Participating Group, the Eligible Individual's Domestic Partner
- A person who would otherwise be an Eligible Individual or Eligible Dependent who is on long-term disability and eligible to enroll in Medicare Part A and Part B
- A person who would otherwise be an Eligible Individual or Eligible Dependent who has been barred from enrolling because their eligibility has been terminated for cause due to such individual's actions
- A person who would otherwise be an Eligible Individual or Eligible Dependent whose coverage by the Plan would be illegal under applicable law

Coverage and Eligibility Exceptions

There may be certain circumstances where an individual who does not meet the eligibility requirements listed above may choose to request a special eligibility determination from the Plan. The individual with requisite authority to make benefits decisions on behalf of the Participating Group must submit the Coverage and Eligibility Exception Request Form to the Plan in these circumstances. The Plan will review the case presented and provide an individual eligibility determination within approximately 30 days after receipt of the form. If eligibility is granted, the effective date of coverage will be the first of the month following the receipt of the enrollment form. The Coverage and Eligibility Exception Request Form is provided in the Appendix section of the Administrative Policy Manual.

Standalone Employee Assistance Program (EAP) Plan

The Plan offers the Employee Assistance Program (EAP) with Cigna as a standalone Plan that Participating Groups may offer to Employees who waived EHP coverage as a qualified opt-out.

Please note that Eligible Individuals who enroll in Medical Trust health coverage are automatically enrolled in the Cigna EAP and should not be enrolled in the Standalone EAP Plan.

If the Standalone EAP Plan is offered by a Participating Group, Billed Groups that elect to enroll Employees who waived EHP coverage as qualified opt-outs must pay for the Standalone EAP Plan coverage. Requiring Employees to contribute toward the cost of the Standalone EAP Plan would violate the Affordable Care Act and subject the Billed Group to significant penalties.

Eligibility for the Standalone EAP Plan is limited to Employees who waived EHP coverage as a qualified opt-out. All Employees of a Billed Group that offers the Standalone EAP Plan who waived EHP coverage as a qualified opt-out must be enrolled in the Standalone EAP Plan.

Since Eligible Individuals do not have the ability to enroll in the Standalone EAP Plan during Annual Enrollment, enrollments must be completed by the employer or Participating Group.

Important Notes

- ***Waiting Periods***

  The Plan may allow Participating Groups to require that an Eligible Individual be eligible for a length of time before being allowed to participate in the Plan, subject to a maximum waiting period of 60 days. It should be noted that requiring a longer waiting period may result in a violation of the Affordable Care Act, which could result in significant penalties.

  Additional information on new hires can be found in the Plan Election and Enrollment Guidelines section.

- ***Medicare/Medicaid***

  Except as noted above, eligibility for Medicare/Medicaid or the receipt of Medicare/Medicaid benefits will not be taken into account in determining eligibility for participation in the EHP. For participation in the SEE Plan, eligibility for Medicare will be taken into account in determining eligibility.

- ***Medicare Secondary Payer (MSP)***

  The Plan must comply with the government's Medicare Secondary Payer (MSP) law, which outlines when Medicare is not responsible for paying first for health claims. The government designed Medicare to provide health coverage for retired individuals. Medicare requires employer group health plans to be the primary payer of health claims for individuals who are working and eligible for active group healthcare coverage. If an Employee who is 65 or older is eligible for coverage under an employer-provided health plan, as defined by the employer's policy, then Medicare will not be the primary payer for health claims.

Each employer must determine which Employees are eligible for employer-provided health benefits. The employer must comply with the Age Discrimination in Employment Act (ADEA), if applicable, which requires employers to offer to their over age 65 Employees and Spouses the same coverage that is offered to Employees and Spouses under age 65, regardless of their Medicare eligibility. In addition, this equal benefit rule applies to coverage offered to full-time and part-time Employees. Those Employees over age 65 who are qualified for employer-provided health benefits and meet the Plan's eligibility rules described in this section must be offered the EHP or SEE Plan, if eligible.

Medicare beneficiaries are free to reject employer plan coverage and retain Medicare as their primary coverage. However, when Medicare is the primary payer, employers cannot offer such Employees (or their Spouses) secondary coverage for items and services covered by Medicare. Medicare states that an employer cannot sponsor, contribute to, or otherwise facilitate enrollment in coverage intended only to supplement Medicare's benefits (e.g., individual Medicare supplement health plans, Medicare HMOs, or Group Medicare Advantage plans) for Medicare beneficiaries who are otherwise eligible for active group medical coverage. Therefore, the Plan does not offer group Medicare supplement health plans, group Medicare HMOs, or Group Medicare Advantage plans to Employees and their Spouses over age 65 who are Medicare beneficiaries, and the Employee and their eligible Spouse can no longer receive a subsidy under The Church Pension Fund Post-Retirement Medical Assistance Plan.

Failure to comply with the MSP rules can result in penalties assessed against the employer. It is the employer's responsibility to comply with the MSP rules, and, by participating in the Plans, the employer agrees to indemnify and hold the Medical Trust harmless from any claims resulting from the failure to comply with the MSP rules.

Note that the MSP rules do not apply to standalone dental coverage.

- **Working for the Church after Retirement**

  Regardless of the retired Employee's status under The Church Pension Fund Clergy Pension Plan, if the Post-65 Former Employee is eligible for employer-provided medical benefits such as coverage under the EHP due to their status as an Employee, Medicare generally prohibits the Plan from offering the Post-65 Former Employee medical coverage under the GMAP.

  If the Post-65 Former Employee who is working for The Episcopal Church after retirement does not qualify for medical coverage under the EHP or SEE Plan, then the Post-65 Former Employee may be eligible to enroll in the GMAP.

  Failure to comply with the MSP rules can result in penalties assessed against the employer. It is the employer's responsibility to comply with the MSP rules, and, by participating in the Plans, the employer agrees to indemnify and hold the Medical Trust harmless from any claims resulting from the failure to comply with the MSP rules.

  Note that the MSP rules do not apply to standalone dental coverage.

Plan Election and Enrollment Guidelines

This section addresses the Plan's rules and requirements related to enrollment and election changes. Topics include effective dates, termination procedures, Significant Life Events, Annual Enrollment, and other procedures.

Eligible Individual Responsibilities
The Plan and its administrators rely on information provided by Eligible Individuals when evaluating the coverage and benefits under the Plan. Eligible Individuals must provide all required information (including their and their enrolled Eligible Dependent's Social Security Number or Individual Taxpayer Identification Number) through a MyCPG Accounts submission or with an enrollment form to the Participating Group.

All information provided must be accurate, truthful, and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information will be considered an intentional misrepresentation of a material fact and may result in the denial of a claim, cancellation or rescission of coverage, or any other legal remedy available to the Plan.

Plan Elections and Changes

Eligible Individuals make their Plan elections and Coverage Tier elections upon first becoming eligible to participate in the Plan.

Plan elections generally remain in place for the entire Plan Year, provided the required contributions for coverage are received by the Plan. An Eligible Individual may not change their elected Plan or Coverage Tier except during Annual Enrollment, unless there is a Significant Life Event.

Important Note: An Eligible Individual (and their Eligible Dependents) may not enroll in or terminate a medical or dental Plan mid-year (i.e., outside of Annual Enrollment) without a Significant Life Event.

Significant Life Events

A Significant Life Event gives an Eligible Individual the opportunity to make a change to enrollment (or to enroll themselves and/or Eligible Dependents). The enrollment change must be requested in writing by the Eligible Individual within 30 days following the event and must be consistent with the event. Significant Life Events may* include:

- marital status change (e.g., marriage, divorce, legal separation, or annulment of marriage)
- establishment or termination of a Domestic Partnership (in Participating Groups offering Domestic Partner coverage)
- change in the number of Eligible Dependents (e.g., an increase through marriage, birth, adoption, or placement for adoption, or a decrease through death or Dependent gaining own health benefits)
- change in Dependent status (e.g., becoming ineligible by reaching a limiting age)
- change in employment status of an Eligible Individual or Eligible Dependent, that affects Plan eligibility (e.g., termination or commencement of employment, change in normally scheduled and compensated hours in a plan year affecting Plan eligibility, significant change in the employer contribution or eligibility for contribution, commencement of or return from an unpaid leave of absence, changing from an Employee to a Pre-65 Former Employee or a Post-65 Former Employee)

* Note: The employer is responsible for designating, in its Cafeteria Plan, which Significant Life Events will permit enrollment changes. Employers are not required to permit changes for all possible Significant Life Events. Please note, however, that employers are required to permit enrollment changes following a HIPAA Special Enrollment Event.

- a judgment, decree, or order (e.g., a Qualified Medical Child Support Order (QMCSO))
- a change in residence or work site for an Eligible Individual or Eligible Dependent that affects network access to the current Plan(e.g., if an Eligible Individual previously resided in an area in which only the PPO was available and then moved into an area where the EPO and PPO are available, the Eligible Individual may elect a new Plan or if an Eligible Individual moved out of the EPO service area, and was therefore no longer eligible for the EPO, the Eligible Individual may elect a new Plan).
  significant change in the cost of the Plan or a significant curtailment of medical coverage during a plan year for an Eligible Individual or Eligible Dependent
- Medicare or Medicaid entitlement (or loss of such entitlement)
- HIPAA Special Enrollment Event (see below)
- enrollment in or termination of a Medicare Part D plan
- change in employment or insurance status of Spouse
- qualification change of a post-65 actively working Eligible Individual or Eligible Individual's Spouse to participate in the SEE Plan or GMAP
- enrollment in a "qualified health plan" through a health insurance exchange in the individual market.
- any other Significant Life Events provided under the applicable regulations and provided for under the employer's Cafeteria Plan

Important Note: A healthcare provider's discontinuation of participation in a Plan network is not a Significant Life Event and does not permit an election change.

The effective date of coverage for an election change due to a Significant Life Event is the first day of the month coincident with or following the Significant Life Event (except in the case of birth, adoption or placement for adoption of a Child, in which case coverage will be effective retroactive to the date of the event). The Eligible Individual must notify the Group Administrator of the occurrence of the Significant Life Event and of the election changes no later than 30 days after the Significant Life Event (or 60 days in the case of loss of eligibility for coverage under a Medicaid program or a state child healthcare program, or eligibility for assistance with coverage under the Plan through Medicaid or a state child healthcare program—see below under "HIPAA Special Enrollment Events") and such election changes are valid for the remainder of the current Plan Year.

The Participating Group must submit notice of the Significant Life Event and the request for an enrollment change or new enrollment, as applicable, to the Medical Trust through MAP within 60 days following the Significant Life Event. If a Significant Life Event occurs and notice of the event and a request for an enrollment change or new enrollment, as applicable, is submitted to the Medical Trust more than 60 days after the occurrence of the event, the Medical Trust will only consider the request if extenuating circumstances prevented the Group Administrator from notifying the Medical Trust of the Significant Life Event and of the Eligible Individual's election change. A description of such extenuating circumstances should be submitted to the Medical Trust together with the request for enrollment change or new enrollment, as applicable. The Medical Trust reserves the right to require the Group Administrator to provide additional information regarding the late request. The Medical Trust will make a determination, in its sole discretion, of whether the late request will be accepted.

Please note that, in all instances, the Eligible Individual must have informed their employer or Group Administrator of the Significant Life Event and the requested enrollment change or new enrollment within 30 days (or 60 days in the case of loss of eligibility for coverage under a

Medicaid program or a state child healthcare program, or eligibility for assistance with coverage under the Plan through Medicaid or a state child healthcare program) following the Significant Life Event. In other words, the “extenuating circumstances” can only relate to the delay in the Group Administrator submitting the required information to the Medical Trust. The Medical Trust cannot consider extenuating circumstances that led to the Eligible Individual failing to provide timely notice of the Significant Life Event and of their new election. In no event will the Medical Trust consider a request for an enrollment change or new enrollment submitted to the Medical Trust more than 180 days after the occurrence of the Significant Life Event.

If a Significant Life Event is expected to occur (e.g., an institution hires a new Employee, who will be an Eligible Individual after their start date), notice of the event and a request for the enrollment change or new enrollment, as applicable, may be submitted to the Medical Trust up to 90 days in advance. If the Significant Life Event does not occur, or does not occur on the date indicated in the notice submitted to the Medical Trust, the Participating Group must notify the Medical Trust as soon as possible. If the Participating Group fails to notify the Medical Trust in a timely manner, the termination of the requested coverage will be handled as described in the Administrative Policy Manual. For purposes of determining the effective date of coverage, any request submitted in advance will be deemed to have been submitted on the date the Significant Life Event actually occurs.

The employer is responsible for providing the Member a Summary of Benefits and Coverage (SBC) for each applicable Plan within 90 days of enrollment resulting from a Significant Life Event.

HIPAA Special Enrollment Events

Certain Significant Life Events are considered to be HIPAA Special Enrollment Events. HIPAA Special Enrollment Events include:

- marriage;
- birth of a Child;
- adoption or placement for adoption of a Child;
- loss of coverage under another group health plan, including
    - the expiration of COBRA coverage if the other coverage was under a COBRA continuation provision, or,
    - if the other coverage was not under COBRA,
        - loss of eligibility for the other coverage or
        - termination of employer contributions toward the Employee’s other coverage;
- loss of eligibility for coverage in a Medicaid program under Title XIX of the Social Security Act or a state child healthcare program under Title XXI of the Social Security Act; and
- eligibility for assistance with coverage under the Plan through a Medicaid program under Title XIX of the Social Security Act or a state child healthcare program under Title XXI of the Social Security Act.

Eligible Individuals will generally have 30 days to elect to enroll in the Plan after a HIPAA Special Enrollment Event, but will have 60 days to elect to enroll in the Plan as a result of a HIPAA Special Enrollment Event that is a loss of eligibility for coverage under a Medicaid program or a state child healthcare program or eligibility for assistance with coverage under the

Plan through Medicaid or a state child healthcare program. In the case of birth, adoption, or placement for adoption of a Child, coverage will be effective retroactive to the date of the event. For all other HIPAA Special Enrollment Events, coverage will be effective as of the first day of the month following the month in which the coverage is requested in writing, or, if earlier, the date described under Significant Life Events, above, provided that the request is submitted to the Medical Trust within 60 days following the occurrence of the HIPAA Special Enrollment Event (or that the request was submitted to the Medical Trust more than 60 days but within 180 days following the occurrence of the HIPAA Special Enrollment Event and the Medical Trust accepted such late request).

The employer is responsible for providing the Member a Summary of Benefits and Coverage (SBC) for each applicable Plan and a Notice of Special Enrollment within 90 days of enrollment resulting from a HIPAA Special Enrollment Event.

Reporting Eligibility and Enrollment Changes

The Group Administrator must report all changes that affect Member benefit coverage and Plan elections to the Plan when they occur, but no later than 60 days after the occurrence. Examples of what should be reported include:

- demographic information change
- dependent information change
- employment status change
- employer change (e.g., transfer to a new church or diocese)
- change resulting from a Significant Life Event
- change resulting from a HIPAA Special Enrollment Event
- death of a Member (including an enrolled Dependent)
- retirement of an Employee
- billing information change
- disability of a Child
- change of gender

The Eligible Individual must notify the Group Administrator when a Significant Life Event or other change occurs. The Group Administrator should request supporting documentation regarding Dependent eligibility or loss of eligibility.

The Group Administrator must then notify the Medical Trust through a MAP submission within 60 days after the event. Failure by the Group Administrator to perform this task could jeopardize the Eligible Individual's / Eligible Dependent's enrollment.

The following additional requirements also apply:

- Health Plan choice may be restricted if an Eligible Individual has Eligible Dependents living outside the service area of a particular Plan.
- If a local managed care plan is elected, additional enrollment forms from the local plan option may be required.
- Pre-65 Former Employees and Post-65 Former Employees who do not receive any contribution assistance from the Participating Group may submit enrollment forms directly to the Plan.
- Certain additional requirements may apply under the GMAP that should be taken into consideration in the processing of enrollment paperwork. Therefore, to ensure timely access to prescription drug coverage, the enrollment form and

all required materials must be received at least three (3) months prior to your desired coverage effective date.

Other changes such as a change of address or phone number can and should be reported to the Plan when they occur through a MAP or MyCPG Accounts submission.

Required Information and Documentation

All of the information requested on MAP or MyCPG Accounts (such as Social Security Number and date of birth) is required in order for a Plan election or other change to be processed.

The Participating Group is responsible for verifying a Member's personal data and may be required to provide the Plan with copies of the following documentation:

- birth certificate
- Social Security card
- Individual Taxpayer Identification Number (ITIN) card
- marriage certificate
- divorce decree
- domestic partnership affidavit
- statement of dissolution of domestic partnership
- child affidavit
- placement or custody order from social services, a welfare agency or court of competent jurisdiction
- adoption petition or decree
- Medicare card
- driver's license

Annual Enrollment

Annual Enrollment is the annual period during which Eligible Individuals of the EHP, the SEE Plan, and GMAP may elect or change health Plans for the following Plan Year for themselves and their Eligible Dependents, or change Dependents covered by the Plan. Eligible Individuals must use the Annual Enrollment website or complete the enrollment form, as appropriate. Generally, Annual Enrollment occurs during the fall with changes becoming effective on January 1 of the following Plan Year.

At the beginning of Annual Enrollment, enrolled Eligible Individuals receive a personalized letter outlining the steps required to make Plan election(s) or other changes for the upcoming Plan Year. The letter contains information about the Annual Enrollment website, instructions, and the dates the Annual Enrollment website will be available. The Medical Trust provides Participating Groups with customizable templates to help them communicate with non-enrolled Eligible Individuals and Eligible Individuals who recently met the eligibility for the Plans.

The Annual Enrollment website, which is accessed through MyCPG Accounts, contains:

- current demographic and coverage information
- available medical and/or dental Plans
- full contribution rates for each Plan and Coverage Tier (note that Employer/Employee cost

share information is not provided)
- options to add or remove Eligible Dependents
- the deadline for submitting Plan elections
- links to Summaries of Benefits and Coverage (SBCs)
- reference material and other helpful resources

Seminarian Annual Enrollment

Annual Enrollment for Seminarians is held in conjunction with Annual Enrollment in the fall, with changes becoming effective January 1 of the following year.

New Plan elections for Seminarians who begin studying in the spring semester may be submitted before the commencement of classes. Plan elections must be submitted before the semester in which the Seminarian is enrolling commences. The Seminary Group Administrator must provide the SBCs for all available Plans to the Seminarian no later than the first day the Seminarian is eligible to enroll in coverage.

Specific Guidelines and Effective Dates of Coverage for Eligible Individuals

Coverage is generally effective on the first day of the month coincident with or following the date an Eligible Individual first becomes eligible to participate in the Plan, provided that they are timely enrolled in the Plan. Completed MAP submissions must be received by the Plan within 60 days of the event. See the *Significant Life Events* and *HIPAA Special Enrollment Events* sections above for coverage effective date guidelines.

New Employees and Newly Eligible Employees

The effective date of coverage for a new Employee is the first day of the month following the Employee's date of hire or date they become eligible. For example, if the date of hire is Monday, June 2, then coverage is effective July 1.

However, if an Employee's date of hire is the first calendar day of the month (e.g., Monday, June 1), coverage for the Employee will commence on the first day of that month (i.e., Monday, June 1), provided that the Plan receives a MAP submission within 60 days of that date.

In order to ensure compliance with the Affordable Care Act, in no event may the effective date of coverage for a new Employee be later than the first of the month following 60 days from the later of the date of hire or date they become eligible.

If the Employee does not elect to enroll (or is not automatically enrolled by the Participating Group, if applicable) within 30 days from the date when they become eligible, the Employee must wait for an applicable Significant Life Event to occur or wait until the next Annual Enrollment period.

Plan elections, once made, cannot be changed for the remainder of the current Plan Year unless the Eligible Individual experiences a Significant Life Event.

The employer must provide the SBCs for all available Plans to the Employee no later than the first day the Employee is eligible to enroll in the Plan.

Religious Orders

The effective date of coverage for a postulant, novice, or professed Member of a Religious Order is the first day of the month following the date in which they are received or accepted by the Religious Order.

However, if a postulant, novice, or member is received or accepted by the Religious Order on the first working day of the month and the first calendar day of the month (e.g., Monday, June 1), coverage for the postulant, novice or member will commence on the first day of that month (i.e., Monday, June 1), provided that the Plan receives a MAP submission within 60 days of that date.

If the postulant, novice or member does not enroll when initially eligible, then they must wait for an applicable Significant Life Event to occur or until the next Annual Enrollment period.

Seminarians

The effective date of coverage for a Seminarian is the first day of the month in which the first semester or term in which they enroll as a full-time student begins.

The Seminarian must make any elections no later than 30 days after the seminary's published registration deadline for that semester.

If the Seminarian does not elect to enroll during the 30-day period described above, then they must wait for an applicable Significant Life Event to occur, or wait to enroll at the beginning of any subsequent semester and be covered starting with the first day of the month that semester begins. Enrollment will continue year-round for the duration of the time in seminary, until the Seminarian is no longer eligible (for example, because of graduation), or they must wait for an applicable Significant Life Event or Annual Enrollment.

Pre-65 Former Employees

A Pre-65 Former Employee from a Participating Group who terminates employment (e.g., due to retirement) but is not Medicare-eligible may continue coverage through the Episcopal Health Plan (EHP) provided an enrollment form is received by the Plan no later than 30 days after the termination date.

If the Pre-65 Former Employee wants to make a plan election change as a result of the termination of employment, then the coverage effective date of the new Plan will be the first day of the month following the termination date. Elections must be received by the Plan no later than 30 days after the termination date.

If the Pre-65 Former Employee does not make an election change within 30 days of the termination date, then they must wait for an applicable Significant Life Event to occur, or wait until the next Annual Enrollment period, to make an election change.

Once the Pre-65 Former Employee becomes Medicare-eligible, they are no longer eligible for the EHP and must actively switch enrollment to the Group Medicare Advantage Plan (GMAP). If the enrolled Spouse/Domestic Partner is not Medicare-eligible at that time, then the enrolled Spouse/Domestic Partner may remain in the EHP until becoming Medicare-eligible, at which time they too are no longer eligible for the EHP and must actively switch

enrollment to the GMAP. The enrolled Children who are not Disabled Children may remain in the EHP until the end of the year in which they reach age 30.

If the Pre-65 Former Employee has a Spouse who becomes age 65, the post-65 Spouse of the Pre-65 Former Employee is allowed to enroll in the GMAP provided they are enrolled in Medicare Parts A and B. The Pre-65 Former Employee remains in the EHP. This reverse split is allowed because the enrolled Eligible Individual is a Pre-65 Former Employee.

Important Notes:

- An Employee who terminates their employment with a Participating Group who does not meet the eligibility requirements for a Pre-65 Former Employee will be offered an Extension of Benefits (as described in the Extension of Benefits section below).
- By definition, a Pre-65 Former Employee who returns to active employment with a Participating Group and becomes eligible for the EHP as an Employee is no longer a Pre-65 Former Employee.
- A Pre-65 Former Employee who returns to active employment with a Participating Group, becomes eligible for the EHP as an Employee, subsequently terminates the new active employment, and once again meets the definition of a Pre-65 Former Employee will be considered a Pre-65 Former Employee who has terminated from the most recent Participating Group. For example, assume that Father Smith works for Diocese A and is enrolled in the EHP. Father Smith's employment with Diocese A ends. If he is eligible to continue to participate in the EHP as a Pre-65 Former Employee, he may choose from the plan options offered by Diocese A. If Father Smith is subsequently employed by Diocese B and becomes eligible to enroll in the EHP by virtue of this new employment, Father Smith will no longer be a Pre-65 Former Employee and will now only be able to choose from the plan options offered by Diocese B. If Father Smith's employment with Diocese B subsequently ends, and he continues to meet the requirements to qualify as a Pre-65 Former Employee, he can choose from the plan options offered by Diocese B. Father Smith will no longer be able to choose from the plan options offered by Diocese A, because he is now a Pre-65 Former Employee of Diocese B.

Pre-65 Former Employee, not covered under the Episcopal Health Plan (EHP)

Enrollment in the EHP for Pre-65 Former Employees who are not currently enrolled in the EHP is limited to those who:

a) waived EHP coverage as a qualified opt-out and either (i) have subsequently experienced a Significant Life Event or (ii) enroll during Annual Enrollment, or
b) join the EHP as part of a new Participating Group during their initial enrollment period, provided they were covered under that group's plan and included in the group census.

For these limited circumstances, the Pre-65 Former Employee may enroll in the EHP at the time of a Significant Life Event or Annual Enrollment and remain in the EHP until such time as the individual becomes Medicare-eligible, at which time the Pre-65 Former Employee is no longer eligible for the EHP and must actively switch enrollment to the GMAP. If the enrolled Spouse/Domestic Partner is not Medicare-eligible at that time, then the enrolled

Spouse/Domestic Partner may remain in the EHP until becoming Medicare-eligible, at which time the Spouse/Domestic Partner too is no longer eligible for the EHP and must actively switch enrollment to the GMAP.

Enrolled Children of such a Pre-65 Former Employee may also remain enrolled in the EHP for so long as they remain an Eligible Dependent.

Post-65 Former Employees

The effective date of coverage for the GMAP for a Post-65 Former Employee is the first day of the month in which they turn age 65, provided that they are enrolled in Medicare Parts A and B and meet the other eligibility requirements of the Plan.

If the Post-65 Former Employee does not enroll when initially eligible, then they must wait for an applicable Significant Life Event to occur or wait until the next Annual Enrollment period.

Dependents

The effective date of coverage for an Eligible Dependent is the same date as the enrolled Eligible Individual's effective date. If the Eligible Individual does not elect to enroll all Eligible Dependents within 30 days of the Eligible Individual's initial eligibility or a subsequent Significant Life Event, then the Eligible Dependents may not enroll until the next Annual Enrollment period or until another Significant Life Event occurs.

New Children

An Eligible Individual's newborn Child is covered under the Plan for the first 30 days immediately following birth only if the newborn Child is enrolled in the Plan. The Eligible Individual must elect to enroll the new Child for coverage within 30 days of the birth to ensure that claims incurred during the first 30 days are covered and for coverage to continue beyond the 30-day period. The coverage effective date will be the date of birth. If applicable, monthly contribution rates will change to reflect the new Coverage Tier on the first day of the month following the date of birth. If the Eligible Individual does not elect to enroll the Child within the 30-day period, the Child may not be enrolled in the Plan until the next Annual Enrollment period or the occurrence of a subsequent Significant Life Event.

Important Notes:

- The birth of a newborn Child constitutes a Significant Life Event that allows an Eligible Individual or an Eligible Individual's Spouse/Domestic Partner who is not enrolled in the Plan to enroll as of the date of birth of the newborn Child.
- A newborn Child may not enroll in the Plan if the Eligible Individual is not enrolled in the Plan.
- The newborn child of a Dependent Child will not be covered by the Plan, even for the first 30 days, unless that child is placed for adoption by, or is a legal ward or foster child of, the Eligible Individual or Eligible Individual's Spouse/Domestic Partner.

Adopted Children

Upon timely notification, coverage for the Child will be effective on the date of adoption, or, if earlier, placement for adoption, in each case, by an Eligible Individual or an Eligible Individual's Spouse/Domestic Partner. If the Eligible Individual does not elect to enroll the

Child within 30 days of that date, then the Child may not enroll until the next Annual Enrollment period or until a subsequent Significant Life Event occurs. If a Child placed for adoption is not adopted, all health coverage ceases when the placement ends and will not be continued. The Plan will only cover expenses incurred by the birth mother, including the birth itself, if the birth mother is an enrolled Member on the date of birth.

Spouses

An enrolled Eligible Individual may enroll their eligible Spouse for coverage under the Plan. If the Eligible Individual does not elect to enroll their eligible Spouse within 30 days after marriage, then the eligible Spouse may not enroll until the next Annual Enrollment period or until a Significant Life Event occurs.

Domestic Partners

An enrolled Eligible Individual may enroll their eligible Domestic Partner for coverage under the Plan and is part of a Participating Group that offers Domestic Partner coverage. The Plan requires a signed affidavit attesting to the Domestic Partnership. If the Eligible Individual does not elect to enroll their eligible Domestic Partner within 30 days after the establishment of a valid Domestic Partnership as certified by a *Domestic Partnership Affidavit,* then the eligible Domestic Partner may not enroll until the next Annual Enrollment period or until a Significant Life Event occurs.

Non-Medicare-eligible Dependents

A Post-65 Former Employee and the Employee's Eligible Dependents may split enrollment between the EHP and the GMAP in cases where the Post-65 Former Employee is eligible for Medicare and the Dependents are not eligible for Medicare and are under age 65. Eligibility in the EHP will end once the Spouse/Domestic Partner becomes Medicare eligible and/or reaches age 65, at which time, the Spouse/Domestic Partner must actively switch enrollment to the GMAP. The enrolled Eligible Individual's enrolled Children who are not a Disabled Child may continue to participate in the EHP until the end of the year in which they reach age 30.

Disabled Child

If the Dependent Child is a Disabled Child prior to their 25th birthday and continues to be a Disabled Child on the last day of the year in which the Child reaches age 30, the Child's eligibility will be extended for as long as the parent is an Eligible Individual enrolled in the EHP, SEE Plan, or GMAP, and the Child continues to meet the Plan's eligibility requirements in all aspects other than age.

In order for the Plan to confirm the status of a Disabled Child, the Eligible Individual must contact Client Services, which will initiate the confirmation process with the Medical Board. The Medical Board will review satisfactory proof of disability and determine the status of the Disabled Child. In connection with this review, the Medical Board will contact the Eligible Individual with the request for documentation. The Plan may require, at any time, a physician's statement certifying the ongoing physical or mental disability.

Children of Surviving Spouses of Limited Means

The Children's Health Insurance Program (CHIP) is a federal program through which the government assists states in providing affordable health insurance to families with children. The program was designed to offer health coverage to uninsured children in families with incomes that are modest but too high to qualify for Medicaid.

Surviving Spouses of limited means may find it more financially advantageous to cover their minor children through CHIP or to cover their minor and adult dependent children through Medicaid. For such persons, Surviving Spouses may opt to (1) cover their minor Children or adult Dependent Children in a government plan, (2) decline coverage from the Plan for the Dependents so covered, and (3) retain the eligibility to re-enroll these Dependents should they lose coverage under the government plan on account of (i) bankruptcy or termination of the government plan, (ii) loss of eligibility under the government plan due to income changes, or (iii) other loss of eligibility for the government plan, not including reaching a limiting age. Dependents must satisfy all other eligibility criteria of the Plan in order to re-enroll. See the HIPAA Special Enrollment section for more details.

Children Subject to a Qualified Medical Child Support Order (QMCSO)
A QMCSO is a judgment, decree or order (including approval of a settlement agreement) or administrative notice that is issued pursuant to a state domestic relations law (including a community property law) or through an administrative process, which directs that a child must be covered under a health plan. The Plan has delegated to the applicable Participating Group the responsibility to determine if a medical child support order is qualified. If the Participating Group determines that a separated or divorced Spouse, or any state child support or Medicaid agency, has obtained a QMCSO, and if the Participating Group offers Dependent coverage, the Plan will allow the enrolled Eligible Individual to provide coverage for any Children named in the QMCSO.

To be qualified, a medical child support order must satisfy all of the following:

- The order recognizes or creates a Child's right to receive group health benefits for which the Eligible Individual is eligible.
- The order specifies the Eligible Individual's name and last known address and the Child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the Child's mailing address.
- The order provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined.
- The order states the period to which it applies.
- If the order is a National Medical Support Notice, it meets the requirements above.

The QMCSO may not require the Plan to provide any type or form of benefit or option not otherwise provided under the Plan.

Children of an enrolled Eligible Individual who must be covered under the Plan in accordance with a QMCSO will be covered beginning on the date the order is approved and continuing until the date or age stipulated. However, Children may not be covered beyond the eligibility age permitted under the Plan.

If a QMCSO requires that the Eligible Individual provide health coverage for the Eligible Individual's Children and the Eligible Individual does not enroll the Children, the Participating Group will enroll the Children upon application from the Eligible Individual's separated or

divorced Spouse, the state child support agency, or Medicaid agency, provided it is required to do so by law. If the Eligible Individual is not enrolled in the Plan, the Participating Group will also enroll the Eligible Individual, because Children may not be enrolled in the Plan without the Eligible Individual also being enrolled. The Participating Group will withhold from the Eligible Individual's pay their share of the cost of such coverage.

If a QMCSO requires a separated or divorced ex-Spouse of an Eligible Individual to cover a Child, the Eligible Individual may change elections and drop coverage for the Child. However, the Eligible Individual may not drop coverage for the Child until the other plan's coverage begins.

Eligible Individuals may not otherwise drop coverage for a Child covered pursuant to a QMCSO unless they submit written evidence to the Participating Group that the QMCSO is no longer in effect.

Leaves of Absence

Leaves of absence encompass all approved leaves with or without pay, including leaves due to workers' compensation, Family and Medical Leave Act, and the sentence of suspension or restriction on ministry of a priest in accordance with Title IV, Canon 19, Section 7 of The Constitution and Canons of The Episcopal Church, 2018.

If the leave of absence is paid leave, or a legally mandated unpaid leave, the Member(s) can retain their active coverage. If the leave of absence is unpaid, and otherwise not legally mandated, then the Member(s) will be terminated and a letter will be sent offering an Extension of Benefits. Upon the enrolled Eligible Individual's return, the employer can reinstate the Member(s). Note that a change to employer premium cost sharing as a result of a leave of absence may constitute a Significant Life Event.

Termination of Individual Coverage

The Group Administrator must submit a request to terminate coverage for an enrolled Eligible Individual through MAP no later than 30 days after the termination event. If the Plan receives a termination request thereafter, then the Participating Group (or enrolled Eligible Individual, if billed directly) will be required to pay the applicable monthly contributions to the Plan up to the coverage termination date.

Coverage ends the earliest of

- the last day of the month in which
  - the enrolled Eligible Individual no longer meets the eligibility requirements (e.g., an Employee's employment ends or a Seminarian graduates from seminary)
  - the Dependent no longer meets the eligibility requirements for any reasons other than death or turning age 30 (e.g., a Spouse is no longer eligible due to divorce from an enrolled Eligible Individual, or an enrolled Eligible Individual ceases to be a Dependent's legal guardian)
  - the Participating Group's participation with the Plan terminates
- the last day of the year in which an enrolled Dependent Child reaches age 30[17] (except if the Child is a Disabled Child in accordance with the terms of the Plan)
- the date on which monthly contributions are deemed delinquent, as determined by the Plan in its sole discretion.
- the date the Plan ceases to exist

When a termination event occurs that relates to the enrolled Eligible Individual's or a Dependent's eligibility, the enrolled Eligible Individual must notify the Group Administrator as soon as possible. The Group Administrator should request supporting documentation regarding such event.

Coverage termination dates resulting from a Significant Life Event where an enrolled Eligible Individual loses or declines coverage will be the last day of the month in which the Significant Life Event occurred, unless otherwise specified.

For Cause

Upon written notice to an Eligible Individual, the eligibility of the Eligible Individual and their Dependent(s) may be immediately terminated if the Eligible Individual or Dependent(s)

- Threaten(s) the safety of the Plan Sponsor, the Claims Administrator, any Group Administrator or any provider, or any personnel of any of the foregoing;
- Commit(s) theft from the Plan Sponsor, the Claims Administrator, any Group Administrator or any provider; or
- Perform(s) an act that constitutes fraud or makes an intentional misrepresentation of material fact in procuring coverage, such as knowingly (1) misrepresenting participation status, (2) presenting an invalid prescription or physician order, or (3) misusing or letting someone else misuse an ID card to obtain care under false pretenses.

Note: Any Eligible Individual or Dependent's fraud will be reported to the authorities for prosecution and appropriate civil remedies will be pursued.

Termination will be effective as soon as administratively practicable following the date notice is sent, and in no event later than the last day of the month during which such notice is sent. All rights cease as of the date of termination, including the right to enroll in the Extension of Benefits program following the termination of coverage.

Persons Barred from Enrolling

A person who would otherwise be an Eligible Individual or Eligible Dependent cannot enroll if such individual has had their eligibility terminated for cause due to their actions.

Death and Surviving Dependents

Except as otherwise stated below, Surviving Dependents are not eligible to remain covered by the EHP, SEE Plan, or GMAP. Coverage will be terminated following the Eligible Individual's death, and Surviving Dependents who were covered under the EHP or SEE Plan on the date the Eligible Individual died will be offered coverage under the Extension of Benefits program. The coverage termination date will be the last day of the month in which the Eligible Individual's death occurred. The new coverage effective date for the Surviving Dependents who enroll in the Extension of Benefits program will be the first day of the month following the Eligible Individual's death date. Surviving Dependents who are or who subsequently become an Eligible Individual in their own right (e.g., through their own employment at an Episcopal institution) are no longer eligible for coverage under the Extension of Benefits program.

Remarriage / Subsequent Domestic Partnership

If a Surviving Spouse remarries (or enters into a Domestic Partnership), any new Dependents acquired after the Eligible Individual's death are ineligible for coverage under the Plan, unless the Dependent is a Child of the Eligible Individual born or adopted up to 12 months after the Eligible Individual's death. The same rules apply to Surviving Domestic Partners who engage in a new Domestic Partnership (or who subsequently marry).

Employee/Seminarian

When an Employee or Seminarian enrolled in the EHP or SEE Plan dies, and they would not have met the definition of a Pre-65 Former Employee or a Post-65 Former Employee if their status as an Employee or Seminarian had terminated immediately prior to the time of their death, their Surviving Dependents who are also enrolled in the EHP or SEE Plan at that time are offered an Extension of Benefits. The coverage termination date will be the last day of the month in which the Eligible Individual's death occurred. The new coverage effective date for the Surviving Dependents who choose to enroll in the Extension of Benefits program will be the first day of the month following the Eligible Individual's date of death.

When an Employee or Seminarian enrolled in the EHP or SEE Plan dies, and they would have met the definition of a Post-65 Former Employee or a Pre-65 Former Employee, in each case, if their status as an Employee or Seminarian had terminated immediately prior to the time of their death, their Surviving Dependents who are also enrolled in the EHP or SEE Plan at that time can remain covered in the EHP until becoming Medicare-eligible, at which time the individual will no longer be eligible for the EHP and must actively enroll in the GMAP, if eligible. Enrolled Children may remain in the EHP until the last day of the year in which they turn 30., or later if the Child is a Disabled Child in accordance with the terms of the Plan. If the Surviving Dependents leave the EHP, they may not return to the Plan, unless they are eligible to enroll in and elect to enroll in the GMAP.

Pre-65 Former Employee, Post-65 Former Employee, or Cleric receiving benefits under The Church Pension Fund Clergy Long-Term Disability Plan

When a Pre-65 Former Employee, Post-65 Former Employee, or a Cleric receiving benefits under The Church Pension Fund Clergy Long-Term Disability Plan enrolled in the EHP or GMAP dies, Surviving Spouses and Surviving Domestic Partners enrolled in the EHP can remain covered in the EHP until becoming Medicare-eligible, at which time the individual will no longer be eligible for the EHP and must actively enroll in the GMAP, if eligible. Surviving Spouses and Surviving Domestic Partners enrolled in the GMAP at the time of the enrolled Eligible Individual's death can remain covered in the GMAP.

Children enrolled in the EHP may remain in the EHP until the last day of the year in which they turn 30,or later if the Child is a Disabled Child in accordance with the terms of the Plan. If the Surviving Dependents leave the EHP, they may not return to the Plan, unless they are eligible to enroll in and elect to enroll in the GMAP.

Dependents

If an enrolled Eligible Dependent dies, the termination date for the deceased Dependent is the end of the month in which the death occurred. The enrolled Eligible Individual's Coverage Tier

and associated monthly contribution may change as a result, beginning on the first day of the month following the death date.

Divorce or Dissolution of a Domestic Partnership

The divorced Spouse (or former Domestic Partner) and/or enrolled Eligible Individual must notify the Participating Group and the Plan of events that may cause a loss of coverage. The coverage termination date is the first of the month following the effective date of the divorce (or of the dissolution of the Domestic Partnership).

Employees and Seminarians

The Spouse/Domestic Partner enrolled in the EHP or the SEE Plan will be offered an Extension of Benefits only and will not be considered eligible for the GMAP at a later date. Please see the Extension of Benefits section for more details.

Post-65 Former Employees or Pre-65 Former Employee with Dependents under age 65

The Pre-65 Spouse or Domestic Partner enrolled in the EHP who gets divorced from (or dissolves a Domestic Partnership with) a Post-65 Former Employee or Pre-65 Former Employee can stay enrolled in the EHP. However, if the Spouse or Domestic Partner leaves the EHP, then they cannot enroll again with the Plan until they become eligible for the GMAP. The Spouse or Domestic Partner can leave the GMAP and join again at future Annual Enrollment periods.

Post-65 Former Employees or Pre-65 Former Employees with Dependents in the GMAP

The Spouse or Domestic Partner enrolled in the GMAP who gets divorced from (or dissolves a Domestic Partnership with) a Post-65 Former Employee or Pre-65 Former Employee can stay enrolled in the GMAP. The Spouse or Domestic Partner can leave the GMAP and join again at future Annual Enrollment periods.

Extension of Benefits Program for the EHP

The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under federal law (known as "COBRA") for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements.[19] Nonetheless, enrolled Eligible Individuals and/or their enrolled Eligible Dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the EHP would otherwise cease. Individuals who elect to continue coverage must pay for the full cost of their coverage.

[19] Under Section 4980B(d) of the Internal Revenue Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

The option to extend coverage depends on whether the individual was covered as an Employee, Spouse, Domestic Partner, or Dependent Child.

- Employees who no longer meet the Plan's eligibility requirements for the EHP or SEE Plan (e.g., as the result of a termination of employment or reduction of scheduled hours) are offered an extension of 36 months starting on the first day of the month following the termination event.
    - Note that, because the SEE Plan requires that the Eligible Individual be actively working for an Eligible Small Employer, Eligible Individuals enrolled in the SEE Plan who terminate employment will be offered continuation of coverage under the EHP in the Extension of Benefits program.
- Spouses and Domestic Partners whose coverage is terminated as a result of the Employee no longer meeting the Plan's eligibility requirements for the EHP or SEE Plan (e.g., as the result of a termination of employment or reduction of scheduled hours), the Employee's death, divorce, legal separation, or termination of a Domestic Partnership are offered an extension of 36 months starting on the first day of the month following the termination event.
    - If the couple divorces (or dissolves their Domestic Partnership) while on an Extension of Benefits, the divorced Spouse (or former Domestic Partner) of the former Employee may choose to remain on their own extension for the remaining period of the current extension.
    - Note that, with respect to former Domestic Partners, an Extension of Benefits will only be available if the Participating Group offers coverage to Domestic Partners generally.
- Dependent Children whose coverage is terminated (including as a result of reaching age 30) are offered an extension of up to 36 months starting on the first day of the month following the termination event.
- Seminarians who cease to be a Seminarian are offered an extension of 36 months starting on the first day of the month following graduation or other separation event.
- Employees whose Medical Trust coverage terminates under the terms of The Church Pension Fund Clergy Long-Term Disability Plan are offered an extension of 36 months starting on the first day of the month following the termination under The Church Pension Fund Clergy Long-Term Disability Plan.

Important Note: Regardless of the type of severance payment agreed upon between the employer and Employee (lump sum or monthly payments), if any, coverage under the Extension of Benefits program is effective the first of the month following the termination date in the Employee's record.

The Plan will make an assessment of whether an individual to be offered an Extension of Benefits is otherwise an Eligible Individual (e.g., a Pre-65 Former Employee). If the Plan determines that they are an Eligible Individual, the Plan will make an offer of coverage consistent with that eligibility.

Newly acquired Dependents during an Extension of Benefits period are eligible for coverage under the extension, provided that the Plan is notified within 30 days of the Significant Life Event.

The Plan notifies individuals regarding their eligibility for an Extension of Benefits within five business days of receiving a termination notice from the Group Administrator. Such notification from the Plan may be by physical mail or by electronic means. The notification includes an enrollment form, an invoice for contributions that are due, and an explanation of the monthly contributions and duration of the extension. If the current Plan is no longer available, an alternate option may be offered.

Recipients of an Extension of Benefits offer have 21 calendar days to respond from the day the offer is sent by the Plan (45 calendar days when the Extension of Benefits is offered to enrolled Eligible Dependents as a result of the death of the enrolled Eligible Individual). Responses must include a payment to cover the contributions that are due. Otherwise, enrollment in the Extension of Benefits is considered declined.

Coverage in effect at the time of the applicable event continues until the last day of the month in which the event occurs. Coverage under the Extension of Benefits program is effective the first of the month following the applicable event so that there is no coverage gap between the termination date and enrollment in the Extension of Benefits.

The Plan will maintain the coverage and invoice the Member directly, without the involvement of the Group Administrator. Note, however, that the employer is required to provide the SBC for the applicable Plans to the Members on the Extension of Benefits prior to Annual Enrollment each year. No conversion option is available at the end of the Extension of Benefits. If the Participating Group ceases to offer the Plan at the annual renewal, the Member will be notified during Annual Enrollment of the need to change plans for the upcoming year.

The Plan will notify Members on an Extension of Benefits of any cost change to the Plan in advance of the new Plan Year.

Coverage under the Extension of Benefits program will cease on the earliest of the following:

- The date that required monthly contributions to the Plan are deemed delinquent, as determined by the Plan in its sole discretion.
- The date the Member becomes a Post-65 Former Employee, is enrolled in Medicare Parts A and B and is not an Eligible Individual for the EHP or SEE Plan.
    - The first of the month following the date the Member is hired by another Participating Group, becomes a Seminarian, or becomes a Member of a Religious Order, and, in each case, is an Eligible Individual for the EHP or SEE Plan.
    - The last day of the last month of the Extension of Benefits period.
    - The last day of the month after the individual submits a written notice to terminate coverage for medical, dental or both (30-day notice is required).
    - The date a Participating Group's participation in the Plan is terminated (whether by the Participating Group or the Medical Trust) and the Participating Group enrolls in

another group health plan. (The Group Administrator will be notified by the Plan of all individuals participating in the Extension of Benefits program.)

  - **IMPORTANT NOTE**: The merger of a Participating Group with or into, or the acquisition of a Participating Group by, another Participating Group, or another transaction of similar effect, shall not result in the cessation of coverage under the Extension of Benefits program, so long as the surviving Participating Group continues to participate in the Plan.

- The last day of the month in which the death of the Member occurred (surviving Dependents may continue coverage under the remaining period of the Extension of Benefits).
- The date the Member's eligibility has been terminated for cause due to such individual's actions.
- The date the Member's coverage by the Plan would be illegal under applicable law.
- The date the Plan ceases to exist.

Important Notes

- **Required Monthly Contributions**

  The Plan does not pro-rate contribution requirements for any health plan regardless of the termination date or the effective date. Any monthly contribution rate change will be effective the first day of the month following the change. Contributions for coverage with a retroactive effective date must be paid upon enrollment.

- **One Type of Coverage**

  The Plan prohibits two Eligible Individuals who are Members from covering each other as an Eligible Dependent in the same Plan (EHP, SEE Plan or GMAP). Therefore, an Eligible Individual who participates in the Plan based on their own eligibility may not be an Eligible Dependent in the same Plan.

  A Child of two Members who both work for The Episcopal Church in Participating Groups and are enrolled Eligible Individuals may not be covered as an enrolled Eligible Dependent by virtue of their relationship with both enrolled Eligible Individuals in the same Plan (EHP, SEE Plan or GMAP) at the same time.

  If two Members who are Spouses (or Domestic Partners, if their Participating Groups offer Domestic Partner benefits) both work for The Episcopal Church in Participating Groups, one of which offers dental benefits and one of which does not, an individual may enroll as an Eligible Individual in a medical Plan and as an Eligible Dependent in a dental Plan, or vice versa.

- **Plan Sponsor**
  We maintain contractual relationships with various health plan vendors on Members' behalf. We are the Plan Sponsor of all Medical Trust health plans.

  The Medical Trust will be responsible for the preparation and delivery of the Forms 1094-B and 1095-B for Members who participate in the Plans that we sponsor.

- **Fully Insured Plans**
  Under certain limited circumstances, the Medical Trust offers fully insured plans to certain Participating Groups or to former employees of certain Participating Groups. The terms of these plans, including the eligibility criteria applicable to employees, former employees and their dependents, as well as the availability and duration of any continuation coverage following a loss of eligibility, may vary from the terms of the Medical Trust's self-funded Plans.

How to Obtain Services

As a Member, you must receive all Covered Services from Network Providers inside the Service Area, except where specifically noted to the contrary in the “Emergency, Post-Stabilization, and Out-of-Area Urgent Care
You Receive from Non–Network Providers” section and other sections below.

Kaiser Permanente gives you access to all of the Covered Services you may need, such as routine care with your own personal Network Physician, hospital care, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in the “Benefits and Cost Sharing” section.

Routine Care

Routine appointments are for medical needs that are not urgent, such as routine preventive care. Try to make your routine care appointments as far in advance as possible.

Urgent Care

You may need Urgent Care if you have an illness or injury that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the Urgent Care or advice nurse telephone number (see the “Customer Service Phone Numbers” section or *kp.org*). Note: Urgent Care received in a Kaiser Permanente Service Area from a Non-Network Provider or emergency department is not covered.

For information about Urgent Care outside the Service Area, please refer to the “Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers” section.

Advice Nurses

Sometimes it’s difficult to know what type of care you need. That's why Kaiser Permanente has telephone advice nurses available to assist you. These advice nurses can help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern, tell you what to do if a Network Provider is closed, or advise you about what to do next, including making a same-day appointment for you if it’s medically appropriate. To reach an advice nurse, please call the advice nurse phone number listed in the “Customer Service Phone Numbers” section.

Your Personal Network Physician

Personal Network Physicians provide Primary Care and play an important role in coordinating care, including hospital stays and referrals to specialists. For the current list of physicians who are available as Personal Network Physicians, and to find out how to select a Personal Network Physician, please call Customer Service at the number listed in the “Customer Service Phone Numbers” section. You can change your Personal Network Physician for any reason.

Kaiser Permanente (KP) generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in KP's network and who is available to accept you or your family members. Until you make this designation, KP designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Customer Service or log onto *kp.org*. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from KP or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in KP's network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain Services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact Customer Service at the number on the back of your ID card.

Telemedicine

Interactive visits between you and your Personal Network Physician using phone, interactive video, internet messaging applications, Click-to-Chat instant messaging, and email are intended to make it more convenient for you to receive medically appropriate Covered Services. When available, you may receive Covered Telemedicine Services listed under the Benefits and Cost Sharing section, subject to the "General Limitations, Coordination of Benefits, and Reductions" section. You are not required to use Telemedicine, but if you do, plan deductible may apply.
https://about.kaiserpermanente.org/our-story/our-care/is-telehealth-right-for-you

Referrals

You are required to obtain a referral from your personal physician prior to receiving specialty care Services under the Plan. If you receive specialty care Services for which you did not obtain a referral, you will be responsible for all the charges associated with those Services.

A written or verbal recommendation by a Network Physician that you obtain non-covered Services (whether Medically Necessary or not) is not considered a referral and is not covered.

A referral is limited to a specific Service, treatment, series of treatments and period. All referral Services must be requested and approved in advance. You will receive a copy of the written referral when it is approved. The Plan will not pay for any care rendered or recommended by a Non-Network Physician beyond the limits of the original referral unless the care is specifically authorized by your Network Physician and approved in advance.

Self-Referrals

You do not need a referral or Prior Authorization to receive care from any of the following:

- your Personal Network Physician
- Network Primary Care Providers in internal medicine, pediatrics, and family practice

- Network Specialists in optometry, psychiatry, substance use disorders
- obstetrical or gynecological care from a Network Provider who specializes in obstetrics or gynecology
- chiropractic and acupuncture Services from a Network Provider

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

Additionally, some regions allow self-referral to certain specialties:

Northwest Region

- Cancer Counseling
- Occupational Health
- Ophthalmology
- Social Services

Georgia Region

- Dermatology
- Ophthalmology

Colorado Region

- Denver/Boulder Service Area
  You may self-refer for consultation (routine office) visits to specialty care departments within Kaiser Permanente except for the anesthesia clinical pain department, laboratory, and radiology, and for specialty procedures such as a CT scan, MRI, colonoscopy, or surgery.
- Northern and Southern Colorado Service Areas
  You may self-refer for consultation (routine office) visits to Network Physician specialty care providers identified as eligible to receive direct referrals in the Provider Directory at *kp.org*. Click "Locate our services" then "Medical staff directory." You can obtain a paper copy of the directory by calling Member Services toll-free at 888-681-7878 or TTY 800-521-4874.

Washington Region

- You may self-refer for services with KFHPWA-designated Specialists at facilities owned and operated by Kaiser Permanente. To access a KFHPWA-designated Specialist, consult your KFHPWA personal physician. For a list of KFHPWA-designated Specialists, view the Provider Directory located at www.kp.org/wa.

Prior Authorizations

Certain Services require Prior Authorization for the Plan to cover them. Your Network Physician will request Prior Authorization when it is required, except that you must request Prior Authorization in order to receive covered Post-Stabilization Care from Non-Network Providers, as described in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care
You Receive from Non–Network Providers" section.

The provider to whom you are referred will receive a notice of Authorization by fax. You will receive a written notice of the Prior Authorization in the mail. This notice will tell you the physician's name, address, and phone number. It will also tell you the time for which the referral is valid and the Services authorized.

Required Prior-Authorization List

- All inpatient and outpatient facility Services (excluding emergencies)
- Office-based habilitative/rehabilitative care: occupational, speech, and physical therapies.
- All Services provided outside a Kaiser Permanente (KP) facility
- All Services provided by Non-Network Providers
- Drugs and Durable Medical Equipment not contained on the KP formulary

Note: For care received in a Kaiser Permanente facility or by Kaiser Permanente providers, authorization is managed by your physician and a component of your physician's referral within the Kaiser system. For care received outside a Kaiser Permanente facility or by non-Kaiser Permanente providers, your physician will request Prior Authorization and/or referral for care.

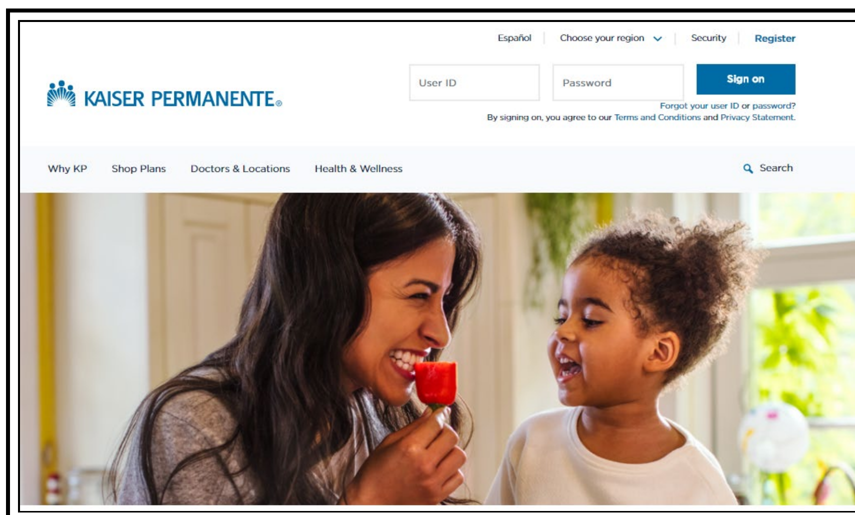
Second Opinions

Upon request and subject to payment of any applicable Cost Share, you may obtain a second opinion from

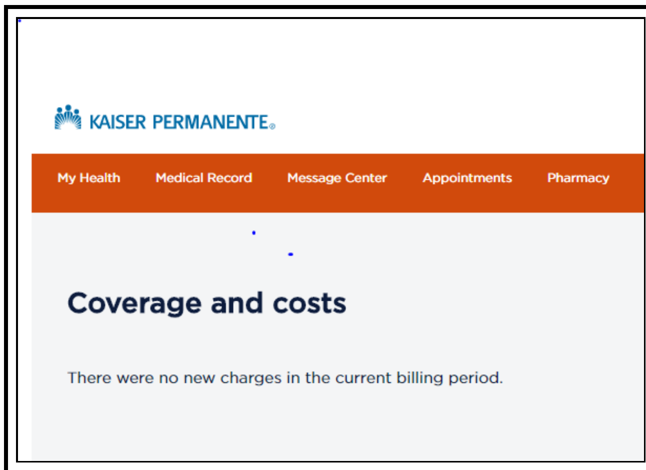
- a Network Physician about any proposed Covered Services, or
- a Non-Network Provider with Prior Authorization.

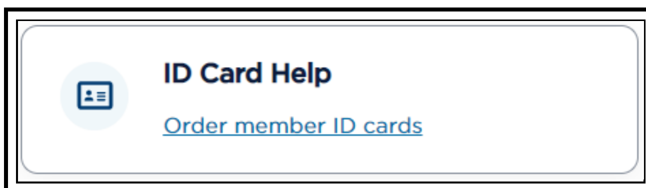
Your Identification Card

Your Kaiser Permanente identification card (ID card) has a medical or health record number on it, which you will need when you call for advice, make an appointment, or go to a provider for Covered Services. When you get care, please bring your Kaiser Permanente ID card and a photo ID. Your medical or health record number is used to identify your medical records and coverage information.



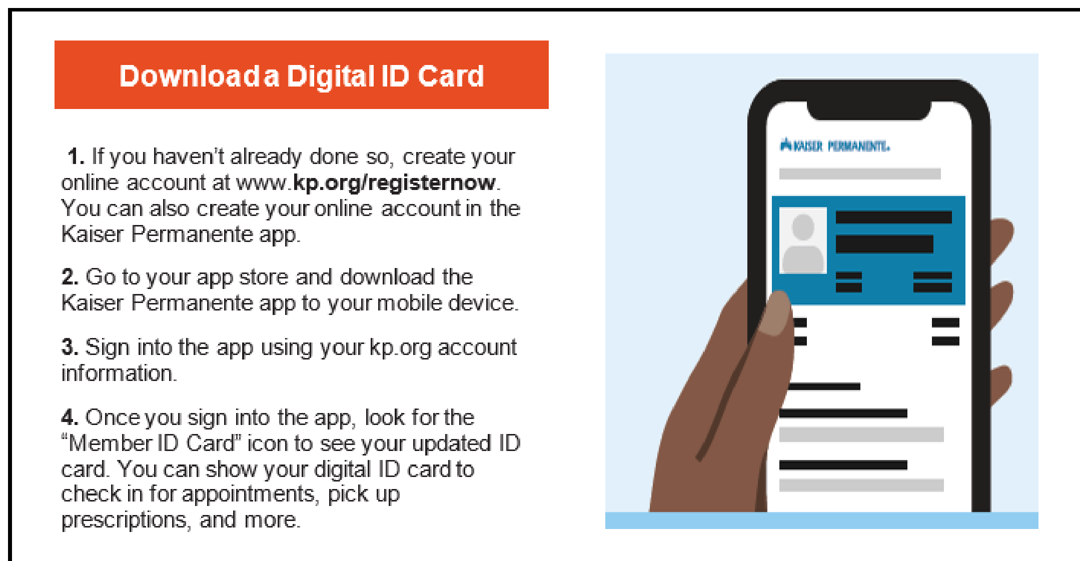
To print a temporary card or replace your Kaiser Permanente ID card, log on to *kp.org*, then select the *Coverage and Costs* menu and the ID Card help option.





Your ID card is for identification only. For the Plan to cover Services, you must be a current Member on the date you receive the Services. Anyone who is not a Member will be billed for any Services they receive, and the amount billed may be different from the Eligible Charges for the Services.

In line with federal requirements, your Kaiser Permanente ID card contains information about some of your benefits and costs, such as your deductible and out-of-pocket maximum.



Receiving Care in Other Kaiser Permanente Regions

You will probably receive most Covered Services in the Service Area of the Kaiser Permanente Region where you live or work. However, if you are in the Service Area of another Kaiser Permanente Region, you will also be able to receive Services from Network Providers in that Region. Referrals or Prior Authorization requirements may differ among Regions. For information about Network Providers in other Kaiser Permanente Regions, please call Customer Service by calling the number on the back of your member ID card.

For 24/7 travel support Anytime, anywhere, call the Away from Home Travel Line at **951-268-3900** or visit www.**kp.org/travel**.

Moving Outside of the Service Area

If you move to an area not within a Kaiser Permanente Service Area, you will be required to change your health plan to one that serves your area. Please contact your employer for instruction.

Getting Assistance

Kaiser Permanente wants you to be satisfied with the healthcare you receive. If you have any questions or concerns about the care you are receiving, please discuss them with your Personal Network Physician or with any other Network Providers who are treating you. They want to help you with your questions. You may also call Customer Service at the number listed in the "Customer Service Phone Numbers" section.

Interpreter Services

If you need interpreter services when you call or when you get Covered Services, please let Kaiser Permanente know. Interpreter services are available 24 hours a day, seven days a week, at no cost to you, at Network Facilities. For more information, please call Customer Service at the number listed in the "Customer Service Phone Numbers" section.

Network Facilities

At most Network Facilities, you can usually receive all the Covered Services you need, including Specialty Care, pharmacy, and lab work. You are not restricted to a particular Network Facility, and you are encouraged to use the Network Facility that is most convenient for you:

- All Network Hospitals provide inpatient Services and are open 24 hours a day, seven days a week.
- Emergency Services are available from Network Hospital emergency departments (please refer to *kp.org* for emergency department locations in your area).
- Same-day appointments are available at many locations (please refer to *kp.org* for Urgent Care locations in your area).
- Many Network Facilities have evening and weekend appointments.

- Many Network Facilities have a customer service department (refer to *kp.org* for locations in your area).
- Additionally, Kaiser Permanente care is available at certain Target clinics in Southern California—visit *kptargetclinic.org*.

For current locations of Network facilities please visit www.kp.org or call Customer Service at the number listed in the "Customer Service Phone Numbers" section. To find a Kaiser Pharmacy visit www.kp.org - select *Pharmacy.*

Network Facilities for your area are listed in greater detail on *kp.org,* which details the types of Covered Services that are available from each Network Facility in your area because some Network Facilities provide only specific types of Covered Services. It explains how to make appointments, lists hours of operation, and includes a detailed telephone directory for appointments and advice.

Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers

This section explains how to obtain covered emergency, post-stabilization, and out-of-area Urgent Care from Non-Network Providers. The Non-Network Provider care discussed in this section is not covered unless it meets both of the following requirements:

- Emergency Care is covered if the care would be covered if you received the care from a Network Provider. You do not need to get Prior Authorization from Kaiser Permanente to get Emergency Services or Urgent Care outside the Service Area from Non–Network Providers. However, you (or someone on your behalf) must get Prior Authorization from Kaiser Permanente to get covered Post-Stabilization Care from Non–Network Providers.
- Post-Stabilization Care is covered if authorized by Kaiser Permanente. For example, Non-Network Skilled Nursing Facility care is not covered as part of authorized Post-Stabilization Care unless Kaiser Permanente authorizes the care and the care would be covered if you received the care from a Network Skilled Nursing Facility inside the Service Area.

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department. You do not need Prior Authorization for Emergency Services. When you have an Emergency Medical Condition, the Plan covers Emergency Services you receive from Network Providers or Non-Network Providers anywhere in the world, as long as the Services would have been covered under the "Benefits and Cost Sharing" section (subject to the "General Exclusions, General Limitations, Coordination of Benefits, and Reductions" section) if you had received them from Network Providers.

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

For ease and continuity of care, you are encouraged to go to a Network Hospital emergency department if you are inside the Service Area, but only if it is reasonable to do so, considering your condition or symptoms. If you have been admitted to a Non-Network hospital, your stay will be covered if Kaiser Permanente is notified within 24 hours or as soon as reasonably possible of stabilization of your condition.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable. Post-Stabilization Care also includes Medically Necessary covered Durable Medical Equipment after discharged from a hospital and related to the same Emergency Medical Condition. For information on covered Durable Medical Equipment, see Durable Medical Equipment (DME), External Prosthetics and Orthotics in the "Benefits and Cost Sharing" section. Post-Stabilization Care received from a Non-Network Provider, including inpatient care at a Non-Network Hospital, is covered until

- your attending emergency physician determines you are able to travel using non-medical/non-emergency medical transportation,
- there is an available Network facility within a "reasonable" distance considering your medical condition, and
- you have access to/can pay for the non-medical transportation.

Note: You will be responsible to pay for any Post-Stabilization Services you consent to pay. For example, if your attending physician determines you are in a condition to provide voluntary consent, and the Non-Network Provider/facility satisfies the enhanced notice and consent process described in the definition of Emergency Services, above, whereby you accept liability for the Services, you will then be responsible for paying those Services. Your attending physician's determinations are binding on the facility.

Note: Giving informed consent does not bind the Plan in any way to cover Post-Stabilization Services; the provider should contact Kaiser Permanente in order to coordinate care.

To request Prior Authorization to receive Post-Stabilization Care from a Non-Network Provider, you (or someone on your behalf) must call Kaiser Permanente toll-free at the telephone number on your Kaiser Permanente ID card before you receive the care if it is reasonably possible to do so (otherwise, call as soon as reasonably possible). A Kaiser Permanente representative will then discuss your condition with the Non-Network Provider. If Kaiser Permanente decides that you require Post-Stabilization Care and that this care would be covered if you received it from a Network Provider, they will authorize your care from the Non-Network Provider or arrange to have a Network Provider (or other designated provider) provide the care. If Kaiser Permanente decides to have a Network Hospital, Network Skilled Nursing Facility, or designated Non-Network Provider provide your care, they may authorize special transportation Services that are medically required to get you to the provider. If this occurs, then those special transportation Services will be covered, even if they would not be covered under "Ambulance Services" in the "Benefits and Cost Sharing" section if a Network Provider had provided them.

Be sure to ask the Non-Network Provider to tell you what care (including any transportation) Kaiser Permanente has authorized, because once your attending emergency physician determines you are able to travel using non-medical/non-emergency medical transportation and there is a Network facility within a reasonable distance considering your medical condition, unauthorized Post-Stabilization Care or related transportation provided by Non-Network Providers is not covered.

Sometimes extraordinary circumstances can delay your ability to call Kaiser Permanente to request authorization for Post-Stabilization Care from a Non-Network Provider (for example, if you are unconscious, or if you are a young child without a parent or guardian present). In these cases, you (or someone on your behalf) must call Kaiser Permanente as soon as reasonably possible.

Urgent Care

You may need Urgent Care if you have an illness or injury that requires prompt medical attention but is not an Emergency Medical Condition. If you are in the Service Area and think you may need Urgent Care, call the urgent care or advice nurse telephone number (see the “Customer Service Phone Numbers” section or sign on to the *kp.org* website).

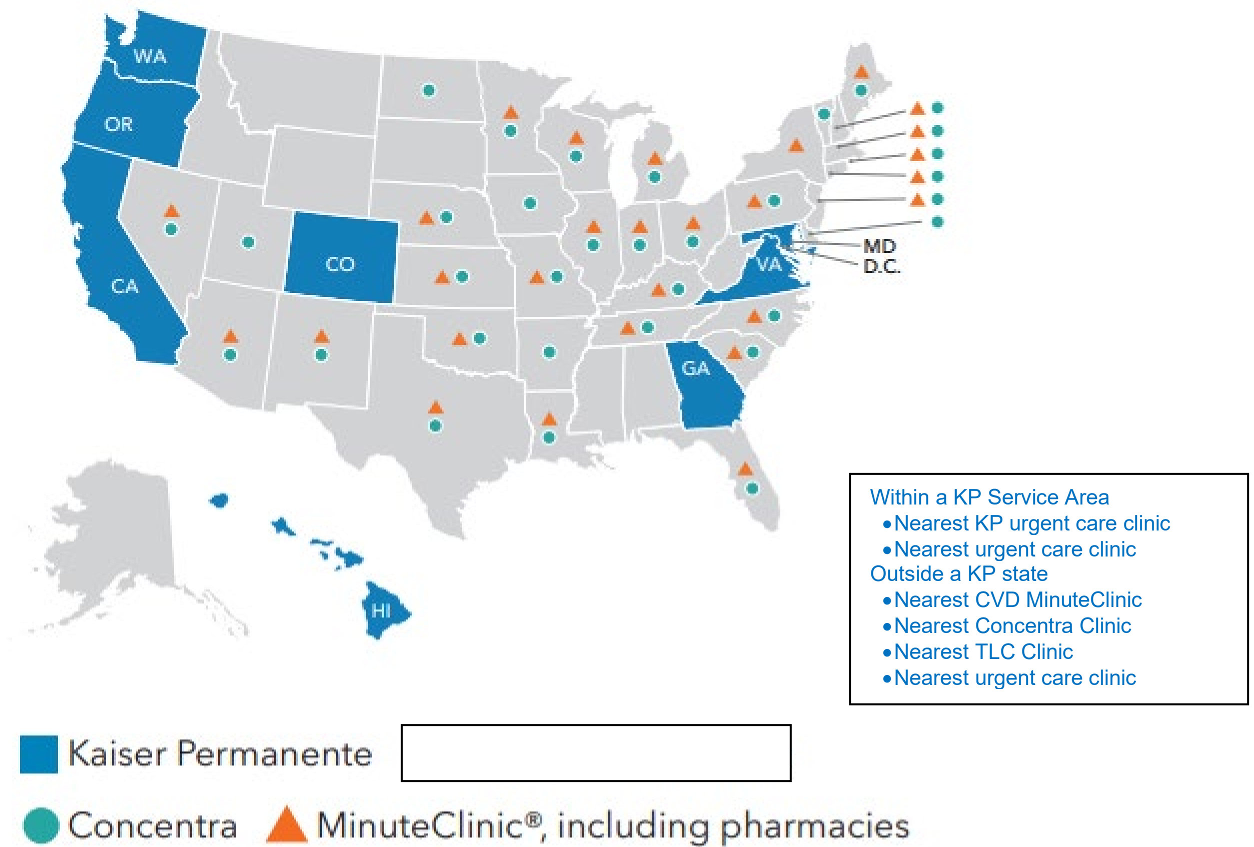
The following Services are not discussed under this section:

- Services that are not Emergency Services, Post-Stabilization Care, or Urgent Care that you receive outside the Service Area, even if those Services are related to your Emergency Medical Condition
- Emergency Services, Post-Stabilization Care, and Urgent Care that you receive from Network Providers

Note: Urgent Care received in a Kaiser Permanente Region from a Non-Network emergency department is not covered, except prior authorized Durable Medical Equipment related to Urgent Care you received outside the Service Area.

Out-of-Area Urgent Care ***kp.org/travel***

Find care near you



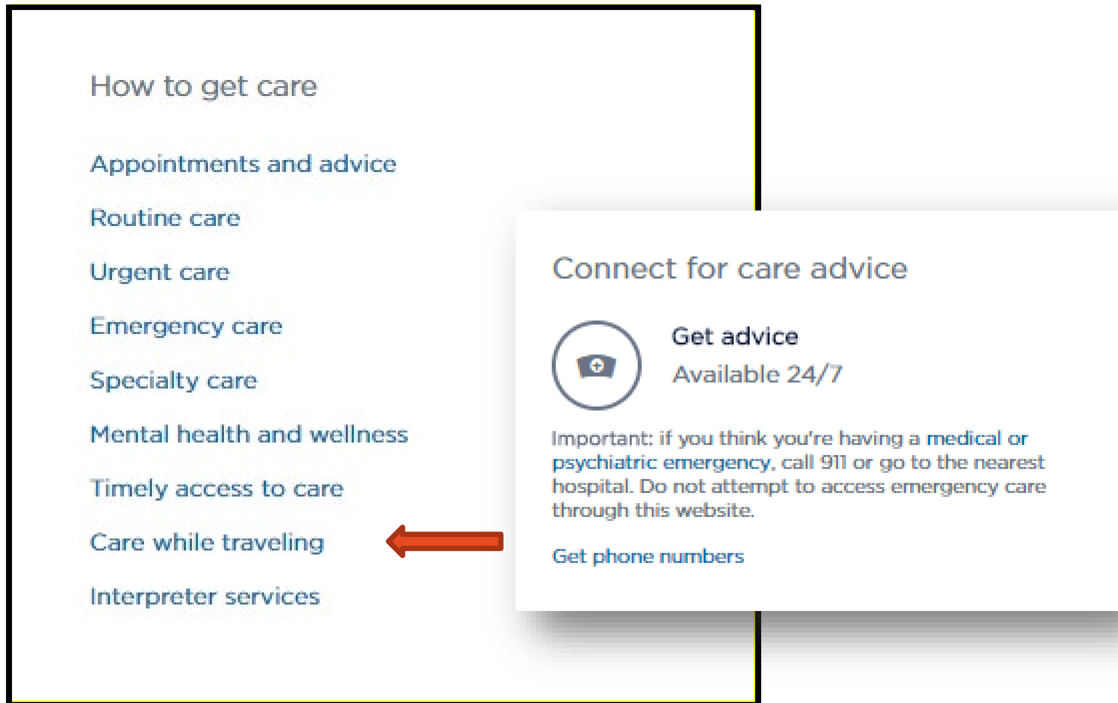
- For **Nonurgent** care you can always schedule in-person visits in states with Kaiser Permanente facilities or use kp.org or the Kaiser Permanente app across the U.S to get 24/7 care and advice from Kaiser Permanente clinicians by phone or online.
- You may also seek Urgent care at The Little Clinics (TLC), MinuteClinic®, Concentra, or any other urgent care facility outside a state where Kaiser Permanente operates.
- If you get care at MinuteClinic®, Cigna, TLC or Concentra outside a state where Kaiser Permanente operates, you'll be charged your standard copay or co-insurance.
- Note: Urgent Care received in Kaiser Permanente Service Areas from a Non-Network Provider or emergency department is not covered.

If you need prompt medical care due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), your Plan covers Medically Necessary Services that you receive from a Non-Network Provider outside the Service Area to prevent serious deterioration of your (or your unborn child's) health if all the following are true:

- You receive the Services from Non-Network Providers while you are temporarily outside the Service Area.
- The care cannot be delayed until you return to the Service Area.
- You reasonably believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to the Service Area.

Follow-up care from a Non-Network Urgent Care Provider is not covered, except prior authorized Durable Medical Equipment related to Urgent Care you received outside the Service Area.

Note: Urgent Care received in Kaiser Permanente Service Areas from a Non-Network Provider or emergency department is not covered.



Services Not Covered Under this "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers" Section

The following Services are not discussed under this section (instead, refer to the "Benefits and Cost Sharing" section):

- Services that are not Emergency Services, Post-Stabilization Care, or Urgent Care that you receive outside the Service Area, even if those Services are related to your Emergency Medical Condition
- Emergency Services, Post-Stabilization Care, and Urgent Care you receive from Network Providers

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Urgent Care outside the Service Area from a Non-Network Provider, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill Kaiser Permanente. To request payment or reimbursement, you must file a claim as described in the “Claims and Appeals” section.

Cost Sharing

The Cost Sharing for Emergency Services, Post-Stabilization Care, and Urgent Care outside the Service Area that you receive from a Non-Network Provider is the Cost

Sharing required for the same Services provided by a Network Provider as described in the "Schedule of Benefits" section. Your required Cost Sharing will be subtracted from any payment made to you or the Non-Network Provider.

- If you receive Emergency Services in the emergency department of a Non-Network Hospital, you pay the Cost Share for an emergency department visit.
- If you were given Prior Authorization for inpatient Post-Stabilization Care in a Non-Network Hospital, you pay the Cost Share for hospital inpatient care.
- If you were given Prior Authorization for Durable Medical Equipment necessary for discharge from a Non-Network Hospital, you pay the Cost Share for Durable Medical Equipment.

Benefits and Cost Sharing

The only Services that are covered under this Plan are those that this “Benefits and Cost Sharing” section says are covered, subject to exclusions and limitations described in this “Benefits and Cost Sharing” section and to all provisions in the “General Exclusions, General Limitations, Coordination of Benefits, and Reductions” section. Exclusions and limitations that apply only to a particular benefit are described in this “Benefits and Cost Sharing” section. Exclusions, limitations, coordination of benefits, and reductions that apply to all benefits are described in the “General Exclusions, General Limitations, Coordination of Benefits, and Reductions” section.

The Services described in this “Benefits and Cost Sharing” section are covered only if all the following conditions are satisfied:

- You are a Member on the date that you receive the Services.
- A Network Physician determines that the Services are Medically Necessary.
- The Services are provided, prescribed, authorized, or directed by a Network Physician except where specifically noted to the contrary in the “Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers” section or the “How to Obtain Services” section.
- You receive the Services from Network Providers inside the Service Area except where specifically noted to the contrary in the following sections for the following Services:
    - authorized referrals as described under “Referrals” and “Self-Referrals” in the “How to Obtain Services” section;
    - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the “Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers” section;
    - care received outside the Service Area as described in the “Receiving Care in Other Kaiser Permanente Regions” section; or
    - emergency ambulance Service as described under “Ambulance Services” in this “Benefits and Cost Sharing” section.

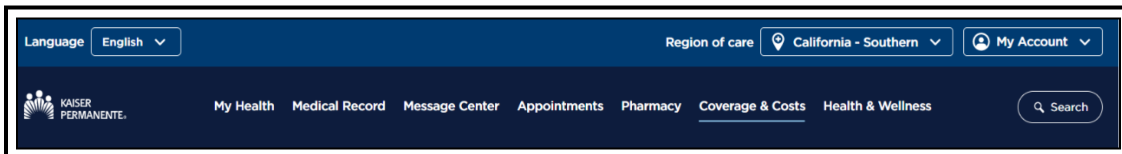
Note: Non-Network Providers may provide a notice and consent form seeking your (or your authorized representative’s) agreement that you will owe the full cost of the bill for the items and Services that the Non-Network Provider furnishes. If you (or your Authorized Representative) consent, then you will be financially responsible for payment for those items and Services (except in the case of Emergency Care Services).

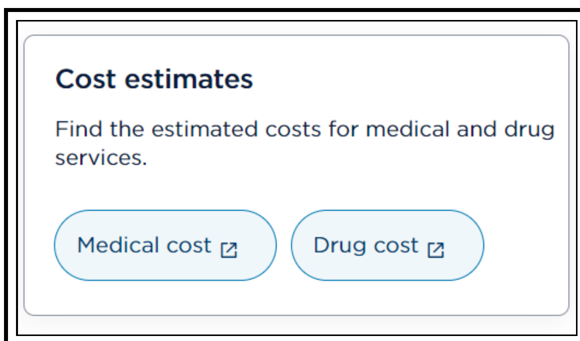
Medical Necessity
A Kaiser Permanente health professional will determine if Services are Medically Necessary for each member.

Cost Sharing (Copayments and Coinsurance)
The "Schedule of Benefits" describes the Cost Sharing you must pay for Covered Services. Cost Sharing is due at the time you receive the Services, unless Network Providers agree to bill you. For items ordered in advance, you pay the Cost Sharing in effect on the order date (although the item will not be covered unless you still have coverage for it on the date you receive it). Copayments are applied per provider per day. Coinsurance is a calculated percentage of the provider Allowable Amount.

Unless specified otherwise, when Services can be provided in different settings, the Cost Sharing is applied per the place of Service in which the care is delivered and according to the type of provider providing the Service. For example, if the Service is provided during a hospital admission, the Hospital Inpatient Services Cost Share is applied. If the same Service is performed in an office setting by a Network Specialist, the specialty care Office Visit Cost Share is applied. If Services are provided in a hospital clinic setting, separate Cost Shares may apply to the hospital clinic charges and the physician charges; both hospital clinic and physician charges will be subject to applicable deductibles and Cost Share.

To estimate your Cost Sharing and plan your medical expenses sign into www.kp.org then select *Coverage and costs.*





Then select *Medical or Drug Cost to get an estimate.* From this page, you will be taken to an external estimation tool and logged out of www.kp.org.

Benefit Maximums and Benefit Limits

The "Schedule of Benefits" describes dollar limits, Benefit or Plan lifetime maximums, and any day, visit, or quantity limits applicable to certain Covered Services. If multiple visits occur on the same day, each visit counts toward the applicable benefit limit.

Deductible

Generally you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. The annual Deductible amounts are listed in the "Schedule of Benefits."

- The Services subject to the Deductible are identified in the "Schedule of Benefits."
- Note: 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.

Out-Of-Pocket Maximums (OOP)

There are limits to the total amount of Cost Sharing you must pay annually for certain Covered Services that you receive in the same Plan Year. Those limits can be found in the "Schedule of Benefits." The OOP limit is the most you could pay in a year for Covered Services. If you have other Family members in this plan, they have to meet their own OOP limits until the overall Family OOP limit has been met.

If you are part of a Family that includes at least two people (counting the Eligible Individual and any Dependents), you reach the Plan Year out-of-pocket maximum when you meet the maximum per Member, or when your Family meets the maximum for a Family (whichever happens first).

After you reach the annual Out-of-Pocket Maximum, you do not have to pay any more Cost Sharing for Services subject to the Plan Year Out-of-Pocket Maximum through the end of the Plan Year. You will continue to pay Cost Sharing for Covered Services that do not apply to the Plan Year Out-of-Pocket Maximum.

Acupuncture Services

Acupuncture and acupressure Services are covered. Coverage is limited to Services within the provider's scope of license. Services include passing long, thin needles through the skin to specific points and application of pressure at acupuncture sites. Limited to 20 visits per Plan Year (unlimited when used for smoking cessation).

To Locate a Network Provider, Contact:

California Regions	American Specialty Health Plans of California *https://www.ashlink.com/ASH/public/applications/providersearch/default.aspx* or call 800-678-9133
Northwest Region	CHP Group *www.chpgroup.com* or 800-449-9479

Georgia Region	(no acupuncture network—utilize any willing provider)
Colorado Region	(no acupuncture network—utilize any willing provider)
Mid-Atlantic Region	((no acupuncture network—utilize any willing provider)
Washington Region	Complementary Medicine at kp.org/WA

Allergy Services

Specialty or Primary Cost Share is based on the rendering provider. Services include allergy testing, serum, and injections.

Ambulance Services

Emergency

Emergency Services provided by ground or air licensed ambulance are covered when you have an Emergency Medical Condition. If provided through the 911 emergency response system, ambulance Services are covered if you reasonably believed that a medical emergency existed, even if you are not transported to a hospital.

Scheduled

Non-emergency, scheduled ambulance trips are covered when a Network 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.

Any applicable Cost Sharing is waived when you are transferred from a Non-Network Facility to a Network Facility for care.

The following destinations are covered when Medically Necessary:

- home to hospital and return
- home to skilled nursing facility
- hospital to skilled nursing facility
- skilled nursing facility to hospital
- skilled nursing facility to home
- home to doctor’s office
- hospital to hospital
- skilled nursing facility to dialysis center and return

Exclusion:

Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, or any other type of transportation (other than a licensed ambulance or psychiatric transport van) is not covered, even if it is the only way to travel to a facility.

Chiropractic Services

Chiropractic Services are covered. Coverage is limited to Services within the provider’s scope of license. Services include plain X-rays and adjunctive therapy associated with spinal, muscle or joint manipulation. Limited to 20 visits per Plan Year.

To Locate a Network Provider, Contact:

California Regions	American Specialty Health Plans of California *ashlink.com/ASH/public/applications/providersearch/default.aspx* or call 800-678-9133
Northwest Region	Complimentary Healthcare Plans *chpgroup.com* or 800-449-9479
Georgia Region	Soteria Health Care Email *FindAGAProvider@SoteriaHealthcare.com*
Mid-Atlantic Region	Optum Health Services 800-428-6337
Colorado Region	Kaiser Centers for Complementary Medicine 844-800-0788 or *kpccm.org*.
Washington Region	Complementary Medicine at kp.org/WA

Exclusions:
The following Services are not covered:

- chiropractic Services for conditions other than neuromusculoskeletal disorders
- behavior training and sleep therapy
- thermography
- any radiologic exam, other than plain film studies, such as magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), bone scans, and nuclear radiology
- non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for vocational rehabilitation
- air conditioners, air purifiers, therapeutic mattresses; chiropractic appliances, supplies, and devices
- Hospital Services, anesthesia, manipulation under anesthesia, and related Services
- adjunctive therapy not associated with spinal, muscle, or joint manipulations, vitamins, minerals, nutritional supplements, and similar products

Clinical Trials

In-Network and referred Non-Network Services for an Approved Clinical Trial are covered for Qualified Individuals to the extent Services identified in the "Schedule of Benefits" are covered outside an Approved Clinical Trial.

"Qualified Individual" means an enrollee who is eligible to participate in an Approved Clinical Trial per 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:

- The referring provider is a Network Provider who has made this determination; or
- the patient provides medical and scientific information establishing this determination.

"Approved Clinical Trial" means 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 condition and that meets one of the following requirements:

- The study or investigation is approved or funded (which may include funding through in-kind contributions) 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 HHS Secretary determines meets all 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.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having an investigational new drug application.

Exclusions:

- Non-Approved Clinical Trials
- Clinical Trials that are Experimental and Investigational items or Services. Items and Services related to Clinical Trials are considered Experimental and Investigational when:
    - provided solely to satisfy data collection and analytical needs of a clinical trial and are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);
    - customarily provided by the research sponsors free of charge for any enrollee in the trial; or
    - needed for reasonable and necessary care arising from the provision of an investigational Item or Service—in particular, for the diagnosis or treatment of complications.
- Items and Services that are provided solely for data collection and analysis and that are not used in the direct clinical management of the patient
- Services which are clearly inconsistent with widely accepted and established standards of care for the patient's diagnosis

Dental Services

Accidental Injury to Teeth

Repair, but not replacement, of sound natural teeth related to an accidental injury is covered. Services must be started as soon as medically appropriate and received within 12 months from the date of the accidental injury. A "sound and natural tooth" is a tooth that (a) has not been restored previously, except if previously restored in an adequate manner with a filling, crown, or bridge, and (b) has not been weakened by existing dental pathology such as decay or periodontal disease. Accidental injury does not include damage as a result of normal activities such as chewing or biting.

Dental-Related Medical Care

Dental Services for Radiation Treatment

Dental evaluation, X-rays, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck are covered.

Dental Services Pursuant to Transplants

Dental Services for potential transplant recipients who require pre-transplant dental evaluation and "clearance" before being placed on the transplant wait list are covered. Services include those necessary to ensure the oral cavity is clear of infection, such as evaluation, relevant X-rays, clearing, fluoride treatment, and extractions.

Dental Anesthesia

For dental procedures, general anesthesia in a Network Hospital or ambulatory surgery center and the Services associated with the anesthesia are covered if any of the following are true:

- you are under age 7;
- you are developmentally disabled;
- you are not able to have dental care under local anesthesia due to a neurological or medically compromising condition; or
- you have sustained extensive facial or dental trauma.

Any other Service related to the dental procedure, such as the dentist's Services, is not covered.

Removal of Impacted Wisdom Teeth

The removal of impacted wisdom teeth is covered.

Exclusions:

- Dental coverage will not be provided for Preventive Care, diagnosis, or treatment of or related to the teeth, jawbones, or gums.
- Dental coverage will not be provided for extractions (except for the removal of impacted wisdom teeth), treatment of cavities, care of the gums or structures directly supporting the teeth, treatment of periodontal abscesses, removal of impacted teeth, orthodontia (including braces), dentures or false teeth, dental implants, or any other dental Services or supplies, except as listed above.

Structures supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process. Exception: Services required prior to transplant.

- Dental coverage will not be provided for treatment of congenitally missing, malpositioned, or supernumerary teeth, except as part of a congenital anomaly.
- Dental procedures and appliances to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).

Dialysis Care

The Plan covers dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

- The Services are provided inside the Service Area.
- You satisfy all medical criteria.
- The facility is certified by Medicare and is a Network Facility.
- A Network Physician provides a written referral for care at the facility.

After the referral to a dialysis facility, the Plan covers equipment, training and medical supplies required for home dialysis. Home dialysis includes home hemodialysis, intermittent peritoneal dialysis, and home continuous ambulatory peritoneal dialysis.

Durable Medical Equipment (DME), External Prosthetics and Orthotics

DME must be on Kaiser Permanente's DME, External Prosthetic, and Orthotic formulary to be covered. A formulary is a list of DME, external prosthetics, and orthotics covered by Kaiser Permanente. Examples of covered items include wheelchairs, hospital beds, and oxygen. Medical supplies of an expendable nature, such as oxygen tubing, are covered if they are required for the effective use of the DME. Drugs purchased at the pharmacy for use in DME equipment are covered under the *Outpatient Prescription Drugs* benefit and not this benefit. To have coverage, you must meet Kaiser Permanente's criteria for use of any equipment and obtain items from a Network Provider. Coverage is limited to the standard item of equipment that adequately meets your medical needs. Kaiser Permanente will decide whether to rent or purchase the covered equipment for your use. You will have to pay for non-covered equipment. Coverage includes fitting and adjustment. When the item continues to be Medically Necessary, coverage includes repair and replacement of the standard item in cases of loss, irreparable damage, wear or replacement required because of a change in your medical condition. You must return the equipment or pay the fair market price of the equipment when it is no longer covered.

The formulary guidelines allow you to obtain non-formulary DME (those not listed on the formulary for your condition) if they would otherwise be covered if KP criteria are met. To request a formulary exception, contact Customer Service by calling the number on the back of your member ID card.

Internally Implanted Devices

Prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints must be implanted during an approved surgery covered under another section of this "Benefits and Cost Sharing" section.

External Prosthetics
External Prosthetics must be on Kaiser Permanente's DME, External Prosthetic, and Orthotic formulary to be covered. Examples of external Prosthetic covered items include:

- artificial arms and legs
- ostomy and urological supplies
- feeding tubes and enteral nutrition that is administered via a feeding tube
- contact lenses following cataract surgery and glasses
- contacts when the intraocular lens is absent and cannot be replaced, such as in aphakia, or when all or part of the iris is missing, as in aniridia

Orthotics
Orthotics must be on Kaiser Permanente's DME, External Prosthetic, and Orthotic formulary to be covered.

Services to determine the need for an external Prosthetic or an Orthotic and any subsequent fittings and adjustments are covered under the heading *Outpatient Services*.

Exclusions:

- Replacement of lost items
- Repair necessitated by misuse
- Exercise or hygiene equipment
- Shipping and handling, or restocking charges associated with obtaining DME, Prosthetics, and Orthotics
- Spare or backup equipment
- Batteries or replacement batteries, except those specialized batteries used in covered DME equipment
- Devices used specifically as safety items or to affect performance in sports-related activities
- Elastic stockings
- Prescribed or non-prescribed medical supplies; examples include:
    - Ace bandages
    - Gauzes and dressings
- Tubings, nasal cannulas, connectors, and masks, except when used with Durable Medical Equipment as described in the Coverage section

Education and Training for Self-Management
Health education and training for self-management is covered when provided by a Network Physician or a qualified Network non-Physician using a standardized curriculum to teach you how to self-manage your disease or condition.

Education and training may be provided in group or individual sessions. Where available, sample conditions include:

- asthma
- diabetes
- coronary artery disease
- obesity
- weight management

- pain management

Emergency Services

Emergency Services include professional, facility and Ancillary Services such as laboratory, X-ray, or imaging Services necessary to diagnose and stabilize your condition in an emergency department. See the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers" section for more information. Any applicable Cost Shares for Emergency Services are waived when you are directly admitted to the hospital from the emergency department.

Fertility Services

Inpatient and outpatient fertility Services include any necessary procedures, laboratory and radiology Services, and drugs administered by medical personnel. Fertility Services include correcting underlying medical conditions causing infertility, and artificial insemination. Additional eligible Services include advanced reproductive technologies such as in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), and variations of these procedures, which include fertility preservation (Iatrogenic) Services of egg or ovarian tissue retrieval and short-term cryopreservation. Services to rule out the underlying medical causes of infertility are part of the medical benefit.

There is a lifetime Benefit Maximum under your health Plan. Your Cost Shares and Deductibles do not count against your Benefit Maximums.

Fertility Preservation (Iatrogenic)

When planned cancer or other medical treatment is likely to produce infertility/sterility, the plan covers the collection of sperm, cryopreservation of sperm, ovulation induction and retrieval of oocyte (egg), oocyte cryopreservation, ovarian tissue cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) is not covered.

Exclusions:

- Donor semen or eggs, and Services related to their procurement and storage
- Cryopreservation and storage greater than one (1) year
- Services to reverse voluntary, surgically induced infertility (for example, because of a vasectomy or tubal ligation)
- Fertility Services when infertility is caused by or related to voluntary sterilization

Gender Affirming Surgery

When authorized by Kaiser Permanente, your Plan covers the cost of:

Below waist surgery:

Assigned at birth male – clitoroplasty, labiaplasty, penile skin inversion, vagina construction, bilateral orchiectomy, penile amputation, urethromeatoplasty, plastic repair of introitus, vaginoplasty

Assigned at birth female – hysterectomy, salpingo oophorectomy, colpectomy, phalloplasty, urethroplasty, scrotoplasty, plastic glans formation, insertion of penile and testicular prosthesis

Above waist surgery:

Assigned at birth male – tracheal shave and facial hair removal, medically necessary breast augmentation if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment is not sufficient for comfort in the social role and Medically Necessary gender confirming facial reconstruction

Assigned at birth female – mastectomy with chest reconstruction and nipple/areola reconstruction or breast reduction

Reasonable transportation and lodging expenses inside and outside of the Service Area when approved in advance by Kaiser Permanente (and subject to IRS limitation). Includes transportation, and lodging for the transgender patient plus one other person.

Voice therapy lessons

Gender Affirming Surgery Limitations and Exclusions

Reversal of genital surgery or surgery to revise secondary sex characteristics

Above waist –

Assigned at birth male – lipoplasty of the waist, face lifts, blepharoplasty, collagen injections, gender confirming facial reconstruction; or

Assigned at birth female – liposuction and cosmetic chest reconstruction, pectoral implants

Blepharoplasty

Rhinoplasty

Voice modification surgery

Abdominoplasty

Below waist Surgery –

Assigned at birth female – liposuction to reduce fat in hips thighs and buttocks, calf implants; or

Assigned at birth male – electrolysis or laser hair removal, except for facial hair removal or when used to prepare the perineum for SRS (Sexual Reassignment Surgery), and pharmaceuticals such as Vaniqa

Cosmetic Surgery – Surgery or other Services that are intended primarily to change or maintain your appearance, voice, or other characteristics, except for the covered transgender surgery Services listed in this "Gender Affirming Surgery" section

Unless covered under the Fertility Benefit, sperm procurement and storage in anticipation of future infertility, gamete preservation and storage in anticipation of future infertility, cryopreservation of fertilized embryos in anticipation of future infertility.

Referrals outside the US.

Other surgeries which have no Medically Necessary role in gender identification and are considered cosmetic in nature

Related Services Covered in this Covered Services Section

- Outpatient hospital or ambulatory surgery center Services

- Outpatient prescription drugs
- Outpatient administered drugs
- Prosthetics and orthotics
- Psychological counseling
- Outpatient imaging and laboratory

Hearing Aids

The following Services are covered up to the benefit maximum listed in the *Schedule of Benefits*:

- Tests to determine the appropriate Hearing Aid model for you.
- Tests to determine the efficacy of the prescribed Hearing Aid.
- Visits for fitting, counseling, adjustment, cleaning, and inspection after the warranty is exhausted.
- Flat Allowance every 36 months.

You do not need to purchase Hearing Aids for both ears at the same time. The maximum benefit amount must be used at the initial point of sale. The 36-month period begins at the initial point of sale. Any unused portion of the Allowance at the point of sale may not be used later. Two Hearing Aids are covered only when both are required to provide significant improvement that is not achievable with only one Hearing Aid, as determined by a Network Provider.

Exclusions:

- Coverage for any Hearing Aid if payment has been made for an Aid in the previous 36 months
- Replacement parts for Hearing Aids
- Replacement of lost or broken Hearing Aids
- Replacement batteries
- Repair of Hearing Aids beyond the warranty
- Directly implanted Hearing Aids and associated surgery (see surgical implants under Durable Medical Equipment and Prosthetics)

Home Health Services

Skilled, part-time or intermittent home health Services are covered when you are confined to your home. Skilled home health Services are those Services provided by nurses, medical social workers, and physical, occupational, and speech therapists. Medical supplies used during a covered home health visit are also covered. The Services are covered only if a Network Physician determines that you require skilled care and it is feasible to maintain effective supervision and control of your care in your home. Home health aide Services are covered only when you are also getting covered home health care from one of the licensed providers mentioned previously. Maximum of 210 visits per calendar year.

Part-time or intermittent home health care visits are defined as follows:

- Up to two hours per visit for visits by a nurse. Each additional increment of two hours counts as a separate visit.

- Up to four hours per visit for visits by a home health aide are covered. Each additional increment of four hours counts as a separate visit.
- If billed by a home health agency, a visit by another provider such as a medical social worker or a physical, occupational, or speech therapist counts as one visit and counts toward the applicable visit limits regardless of the number of hours present.

The following types of Services and supplies are covered only as described under these headings in this *Benefits and Cost Sharing* section:

- Durable Medical Equipment (DME), external Prosthetics, and Orthotics
- home infusion Services
- outpatient laboratory, X-ray, imaging, and other special diagnostic procedures
- outpatient prescription drugs

Exclusions:

- Custodial Care, including bathing, feeding, changing, or other Services that do not require skilled care (for example, care 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 the care would be covered if it were provided by a qualified medical professional in a hospital or a skilled nursing facility.
- Services of a person who usually lives with you or who is a member of your or your spouse's family.
- Private duty nursing care in the home.
- Homemaker Services and supplies, including meals delivered to your home.
- Home health care a Network Physician determines may be more appropriately provided for you in a Network Facility, Network Hospital or a Network Skilled Nursing Facility.

Home Infusion Services

Home infusion therapy is the administration of drugs in your home using intravenous, subcutaneous, and epidural routes (into the bloodstream, under the skin, and into the membranes surrounding the spinal cord). Home infusion includes intravenous delivery of parenteral nutrition when nutritional needs cannot be met by the oral or enteral route as determined by a Network Physician. The infusion therapy must be delivered by a licensed pharmacy. Home Services are also provided to ensure proper patient education and training and to monitor the care of the patient in the home. These Services may be provided directly by infusion pharmacy nursing staff or by a qualified home health agency. You do not need to be confined to your home to receive home infusion Services. The following are covered home infusion Services:

- administration
- professional pharmacy Services
- care coordination
- all necessary supplies and equipment, including delivery and removal of supplies and equipment
- drugs and biologicals
- nursing visits related to infusion

Hospice

If a Network Physician diagnoses you with a terminal illness and determines that your life expectancy is twelve (12) months or less, you may choose home-based Hospice care instead of traditional Services that you would otherwise receive for your illness. If you choose Hospice care, you are choosing to receive care to reduce or relieve pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may continue to receive Covered Services for conditions other than the terminal illness. You may change your decision to receive Hospice care at any time.

The following Services and supplies are covered on a 24-hour basis:

- Network Physician and nursing care
- counseling and bereavement Services
- physical, occupational, speech, or respiratory therapy for purposes of symptom control or to enable you to maintain activities of daily living
- medical social Services
- home health aide and homemaker Services
- Durable Medical Equipment and medical supplies
- palliative drugs, in accordance with Kaiser Permanente's drug formulary guidelines
- short-term (no more than five days at a time) inpatient care, limited to respite care and care for pain control, and acute and chronic symptom management
- dietary counseling

Exclusions:

- Funeral arrangements
- Financial or legal counseling

Hospital Inpatient Services

The following inpatient Services are covered:

- Acute inpatient rehabilitation including physical, occupational, and speech therapy
- Anesthesia
- Bariatric surgery when you meet certain medical criteria
- Blood and blood products and their administration
- Diagnostic x-rays and lab tests, and other diagnostic tests such as EEGs/EKGs and endoscopic procedures
- Dialysis
- Dressings and medical supplies used or applied during an inpatient hospital admission
- Drugs that require administration or observation by medical personnel
- Network Physician Services, including consultation and treatment by specialists
- General nursing care
- Medical social Services
- Medically necessary surgical or non-surgical treatment of TMJ. Dental treatment of TMJ dysfunction is not covered.
- Maternity care and delivery (including cesarean section and newborn care)
- Operating and recovery room including FDA-approved internally implanted Prosthetic devices such as pacemakers or artificial hips

- Respiratory therapy
- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units

Exclusions

- Private Duty Nursing except when Medically Necessary
- Private room, except when Medically Necessary or when a semi-private room is unavailable
- Services performed in the following:
  - nursing or convalescent homes for Custodial Care
  - institutions primarily for rest or for the aged
  - rehabilitation facilities (except for physical therapy)
  - spas
  - sanitariums
  - infirmaries at schools, colleges, or camps
- Any part of a Hospital stay that is primarily custodial
- Hospital Services received in clinic settings that do not meet the Plan's definition of a Hospital or other covered Facility
- Inpatient rehabilitation when the member is medically stable and
  - does not require skilled nursing care,
  - does not require the constant availability of a Physician,
  - the treatment is for maintenance therapy,
  - the Member has no restorative potential,
  - the treatment is for congenital learning or neurological disability/disorder, or
  - the treatment is for communication training, educational training, or vocational training.

Maternity Services

See the Preventive Services section for information on Prenatal Services covered at zero Cost Share.

The Plan covers physician charges for maternity care, delivery, and postnatal care. Also covered are hospital Services (including network birthing centers) and newborn care. Services provided by doulas are not covered.

Notes:

- If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge.
- Circumcision is covered for Eligible Dependents during the first 31 days of life regardless of Medical Necessity, and thereafter only when Medically Necessary.
- Newborn child. Newborns are only covered if enrolled in the plan; exception for well-newborn charges* billed as ancillary feeds on the mother's hospital bill.
  * Charges for well newborns (as defined by the hospital), billed as part of the mother's bill will be attributed to the mother's Cost Share requirements. Charges billed separately for Eligible sick and well newborns (as defined by

the hospital) are subject to all Plan provisions including their own Cost Share requirements.

- Note: 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.

Medical Foods

Medical foods are foods that are prescribed by a Network Provider and used in the treatment of certain medical conditions, such as phenylketonuria (PKU) and other inherited diseases of amino acids and organic acids caused by genetic defects that can lead to life threatening abnormalities in body chemistry. Medical foods are not foods that are generally available in retail grocery stores. Medical foods are not used with feeding tubes. For coverage of nutritional formulas delivered via a feeding tube, see the Durable Medical Equipment, External Prosthetics, and Orthotics heading in this *Benefits and Cost Sharing* section.

Mental Health Services

Evaluation, crisis intervention, and treatment are covered for mental health conditions.

- **Inpatient**
  Inpatient psychiatric care (including at Mental Health Residential Treatment Centers) is covered in a Network Hospital or licensed residential treatment facility. Coverage includes room and board, drugs, Services of Network Physicians, and Services of other Network Providers who are mental health professionals.

- **Outpatient Therapy**
  The following outpatient mental health care is covered:
  - partial hospitalization, sometimes known as day-night treatment programs
  - intensive outpatient programs
  - individual and group visits for diagnostic evaluation and psychiatric treatment
  - other Services:
    - psychological testing
    - electroconvulsive therapy (ECT)
    - visits for monitoring drug therapy

- **Cigna Employee Assistance Program (EAP)**
  The Cigna Employee Assistance Program (EAP) is available to all Members enrolled in any active Medical Trust medical Plan, their Dependents and other members of their households. See below under “Other Services Provided under the Plan” for more information on the Cigna EAP.

Nutritional Counseling

Nutritional counseling is covered, but is limited to 6 visits per Plan Year (limit applies to office/Outpatient setting only). This benefit is unlimited if related to a diagnosis of diabetes.

Orthognathic Surgery

Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided

- the deformity, disfigurement, or severe congenital condition is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; and
- the Orthognathic surgery is Medically Necessary as a result of tumor, trauma, or disease.

Repeat or subsequent Orthognathic surgeries for the same condition are covered only when the previous Orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined to be Medically Necessary by KPIC.

Outpatient Laboratory, X-ray, Imaging and Other Special Diagnostic Procedures

Outpatient laboratory, radiology, and diagnostic Services are covered when provided in an urgent care; a freestanding laboratory, radiology, or imaging center; or a hospital outpatient department for the diagnosis of an illness or injury. Such Services include:

- laboratory tests, including tests for specific genetic disorders for which genetic counseling is available
- X-rays and diagnostic imaging, including magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET); and nuclear medicine exams
- special procedures such as electrocardiograms and electroencephalograms, which are included in your Office Visit Cost Share

Outpatient laboratory, radiology, and diagnostic Services performed during an office visit are considered part of the office visit.

Note: See "*Preventive Exams and Services* " for information on covered preventive laboratory, X-ray, imaging, and diagnostic procedures.

Outpatient Prescription Drugs

Outpatient drugs, supplies, and supplements are covered when **ALL** the requirements below (1–5) are met:

1. The item is prescribed by a Network Provider authorized to prescribe drugs or by one of the following Non-Network Providers:
   - a dentist;
   - a Non-Network Provider to whom you have been referred by a Network Physician;
   - a Non-Network Provider if you got the prescription in conjunction with covered Out-of-Area Urgent Care or Emergency Services;
   - a Community Pharmacy in a Service Area outside of California; or
   - the first refill of a prescription originally filled prior to enrollment in the Plan.
2. The item is prescribed in accordance with Kaiser Permanente drug formulary guidelines.
3. Items provided to eligible newborns during the first 31 days of life and/or prior to enrollment of a newborn, require prepayment and claims submission for reimbursement.
4. You get the item from a Network Pharmacy or the Kaiser Permanente Mail Order Service, except that you can get the item from a Non-Network Pharmacy if you

obtain the prescription in conjunction with covered Urgent Care or Emergency Service outside the Service Area and it is not possible for you to get the item from a Network Pharmacy. Please refer to *kp.org* for the locations of Network Pharmacies in your area.

5. The item is one of the following:
   - Drugs that require a prescription by law, including:
     - contraceptive drugs including the emergency contraceptive pill and devices, such as diaphragms and cervical caps and over the counter contraceptives when prescribed by a Network Physician;
     - fertility drugs;
     - drugs for the treatment of sexual dysfunction; and
     - smoking cessation products; or
   - Drugs that don't require a prescription but are listed on Kaiser Permanente's drug formulary; or
   - Diabetic supplies such as insulin, syringes, pen delivery devices, blood glucose monitors, test strips, and tablets (other diabetic supplies may be covered under Durable Medical Equipment); or
   - Specialty drugs—high cost drugs contained on the KP specialty drug list. To obtain a list of specialty drugs on the KP formulary, or to find out if a non-formulary drug is on the specialty drug list, please call Customer Service.

Kaiser Permanente uses a formulary. A formulary is a list of drugs that have been approved for coverage by the Pharmacy and Therapeutics Committee. The drug formulary guidelines allow you to obtain non-formulary prescription drugs (those not listed on the drug formulary for your condition) if they would otherwise be covered if pharmacy criteria are met. To request a formulary exception, contact Customer Service. Prescriptions written by dentists are not eligible for non-formulary exceptions.

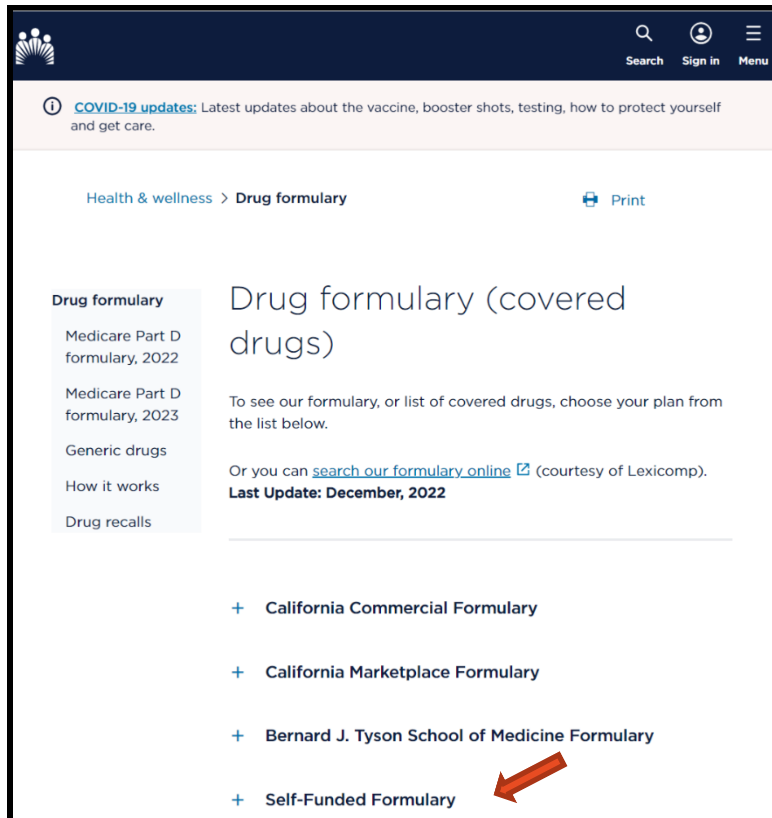
The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, the formulary includes a predetermined amount of an item that constitutes a Medically Necessary day's supply. The pharmacy may reduce the day supply dispensed 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. (The Pharmacy can tell you if a drug you take is one of these drugs.) Note: episodic drugs prescribed for the treatment of sexual dysfunction disorders may be limited by number of doses within a 30-day period.

Mail Order Service, subject to any Limitations, Copayments, and Deductibles, is available. Not all drugs are available through the Mail Order Service. Examples of drugs that cannot be mailed include:

- controlled substances as determined by state and/or federal regulations;
- drugs that are illegal under the applicable state law;
- medications that require special handling; and
- medications affected by temperature.

Refills may be ordered from Kaiser Pharmacies, the Mail Order program, or online at *kp.org*. A Kaiser Pharmacy can provide more information about obtaining refills.

To locate a Network Pharmacy, view the formulary, learn more about mail order, or print a claim form, sign on to *kp.org* or call OptumRx at 866-427-7701.



For outpatient prescription drugs and/or items covered under this Outpatient Prescription Drug section and obtained at a pharmacy owned and operated by Kaiser Permanente, you may use certain manufacturer coupons you have procured when allowed by law (i.e., on HSA plans, you must satisfy your deductible prior to using a coupon) and approved by Kaiser Permanente, as payment of Your Cost Sharing. You will owe any additional amount if the coupon does not cover the entire amount of Your Cost Sharing for Your prescription. If the coupon is for an amount greater than the Cost Sharing amount You owe for Your prescription, no credit, cash, or other refund will be given for the excess amount. When a coupon is accepted toward satisfaction of Your Cost Sharing, an amount equal to the coupon value and, if applicable, any additional amount that you pay will accumulate to Out-of-Pocket Maximum. Kaiser Permanente reserves the right to change the terms and conditions of its coupon program, including but not limited to the types and amounts of coupons that will be accepted at any time without prior notice. You may obtain information regarding the Kaiser Permanente coupon program at *kp.org*; search for the term “coupons.” Acceptance of Your coupon does not relieve You of Your responsibility regarding Cost Sharing if the drug manufacturer does not honor the coupon in whole or in part or if Kaiser Permanente later determines that the coupon was not allowed. *www.kp.org/rxcoupons*

Exclusions:

- If a Service is not covered under this Plan, any drugs or supplies needed relating to that Service are not covered.

- Compounded products, unless the drug is listed on the drug formulary or one of the ingredients requires a prescription by law.
- Drugs used to enhance athletic performance.
- Drugs prescribed for cosmetic purposes.
- Replacement of lost, damaged, or stolen drugs.
- Drugs that shorten the duration of the common cold.
- Special packaging. Packaging of prescription medications is limited to Kaiser Permanente standard packaging.
- Drugs which are available over the counter and prescriptions for which drug strength may be realized by the over-the-counter product. (Exception: those items listed in the Schedule of Benefits and the Preventive Exams and Services section below.)
- Drugs or devices for which there is an over-the-counter equivalent.
- Drugs or other items that are illegal under applicable law.

Note: Drugs that are legally prohibited in certain states may only be ingested while physically in the state in which the drug is legal. In no event may a member legally obtain a drug in one state through the Plan and ingest it in a state in which the drug is prohibited by law.

Outpatient Services

The following outpatient care is covered for Services to diagnose or treat an injury or disease:

- Primary Care office visits including nutrition visits with Registered Dieticians (R.D.), state licensed nutritionists, and Certified Diabetic Educators (C.D.E.)
- Specialty Care office visits, including consultation and second opinions
- Acupuncture
- Allergy Services
- Ambulance
- Bariatric surgery when you meet certain medical criteria
- Blood and blood products and their administration
- Chemotherapy
- Chiropractic care
- Dental Services for accidental injury to teeth, dental radiation, dental anesthesia, organ transplantation
- Diagnostic x-rays and lab tests, and other diagnostic tests such as EEGs EKGs performed during an office visit
- Dialysis Services
- Drugs that require administration or observation by medical personnel
- Durable Medical Equipment
- Habilitative and rehabilitative Services
- Health education
- Hearing exam and Hearing Aids / Services
- House calls by a Network Physician when care can best be provided in your home
- Infusion Services provided in an outpatient setting
- Injections (except preventive immunizations)
- Lymphedema treatment
- Medical supplies used during an outpatient visit

- Medically necessary surgical or non-surgical treatment of temporomandibular joint (TMJ) dysfunction. Dental treatment of TMJ dysfunction is not covered.
- Maternity—prenatal and postnatal visits
- Obstructive sleep apnea diagnosis and treatment
- Outpatient surgery including FDA-approved internally implanted Prosthetic devices such as breast implants following a covered mastectomy. (Applicable Cost Share is waived if admitted when both Services occur in the same facility. The inpatient coinsurance applies for outpatient surgeries resulting in an admission to the same facility.)
- Physical, occupational, and speech therapies
- Preventive Care Services (see "Preventive Care Services" in this Benefits and Cost Sharing" section for more details)
- Prosthetics and orthotics
- Radiation therapy
- Respiratory therapy
- Surgical procedures performed in the office

Note: See *Preventive Exams and Services* for information on covered preventive Services.

Exclusions

- Genetic testing unless Medically Necessary
- Screening tests done at your place of work at no cost to you
- Free screening Services offered by a government health department
- Tests done by a mobile screening unit, unless a doctor not affiliated with the mobile unit prescribes the tests
- Flu vaccines supplied by a government agency or otherwise provided at no cost to you

Preventive Exams and Services

The Preventive Services listed on *www.kp.org* are covered as required by the Patient Protection Affordable Care Act (PPACA) and are not subject to Deductibles, Copayments or Coinsurance.

Northern California- *https://healthy.kaiserpermanente.org/northern-california/learn/preventive-services*
Southern California- *https://healthy.kaiserpermanente.org/southern-california/learn/preventive-services*
Colorado- *https://healthy.kaiserpermanente.org/colorado/learn/preventive-services*
Georgia- *https://healthy.kaiserpermanente.org/georgia/learn/preventive-services*
Maryland/Virginia/Washington, D.C.- *https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/learn/preventive-services*
Oregon/SW Washington- *https://healthy.kaiserpermanente.org/oregon-washington/learn/preventive-services*
Washington- *https://healthy.kaiserpermanente.org/washington/learn/preventive-services*

Consult with your physician to determine what preventive Services are appropriate for you. Please note, state-specific preventive mandates and recommendations in effect for less than one year may not be applicable to your Plan.

Preventive care refers to measures taken to prevent diseases rather than curing them or treating their symptoms. Preventive care:

- protects against disease such as in the use of immunizations;
- promotes health, such as counseling on healthy lifestyles; and
- detects disease in its earliest stages before noticeable symptoms develop, such as screening for breast cancer.

Preventive Services may change according to federal guidelines and your benefits will be updated to include these changes as they are made throughout the Plan year.

For a complete list of current United States Preventive Services Task Force (USPSTF) A&B recommended preventive Services required under the Patient Protection Affordable Care Act for which Cost Share does not apply, please call the Customer Service number on the back of your ID card or visit
www.healthcare.gov/center/regulations/prevention.html.

- Recommendations in effect for less than one year may not be applicable to your plan.
- Preventive Services will be applied based on the member's medical status regardless of stated gender.

Exclusions for Preventive Care

- Personal and convenience supplies associated with breast-feeding equipment such as pads, bottles, and carrier cases.
- Upgrades of breast-feeding equipment, unless determined to be Medically Necessary and prescribed by your physician.
- Immunizations administered strictly for the purpose of travel outside of the United States (exception: COVID-19 immunizations). Travel vaccines are not classified as Preventive Care but are covered under the Plan and subject to applicable Cost Sharing.

Note: The following Services are not included under the Preventive Exams and Services benefit but may be Covered Services elsewhere in this Plan Document Handbook:

- lab, imaging, and other ancillary Services associated with prenatal care not inclusive to routine prenatal care
- non-routine prenatal care visits
- non-preventive Services performed in conjunction with a sterilization
- lab, imaging, and other ancillary Services associated with sterilizations
- treatment for complications that arise after a sterilization procedure

Reconstructive Surgery

Coverage is provided for inpatient and outpatient reconstructive Services that

- will result in significant improvement in physical function for conditions because of injuries, illness, congenital defects, or Medically Necessary surgery; or
- will correct significant disfigurement resulting from an injury, illness, congenital defects, or Medically Necessary surgery.

Following Medically Necessary removal of all or part of a breast, reconstruction of the breast as well as surgery and reconstruction of the other breast to produce a symmetrical appearance is covered.

Correction of congenital hemangioma (known as port wine stain) is limited to hemangiomas of the face and neck for children aged 18 years and younger.

Exclusions:

- Plastic surgery or other cosmetic Services and supplies intended primarily to change your appearance, including cosmetic surgery related to bariatric surgery

Rehabilitative and Habilitative Services (Including Early Intervention Services for Developmental Delays)

Rehabilitation is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible. Habilitative Services are therapeutic Services that are provided to children with congenital conditions (present from birth) and developmental delays to enhance the child's ability to function and advance. Habilitative Services are like rehabilitative Services that are provided to adults or children who acquire a condition later in life. Rehabilitative Services are geared toward reacquiring a skill that has been lost or impaired, while habilitative Services are provided to help acquire a skill in the first place, such as walking or talking. Habilitative Services include, but are not limited to, physical therapy, occupational therapy, and speech therapy for the treatment of a child with a congenital or genetic birth defect or developmental delays.

The following rehabilitative and habilitative Services are covered as described in the "Benefits and Cost Sharing" section:

- inpatient and outpatient multidisciplinary rehabilitation in an approved organized multidisciplinary program or facility;
- outpatient physical, occupational, and speech therapy (not billed by a Home Health Care agency);
- outpatient cardiac rehabilitation; or
- outpatient pulmonary rehabilitation.

Exclusions:

- Maintenance therapy, or treatment when the Member has no restorative potential
- Treatment for congenital learning or neurological disability/disorder
- Treatment for communication training, educational training, or vocational training
- Therapy primarily indicated for vocational training or retraining purposes, including sports physical therapy
- Speech therapy that is not Medically Necessary, such as
  - therapy for educational placement or other educational purposes;
  - training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or
  - therapy for tongue thrust in the absence of swallowing problems
- Physical therapy Services administered under the home health or hospice benefit, or in a hospital or skilled nursing facility

- Passive modalities and/or treatment Services associated with physical therapy (e.g., electrical stimulation)

The following additional habilitative Services are considered Covered Services.

Treatment for Pervasive Developmental Disorders

Covered Services for pervasive developmental disorder or autism include:

- Medically Necessary inpatient, Skilled Nursing Home, and outpatient care;
- behavioral health treatment; and
- applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a person with pervasive developmental disorder or autism and that meet all the following criteria:
  - The treatment is referred by Kaiser Permanente Insurance Company (KPIC) and administered by a Network Provider. Reminder: Certain Services require Prior Authorization:

    Required Prior Authorization List
    - all inpatient and outpatient facility Services (excluding emergencies);
    - office-based habilitative/rehabilitative care: ABA, occupational, speech, and physical therapies;
    - all Services provided outside a KP facility;
    - all Services provided by Non-Network Providers; and
    - drugs and Durable Medical Equipment not contained on the KP formulary.
  - The treatment plan has measurable goals over a specific timeline that is developed and approved by the Network qualified autism Service Provider.
  - The treatment plan is reviewed no less than once every six months by the qualified autism Service Provider and modified whenever appropriate and the treatment plan
    - includes the behavioral health impairments to be treated;
    - includes an intervention plan that includes the Service type, number of hours, and parent participation needed to achieve the plan's goal and objectives and the frequency at which the progress is evaluated and reported;
    - utilizes evidence-based practices with demonstrated clinical efficacy in treating pervasive developmental disorder or autism; and
    - discontinues intensive behavioral intervention Services when the treatment goals and objectives are achieved or no longer appropriate.
  - The treatment plan is not used for either of the following:
    - for purposes of providing (or for the reimbursement of) respite care, day care, or educational Services; or
    - to reimburse a parent for participating in the treatment program.

Exclusions:

- Services not identified in an approved treatment plan
- 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 to read, whether or not the individual has dyslexia
- Educational testing
- Teaching skills for employment or vocational purposes
- Professional growth courses
- Training for a specific job or employment counseling.
- Speech therapy that is not Medically Necessary, such as (a) therapy for educational placement or other educational purposes, or (b) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation, or (c) therapy for tongue thrust in the absence of swallowing problems

Skilled Nursing Facility (SNF) Services

Skilled inpatient Services and supplies must be Services customarily provided by a Network Skilled Nursing Facility and must be above the level of Custodial Care or intermediate care. The following Services and supplies are covered:

- Network Physician and nursing Services;
- room and board;
- medical social Services;
- prescribed drugs;
- respiratory therapy;
- physical, occupational, and speech therapy;
- medical equipment ordinarily furnished by the Network Skilled Nursing Facility;
- medical supplies;
- imaging and laboratory Services ordinarily provided by the Network Skilled Nursing Facility; and
- blood, blood products, and their administration.

Substance Use Disorder Services

- **Inpatient**
  Hospitalization (including Residential Treatment) is covered for medical management of withdrawal symptoms, including room and board, Network Physician Services, drugs that require administration or observation by medical personnel, dependency recovery Services, and counseling. Substance Use Disorder Rehabilitation Services in a licensed residential treatment Network Facility are also covered.

- **Outpatient**
  The following Services for treatment of Substance Use Disorders are covered:

- partial hospitalization, sometimes known as day-night treatment programs;
- intensive outpatient programs;
- individual and group counseling visits; and
- visits for medical treatment for withdrawal symptoms.

Transplant Services

Inpatient and outpatient Services for transplants of organs or tissues are covered—*for example*:

- bone marrow transplant/stem cell rescue
- cornea
- heart
- heart & lung
- liver
- lung
- kidney; simultaneous kidney & pancreas
- pancreas; pancreas after kidney alone
- small bowel; small bowel & liver

The Services are covered if:

- Kaiser Permanente Insurance Company (KPIC) has determined that you meet certain medical criteria for patients needing transplants; and
- KPIC provides a written referral to an approved transplant facility. The facility may be located outside the Service Area. Transplants are covered only at a facility approved by KPIC, even if another facility within the Service Area could perform the transplant.

Covered Services include:

- Reasonable transportation and lodging expenses outside of the Service Area when approved in advance by Kaiser Permanente (subject to certain limitations). Coverage will include the transplant recipient, plus one parent or guardian if the transplant recipient is a minor or one other person if the transplant recipient is an adult.
- Reasonable medical and hospital expenses of an organ/tissue donor which are directly related to a covered transplant are covered only if such expenses are incurred for Services within the United States. Coverage of expenses for these Services is subject to Living Donor Guidelines on *kp.org*.

Limitations and Exclusions:

- Kaiser Permanente does not assume responsibility for providing or assuring the availability of a donor or donor tissue/organs.
- Health Services for organ and tissue transplants, except those described in the coverage section of this document.
- Health Services connected with the removal of an organ or tissue from you for purposes of a transplant to another person (donor costs for removal are payable for a transplant through the organ recipient's benefits under the plan).
- Transplant Services that are not performed at a designated facility.
- Any multiple organ transplant not listed as a covered health Service in the coverage section of this document, unless determined to be a proven procedure for the involved diagnosis.

Urgent Care Services

Urgent Care Services are sometimes referred to as afterhours care.

- **In the Service Area**
  Urgent Care Services are covered and may be provided in your doctor's office after office hours or a Network Urgent Care facility. If you think you may need urgent care, call the advice nurse telephone number for help. (See the *Customer Service Phone Numbers* section or *kp.org.*)

  Exclusion:
  Except as noted below, Urgent Care Services from Non-Network Providers are not covered.

- **Outside of the Service Area**
  Urgent Care Services are also covered when you are temporarily away from the Service Area. Urgent Care Services are covered when they are Medically Necessary and it is not reasonable given the circumstances to obtain the Service through Network Providers. See the *Emergency, Post-Stabilization, and Out-of-Area Urgent Care You Receive from Non–Network Providers* section for more information.

Other Services Provided under the Plan

Cigna Employee Assistance Program (EAP)

The Cigna Employee Assistance Program (EAP), managed by Evernorth Behavioral Health, Inc. and Evernorth Care Solutions, Inc., is available to all Members enrolled in any active Medical Trust medical Plan and their Dependents. Dependents do not need to be enrolled in the Member's medical Plan to use the EAP. This Benefit is available to other members of your household.

The EAP offers an array of services designed to assist you with work, life, and family issues. EAP services are free, confidential, and available 24/7 through ***mycigna.com*** or by phone.

EAP services include

- Phone and website access 24/7
- In-person counseling (up to 10 sessions per issue with $0 Copayment)
- Immediate help during a crisis
- Local resources in your community on a wide range of topics, including elder and child-care providers, support groups, and so much more
- Tips and guidance to help balance work with family life, including a free legal or financial consultation.

To access the Cigna EAP services, register on the EAP website at ***mycigna.com*** and use the employer ID "Episcopal" or call 866-395-7794. If you are already registered

because you are enrolled in another Cigna plan, policy or product (medical or dental, for instance), you do not need to register again.[5]

Pastoral Support Network (PSN)
The Pastoral Support Network (PSN) offers counseling and support services with a particular sensitivity to the unique issues priests and their families may experience. If there's an issue with which you'd like assistance, you can talk with a PSN counselor over the phone or get a referral for a counseling professional in your area.

The PSN is part of your EAP benefit and is completely confidential. Neither your congregation/employer nor The Episcopal Church Medical Trust will be notified when you use the services.

The PSN is offered at no cost and is available to all the family members in your household.

For more information or to talk with a PSN specialist, call 866-395-7794.

EyeMed Vision Care
If you enroll in an Anthem, Cigna, or Kaiser Plan offered through the Medical Trust, you will receive vision Benefits through EyeMed Vision Care's Insight Network®.

Vision Benefits include an annual eye exam with no copay when you use a network provider, and prescription eyewear or contact lenses offered through a broad-based network of ophthalmologists, optometrists, and opticians at retail chains and independent provider locations. Certain calendar-year benefit limitations apply.

Review the ***EyeMed Summary of Benefits*** for information about covered services under this Plan.

If you are already registered on the EyeMed site, visit ***eyemedvisioncare.com/ecmt*** and use your EyeMed member account credentials to log in for details. Click "Need to register?" to create an EyeMed member account.

To contact EyeMed's Member Services team, call 866-723-0513.

Health Advocate
This program is like having your own healthcare navigator at no cost to you! Health Advocate offers help when you have questions about your medical care—from finding a doctor and scheduling an appointment to understanding treatment options for a medical condition to understanding your benefits or resolving a claim.

This service can help you navigate the healthcare system and make the most of your benefits. It is available for you, your dependents, your parents, and your parents-in-law (even if they do not live with you).

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[5] If you previously registered a myCigna account while you participated in a Cigna-administered medical or dental plan, and you no longer participate in such a plan, you may need to reregister to access online EAP resources.

Call as often as you need and speak toll-free with a health advocate about your healthcare options. Your information is confidential. Your employer does not receive and does not have access to any of your confidential information. You will be asked to complete and submit forms to protect your privacy.

To access Health Advocate, visit ***healthadvocate.com/ecmt*** or call 866-695-8622, Monday to Friday, 8:00 AM to 7:00 PM ET.

UHC Global Travel Medical Assistance
When you enroll in a medical Plan offered through the Medical Trust, you have access to UnitedHealthcare Global Assistance®. This travel assistance program can help you with travel needs you encounter while you are outside the United States or 100 or more miles away from home.

The program includes these features:

- Assistance in obtaining medical treatment—whether you need a local referral for treatment or evacuation due to a medical emergency UnitedHealthcare Global Assistance staff will help make the arrangements.
- Assistance with providing insurance information and medical records for treatment
- Assistance with replacement of prescriptions, medical devices, and corrective lenses
- Assistance procuring emergency travel arrangements and replacement of lost or stolen travel documents
- Emergency fund transfers
- Destination profiles, which include health and security risks for more than 170 countries

Important Note: UnitedHealthcare Global Assistance is not travel insurance. It does not cover your medical or other costs while you are traveling. If you incur costs, and depending on where you travel, you may be required to pay for your healthcare services. UnitedHealthcare Global Assistance's role is solely to arrange for care and other services.

If you have an emergency medical event while traveling, contact Kaiser Permanente using the number on your member ID card.

For more information about UnitedHealthcare Global Assistance services, please visit ***members.uhcglobal.com*** or call 800-527-0218.

General Exclusions, General Limitations, Coordination of Benefits, and Reductions

The Services listed in this section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered. Additional exclusions that apply only to a benefit are listed in the description of that benefit in the Benefits and Cost Sharing "Benefits and Cost Sharing" section. The Plan will not provide benefits for any of the Services, treatments, items, or supplies described in this section, regardless of Medical Necessity or recommendation of a healthcare provider. This list is intended to give you a description of Services and supplies not covered by the Plan but is not intended to be

all-inclusive. Some of the Services listed in this chapter as not covered by the Plan may be covered by your pharmacy, dental, or vision plans. This section uses headings to help you find specific exclusions more easily.

Alternative treatments – Acupressure, aromatherapy, massage therapy (except when provide as a procedure during a covered therapy), rolfing, holistic or homeopathic care.
Before coverage begins – Any Services, drugs, or supplies you receive while you are not enrolled in this Plan.
Behavioral/conduct problems – Any educational Services and programs or therapies for behavioral/conduct problems. This exclusion does not apply to coverage for medication management.
Blood – Cord blood storage and the cost of whole red blood or red blood cells when they are donated or replaced and billed, except expenses for administration and processing of blood and blood products (except blood factors) covered as part of Inpatient and Outpatient Services and autologous donation in anticipation of scheduled Services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
Care by Non-Network Providers except for authorized referrals, emergencies, and out-of-area Urgent Care
Care in a halfway house
Comfort, Convenience, or Luxury Items and Services – Equipment or Services that basically serve comfort, convenience, or luxury functions, or are primarily for the comfort, convenience, or luxury of a person caring for you or your Dependent, or Services and supplies not directly related to medical care. Examples include: radio and television; telephone; beauty/barber service; guest meals and accommodations; guest service, supplies, and equipment; air cleaners; air conditioners; air purifiers and filters; batteries and battery chargers; dehumidifiers; dust collection services; elevators; exercycles or other physical fitness equipment; homemaker services; hospital admission kit; take-home supplies; humidifiers; heating pads; hot water bottles; water beds; hot tubs; over-the-counter convenience items; shower/bath benches; any other clothing or device that could be used in the absence of an Illness or Injury; devices and computers to assist in communication and speech; home remodeling to accommodate a health need (such as, but not limited to, ramps, electric chairlifts, Hoyer lifts, and swimming pools); and similar incidental services for personal comfort.
Cosmetic Services – Except for medically necessary reconstructive surgery and related Services**.**
Custodial Care – This exclusion does not apply to Services covered under "Hospice Care."
Dental coverage will not be provided for extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, orthodontia (including braces), false teeth, or any other dental Services or supplies, except as otherwise covered under this Plan Document Handbook. This exclusion does not apply to accidental injury to sound and natural teeth. See other section for Covered Services.
Dental procedures and appliances to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders)
Dental Services not listed elsewhere in your coverage. This exclusion does not apply to accidental injury to sound and natural teeth.
Education – Services other than Health Education or Self-Management of a medical condition as determined by the Plan to be primarily educational in nature.
Excluded Providers – Services, supplies, equipment, or prescriptions provided by OIG (Office of the Inspector General)-excluded providers.
Experimental or Investigational Services Kaiser Permanente determines that a Service is experimental and investigational when - 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 Service is to be provided; - it has not been approved by the FDA and, lacking such approval, cannot be legally performed or marketed in the United States; - it is the subject of a current new drug or device application on file with the FDA; - it has not been approved or granted by the US Food and Drug Administration (FDA) excluding off-label use of

<table>
<tr><td>FDA approved drugs and devices;
 - it 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;
 - it is subject to approval or review of an Institutional Review Board or other body that approves or reviews research;
 - it is provided pursuant to informed consent documents that describe the Services as experimental or investigational, or indicate that the Services are being evaluated for their safety, toxicity, or efficacy;
 - the prevailing opinion among experts 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 Service; or
- it is provided for Non-referred Services in connection to an approved clinical trial and/or Services in connection with a non-approved clinical trial.</td></tr>
<tr><td>Fertility Services – The following and related Services: reversal of male and female voluntary sterilization; Fertility Services when the infertility is caused by or related to voluntary sterilization; donor semen or eggs, and Services related to their procurement and storage, including cryopreservation; and any experimental, investigational, or unproven fertility procedures or therapies. This exclusion does not apply to Services to rule out the underlying medical causes of infertility.</td></tr>
<tr><td>Foot care except when Medically Necessary</td></tr>
<tr><td>Foot Care and Shoes
- Except when needed for severe systemic disease:
routine foot care (including the cutting or removal of corns and calluses)
nail trimming, cutting, or debriding
- Hygienic and preventive maintenance foot care. Examples include but are not limited to
cleaning and soaking the feet
applying skin creams in order to maintain skin tone
other services that are performed when there is not a localized illness, injury, or symptom involving the foot
- Foot care and orthotics except when Medically Necessary for care of the diabetic foot, peripheral vascular or circulatory disease, or severe foot Injury
- Treatment of flat feet
- Shoe inserts
- Orthopedic shoes (except when an orthopedic shoe is joined to a brace)</td></tr>
<tr><td>Gender Affirming–Related Services listed below:
Sperm procurement and storage in anticipation of future infertility, unless covered under Fertility Services benefit
Gamete preservation and storage in anticipation of future infertility, unless covered under Fertility Services benefit
Cryopreservation of fertilized embryos in anticipation of future infertility, unless covered under Fertility Services benefit
Other electrolysis or laser hair removal not specified as covered
Vaniqa</td></tr>
<tr><td>Government Obligations – Any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy for which the federal government has primary responsibility for payment. Also excluded are charges for Services directly related to military service (including any disabilities related to such military service) provided or available from the Veterans’ Administration, foreign governmental agency, or military medical facilities as required by law.</td></tr>
<tr><td>Governmental Programs
- Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
- Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers’ compensation, no-fault auto insurance, or similar legislation.</td></tr>
<tr><td>Hypnotherapy (Hypnosis)</td></tr>
</table>

Illegal Services – Treatments, procedures, equipment, drugs, devices, supplies or any other plan benefit, in each case, that are illegal under applicable law.
Licensed Provider Charges for a Provider acting outside the scope of his license
Massage Therapy except when provided as a part of other covered Services.
Medical supplies – Disposable supplies for home use
Medicare Benefits – Your Benefits are reduced by any benefits to which you are entitled under Medicare except for members whose Medicare benefits are secondary by law.
Network or Non-Network Provider (Close Relative) – Services rendered by a Network or Non-Network Provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, or brother or sister by blood, marriage, or adoption.
Nutritional supplements and formulae except for formula needed for the treatment of inborn errors of metabolism.
Obesity – Fees or costs associated with weight reduction programs, fees and charges relating to fitness programs, weight loss or weight control programs, except for Network diabetes prevention programs.
Outpatient Prescription Drugs - Drugs prescribed for cosmetic purposes - Drugs that shorten the duration of the common cold - Drugs used to enhance athletic performance - As determined by Kaiser, drugs which are available over the counter and prescriptions for which drug strength may be realized by the over-the-counter product except where noted in your Schedule of Benefits - Experimental or Investigational Drugs - If a Service is not covered under this Plan, any drugs or supplies needed in connection with that Service are not covered. - As determined by Kaiser, prescription drugs for which there is an over-the-counter drug equivalent except where noted in your Schedule of Benefits. - Replacement of lost, damaged, or stolen drugs - Special packaging; packaging of prescription medications is limited to Kaiser Permanente standard packaging.
Personal Comfort Items for Home Use – Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for you or your Dependent, i.e., exercycles or other physical fitness equipment, elevators, Hoyer lifts, shower/bath benches, air conditioners, air purifiers and filters, batteries and charges, dehumidifiers, humidifiers, air cleaners, and dust collection devices.
Personal Comfort Items when Inpatient – Services and supplies not directly related to medical care, such as guest meals and accommodations, hospital admission kit, barber services, telephone charges, radio and television rentals, homemaker services, over-the-counter convenience items and take-home supplies.
Physical Appearance - Cosmetic surgery, Services and supplies, and therapies, except for Medically Necessary reconstructive surgery and related Services. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance. - Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions. - Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, personal training, and diversion or general motivation. - Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
Private Duty Nursing as a registered bed patient unless a Network Physician determines Medical Necessity.
Private Duty Nursing in home or long-term facility
Private room unless medically necessary or if a semi-private room is not available.

Providers - Care by out-of-network providers except for authorized referrals, emergencies, or Services from other Kaiser Permanente plans. - Treatment not prescribed or recommended by a healthcare provider. - Services given by an unlicensed healthcare provider or performed outside the scope of the provider's license. - Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent, or child. This includes any Service the provider may perform on themselves. - Services performed by a provider with your same legal residence.
Religious, personal growth counseling, or marriage counseling, including Services and treatment related to religious, personal growth counseling, or marriage counseling, unless the primary patient has a mental health diagnosis.
Residential Accommodations Residential accommodations to treat medical or behavioral health conditions, except when provided in a *Hospital*, *Hospice*, *Skilled Nursing Facility*, or *Mental Health Residential Treatment Center*. This exclusion includes procedures, equipment, services, supplies or charges for the following: - domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included - care provided or billed by a hotel; health resort; convalescent home, rest home, nursing home, or other extended-care Facility home for the aged, infirmary; school infirmary; institution providing education in special environments; supervised living or halfway house; or any similar Facility or institution - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or Outward Bound program, even if psychotherapy is included
Services, drugs, or supplies if not Medically Necessary
Services billed more than 365 days after the date of service or dispensing
Services for conditions that a Network Physician determines are not responsive to therapeutic treatment
Services provided outside the United States – Services, other than Emergency Services, received outside the United States whether or not the Services are available in the United States.
Services related to a non-Covered Service – All Services, drugs, or supplies related to the non-Covered Service are excluded from coverage, except Services we would otherwise cover for the treatment of complications and rehabilitation of the non-Covered Service.
Services that are the subject of a Non-Network Provider's notice and consent Amounts owed to Non-Network Providers for non-Emergency Services when you or your authorized representative consent to waive your right against surprise billing/balance billing (unexpected medical bills) under applicable federal law.
Shoes – Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
Surrogacy – Services related to conception, pregnancy, or delivery in connection with a surrogate arrangement. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.
Testing for ability, aptitude, intelligence, or interest
Third-Generation Dependents – Services related to third-generation dependents, unless enrolled as an Eligible Dependent.
Third-Party Requests – Services, reports, and/or examinations in connection with employment, participation in employee programs, insurance, disability, licensing, immigration applications, or on court order or for parole or probation.
Travel or transportation expenses – Travel or transportation expenses even though prescribed by a Network Physician or Non-Network Physician, except as noted as covered in the Schedule of Benefits.
Vision (Surgical Correction) – Radial keratotomy, and surgery, Services, evaluations, or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.

Vision - Low vision aids, eyeglasses, lenses, contact lenses, and follow-up care thereof, except that Covered Expenses will include vision therapy for eye coordination deficits and purchase of the first pair of eyeglasses, lenses, frames, or contact lenses that follow cataract surgery or loss of lens due to eye disease for aphakia or aniridia. - Surgery, Services, evaluations, or other related treatments or supplies that are intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism, including but not limited to procedures such as radial keratotomy, laser, and other refractive eye surgery, or any other correction of vision due to a refractive problem.
Vision Hardware (eyeglasses, lenses, contact lenses) as prescribed to correct visual acuity
Waived fees/Free Care (no charge items)
Workers' Compensation – Services for any condition or injury recognized or allowed as a compensable loss through any workers' compensation, occupational disease, or similar law. Exception: Benefits are provided for actively employed partners and small business owners not covered under a Workers' Compensation Act or similar law, if covered by the Plan. Services or supplies for injuries or diseases related to you or your Dependent's job to the extent you are, or your Dependent is, required to be covered by a workers' compensation law.
Other Exclusions - Expenses for copying or preparing medical reports, itemized bills, or claim forms - Mailing and/or shipping and handling expenses (there may be certain exceptions—contact your health plan for more information) - Expenses for failure to keep an appointment - Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks - Services usually given without charge, even if charges are billed - Expenses in excess of usual, customary, and reasonable fees

General Limitations

Network Providers will try to provide or arrange for the provision of Covered Services in the event of unusual circumstances that delay or render impractical the provision of Services, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Network Provider's facility, complete or partial destruction of facilities, or labor disputes. Neither the Plan, KPIC, nor any Network Providers shall have any liability for delaying or failing to provide Services in the event of this type of unusual circumstance.

Coordination of Benefits

This *Coordination of Benefits* (COB) section describes how payment of claims for Services under the Plan will be coordinated with those of any other plan under which you are entitled to have claims for Services paid.

When Coordination of Benefits Applies

This *Coordination of Benefits* section applies when an enrolled Eligible Individual or a Dependent has healthcare coverage under more than one benefit plan under which claims for Services are to be paid.

The order of benefit determination rules described in this *Coordination of Benefits* section govern the order in which each Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan, the one that must pay first, pays in accordance with its terms without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the payments it makes so that payments from all plans do not exceed 100% of the total Allowable Expenses.

Definitions
For purposes of this *Coordination of Benefits* section only, terms are defined as follows:

"**Coverage Plan**" is any of the following that provides payment 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 Coverage Plan and there is no COB among those separate contracts.

- Coverage Plan includes: group and non-group insurance; health maintenance organization (HMO) contracts; closed panel 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.
- Coverage Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited health benefit coverage, as defined by state law; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; and coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

"**This Coverage Plan**" means the part of the contract providing the healthcare 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 healthcare benefits is separate from This Coverage 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.

"**Primary Coverage Plan**" or "**Secondary Coverage Plan**." Order of benefit determination rules determine whether This Coverage Plan is a Primary Coverage Plan or Secondary Coverage Plan when compared to another Coverage Plan covering the person. When This Coverage Plan is primary, it determines payment of claims for Services first before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When This Coverage Plan is secondary, it determines payment of claims for Services after those of another Coverage Plan and may reduce its payments so that all payments and benefits of all Coverage Plans do not exceed 100% of the total Allowable Expense.

"**Allowable Expense**" means a healthcare expense, including Cost Sharing, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of Services (for example, an HMO), the reasonable cash value of each Service will be considered an Allowable Expense and a benefit paid. An expense or an expense for a Service that is not covered by any of the Coverage Plans 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 additional examples of expenses or Services that are not Allowable Expenses:

- If a covered person is confined in a private hospital room, the difference between the cost of a semi-private hospital room and the private room (unless the patient's stay in a private hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for hospital private rooms) is not an Allowable Expense.
- If a person is covered by two or more Coverage Plans that compute their benefit payments based on usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount more than the highest of the usual and customary fees (or other reimbursement amount) for a specific benefit is not an Allowable Expense.
- If a person is covered by two or more Coverage Plans that provide benefits or Services based on negotiated fees, an amount more than the highest of the negotiated fees is not an Allowable Expense.
- If a person is covered by one Coverage Plan that calculates its benefits or Services based on usual and customary fees and another Coverage Plan that provides its benefits or Services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans. However, if the provider has contracted with the Secondary Coverage Plan to provide the benefit or Service for a payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Coverage Plan to determine its benefits.
- The amount a benefit is reduced by the Primary Coverage Plan because a covered person does not comply with the Coverage Plan provisions is not an Allowable Expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

"Claim Determination Period" means a calendar year.

"**Closed Panel Plan**" is a Coverage Plan that provides healthcare benefits to covered persons primarily in the form of Services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that excludes coverage for Services provided by other providers, except in cases of emergency or referral by a panel member.

"**Custodial Parent**" means a parent awarded 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 Coverage Plans which pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Coverage Plan pays or provides its benefits per its terms of coverage and without regard to the benefits of any other Coverage Plan(s).

B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Coverage Plans state that the complying plan is primary; provided, however, coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written about a closed panel Coverage Plan to provide non-network benefits.

C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.

D. Each Coverage Plan determines its order of benefits using the first of the following rules that applies:

1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a Dependent, for example as an employee, member, or retiree, is primary and the Coverage Plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, because of federal law, Medicare is secondary to the Coverage Plan covering the person as a Dependent; and primary to the Coverage Plan covering the person as other than a Dependent (for example, a retired employee), then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, or retiree is secondary and the other Coverage Plan is primary.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Coverage Plan, the order of benefits is determined as follows:

a. For a Dependent Child whose parents are married or are living together:

(i) The Coverage Plan of the parent whose birthday falls earlier in the calendar year is primary.

(ii) If both parents have the same birthday, the Coverage Plan that has covered the parent the longest is primary.

b. For a Dependent Child whose parents are divorced or separated or are not living together:

(i) If a court decree states that one of the parents is responsible for the child's healthcare expenses or healthcare coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.

(ii) If a court decree states that both parents are responsible for the Dependent Child's healthcare expenses or healthcare coverage, the provisions of subparagraph (a) above shall determine the order of benefits; or

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare 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 healthcare expenses or healthcare coverage, the order of benefits for the Dependent Child are as follows:

- The Coverage Plan of the custodial parent
- The Coverage Plan of the spouse of the custodial parent
- The Coverage Plan of the non-custodial parent, and then
- The Coverage Plan of the spouse of the non-custodial parent

c. For a Dependent Child covered under more than one Coverage Plan of individuals who are 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.

3. Active or inactive (retired or laid-off) employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The Coverage Plan covering that same person as a retired or laid-off employee is the Secondary Coverage 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 retiree or laid-off employee. If the other Coverage Plan does not have this rule, and thus, the Coverage 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. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law is also covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and thus, the Coverage 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 Coverage Plan that covered the person as an employee, member, or retiree longer is primary and the

Coverage Plan that covered the person the shorter period is the Secondary Coverage Plan.

6. If a husband or wife is covered under This Coverage Plan as an employee and as a Dependent (if the Plan's eligibility rules allow this), the benefits for the Dependent will be coordinated as if they were provided under another Coverage Plan. This means the Coverage Plan of the person as an Employee will pay first.

7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this *Coordination of Benefits* section. In addition, This Coverage Plan will not pay more than it would have paid had it been the Primary Coverage Plan.

Effect on the Benefits of this Plan

When This Coverage Plan is secondary, it may reduce its benefits so that the total amount of benefits paid or provided by all Coverage Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Coverage Plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any Allowable Expense under the Secondary Coverage Plan that is unpaid by the Primary Coverage Plan. The Secondary Coverage Plan may then reduce its payment by the amount so that when combined with the amount paid by the Primary Coverage Plan, the total benefits paid or provided by all Coverage Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Coverage Plan shall credit to its plan deductible, if any, the amounts that it would have credited to its deductible in the absence of other healthcare coverage.

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-participating provider, benefits are not payable by one Closed Panel Plan; COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.

This Coverage Plan complies with the Medicare Secondary Payer regulations. If a Covered Person is also receiving benefits under Medicare, including Medical Prescription Drug Coverage, federal law may require this Plan to be primary. When This Coverage Plan is not primary, the Plan will coordinate benefits with Medicare.

- The person is enrolled in a Medicare Advantage plan and receives non-Covered Services because the person did not follow all rules of that plan. Medicare benefits are determined as if the Services were covered under Medicare Parts A and B.
- The person receives Services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the Services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The Services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare

benefits are determined as if the Services were provided by a facility that is eligible for reimbursement under Medicare.
    - The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.
- To determine when Medicare is primary, see the excerpt from *https://www.medicare.gov/publications* below:

How does my other insurance work with Medicare?

When you have other insurance (like group health plan, retiree health, or Medicaid coverage) and Medicare, there are rules for whether Medicare or your other coverage pays first.

If you have **retiree** health coverage (like insurance from your or your spouse's former employment)...	Medicare pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's **current** employment, and the employer has **20 or more employees**...	Your group health plan pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's **current** employment, and the employer has **fewer than 20 employees**...	Medicare pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family member's **current** employment, and the employer has **100 or more employees**...	Your group health plan pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family member's **current** employment, and the employer has **fewer than 100 employees**...	Medicare pays first.
If you have group health plan coverage based on your or a family member's employment or former employment, and you're eligible for Medicare because of End-Stage Renal Disease (ESRD)...	Your group health plan pays first for the first 30 months after you become eligible for Medicare. Medicare pays first after this 30-month period.
If you have TRICARE...	Medicare pays first, unless you're on active duty, or get items or services from a military hospital or clinic, or other federal health care provider.
If you have Medicaid...	Medicare pays first.

Important! If you're still working and have employer coverage through work, contact your employer to find out how your employer's coverage works with Medicare.

Here are some important facts to remember about how other insurance works with Medicare-covered services:

- The insurance that pays first (primary payer) pays up to the limits of its coverage.
- The insurance that pays second (secondary payer) only pays if there are costs the primary payer didn't cover.
- The secondary payer (which may be Medicare) might not pay all of the uncovered costs.
- If your group health plan or retiree health coverage is the secondary payer, you might need to sign up for Part B before your insurance will pay.

Visit **Medicare.gov/publications** to view the booklet, "Medicare and Other Health Benefits: Your Guide to Who Pays First." You can also call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Important! If you have other insurance or changes to your insurance, you need to let Medicare know by calling Medicare's Benefits Coordination & Recovery Center at 1-855-798-2627. TTY users can call 1-855-797-2627.

If you have Part A, you may get a "Health Coverage" form (IRS Form 1095-B) from Medicare. This form verifies that you had health coverage in the past year. Keep the form for your records. Not everyone will get this form. If you don't get Form 1095-B, don't worry. You don't need it to file your taxes.

For more information on Medicare and ESRD, see *https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/End-Stage-Renal-Disease-ESRD/ESRD*

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and Services are needed to apply these COB rules and to determine benefits payable under This Coverage Plan and other Coverage Plans. The Plan has the right to release or obtain any information and make or recover any payments considered necessary to administer this *Coordination of Benefits* section. This shall include getting the facts needed from, or giving them to, other organizations or persons for applying these rules and determining benefits payable under This Coverage Plan and other Coverage Plans covering the person claiming benefits. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Coverage Plan must provide any facts needed to apply those rules and determine benefits payable. If you do not provide the information needed to apply these rules and determine the benefits payable, your claim for benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, reimbursement to that Plan of that amount will be made to the Plan that made the payment. That amount will then be treated as though it was a benefit paid under This Plan and that amount will not be paid 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 the Plan is more than it should have paid under this *Coordination of Benefits* section, it may receive 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.

Reductions

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include anyone on whose behalf the Plan pays or provides any Benefit including, but not limited to, the representative of the Plan Member's estate, heir, descendant, a minor Child or Dependent of any Plan Member or person entitled to receive any Benefits from the Plan. References to "you" or "your" also includes anyone to whom a Plan Member or a Plan Member's representative transfers or assigns (or purports to transfer or assign) any recovery or right of recovery from a responsible party.

Subrogation applies when the Plan has paid benefits on your behalf for a sickness, injury or other medical condition for which any third party may be allegedly responsible. The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for damages arising out of or connected to the sickness, illness or other medical condition , in an amount up to the amount of the benefits the Plan has paid that are related to the sickness, injury or other medical condition for which a third party is may be liable.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a sickness, injury or other medical condition for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you receive for that sickness, injury or other medical condition. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Third parties include but are not limited to the following persons and entities:

- A person or entity alleged to have caused you to suffer a sickness, injury, other medical condition or any other form of damages, or who is legally responsible for the Sickness, Injury, other medical condition or any other form of damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury, other medical condition or any other form of damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a sickness, injury or other

medical condition you allege or could have alleged were the responsibility of any third party.

- Any person or entity that is liable for payment to you on any equitable or legal liability theory arising out of or connected to a sickness, injury or other medical condition you allege or could have alleged were the responsibility of any third party.

You agree as follows:

- You will cooperate with the Plan and Kaiser Permanente Insurance Company (KPIC) in protecting their respective legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan and KPIC, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan or KPIC.
  - Signing and/or delivering such documents as the Plan, KPIC or their respective agents reasonably request in connection with the subrogation and/or reimbursement claim.
  - Responding to requests for information about any accident, injuries or similar occurrences.
  - Making court appearances.
  - Obtaining the Plan and KPIC's consent or their respective agents' consent before (i) releasing any party from liability or from the obligation to make payment of medical expenses or (ii) waiving, releasing or reducing the Plan or KPIC's rights under this Subrogation and Reimbursement section.
  - Complying with the terms of this Subrogation and Reimbursement section.

  Your failure to cooperate with the Plan or KPIC or otherwise to comply with the terms of this Subrogation and Reimbursement section is considered a breach of contract. As such, the Plan has the right to terminate benefits to you or your dependents, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness, injury or other medical condition caused or alleged to have been caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan, KPIC, or their respective agents, or otherwise failing to abide by the terms of the Plan, including this Subrogation and Reimbursement section. If the Plan incurs attorneys' fees and costs to collect third-party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan, at the prime rate from time to time published by *The Wall Street Journal*.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, this first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier. Such superiority shall be

notwithstanding anything to the contrary in any agreement between you and such medical provider, whenever such agreement may be entered into, unless the Plan has provided an express written waiver of this provision.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs or beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation or reimbursement rights.
- Benefits paid by the Plan may also be benefits advanced.
- If you receive any payment from any party because of sickness, injury, or other medical condition, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust for the benefit of the Plan, either in a separate bank account in your name or in your representative's trust account. To the extent you fail to do so, those funds shall be deemed to be held in constructive trust for the benefit of the Plan.
- The Plan's rights to recovery will not be reduced due to your own negligence, including due to the application of any contributory or comparative negligence defenses.
- By participating in and accepting benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy—including but not limited to no-fault benefits, PIP benefits, and/or medical payment benefits—other coverage or against any third party, to the full extent of the benefits the Plan has paid for the sickness, injury, or other medical condition. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue, and recover on any such claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under the provisions of this Subrogation and Reimbursement section, including but not limited to providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing a reimbursement lawsuit to recover the full amount of medical benefits you receive for the sickness, injury or other medical condition out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this Subrogation and Reimbursement section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death, the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages.
- The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind (other than by a written agreement between you and the Plan).
- No allocation of damages, settlement funds, or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest, unless the Plan provides written consent to such allocation.
- The provisions of this Subrogation and Reimbursement section apply to the parent(s), guardian(s), or other representative(s) of a Dependent child who incurs a sickness, injury, or other medical condition caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness, injury, or other medical condition, the terms of this Subrogation and Reimbursement section shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a sickness, injury, or other medical condition while you are covered under this Plan, the provisions of this Subrogation and Reimbursement section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights, (2) resolve all disputes regarding the interpretation of the language of this Subrogation and Reimbursements section and (3) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan. Any such constructions, interpretations and decisions shall be final and binding.

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

Health Plan Services
3701 Boardman-Canfield Rd., Bldg. B
Canfield, OH 44406-7005

For the Plan to determine the existence of any rights the Plan may have and to satisfy those rights, you must complete and send all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay the Plan directly. You may not agree to waive, release, or reduce the Plan or KPIC's rights under this Subrogation and Reimbursement section without the Plan or KPIC's, as applicable, prior written consent.

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

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

You will provide the Plan, the KPIC, or its representative notice of any recovery you or your agent obtains prior to their receipt of such recovery or, if you or your agent did not learn of the recovery prior to such receipt, within five days after the recovery. You will refrain from any disbursement of settlement proceeds or any other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

Surrogacy Arrangements
If you enter into a Surrogacy Arrangement, you must pay the Plan charges for Covered Services you receive related to conception, pregnancy, delivery, or postpartum care relating to that arrangement ("Surrogacy Health Services"), except that the amount you must pay 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. Note: This "Surrogacy Arrangements" section does not affect your obligation to pay Cost Sharing for these Services; you will be credited any such payments toward the amount you must reimburse the Plan under this paragraph.

By accepting Surrogacy Health Services, you automatically assign to the Plan 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 the Plan's rights, the Plan will also have an equitable 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 the Plan's lien. The assignment and the Plan's lien will not exceed the total amount of your obligation to the Plan under the preceding paragraph.

Within 30 days after entering a Surrogacy Arrangement, you must send written notice of the arrangement, including all 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; and
- any other information the Plan may request to satisfy its rights, to:

  Health Plan Services
  3701 Boardman-Canfield Rd., Bldg. B
  Canfield, OH 44406-7005

You must complete and send all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary to determine the existence of any rights the Plan may have under this “Surrogacy Arrangements” section and to satisfy those rights. You may not agree to waive, release, or reduce the Plan’s rights under this “Surrogacy Arrangements” section without the Plan’s prior, written consent.

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

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, KPIC shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision. Any such interpretations shall be final and binding.

Jurisdiction

By accepting Benefits (whether the payment of such Benefits is made to you or made on behalf of you to any Provider) from the Plan, you agree that any court proceeding with respect to this “Subrogation and Reimbursement” section may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such Benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond to you by reason of present or future domicile.

US Department of Veterans Affairs
For any Services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, the Plan will not pay the Department of Veterans Affairs, and when the Plan covers any such Services the Plan 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. The Plan will provide Covered Services even if it is unclear whether you are entitled to a Financial Benefit, but the Plan 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; or
- 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.

Dispute Resolution

Grievances

You may appoint an authorized representative to help you file your grievance. A written authorization must be received from you before any information will be communicated to your representative.

Kaiser Permanente is committed to providing quality care and a timely response to your concerns. You can discuss your concerns with Kaiser Permanente's representatives at most Network Facilities, or you can call Customer Services at the number on your ID card.

You can file a grievance for any issue. Here are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received.
- 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.

Your grievance must explain your issue, such as the reasons why you are dissatisfied about Services you received. You must submit your grievance orally or in writing within 180 days of the date of the incident that caused your dissatisfaction.

Grievances may be submitted in one of the following ways:

- at a Kaiser Permanente Facility (please refer to *kp.org* for addresses)
- by calling Customer Service at the number on the back of your ID card
- through *kp.org*

You will receive a confirmation letter within five days after receipt of your grievance. You will receive a written decision within 30 days after receipt of your grievance. Note: If your issue is resolved to your satisfaction by the end of the next business day after your grievance is received orally, or at *kp.org*, and a Customer Services representative notifies you orally about Kaiser Permanente's decision, you will not receive a confirmation letter.

Claims and Appeals

To obtain payment for Services you have paid for or to obtain review of a claims payment decision, you must follow the procedures outlined in this "Claims and Appeals" section.

You may designate someone to act on your behalf (your "Authorized Representative"). If you wish to designate an Authorized Representative to act on your behalf in pursuing a Benefit claim or appeal, the designation must be explicitly stated in writing and it must authorize disclosure of protected health information with respect to the claim by Kaiser Permanente, and the Authorized Representatives to one another. If a document is not sufficient to constitute a designation of an Authorized Representative, as determined by the Claims Administrator, then this Plan will not consider a designation to have been made and will not consider the claim or appeal to have been properly filed. You should carefully consider whether to designate an Authorized Representative. An Authorized Representative may make decisions independent of you, such as whether and how to appeal a claim denial.

If you miss a deadline for filing a claim or appeal, your review may be declined. Before you can file a legal action, you must meet any deadlines and exhaust the claims and appeals procedures set forth in this "Claims and Appeals" section. There is no charge for claims or appeals, but you must bear the cost of anyone you hire to represent or help you.

Timing of Claim Determinations

The Plan adheres to certain time limits when processing claims for Benefits. If you do not follow the proper procedures for submitting a claim, KPIC will notify you of the proper procedures within the time frames shown in the chart below. If additional information is needed to process your claim, KPIC will notify you within the time frames shown in the chart below, and you will be provided additional time within which to provide the requested information as indicated in the chart below in this "Timing of Claim Determinations" section.

Determination on your claim will be made within the time frames indicated below based upon the type of claim: Urgent Claim, Pre-Service Claim, Post-Service Claim, or Concurrent Care Claim.

- An "Urgent Care Claim" is any claim for a Service with respect to which the application of the time periods for making non-urgent care determinations either (a) could seriously jeopardize your life, health, or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services that are the subject of the claim, or a claim that your attending provider determines is urgent.

- A "Pre-Service Claim" is any claim for a Service with respect to which the terms of the Plan condition receipt of the Service, in whole or in part, on approval of the Service in advance.

- A "Post-Service Claim" is any claim for a Service that is not a Pre-Service Claim, a Concurrent Care Claim, or an Urgent Care Claim. Any claim of improper "surprise billing" is a Post-Service Claim.

- A “Concurrent Care Claim” is any claim for Services that are part of an on-going course of treatment that was previously approved for a specific period or number of treatments.

Type of Notice or Claim Event	Urgent Care Claim	Pre-Service Care Claim	Post-Service Care Claim
Notice of Failure to Follow the Proper Procedure to File a Claim	Not later than 24 hours after receiving the improper claim.	Not later than five (5) days after receiving the improper claim.	Not applicable.
Notice of Initial Claim Decision	If the claim when initially filed is proper and complete, a decision will be made as soon as possible, considering the medical exigencies, but not later than 72 hours after receiving the initial claim. If the claim is not complete, the KPIC will notify you as soon as possible, but not later than 24 hours of receipt of the claim. You will have 48 hours to provide the information necessary to complete the claim. A decision will be made not later than 48 hours after the administrator receives the requested information, or within 48 hours after the expiration of the 48-hour deadline for submitting additional information, whichever is earlier.	If the claim when initially filed is proper and complete, a decision will be made within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the initial claim is received, unless an extension, of up to 15 days, is necessary due to matters beyond the control of the Plan. You will be notified within the initial 15 days if an extension will be needed. The notice will state the reason for the extension. A decision will be made not later than 15 days after the initial claim is received, unless additional information is required from you. You will be notified during the initial 15-day period and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving the additional information, or within 15 days after the expiration of the 45-day deadline for submitting additional information, which-ever is earlier.	A decision will be made within a reasonable amount of time, but not later than 30 days after the initial claim is received, unless an extension, of up to 15 days, is necessary due to matters beyond KPIC’s control. You will be notified within the initial 30 days if an extension will be needed. The notice will state the reason for the extension. A decision will be made not later than 30 days after the initial claim is received, unless additional information is required from you. You will be notified during the initial 30-day period and will have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving the additional information or, within 15 days after the expiration of the 45-day deadline for submitting additional information, whichever is earlier.

* All listed time frames are calendar days

Concurrent Care Claims

If you have a Concurrent Care Claim that is also an Urgent Care Claim to extend a previously approved ongoing course of treatment provided over a period of time or number of treatments, KPIC will make a determination as soon as possible, taking into account the medical exigencies, and notify you of the determination within twenty-four (24) hours after receipt of the claim, provided that the claim was made to KPIC at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments previously approved. If your request for extended treatment is not made at least twenty-four (24) hours prior to the end of the prescribed period or number of treatments, the request will be treated as an Urgent Care Claim and decided according to the time frames described above.

If your Concurrent Care Claim is not an Urgent Care Claim, and there is a reduction or termination of the previously approved on-going course of treatment provided over a period of

time or number of treatments (other than by Plan amendment or termination) before the end of the period of time or number of treatments, you will be notified by KPIC sufficiently in advance of the reduction or termination to allow you to appeal the denial and receive a determination on appeal before the reduction or termination of the Benefit.

Post Service Claims
To obtain payment for Services you have paid for or to obtain review of a claims payment decision, you must follow the procedures outlined in this “Claims and Appeals” section.

If you miss a deadline for filing a claim or appeal, your review may be declined. Before you can file a legal action or commence arbitration, you must meet any deadlines and exhaust the claims and appeals procedures set forth in this “Claims and Appeals” section. There is no charge for claims or appeals, but you must bear the cost of anyone you hire to represent or help you. The Episcopal Church Medical Trust has contracted with Health Advocate to support you in the appeal process. Contact Health Advocate at 866-695-8622.

How to File a Claim
Network Providers are responsible for submitting claims for their Services on your behalf and will be paid directly by KPIC for the Services they render. If a Network Provider bills you for a Covered Service (other than for Cost Sharing), please call Customer Service at the telephone numbers listed in the *Customer Service Phone Numbers* section.

For Services rendered by Non-Network Providers, where the provider agrees to submit a claim on your behalf, eligible claims payment to the provider will require you to direct that Benefit payment on your behalf be paid directly to the provider (assignment of Benefits). Even if the Non-Network Provider agrees to bill on your behalf, you are responsible for making sure that the claim is received within 365 days of the date of service and that all information necessary to process the claim is received.

To receive reimbursement for Services you have paid for, you must complete and mail a claim form or (or write a letter) to the Claims Administrator at the address listed in the “Customer Service Phone Numbers” section, **within 365 days after you receive Services.** The claim form (or letter) must explain the Services, the date you received them, where you received them, who provided them, and why you think the Plan should pay for them. Include a copy of the bill and any supporting documents. Your claim form (or letter) and the related documents constitutes your claim.

Your claim must include all the following information:

- patient name, address, and Kaiser Permanente ID card medical or health record number
- date(s) of service
- diagnosis
- procedure codes and description of the Services
- charges for each Service
- the name, address, and tax identification number of the provider
- the date the injury or illness began
- any information regarding other medical coverage

To obtain a medical or pharmacy claim form, visit the Kaiser Permanente website at *kp.org,* log in, and then go to *My Health Manager,* then *My Plan and Coverage,* then select the bullet

Claims Summary. The claim form will inform you about other information that you must include with your claim.

If KPIC pays a Post-Service Claim, it will pay you directly, except that it will pay the provider if your claim includes a written request to pay your Benefits directly to the provider (assignment of Benefits) or, before the claim is processed, a written notice is received indicating you have assigned your right to payment to the provider.

Restrictions Against Assignment of Benefits

Benefits, rights and interests under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, or execution of levy of any kind, either voluntary or involuntary, by any person, and any such attempts shall be void. Further, you may not assign any administrative, statutory, or legal rights or causes of action you may have, including, but not limited to, any right to make a claim for Plan Benefits, to request Plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits, and any such attempts shall be void. However, a Member may direct that Benefits payable to them be paid to an institution in which their covered Dependent is hospitalized or to any other provider of Services or supplies authorized under this Plan. Such payment will release the Plan and Kaiser from all liability to the extent of any payment made. Notwithstanding the foregoing, the Plan reserves the right to refuse to honor such direction and to make payment directly to the Member. When payments are made directly to the Member, the Member is responsible for reimbursing the provider. No payment by the Plan pursuant to such direction shall be considered recognition by the Plan of a duty or obligation to pay a provider of Services or supplies except to the extent the Plan actually chooses to do so. If a provider is overpaid because of accepting duplicate payments from the Member and the Plan, it is the provider's responsibility to reimburse the overpayment to the Member. The Plan may pay all healthcare Benefits for Covered Services directly to a provider without the Member's authorization. This discrete authorization or permission to pay any healthcare Benefits to a provider shall not be relied upon or interpreted as granting the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare Services or items.

If you have any questions about submitting a claim for payment for a Service from a Non-Network Provider, please call Customer Service at the telephone number listed on your ID card or in the "Customer Service Phone Numbers" section.

If a Claim Is Denied

If all or part of your claim is denied, KPIC will send you a written notice. If the notice of denial involves an Urgent Care Claim, the notice may be provided orally (a written or electronic confirmation will follow within three days). This notice will explain the reasons for the denial, including references to specific Plan provisions upon which the denial was based.

- If the claim was denied because you did not furnish complete information or documentation, the notice will specify the additional materials or information needed to support the claim and an explanation of why the information or materials are necessary.
- If the claim is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either (a) include the specific rule, guideline, protocol, or other similar criterion, or (b) or include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy

of the rule, guideline, protocol, or other criterion will be provided free of charge upon request.
- If the claim is denied based on a Medical Necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that this explanation will be provided free of charge upon request.

The notice will also state how and when to request a review of the denied claim. If applicable, the notice will also contain a statement of your right to bring a legal action regarding an adverse benefit determination following completion of all levels of review, and the availability of, and contact information for, any applicable office of health insurance consumer assistance ombudsman.

Note: You have the right to request any diagnostic and treatment codes and their meanings that may be the subject of your claim. To make such a request, contact Customer Service at the number on your ID card.

How to Appeal a Denied Claim

You may appeal a denied claim by submitting a written request for review to the Plan. You must make the appeal request within 180 days after the date of the denial notice. Send the written request to the Plan at:

For **Pre-Service and Concurrent Care Denials** send your written appeal to the address that corresponds to the region in which you receive your care:

California	Colorado
Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 800-788-0710	Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 866-466-4042 Phone: 855-364-3184

Georgia	Mid-Atlantic (DC, MD, VA)
Kaiser Foundation Health Plan of Georgia Member Relations, Appeals Nine Piedmont Center 3495 Piedmont Rd NE Atlanta, GA 30305-1736 Fax: 404-949-5001 Phone: 855-354-3185	Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 800-788-0710, 888-225-7202
Northwest	**Washington**
Kaiser Foundation Health Plan of the Northwest Member Relations, Appeals 500 NE Multnomah St., Suite 100 97232-2099 Fax: 855-347-7239 Phone: 866-616-0047	**Kaiser Permanente Appeals** P.O. Box 34593 Seattle, WA 98124-1593 Attn: Appeal Coordinator Fax 206-630-1859 Toll-Free 866-458-5479

Or for Urgent appeals submitted over the phone, call:

Oral Appeal
800-788-0710 Or the number on the back of your Kaiser Permanente ID card

The request must explain why you believe a review is in order and it must include supporting facts and any other pertinent information. KPIC may require you to submit such additional facts, documents, or other material as it may deem necessary or appropriate in making its review.

In addition, under Public Health Service Act (PHS ACT) Section 279.3, states with Consumer Assistance Programs may be available in your state to assist you in filing your appeal. A list of state Consumer Protection Agencies is available on *kp.org* (Log into *My Health Manager*, select *Manage My Plan & Coverage*, then click on *Claims Summary* list of the State Assistance Programs under the Resources banner) or *https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/#statelisting*.

Procedures on Appeal

As part of the review procedure, you may submit written comments, documents, records, and other information relating to the claim.

Also, you may give testimony in writing or by telephone. Please send your written testimony to the address mentioned in the acknowledgement letter, which will be sent to you within five days after KPIC receives your appeal. To arrange to give testimony by telephone, you should call the phone number mentioned in the acknowledgement letter. KPIC will add the information that you provide through testimony or other means to your appeal file and KPIC will review it without regard to whether this information was filed or considered in its initial decision regarding your request for Services.

Upon request and free of charge, you will be provided reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim.

KPIC will review the claim, considering all comments, documents, records, and other information submitted relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination.

The review will not afford deference to the initial claim denial and will be conducted by the Claims Fiduciary, who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual.

In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary, the Claims Fiduciary will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and that healthcare professional will not be the individual who was consulted in connection with the adverse Benefit determination that is the subject of the appeal (or the subordinate of that individual).

Upon request, KPIC will provide for the identification of any medical or vocational experts whose advice was obtained on behalf of KPIC about the adverse benefit determination, without regard to whether the advice was relied upon in making the Benefit determination.

Benefits for an ongoing course of treatment will not be reduced or terminated while an appeal is pending. However, if the appeal is denied in whole or in part, you may be financially responsible for the cost of the denied portion.

Timing of Initial Appeal Determinations

KPIC will act upon each request for a review within the time frames indicated in the chart below:

Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Not later than 72 hours after receiving the appeal.	Not later than 15 days after receiving the appeal	Not later than 30 days after receiving the appeal.

* All listed time frames are calendar days

Notice of Determination on Initial Appeal

Within the time prescribed in the *Timing of Initial Appeal Determinations* section, Plan will provide you with written notice of its decision. If the Plan determines that Benefits should have been paid, the Plan will take whatever action is necessary to pay them as soon as possible.

If your claim is denied on review, the notice will state:

- The reasons for the denial, including references to the specific Plan provisions upon which the denial was based.
- That you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either (a) include the specific rule, guideline, protocol, or other similar criterion, or (b) include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or

other criterion will be provided free of charge upon request.

- If the claim is denied based on a Medical Necessity, Experimental, or similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request.
- For Pre-Service Claims and Post-Service Claims, the notice will also state how and when to request a review of the denial of the initial appeal.
- For Urgent Care Claims, the notice will also describe any voluntary appeal procedures offered by the Plan and your right to obtain information about those procedures.
- The notice will also include a statement of your right to bring an action following an adverse benefit determination following completion of all levels of review.

How to File a Final Pre-Service Claim Appeal

For Pre-Service Claims, you may file a voluntary Pre-Service Claim Appeal. You may appeal the denial of your initial appeal by submitting a written request for review to the Plan. You must make the appeal request within 180 days after the date of notice that your initial appeal is denied. Send the written request to the Plan at:

For **Pre-Service and Concurrent Care Denials,** send your written appeal to the address that corresponds to the region in which you receive your care:

California	Colorado
Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 800-788-0710	Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 866-466-4042 Phone: 855-364-3184
Georgia	**Mid-Atlantic (DC, MD, VA)**
Kaiser Foundation Health Plan of Georgia Member Relations, Appeals Nine Piedmont Center 3495 Piedmont Rd NE Atlanta, GA 30305-1736 Fax: 404-949-5001 Phone: 855-354-3185	Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 800-788-0710, 888-225-7202
Northwest	**Washington**
Kaiser Foundation Health Plan of the Northwest Member Relations, Appeals 500 NE Multnomah St., Suite 100 97232-2099 Fax: 855-347-7239 Phone: 866-616-0047	**Kaiser Permanente Appeals** P.O. Box 34593 Seattle, WA 98124-1593 Attn: Appeal Coordinator Fax: 206-630-1859 Toll-Free 866-458-5479

Or for Urgent appeals submitted over the phone, call:

Oral Appeal
800-788-0710 Or the number on the back of your Kaiser Permanente ID card

How to File a Final Post-Service Claim Appeal

For Post-Service Claims, you may file a voluntary Post-Service Claim Appeal. You may appeal the denial of your initial appeal by submitting a written request for review to the Plan. You must make the appeal request within 180 days after the date of notice that your initial appeal is denied. Send the written request to the Plan at:

Medical & Pharmacy Claims
The Episcopal Church Medical Trust PO Box 2745 New York, NY 10163 Attn: Clinical Director

Timing of Final Appeal Determinations

For Pre-Service Claims and Post-Service Claims, the Plan will act upon each request for a review of the denial of your initial appeal within the time frames indicated in the chart below:

Pre-Service Claim	Post-Service Claim
Not later than 15 days after the appeal is received.	Not later than 30 days after the appeal is received.

* All listed time frames are calendar days

Notice of Determination on Final Appeal

Within the time prescribed in *Timing of Final Appeal Determinations* section, the Plan will provide you with written notice of its decision. If the Plan determines that Benefits should have been paid, the Plan will take whatever action is necessary to pay them as soon as possible.

If your claim is denied on review, the notice will state:

- The reasons for the denial, including references to specific Plan provisions upon which the denial was based.
- That you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim for Benefits.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either (a) include the specific rule, guideline, protocol, or other similar criterion, or (b) include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request.
- If the claim is denied based on a Medical Necessity, Experimental treatment or similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that this explanation will be provided free of charge upon request.

- Any voluntary appeal procedures offered by the Plan and your right to obtain the information about those procedures.

Next Steps

If after exhausting the appeals process, you are still not satisfied, your remaining remedies include the right to sue and voluntary dispute resolution options, such as mediation or independent external review, as described below.

You must commence any legal or equitable action for benefits within one year after the date that notification is sent to the participant or beneficiary (and/or their authorized representative) that the adverse benefit determination has been upheld on appeal.

External Review

If your first level appeal is denied, and either your second level appeal is also denied or you elect not to submit a second level appeal, you may have the right to request an external review. "External review" is a review of an Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

The Episcopal Church Medical Trust has contracted with Health Advocate to facilitate the external review program. Health Advocate will rotate between several EROs to conduct the review of your appeal.

Only Adverse Benefit Determinations involving medical judgment, such as a denial based on Medical Necessity, determinations involving a rescission of coverage, and determinations involving "surprise billing" claims will be eligible for external review. For example, external review will not be available for a denial based on your ineligibility to participate in the Plan (except to the extent that it involves a rescission of coverage).

The External Review Request Form includes an Appointment of Authorized Representative section. If you would like to designate an Authorized Representative now, you should complete the Appointment of Authorized Representative section of the form. Additionally, the Authorized Representative should provide notice of commencement of the action on your behalf to you, which KPIC may verify with you prior to recognizing the Authorized Representative status. In any event, a provider with knowledge of your medical condition acting in connection with an urgent care claim will be recognized by this Plan as your Authorized Representative.

A "final external review decision" is a determination by an ERO at the conclusion of an external review. You must complete the first level appeal for the Plan involved before you can request external review.

Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal. You may file a voluntary appeal for external review of any Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination that you receive from the Plan or its designee will describe the process to follow if you wish to pursue an external review and will include a copy of the Request for External Review Form. You must submit the Request for External Review Form within four (4) months of the date you received the Adverse Benefit Determination notice. 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. You also must include a copy of the notice of Adverse Benefit Determination and all other pertinent information that supports your request.

The external review process under this Plan gives you the opportunity to receive a review of an Adverse Benefit Determination conducted pursuant to applicable law. Your request will be eligible for external review if the following are satisfied:

- the mandatory level of appeal has been exhausted and the denial is not based on ineligibility to participate in the Plan; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

Send your request for an external review along with all required information to:

The Episcopal Church Medical Trust
c/o Health Advocate
PO Box 977
Blue Bell, PA 19422

Phone: 866-695-8622 (toll-free)
Fax: 610-941-4200

If you file a voluntary external appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other Benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action. If you choose not to file for an external voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review
You cannot request an external review if the Adverse Benefit Determination (denial) was based upon your eligibility for Benefits.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for external review, you will be informed in writing of the steps necessary to request an external review.

The Medical Trust has contracted with Health Advocate to coordinate the external review process. Health Advocate refers the case for review to a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, your heirs, the health Plan vendor (Kaiser), and the Medical Trust unless otherwise allowed by law.

Preliminary Review
Within five business days following the date of receipt of the request, the Plan or its designee must provide a preliminary review determining:

- you were covered under the Plan at the time the Service was requested or provided;
- the determination does not relate to eligibility;
- you have exhausted the mandatory internal appeals process; and
- you have provided all paperwork necessary to complete the external review.

Within one (1) business day after completion of the preliminary review, the Plan or its designee must issue to you a notification in writing. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility. If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan or its designee must allow you to perfect the request for external review within the four (4) month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to ERO

The Plan or its designee will assign an accredited ERO to conduct the external review. The assigned ERO will, in a timely manner, notify you in writing of the request's eligibility and acceptance for external review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the external review. Within one (1) business day after receiving additional information, the ERO will forward the information to the Plan which may reconsider its adverse decision. If the Plan decides, upon reconsideration, to reverse its decision and provide coverage or payment, it will, within one (1) business day, after making the decision, notify you, the Medical Trust, and Kaiser Permanente.

The ERO will review all of the information and documents received in a timely manner. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- your medical records
- the attending healthcare professional's recommendation
- reports from appropriate healthcare professionals and other documents submitted by the Plan or issuer, you, or your treating provider
- the terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law
- 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
- any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law
- the opinion of the ERO's clinical reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewers consider appropriate

The assigned ERO must provide written notice of the final external review decision within 45 days after the ERO receives the request for the external review. The ERO must deliver the notice of final external review decision to you, the Medical Trust, and Kaiser Permanente. After a final external review decision, the ERO must maintain records of all claims and notices associated with the external review process for six years. An ERO must make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying Benefits) for the claim.

Expedited External Review
The Plan must allow you to request an expedited external review at the time you receive:

(a) an Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal 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) an Adverse Benefit Determination that concerns an admission, availability of care, continued stay, or healthcare item or Service regarding an issue for which you received emergency Services, but have not been discharged from a Facility.

Immediately upon receipt of the request for expedited external review, the Plan or its designee will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan or its designee must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO
Upon a determination that a request is eligible for external review following preliminary review, the Plan or its designee will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO 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 ERO must provide written confirmation of the decision to you, the Medical Trust, and the Plan.

Requirements Relating to Commencing Legal Action
No legal action of any kind related to a Benefit decision may be commenced by you, unless it is commenced within one (1) year of the Plan's final decision on the claim or other request for Benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or Benefit request is the final decision date. You must exhaust the Plan's mandatory internal appeals procedure, not including any voluntary level of appeal, before taking legal action of any kind against the Plan. As described in more detail under *Arbitration for All Other Claims*, below, legal action may be pursued only and exclusively by submitting the matter to arbitration.

Assignment of Benefits
If any person to whom Benefits are payable is a minor or, in the opinion of Kaiser, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Kaiser may at its option make payment to the person or institution appearing to have assumed his custody and support.

When a Member passes away, Kaiser may receive notice that an executor of the estate has been established. The executor has the same rights as the Member and Benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release the Plan and Kaiser from all liability to the extent of any payment made.

Special Election for Employees and Spouses Age 65 and Over

If an Eligible Individual remains actively employed after reaching age 65 and is eligible to participate in the Plan, the Eligible Individual and/or eligible Spouse may choose to remain covered under the Plan without reduction for Medicare Benefits. An Eligible Individual and/or Spouse may also choose to end coverage under the Plan and enroll only in Medicare; however, neither the Eligible Individual nor the Spouse may be enrolled in a Group Medicare Advantage plan or Medicare Supplement plan sponsored by the Medical Trust. If coverage remains under the Plan, the Plan will be the primary payer of Benefits, and Medicare will be the secondary payer (unless the Eligible Individual and/or Spouse qualifies for a SEE Plan).

If the Eligible Individual is under age 65 and their Spouse is over age 65, the Spouse can make their own choice to remain covered under the Plan or to terminate coverage and enroll only in Medicare. However, the Spouse may not choose to enroll in a Group Medicare Advantage plan or Medicare Supplement plan sponsored by the Medical Trust.

Alternative Payee Provision
Benefits are generally payable to the provider of Services or supplies. The Plan may choose to make payments to a Member's separated/divorced Spouse, state child support agencies, or Medicaid agencies if required by a qualified medical child support order (QMCSO) or state Medicaid law.

Any payment made by the Plan in accordance with this provision will fully release the Plan and Kaiser Permanente of its liability to the Member.

Forfeitures
If the Plan cannot provide Benefits to a Member because after a reasonable search, the Plan cannot locate the Member within a period of two (2) years after the payment of Benefits becomes due, such amounts otherwise due to the Member shall be considered "unclaimed property". Unclaimed property amounts will be considered forfeitures that are deemed to occur as of the end of the two-year period. All forfeitures shall be and remain Plan assets, and in no event shall any such forfeiture escheat to, or otherwise be paid to, any governmental unit under any escheat or unclaimed property law.

Reliance on Documents and Information
Information required by the Medical Trust may be provided in any form or document that the Medical Trust considers acceptable and reliable. The Medical Trust relies on the information provided by individuals when evaluating coverage and Benefits under the Plan. All such information, therefore, must be accurate, truthful, and complete. The Medical Trust is entitled to conclusively rely upon, and will be protected for any action taken in good faith in relying upon, any information a Member, an Eligible Individual, a dependent or another person provides to the Medical Trust. In addition, any fraudulent statement, omission, or concealment of facts, misrepresentation, or incorrect information may result in the denial of the claim, cancellation or rescission of coverage, or any other legal remedy available to the Plan.

No Waiver
The failure of the Medical Trust to enforce strictly any term or provision of the Plan will not be construed as a waiver of such term or provision. The Medical Trust reserves the right to enforce strictly any term or provision of the Plan at any time.

Jurisdiction and Venue
By participating in the Plan or by seeking or receiving any benefit under the Plan, each Member consents, subject to the Member's agreement to arbitrate set forth in the "Kaiser

Permanente Binding Arbitration" and "Arbitration for All Other Claims" sections below, to the venue and exclusive jurisdiction of the courts located in New York City in the State of New York.

No Guarantee of Tax Consequences
Although the Plan intends to offer some Benefits on a tax-favored basis, there is no guarantee that any particular tax result will apply. Nothing in this Plan Document Handbook constitutes tax, medical, financial or legal advice. If you have questions about the tax, financial, or legal consequences of a Benefit, you should consult your personal tax, legal, or financial advisor.

Physician/Patient Relationship
This Plan is not intended to disturb the Physician/patient relationship. Physicians and other providers are not agents or delegates of the employer, the Medical Trust, the ECCEBT, or any Claims Administrator. Any provider, including any employee or other individual associated with such provider, who provides medical services to a Member does so as an independent contractor and shall be solely responsible for any medical advice and medical services provided or not provided to the Member. Nothing contained in the Plan will require a Member to commence or continue medical treatment by a particular provider. Furthermore, nothing in the Plan will limit or otherwise restrict a Physician's judgment with respect to the Physician's ultimate responsibility for patient care in the provision of medical Services to the Member.

The Plan is Not a Contract of Employment
Nothing contained in the Plan will be construed as a contract or condition of employment between the employer and any employee. All employees are subject to discharge to the same extent as if the Plan had never been adopted.

Plan Administration
The Medical Trust has full discretion and authority to interpret Plan provisions, make factual determinations, and address other issues that may arise. Subject to any right that a Member has to appeal a decision, the Medical Trust's determinations are final and binding. To the extent that the Medical Trust delegates administrative authority under the Plan(s) to another party, such as a Claims Administrator, that party shall act with the same discretion and authority as the Medical Trust.

Unauthorized Use of Identification Card
If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims for Services or payment involving all media (paper or electronic) may invalidate any payment or claims for Services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical Services and/or prescription drugs.

Kaiser Permanente Binding Arbitration

Binding Arbitration for Members Assigned to a Kaiser Permanente California Region

This *Binding Arbitration for Members Assigned to a Kaiser Permanente California Region* section applies only to Members who are assigned to a Kaiser Permanente California Region.

For all claims subject to this *Binding Arbitration for Members Assigned to a Kaiser Permanente California Region* section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration.

Scope of Arbitration

Any dispute shall be submitted to binding arbitration if all 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 a Member Party's relationship to Kaiser Permanente or KPIC as a Member, a Member, or a patient, 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 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.
- The claim is *not* within the jurisdiction of the Small Claims Court.

As referred to in this *Binding Arbitration for Members Assigned to a Kaiser Permanente California Region* section, "Member Parties" include

- a Member
- an Eligible Individual's or Dependent's heir, relative, or personal representative
- any person claiming that a duty to them arises from an Eligible Individual's or Dependent's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include

- Kaiser Permanente Insurance Company (KPIC)
- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals (KFH)
- KP Cal, LLC (KP Cal)
- The Permanente Medical Group, Inc. (TPMG)
- Southern California Permanente Medical Group (SCPMG)
- The Permanente Federation, LLC
- The Permanente Company, LLC
- any KFH, TPMG, or SCPMG 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.

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 telephone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include all claims against Respondents that are based on the same incident, transaction, or related circumstances in the Demand for Arbitration.

Serving Demand for Arbitration
KPIC, Kaiser Foundation Health Plan, Inc., KFH, KP Cal, TPMG, SCPMG, 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 one of the following:

If the claim relates to a Member who is assigned to the Kaiser Permanente Northern California Region:

Kaiser Foundation Health Plan, Inc.
Legal Department
1950 Franklin St., 17th Floor
Oakland, CA 94612

If the claim relates to a Member who is assigned to the Kaiser Permanente Southern California Region:

Kaiser Foundation Health Plan, Inc.
Legal Department
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 Customer Service at the telephone number listed on your ID card.

Number of Arbitrators
The number of arbitrators may affect the Claimant's responsibility for paying the neutral arbitrator's fees and expenses.

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 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
Kaiser Foundation Health Plan, Inc. will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure") at *oia-kaiserarb.com*. 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 for Members Assigned to a Kaiser Permanente California Region* 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.

Rules of Procedure
Arbitrations shall be conducted per the 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 Customer Service at the telephone number listed in the "Customer Service Phone Numbers."

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 Respondents 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 for Members Assigned to a Kaiser Permanente California Region* 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 for Members Assigned to a Kaiser Permanente California Region* 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 for Members Assigned to a Kaiser Permanente California Region* 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 non-arbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Arbitration Agreement for Members Assigned to the Kaiser Permanente Northern California Region or Southern California Region

I understand that if I am assigned to the Kaiser Permanente Northern California Region or Southern California Region, then except for Small Claims Court cases, cases subject to a Medicare appeals procedure**,** and certain Benefit-related disputes, any dispute between myself, my heirs or relatives, or other associated parties on the one hand and Kaiser Permanente Parties on the other hand (Kaiser Permanente Insurance Company, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, The Permanente Medical Group, the Southern California Permanente Medical Group, or other associated parties), for alleged violation of any duty relating to or arising from a relationship to any of the Kaiser Permanente Parties as a participant in this medical Plan, a Member, or a patient, including any claim for medical or hospital malpractice (a claim that medical Services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the delivery of Services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in this Plan Document Handbook.

Arbitration for All Other Claims

Subject to exhaustion of the procedures set forth in the “Claims and Appeals” section above, a Member who believes that they are entitled to Benefits under the Plan may pursue such claim only and exclusively by submitting the matter to arbitration. Any such arbitration must be commenced no later than one (1) year after the date the procedures set forth in the “Claims and Appeals” section above are exhausted.

For any controversy, claim, or dispute arising out of or related in any way to the Plan aside from one described in the immediately preceding paragraph, including but not limited to any claims for breach of fiduciary duty, a Member may pursue such controversy, claim, or dispute only and exclusively by submitting the matter to arbitration. Any such arbitration must be commenced no later than two (2) years after the date on which the Member knew or should have known the information that forms the basis of such controversy, claim, or dispute.

In any such arbitration, the parties shall select an arbitrator from a list of names supplied by JAMS, Inc. (“JAMS”) in accordance with JAMS’s procedures for selection of arbitrators, and the arbitration shall be conducted in accordance with the JAMS Employment Arbitration Rules and Procedures and subject to the JAMS Policy on Employment Arbitration Minimum Standards of Procedural Fairness. The arbitrator’s authority shall be governed by the same principles that would apply to such an action in court, including, to the extent applicable, any deferential standard of review applicable to such actions and appropriate limits on discovery beyond the administrative record. In addition, the arbitrator’s decision shall be final and binding on all parties and may be enforced in any court of competent jurisdiction. The arbitrator selected must have substantial familiarity with and knowledge of group health plans, preferably with those that are not subject to ERISA.

Waiver of Class, Collective, and Representative Actions

Members must bring any controversy, claim, or dispute in arbitration on an individual basis only, and not on a class, collective, or representative basis, and must waive the right to commence, be a party to, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to the Plan, including, but not limited to, any claims related to the Plan (“class action waiver”).

By participating in the Plan or by seeking or receiving any benefit under the Plan, to the fullest extent permitted by law, a Member waives any right to commence, be a party to in any way, recover from, and/or be an actual or putative member or representative of any class, collective, or representative action arising out of or relating to any claim, dispute, or controversy arising out of or relating to the Plan. Notwithstanding anything to the contrary in this Plan, if, for any reason, the waiver of a Member’s right to commence, be a party to, recover from, or be an actual or putative member or representative of any class, collective, or representative action within or outside of an arbitration proceeding is found to be unenforceable by a court of competent jurisdiction, the requirement to arbitrate shall no longer apply, and any class, collective, or representative claim shall be filed, litigated, and adjudicated in a court of competent jurisdiction and not in arbitration.

In any arbitration, the Member may not seek or receive any remedy that has the purpose or effect of providing additional benefits or monetary relief to any other Member or beneficiary. Notwithstanding anything to the contrary in this Plan, if, for any reason, a court of competent jurisdiction were to find this restriction on the scope of remedies unenforceable or invalid as to a particular controversy, claim, or dispute, then the requirement to arbitrate shall no longer apply to such controversy, claim, or dispute, and that controversy, claim, or dispute shall be filed, litigated, and adjudicated in a court of competent jurisdiction and not in arbitration.

Continuity of Care

Your Plan uses Network providers to provide Benefits. Should a Network Provider contract terminate, Continuing Care Patients have a right to elect to continue continued transitional care from that terminated provider under the same terms and conditions for the shorter of a 90-day period or until you are no longer a Continuing Care Patient. A Continuing Care Patient is an individual who, with respect to a provider:

a) is undergoing a course of treatment for a serious and complex condition from the provider or facility;
b) is undergoing a course of institutional or inpatient care from the provider or facility;
c) is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
d) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
e) is or was determined to be terminally ill (as determined under specified Medicare rules) and is receiving treatment for such illness from such provider or facility.

Miscellaneous Provisions

Overpayment Recovery

Any overpayment made for Services will be recovered from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Qualified Medical Child Support Order

The Plan will provide coverage as required by any qualified medical child support order ("QMCSO"), as defined in ERISA §609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Members and beneficiaries can obtain, without charge, a copy of these procedures from the Plan Administrator.

Joint Notice of Privacy Practices

This section describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction

Church Pension Group Services Corporation, doing business as The Episcopal Church Medical Trust (Medical Trust), is the Plan Sponsor of certain group health plans (each a Plan and together the Plans) that are subject to the Health Insurance Portability and Accountability Act of 1996 and the regulations enacted thereunder (HIPAA).

HIPAA places certain restrictions on the use and disclosure of Protected Health Information (PHI) and requires the Medical Trust to provide this Joint Notice of Privacy Practices (the "Notice") to you. PHI is your individually identifiable health information that is created, received, transmitted, or maintained by the Plans or its business associates, regardless of the form of the information. It does not include employment records held by your employer in its role as an employer. This Notice describes how your PHI may be used and disclosed by the Plans and by employees of the Medical Trust that are responsible for internal administration of the Plans.

It also describes your rights regarding the use and disclosure of such PHI and how you can gain access to it.

What This Notice Applies To

This Notice applies only to health Benefits offered under the Plans. The health Benefits offered under the Plans include, but may not be limited to, medical Benefits, prescription drug Benefits, dental Benefits, the healthcare flexible spending account, and any healthcare or medical services offered under the Employee Assistance Program benefit. This Notice does not apply to Benefits offered under the Plans that are not health Benefits.

Some of the Plans provide Benefits through the purchase of insurance. If you are enrolled in an insured Plan, you will also receive a separate notice from that Plan, which applies to your rights under that Plan.

Duties and Obligations of the Plans

The privacy of your PHI is protected by HIPAA. The Plans are required by law to

- maintain the privacy of your PHI,
- provide you with a notice of the Plans' legal duties and privacy practices with respect to your PHI, and
- abide by the terms of the Notice currently in effect.

When the Plans May Use and Disclose Your PHI

The following categories describe the ways the Plans are required to use and disclose your PHI without obtaining your written authorization:

- **Disclosures to You.** The Plans will disclose your PHI to you or your personal representative within the legally specified period following a request.
- **Government Audit.** The Plans will make your PHI available to the US Department of Health and Human Services when it requests information relating to the privacy of PHI.

- **As Required by Law.** The Plans will disclose your PHI when required to do so by federal, state, or local law. For example, the Plans may disclose your PHI when required by national security laws or public health disclosure laws.

The following categories describe the ways that the Plans may use and disclose your PHI without obtaining your written authorization:

- **Treatment.** The Plans may disclose your PHI to your Providers for treatment, including the provision of care or the management of that care. For example, the Plans might disclose PHI to assist in diagnosing a medical condition or for pre-certification activities.
- **Payment.** The Plans may use and disclose your PHI to pay Benefits. For example, the Plans might use or disclose PHI when processing payments, sending Explanations of Benefits (EOBs) to you, reviewing the Medical Necessity of services rendered, conducting claims appeals and coordinating the payment of Benefits between multiple medical Plans.
- **Healthcare Operations.** The Plans may use and disclose your PHI for Plan operational purposes. For example, the Plans may use or disclose PHI for quality assessment and claim audits.
- **Public Health Risks.** The Plans may disclose your PHI for certain required public health activities (such as reporting disease outbreaks) or to prevent serious harm to you or other potential victims where abuse, neglect, or domestic violence is involved.
- **National Security and Intelligence Activities.** The Plans may disclose your PHI for specialized government functions (such as national security and intelligence activities).
- **Health Oversight Activities.** The Plans may disclose your PHI to health oversight agencies for activities authorized by law (such as audits, inspections, investigations, and licensure).
- **Lawsuits and Disputes.** The Plans may disclose your PHI in the course of any judicial or administrative proceeding in response to a court's or administrative tribunal's order, subpoena, discovery request, or other lawful process.
- **Law Enforcement.** The Plans may disclose your PHI for a law enforcement purpose to a law enforcement official, if certain legal conditions are met (such as providing limited information to locate a missing person).
- **Research.** The Plans may disclose your PHI for research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability).
- **To Avert a Serious Threat to Health or Safety.** The Plans may disclose your PHI to avert a serious threat to the health or safety of you or any other person.
- **Workers' Compensation.** The Plans may disclose your PHI to the extent necessary to comply with laws and regulations related to workers' compensation or similar programs.
- **Coroners, Medical Examiners, and Funeral Directors.** The Plans may disclose your PHI to coroners, medical examiners, or funeral directors for purposes of identifying a decedent, determining a cause of death, or carrying out their respective duties with respect to a decedent.
- **Organ and Tissue Donation.** If you are an organ donor, the Plans may release your PHI to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, the Plans may release your PHI as required by military command authorities.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plans may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **Business Associates.** The Plans may contract with other businesses for certain Plan administrative services. The Plans may release your PHI to one or more of their business associates for Plan administration if the business associate agrees in writing to protect the privacy of your information.
- **Plan Sponsor.** The Episcopal Church Medical Trust, as sponsor of the Plans, will have access to your PHI for Plan administration purposes. Unless you authorize the Plans otherwise in writing (or your individual identifying data is deleted from the information), your PHI will be available only to the individuals who need this information to conduct these Plan administration activities, but this release of your PHI will be limited to the minimum disclosure required, unless otherwise permitted or required by law.

The following categories describe the ways that the Plans may use and disclose your PHI upon obtaining your written authorization:
- most uses and disclosures of psychotherapy notes;
- uses and disclosures of PHI for marketing purposes; and
- uses and disclosures that constitute a sale of PHI.

Any other use or disclosure of your PHI not identified in this section will be made only with your written authorization.

Authorizing Release of Your PHI
To authorize release of your PHI, you must complete a medical information authorization form. An authorization form is available at *cpg.org* or by calling 800-480-9967. You have the right to limit the type of information that you authorize the Plans to disclose and the persons to whom it should be disclosed. You may revoke your written authorization at any time. The revocation will be followed to the extent action on the authorization has not yet been taken.

Interaction with State Privacy Laws
If the state in which you reside provides more stringent privacy protections than HIPAA, the more stringent state law will still apply to protect your rights. If you have a question about your rights under any particular federal or state law, please contact the Church Pension Group Privacy Officer. Contact information is included at the end of this Notice.

Fundraising
The Plans may contact you to support their fundraising activities. You have the right to opt out of receiving such communications.

Underwriting
The Plans are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Your Rights With Respect to Your PHI
You have the following rights regarding PHI the Plans maintain about you:

- **Right to Request Restrictions.** You have the right to request that the Plans restrict their uses and disclosures of your PHI. You will be required to provide specific information as to the disclosures that you wish to restrict and the reasons for your request. The Plans are not required to agree to a requested restriction, but may in certain circumstances. To request a restriction, please write to the Church Pension Group Privacy Officer and provide specific information as to the disclosures that you wish to restrict and the reasons for your request.
- **Right to Request Confidential Communications.** You have the right to request that the Plans' confidential communications of your PHI be sent to another location or by alternative means. For example, you may ask that all EOBs be sent to your office rather than your home address. The Plans are not required to accommodate your request unless your request is reasonable and you state that the ordinary communication process could endanger you. To request confidential communications, please submit a written request to the Church Pension Group Privacy Officer.
- **Right to Inspect and Copy.** You have the right to inspect and obtain a copy of the PHI held by the Plans. However, access to psychotherapy notes, information compiled in reasonable anticipation of or for use in legal proceedings, and under certain other, relatively unusual circumstances, may be denied. Your request should be made in writing to the Church Pension Group Privacy Officer. A reasonable fee may be imposed for copying and mailing the requested information. You may contact the Medical Trust Plan Administration at *jservais@cpg.org* for a full explanation of the Medical Trust's fee structure.
- **Right to Amend.** You have the right to request that the Plans amend your PHI or record if you believe the information is incorrect or incomplete. To request an amendment, you must submit a written request to the Medical Trust Plan Administration at *jservais@cpg.org*. Your request must list the specific PHI you want amended and explain why it is incorrect or incomplete and be signed by you or your authorized representative. All amendment requests will be considered carefully. However, your request may be denied if the PHI or record that is subject to the request
  - is not part of the medical information kept by or for the Plans;
  - was not created by or on behalf of the Plans or its third-party administrators, unless the person or entity that created the information is no longer available to make the amendment;
  - is not part of the information that you are permitted to inspect and copy; or
  - is accurate and complete.

Right to an Accounting of Disclosures. You have the right to receive information about when your PHI has been disclosed to others. Certain exceptions apply to this rule. For example, a Plan does not need to account for disclosures made to you or with your written authorization, or for disclosures that occurred more than six years before your request. To request an accounting of disclosures, you must submit your request in writing to the Medical Trust Plan Administration at *jservais@cpg.org* and indicate in what form you want the accounting (e.g., paper or electronic). Your request must state a time period of no longer than six years and may not include dates before your coverage became effective. The Medical Trust Plan Administration will then notify you of any additional information required for the accounting request. A Plan will provide you with the date on which a disclosure was made, the name of the person or entity to whom PHI was disclosed, a description of the PHI that was disclosed, the reason for the disclosure and certain other information. If you request this accounting more than once in a 12-month period, you may be charged a reasonable, cost-based fee for responding to these additional requests. You

may contact Medical Trust Plan Administration at *jservais@cpg.org* for a full explanation of the Medical Trust's fee structure.

Breach Notification. You have the right to receive a notification from the Plans if there is a breach of your unsecured PHI.

Right to a Paper Copy of This Notice. You are entitled to get a paper copy of this Notice at any time, even if you have agreed to receive it electronically. To obtain a paper copy of this Notice, please contact the Church Pension Group Privacy Officer.

If You Are a Person in the European Union, the Following Provisions Will Also Be Applicable to You:
For the purposes of the General Data Protection Regulation 2016/679 (the "GDPR"), the Data Controller is Church Pension Group Services Corporation registered in the State of Delaware in the United States with a registered address at 19 East 34th Street, New York, NY 10016.

You can request further information from our Privacy Officer at *privacy@cpg.org*.

In addition to your rights with respect to your PHI addressed above, you may have additional or overlapping rights under the GDPR. GDPR rights regarding your PHI include the following:

- You may access and export a copy of PHI.
- You may request deletion of, and update to PHI.
- You have the right to be informed about any automated decision-making of PHI including the significance and consequences of such processing for you.
- You may also object to or restrict the Plans' use of PHI. For example, you can object at any time to the Plans' use of PHI for direct marketing purposes.
- Where you believe that the Plans have not complied with its obligations under this Privacy Policy or the applicable law, you have the right to make a complaint to an EU Data Protection Authority.
- If the Plans obtained your consent to use your PHI, you may withdraw that consent at any time.

Data Retention
We only retain PHI collected for a limited time period as long as we need it to fulfill the purposes for which have initially collected it, unless otherwise required by law.

Data Transfers
We maintain servers in the United States and Canada, and your information may be processed on servers located in the United States and Canada. Data protection laws vary among countries, with some providing more protection than others. Regardless of where your information is processed, we apply the same protections described in this policy.

If You Believe Your Privacy Rights Have Been Violated
If you believe your privacy rights have been violated by any Plan, you may file a complaint with the Church Pension Group Privacy Officer and with the Secretary of the US Department of Health and Human Services.

All complaints must be filed in writing. You will not be retaliated against for filing a complaint.

To contact the Church Pension Group Privacy Officer:

Privacy Officer
The Church Pension Group
19 East 34th Street
New York, NY 10016
212-592-8365
privacy@cpg.org

To contact the Secretary of the US Department of Health and Human Services:

US Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, SW
Washington, DC 20201

202-619-0257 | 800-368-1019 (toll-free)
https://www.hhs.gov/about/contact-us/index.html

Effective Date
This Notice is effective as of August 29, 2018.

Changes
Each Plan sponsored by the Medical Trust reserves the right to change the terms of this Notice and information practices and to make the new provisions effective for all PHI it maintains, including any PHI it currently maintains as well as PHI it receives or holds in the future, as permitted by applicable law. Any material amendment to the terms of this Notice, and these information practices will be provided to you via mail or electronically with your prior written consent.

Newborn Baby and Mother Protection Act

Group health plans, such as the Plan, generally may not, under federal law, restrict benefits for any hospital stay in connection with childbirth for the mother 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 mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not more than 48 hours (or 96 hours). Coverage of childbirth hospital Services is subject to all provisions of this Plan Document Handbook, such as the provisions concerning exclusions and Cost Sharing.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 was passed into law on October 21, 1998. This federal law requires all group health plans that provide coverage for a mastectomy must also provide coverage for the following Services:

- 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
- treatment of physical complications of the mastectomy, including lymphedema

The Plan covers mastectomies and related Services subject to all provisions of this Plan Document Handbook, such as the provisions concerning exclusions, Copayments, and Coinsurance.

Service Areas

Members must live or work in a Kaiser Service Area at the time of enrollment. You cannot continue enrollment as a Member if you move outside a Kaiser Permanente Service Area. To verify your ZIP code, visit *https://individual-family.kaiserpermanente.org/healthinsurance*

Service Areas for California

NORTHERN CALIFORNIA	
County	**City**
ALAMEDA	ALAMEDA, ALBANY, BERKELEY, CASTRO VALLEY, DUBLIN, EMERYVILLE, FREMONT, HAYWARD, LIVERMORE, NEWARK, OAKLAND, PIEDMONT, PLEASANTON, SAN LEANDRO, SAN LORENZO, SUNOL, UNION CITY
AMADOR	IONE, PLYMOUTH
CONTRA COSTA	ALAMO, ANTIOCH, BETHEL ISLAND, BRENTWOOD, BYRON, CANYON, CLAYTON, CONCORD, CROCKETT, DANVILLE, DIABLO, DISCOVERY BAY, EL CERRITO, EL SOBRANTE, HERCULES, KNIGHTSEN, LAFAYETTE, MARTINEZ, MORAGA, OAKLEY, ORINDA, PINOLE, PITTSBURG, PLEASANT HILL, PORT COSTA, RICHMOND, RODEO, SAN PABLO, SAN RAMON, WALNUT CREEK
EL DORADO	COLOMA, COOL, DIAMOND SPRINGS, EL DORADO, EL DORADO HILLS, GARDEN VALLEY, GEORGETOWN, GREENWOOD, LOTUS, PILOT HILL, PLACERVILLE, RESCUE, SHINGLE SPRINGS
FRESNO	AUBERRY, BIOLA, BURREL, CARUTHERS, CLOVIS, DEL REY, FIVE POINTS, FOWLER, FRESNO, FRIANT, HELM, KERMAN, KINGSBURG, LATON, ORANGE COVE, PARLIER, PIEDRA, PRATHER, RAISIN CITY, REEDLEY, RIVERDALE, SAN JOAQUIN, SANGER, SELMA, SQUAW VALLEY, TOLLHOUSE, TRANQUILITY
KINGS	HANFORD
MADERA	AHWAHNEE, BASS LAKE, COARSEGOLD, MADERA, NORTH FORK, O'NEALS, OAKHURST, RAYMOND, WISHON
MARIN	BELVEDERE TIBURON, BOLINAS, CORTE MADERA, DILLON BEACH, FAIRFAX, FOREST KNOLLS, GREENBRAE, INVERNESS, KENTFIELD, LAGUNITAS, LARKSPUR, MARSHALL, MILL VALLEY, NICASIO, NOVATO, OLEMA, POINT REYES STATION, ROSS, SAN ANSELMO, SAN GERONIMO, SAN QUENTIN, SAN RAFAEL, SAUSALITO, STINSON BEACH, TOMALES, WOODACRE
MARIPOSA	FISH CAMP, LA GRANGE
MERCED	GUSTINE
NAPA	AMERICAN CANYON, ANGWIN, CALISTOGA, DEER PARK, NAPA, OAKVILLE, POPE VALLEY, RUTHERFORD, SAINT HELENA, YOUNTVILLE
PLACER	APPLEGATE, AUBURN, GRANITE BAY, LINCOLN, LOOMIS, MEADOW VISTA, NEWCASTLE, PENRYN, ROCKLIN, ROSEVILLE, SHERIDAN, WEIMAR
SACRAMENTO	ANTELOPE, CARMICHAEL, CITRUS HEIGHTS, COURTLAND, ELK GROVE, ELVERTA, FAIR OAKS, FOLSOM, GALT, HERALD, HOOD, ISLETON, MATHER, MCCLELLAN, NORTH HIGHLANDS, ORANGEVALE, RANCHO CORDOVA, REPRESA, RIO LINDA, RYDE, SACRAMENTO, SLOUGHHOUSE, WALNUT GROVE, WILTON
SAN FRANCISCO	SAN FRANCISCO
SAN JOAQUIN	ACAMPO, CLEMENTS, ESCALON, FARMINGTON, FRENCH CAMP, HOLT, LATHROP, LINDEN, LOCKEFORD, LODI, MANTECA, RIPON, SAN JOAQUIN, STOCKTON, THORNTON, TRACY, VICTOR, WOODBRIDGE
SAN MATEO	ATHERTON, BELMONT, BRISBANE, BURLINGAME, DALY CITY, EL GRANADA, HALF MOON BAY, LA HONDA, LOMA MAR, MENLO PARK, MILLBRAE, MONTARA, MOSS BEACH, PACIFICA, PESCADERO, PORTOLA VALLEY, REDWOOD CITY, SAN BRUNO, SAN CARLOS, SAN FRANCISCO, SAN GREGORIO, SAN MATEO, SOUTH SAN FRANCISCO

SANTA CLARA	ALVISO, CAMPBELL, COYOTE, CUPERTINO, GILROY, HOLY CITY, LOS ALTOS, LOS GATOS, MILPITAS, MORGAN HILL, MOUNT HAMILTON, MOUNTAIN VIEW, NEW ALMADEN, PALO ALTO, REDWOOD ESTATES, SAN JOSE, SAN MARTIN, SANTA CLARA, SARATOGA, STANFORD, SUNNYVALE
SANTA CRUZ	APTOS, BEN LOMOND, BOULDER CREEK, BROOKDALE, CAPITOLA, DAVENPORT, FELTON, FREEDOM, MOUNT HERMON, SANTA CRUZ, SCOTTS VALLEY, SOQUEL, WATSONVILLE
SOLANO	BENICIA, BIRDS LANDING, DIXON, ELMIRA, FAIRFIELD, RIO VISTA, SUISUN CITY, TRAVIS AFB, VACAVILLE, VALLEJO
SONOMA	BODEGA, BODEGA BAY, BOYES HOT SPRINGS, CAMP MEEKER, CAZADERO, CLOVERDALE, COTATI, DUNCANS MILLS, EL VERANO, ELDRIDGE, FORESTVILLE, FULTON, GEYSERVILLE, GLEN ELLEN, GRATON, GUERNEVILLE, HEALDSBURG, JENNER, KENWOOD, MONTE RIO, OCCIDENTAL, PENNGROVE, PETALUMA, RIO NIDO, ROHNERT PARK, SANTA ROSA, SEBASTOPOL, SONOMA, VALLEY FORD, VILLA GRANDE, VINEBURG, WINDSOR
STANISLAUS	CERES, CROWS LANDING, DENAIR, EMPIRE, HICKMAN, HUGHSON, KEYES, MODESTO, NEWMAN, OAKDALE, PATTERSON, RIVERBANK, SALIDA, TURLOCK, VERNALIS, WATERFORD, WESTLEY
SUTTER	KNIGHTS LANDING, NICOLAUS, PLEASANT GROVE, RIO OSO, ROBBINS SACRAMENTO
TULARE	DINUBA, SULTANA, TRAVER
YOLO	CAPAY, CLARKSBURG, DAVIS, SACRAMENTO, WEST SACRAMENTO, WINTERS, WOODLAND, YOLO, ZAMORA
YUBA	BEALE AFB, OLIVEHURST, WHEATLAND
SOUTHERN CALIFORNIA	
KERN	ARVIN, BAKERSFIELD, BODFISH, BUTTONWILLOW, CALIENTE, CALIFORNIA CITY, CANTIL, DELANO, EDISON, FELLOWS, FRAZIER PARK, GLENNVILLE, KEENE, KERNVILLE, LAKE ISABELLA, LAMONT, LOST HILLS, MARICOPA, MC FARLAND, MC KITTRICK, MOJAVE, PINE MOUNTAIN CLUB, ROSAMOND, SHAFTER, TAFT, TEHACHAPI, TUPMAN, WASCO, WOFFORD HEIGHTS, WOODY
LOS ANGELES	ACTON, AGOURA HILLS, ALHAMBRA, ALTADENA, ARCADIA, ARTESIA, AZUSA, BALDWIN PARK, BELL, BELL GARDENS, BELLFLOWER, BEVERLY HILLS, BURBANK, CALABASAS, CANOGA PARK, CANYON COUNTRY, CARSON, CASTAIC, CERRITOS, CHATSWORTH, CITY OF INDUSTRY, CLAREMONT, COMPTON, COVINA, CULVER CITY, DIAMOND BAR, DODGERTOWN, DOWNEY, DUARTE, EL MONTE, EL SEGUNDO, ENCINO, GARDENA, GLENDALE, GLENDORA, GRANADA HILLS, HACIENDA HEIGHTS, HARBOR CITY, HAWAIIAN GARDENS, HAWTHORNE, HERMOSA BEACH, HUNTINGTON PARK, INGLEWOOD, LA CANADA FLINTRIDGE, LA CRESCENTA, LA MIRADA, LA PUENTE, LA VERNE, LAKE HUGHES, LAKEWOOD, LANCASTER, LAWNDALE, LEBEC, LITTLEROCK, LLANO, LOMITA, LONG BEACH, LOS ANGELES, LYNWOOD, MALIBU, MANHATTAN BEACH, MARINA DEL REY, MAYWOOD, MISSION HILLS, MONROVIA, MONTEBELLO, MONTEREY PARK, MONTROSE, MOUNT WILSON, NEWHALL, NORTH HILLS, NORTH HOLLYWOOD, NORTHRIDGE, NORWALK, PACIFIC PALISADES, PACOIMA, PALMDALE, PALOS VERDES PENINSULA, PANORAMA CITY, PARAMOUNT, PASADENA, PEARBLOSSOM, PICO RIVERA, PLAYA DEL REY, PLAYA VISTA, POMONA, PORTER RANCH, RANCHO PALOS VERDES, REDONDO BEACH, RESEDA, ROSEMEAD, ROWLAND HEIGHTS, SAN DIMAS, SAN FERNANDO, SAN GABRIEL, SAN MARINO, SAN PEDRO, SANTA CLARITA, SANTA FE SPRINGS, SANTA MONICA, SHERMAN OAKS, SIERRA MADRE, SIGNAL HILL, SOUTH EL MONTE, SOUTH GATE, SOUTH PASADENA, STEVENSON RANCH, STUDIO CITY, SUN VALLEY, SUNLAND, SYLMAR, TARZANA, TEMPLE CITY, TOLUCA LAKE, TOPANGA, TORRANCE, TUJUNGA, UNIVERSAL CITY, VALENCIA, VALLEY VILLAGE, VALYERMO, VAN NUYS, VENICE, VERDUGO CITY, WALNUT, WEST COVINA, WEST HILLS, WEST HOLLYWOOD, WHITTIER, WILMINGTON, WINNETKA, WOODLAND HILLS

ORANGE	ALISO VIEJO, ANAHEIM, ATWOOD, BREA, BUENA PARK, CAPISTRANO BEACH, CORONA DEL MAR, COSTA MESA, CYPRESS, DANA POINT, EAST IRVINE, EL TORO, FOOTHILL RANCH, FOUNTAIN VALLEY, FULLERTON, GARDEN GROVE, HUNTINGTON BEACH, IRVINE, LA HABRA, LA PALMA, LADERA RANCH, LAGUNA BEACH, LAGUNA HILLS, LAGUNA NIGUEL, LAGUNA WOODS, LAKE FOREST, LOS ALAMITOS, MIDWAY CITY, MISSION VIEJO, NEWPORT BEACH, NEWPORT COAST, ORANGE, PLACENTIA, RANCHO SANTA MARGARITA, SAN CLEMENTE, SAN JUAN CAPISTRANO, SANTA ANA, SEAL BEACH, SILVERADO, STANTON, SUNSET BEACH, SURFSIDE, TRABUCO CANYON, TUSTIN, VILLA PARK, WESTMINSTER, YORBA LINDA
RIVERSIDE	BANNING, BEAUMONT, CABAZON, CALIMESA, CATHEDRAL CITY, COACHELLA, CORONA, DESERT HOT SPRINGS, HEMET, HOMELAND, INDIAN WELLS, INDIO, LA QUINTA, LAKE ELSINORE, MARCH AIR RESERVE BASE, MECCA, MENIFEE, MIRA LOMA, MORENO VALLEY, MURRIETA, NORCO, NORTH PALM SPRINGS, NUEVO, PALM DESERT, PALM SPRINGS, PERRIS, QUAIL VALLEY, RANCHO MIRAGE, RIVERSIDE, SALTON CITY, SAN JACINTO, SUN CITY, TEMECULA, THERMAL, THOUSAND PALMS, WHITEWATER, WILDOMAR, WINCHESTER
SAN BERNARDINO (Partial County)	ANGELUS OAKS, APPLE VALLEY, BIG BEAR CITY, BIG BEAR LAKE, BLOOMINGTON, BLUE JAY, BRYN MAWR, CEDAR GLEN, CEDARPINES PARK, CHINO, CHINO HILLS, COLTON, CREST PARK, CRESTLINE, FAWNSKIN, FONTANA, FOREST FALLS, GRAND TERRACE, GREEN VALLEY LAKE, GUASTI, HESPERIA, HIGHLAND, JOSHUA TREE, LAKE ARROWHEAD, LANDERS, LOMA LINDA, LYTLE CREEK, MENTONE, MONTCLAIR, MORONGO VALLEY, MT BALDY, ONTARIO, PATTON, PHELAN, PINON HILLS, PIONEERTOWN, RANCHO CUCAMONGA, REDLANDS, RIALTO, RIMFOREST, RUNNING SPRINGS, SAN BERNARDINO, SKYFOREST, SUGARLOAF, TWENTYNINE PALMS, TWIN PEAKS, UPLAND, VICTORVILLE, WRIGHTWOOD, YUCAIPA, YUCCA VALLEY
SAN DIEGO (Partial County)	ALPINE, BONITA, BONSALL, CAMP PENDLETON, CARDIFF BY THE SEA, CARLSBAD, CHULA VISTA, CORONADO, DEL MAR, DESCANSO, DULZURA, EL CAJON, ENCINITAS, ESCONDIDO, FALLBROOK, GUATAY, IMPERIAL BEACH, JAMUL, LA JOLLA, LA MESA, LAKESIDE, LEMON GROVE, NATIONAL CITY, OCEANSIDE, PALA, PALOMAR MOUNTAIN, PAUMA VALLEY, PINE VALLEY, POTRERO, POWAY, RAMONA, RANCHO SANTA FE, SAN DIEGO, SAN LUIS REY, SAN MARCOS, SAN YSIDRO, SANTEE, SOLANA BEACH, SPRING VALLEY, TECATE, VALLEY CENTER, VISTA, WARNER SPRINGS
TULARE	RICHGROVE
VENTURA (Partial County)	BRANDEIS, CAMARILLO, FILLMORE, MOORPARK, NEWBURY PARK, OAK PARK, OAK VIEW, OXNARD, PIRU, POINT MUGU NAWC. PORT HUENEME, PORT HUENEME CBC BASE, SANTA PAULA, SIMI VALLEY, SOMIS, THOUSAND OAKS, VENTURA, WESTLAKE VILLAGE

Service Areas for Colorado

County	City
ADAMS	AURORA, BENNETT, BRIGHTON, BROOMFIELD, COMMERCE CITY, DENVER, DUPONT, EASTLAKE, HENDERSON, , THORNTON, WESTMINSTER
ALBANY	JELM
ARAPAHOE	AURORA, BENNETT, DENVER, ENGLEWOOD, LITTLETON, WATKINS
BOULDER	ALLENSPARK, ELDORADO SPRINGS, HYGIENE, JAMESTOWN, LAFAYETTE, LONGMONT, LOUISVILLE, LYONS, NEDERLAND, NIWOT, PINECLIFFE, WARD
BROOMFIELD	BROOMFIELD
CLEAR CREEK	IDAHO SPRINGS
CROWLEY	OLNEY SPRINGS

CUSTER	WETMORE
DENVER	DENVER, LITTLETON
DOUGLAS	CASTLE ROCK, ENGLEWOOD, FRANKTOWN, LARKSPUR, LITTLETON, LONE TREE, LOUVIERS, PARKER, SEDALIA
ELBERT	ELIZABETH, KIOWA
EL PASO	CALHAN, CASCADE, COLORADO SPRINGS, ELBERT, FOUNTAIN, GREEN MOUNTAIN FALLS, MANITOU SPRINGS, MONUMENT, PALMER LAKE, PEYTON, RAMAH, U S A F ACADEMY, YODER,
ELBERT	ELBERT, RAMAH
FREMONT	BROOKSIDE, CANON CITY, COAL CREEK, COALDALE, COTOPAXI, FLORENCE, HILLSIDE, HOWARD, PENROSE, ROCKVALE,
GILPIN	BLACK HAWK, CENTRAL CITY, ROLLINSVILLE
HUERFANO	RYE
JEFFERSON	ARVADA, BROOMFIELD, BUFFALO CREEK, CONIFER, DENVER, EVERGREEN, GOLDEN, IDLEDALE, INDIAN HILLS, KITTREDGE, LITTLETON, MORRISON, PINE, WHEAT RIDGE
KIMBALL	BUSHNELL, KIMMBALL
LARAMIE	PINE BLUFFS
LARIMER	BELLVUE, BERTHOUD, CARR, DRAKE, ESTES PARK, FORT COLLINS, GLEN HAVEN, LAPORTE, LIVERMORE, LOVELAND, LYONS, MASONVILLE, RED FEATHER LAKES, ROCKY MTN. NATIONAL PARK, SEVERANCE, TIMNATH, VIRGINIA DALE, WELLINGTON, WINDSOR
LINCOLN	RUSH
MORGAN	HOYT, ORCHARD, WIGGINS
OTERO	FOWLER
PARK	BAILEY, GUFFEY, LAKE GEORGE, PINE
PUEBLO	AVONDALE, BEULAH, BOONE, COLORADO CITY, PUEBLO, RYE,
TELLER	CRIPPLE CREEK, DIVIDE, FLORISSANT, VICTOR, WOODLAND PARK
WELD	AULT, BRIGGSDALE, BRIGHTON, CARR, DACONO, EATON, ERIE, EVANS, FIRESTONE, FORT LUPTON, FORT MORGAN, FREDERICK, GALETON, GARDEN CITY, GILL, GILCREST, GREELEY, GROVER, HEREFORD, HUDSON, JOHNSTOWN, KEENESBURG, KERSEY, LA SALLE, LONGMONT LOVELAND, LUCERNE, MEAD, MILLIKEN, NEW RAYMER, NUNN, ORCHARD, PIERCE, PLATTEVILLE, RAYMER, ROGGEN, SEVERANCE, STONEHAM, WINDSOR

Service Areas for Denver/Boulder, Colorado

County	City
ADAMS	AURORA, BENNETT, BRIGHTON, BROOMFIELD, COMMERCE CITY, DENVER, DUPONT, EASTLAKE, HENDERSON, THORNTON, WESTMINSTER
ARAPAHOE	AURORA, BENNETT, DENVER, ENGLEWOOD, LITTLETON, WATKINS
BOULDER	ALLENSPARK, ELDORADO SPRINGS, HYGIENE, JAMESTOWN, LAFAYETTE, LONGMONT, LOUISVILLE, LYONS, NEDERLAND, NIWOT, PINECLIFFE, WARD
BROOMFIELD	BROOMFIELD
CLEAR CREEK	IDAHO SPRINGS
DENVER	DENVER, LITTLETON
DOUGLAS	CASTLE ROCK, ENGLEWOOD, FRANKTOWN, LITTLETON, LONE TREE, LOUVIERS, PARKER, SEDALIA
ELBERT	ELIZABETH, KIOWA
GILPIN	BLACK HAWK, CENTRAL CITY, ROLLINSVILLE
JEFFERSON	ARVADA, BROOMFIELD, BUFFALO CREEK, CONIFER, DENVER, EVERGREEN, GOLDEN, IDLEDALE, INDIAN HILLS, KITTREDGE, LITTLETON, MORRISON, PINE, WHEAT RIDGE

LARIMER	LYONS
PARK	BAILEY, PINE
WELD	BRIGHTON, DACONO, ERIE, FIRESTONE, FORT LUPTON, FREDERICK, GILCREST, HUDSON, KEENESBURG, LONGMONT

Service Areas for Southern Colorado

COUNTY	CITY
CROWLEY	OLNEY SPRINGS
CUSTER	WETMORE
DOUGLAS	LARKSPUR
EL PASO	CALHAN, CASCADE, COLORADO SPRINGS, ELBERT, FOUNTAIN, GREEN MOUNTAIN FALLS, MANITOU SPRINGS, MONUMENT, PALMER LAKE, PEYTON, RAMAH, U S A F ACADEMY, YODER
ELBERT	ELBERT, RAMAH
FREMONT	BROOKSIDE, CANON CITY, COAL CREEK, COALDALE, COTOPAXI, FLORENCE, HILLSIDE, HOWARD, PENROSE, ROCKVALE
HUERFANO	RYE
LINCOLN	RUSH
OTERO	FOWLER
PARK	GUFFEY, LAKE GEORGE
PUEBLO	AVONDALE, BEULAH, BOONE, COLORADO CITY, PUEBLO, RYE
TELLER	CRIPPLE CREEK, DIVIDE, FLORISSANT, VICTOR, WOODLAND PARK

Service Areas for Mid-Atlantic

COUNTY	CITY	STATE
DISTRICT OF COLUMBIA	NAVAL ANACOST ANNEX, PARCEL RETURN SERVICE, WASHINGTON, WASHINGTON NAVY YARD	DC
ANNE ARUNDEL	ANNAPOLIS, ARNOLD, CHURCHTON, CROFTON, CROWNSVILLE, CURTIS BAY, DAVIDSONVILLE, DEALE, EDGEWATER, FORT GEORGE G MEADE, FRIENDSHIP, GALESVILLE, GAMBRILLS. GIBSON ISLAND, GLEN BURNIE, HANOVER, HARMANS, HARWOOD, LAUREL, LINTHICUM HEIGHTS, LOTHIAN, MAYO, MILLERSVILLE, ODENTON, PASADENA, RIVA, SEVERN, SEVERNA PARK, SHADY SIDE, TRACYS LANDING, WEST RIVER	MD
BALTIMORE	BALDWIN, BALTIMORE, BORING, BROOKLANDVILLE, BUTLER, CATONSVILLE, CHASE, COCKEYSVILLE, DUNDALK, ESSEX, FORK, FORT HOWARD, FREELAND, GLEN ARM, GLYNDON, GWYNN OAK, HALETHORPE, HUNT VALLEY, HYDES, KINGSVILLE, LONG GREEN, LUTHERVILLE TIMONIUM, MARYLAND LINE, MIDDLE RIVER, MONKTON, NOTTINGHAM, OWINGS MILLS, PARKTON, PARKVILLE, PERRY HALL, PHOENIX, PIKESVILLE, RANDALLSTOWN, REISTERSTOWN, RIDERWOOD, ROSEDALE, SPARKS GLENCOE, SPARROWS POINT, STEVENSON, TOWSON, UPPER FALLS, UPPERCO, WHITE MARSH, WINDSOR MILL	MD
BALTIMORE CITY	BALTIMORE, BROOKLYN	MD
CALVERT	BARSTOW, CHESAPEAKE BEACH, DUNKIRK, HUNTINGTOWN, NORTH BEACH, OWINGS, PRINCE FREDERICK, SUNDERLAND	MD
CARROLL	FINKSBURG, HAMPSTEAD, KEYMAR, LINEBORO, MANCHESTER, MARRIOTTSVILLE, NEW WINDSOR, SYKESVILLE, TANEYTOWN, UNION BRIDGE, WESTMINSTER	
CHARLES	BENEDICT, BRYANS ROAD, BRYANTOWN, HUGHESVILLE, INDIAN HEAD, IRONSIDES, ISSUE, LA PLATA, MARBURY, POMFRET, PORT TOBACCO, WALDORF, WHITE PLAINS	MD

FREDERICK	ADAMSTOWN, BRADDOCK HEIGHTS, BRUNSWICK, BUCKEYSTOWN, BURKITTSVILLE, FREDERICK, IJAMSVILLE, JEFFERSON, KNOXVILLE, LADIESBURG, LIBERTYTOWN, MIDDLETOWN, MONROVIA, MOUNT AIRY, NEW MARKET, NEW MIDWAY, POINT OF ROCKS, TUSCARORA, UNIONVILLE, WALKERSVILLE	MD
HARFORD	ABERDEEN, ABERDEEN PROVING GROUND, ABINGDON, BEL AIR, BELCAMP, BENSON, CHURCHVILLE, DARLINGTON, EDGEWOOD, FALLSTON, FOREST HILL, GUNPOWDER, HAVRE DE GRACE, JARRETTSVILLE, JOPPA, PERRYMAN, PYLESVILLE, STREET, WHITE HALL, WHITEFORD	MD
HOWARD	ANNAPOLIS JUNCTION, CLARKSVILLE, COLUMBIA, COOKSVILLE, DAYTON, DHS, ELKRIDGE, ELLICOTT CITY, FULTON, GLENELG, GLENWOOD, HIGHLAND, JESSUP, LISBON, SAVAGE, SIMPSONVILLE, WEST FRIENDSHIP, WOODBINE, WOODSTOCK	MD
MONTGOMERY	ASHTON, BARNESVILLE, BEALLSVILLE, BETHESDA, BOYDS, BRINKLOW, BROOKEVILLE, BURTONSVILLE, CABIN JOHN, CHEVY CHASE, CLARKSBURG, DAMASCUS, DERWOOD, DICKERSON, GAITHERSBURG, GARRETT PARK, GERMANTOWN, GLEN ECHO, KENSINGTON, MONTGOMERY VILLAGE, OLNEY, POOLESVILLE, POTOMAC, ROCKVILLE, SANDY SPRING, SILVER SPRING, SPENCERVILLE, SUBURB MARYLAND FAC, TAKOMA PARK, WASHINGTON GROVE	MD
PRINCE GEORGE'S	ACCOKEEK, ANDREWS AIR FORCE BASE, AQUASCO, BELTSVILLE, BLADENSBURG, BOWIE, BRANDYWINE, BRENTWOOD, CAPITOL HEIGHTS, CHELTENHAM, CLINTON, COLLEGE PARK, DISTRICT HEIGHTS, FORT WASHINGTON, GLENN DALE, GREENBELT, HYATTSVILLE, LANHAM, LAUREL, MOUNT RAINIER, OXON HILL, RIVERDALE, SOUTHERN MARYLAND FACILITY, SUITLAND, TEMPLE HILLS, UPPER MARLBORO	MD
ALEXANDRIA CITY	ALEXANDRIA	VA
ARLINGTON	ARLINGTON, FORT MYER	VA
CAROLINE	CORBIN, PORT ROYAL, RAPPAHANNOCK ACADEMY, RUTHER GLEN, WOODFORD	VA
CULPEPER	RICHARDSVILLE	VA
FAIRFAX	ALEXANDRIA, ANNANDALE, BURKE, CENTREVILLE, CHANTILLY, CLIFTON, DUNN LORING, FAIRFAX, FAIRFAX STATION, FALLS CHURCH, FORT BELVOIR, GREAT FALLS, GREENWAY, HERNDON, LORTON, MC LEAN, MERRIFIELD, MOUNT VERNON, NEWINGTON, OAKTON, RESTON, SPRINGFIELD, VIENNA, WEST MCLEAN	VA
FAIRFAX CITY	FAIRFAX	VA
FALLS CHURCH CITY	FALLS CHURCH	VA
FAUQUIER	CATLETT, GOLDVEIN, MIDLAND	VA
FREDERICKSBURG CITY	FREDERICKSBURG	VA
HANOVER	BEAVERDAM	VA
KING GEORGE	DAHLGREN, DOGUE, JERSEY, KING GEORGE, NINDE, ROLLINS FORK, SEALSTON	VA
LOUDOUN	ALDIE, ASHBURN, BLUEMONT, CHANTILLY, DULLES, HAMILTON, LEESBURG, LINCOLN, LOVETTSVILLE, MIDDLEBURG, PAEONIAN SPRINGS, PHILOMONT, PURCELLVILLE, ROUND HILL, STERLING, UPPERVILLE, WATERFORD	VA
LOUISA	BUMPASS, MINERAL, TREVILIANS	VA
MANASSAS CITY	MANASSAS, MANASSAS PARK CITY	VA
ORANGE	LOCUST GROVE, ORANGE, UNIONVILLE	VA

PRINCE WILLIAM	BRISTOW, BROAD RUN, CATHARPIN, DUMFRIES, GAINESVILLE, HAYMARKET, MANASSAS, NOKESVILLE, OCCOQUAN, QUANTICO, TRIANGLE, WOODBRIDGE	VA
SPOTSYLVANIA	FREDERICKSBURG, PARTLOW, SPOTSYLVANIA, THORNBURG	VA
STAFFORD	BROOKE, FREDERICKSBURG, GARRISONVILLE, HARTWOOD, QUANTICO, RUBY, STAFFORD	VA
WESTMORELAND	COLONIAL BEACH	VA

Service Areas for the Northwest

COUNTY	CITY	STATE
BENTON	CORVALLIS, PHILOMATH	OR
CLACKAMAS	BEAVERCREEK, BORING, BRIGHTWOOD, CANBY, CLACKAMAS, COLTON, EAGLE CREEK, ESTACADA, GLADSTONE, HAPPY VALLEY, LAKE OSWEGO, MARYLHURST, MOLALLA, MULINO, OREGON CITY, PORTLAND, RHODODENDRON, SANDY, WELCHES, WEST LINN, WILSONVILLE	OR
COLUMBIA	CLATSKANIE, COLUMBIA CITY, DEER ISLAND, RAINIER, SAINT HELENS, SCAPPOOSE, VERNONIA, WARREN	OR
HOOD RIVER	CASCADE LOCKS	OR
LINN	ALBANY, CRABTREE, LEBANON, LYONS, MILL CITY, SCIO, TANGENT	OR
MARION	AUMSVILLE, AURORA, DETROIT, DONALD, GATES, GERVAIS, HUBBARD, JEFFERSON, KEIZER, MEHAMA, MOUNT ANGEL, SAINT BENEDICT, SAINT PAUL, SALEM, SCOTTS MILLS, SILVERTON, STAYTON, SUBLIMITY, TURNER, WOODBURN	OR
MULTNOMAH	BRIDAL VEIL, CORBETT, FAIRVIEW, GRESHAM, PORTLAND, TROUTDALE	OR
POLK	DALLAS, FALLS CITY, INDEPENDENCE, MONMOUTH, RICKREALL, SALEM	OR
WASHINGTON	ALOHA, BANKS, BEAVERTON, BUXTON, CORNELIUS, FOREST GROVE, GALES CREEK, GASTON, HILLSBORO, MANNING, NORTH PLAINS, PORTLAND, SHERWOOD, TIMBER, TUALATIN	OR
YAMHILL	AMITY, CARLTON, DAYTON, DUNDEE, GRAND RONDE, LAFAYETTE MCMINNVILLE, NEWBERG, SHERIDAN, WILLAMINA, YAMHILL	OR
CLARK	AMBOY, BATTLE GROUND, BRUSH PRAIRIE, CAMAS, HEISSON, LA CENTER, RIDGEFIELD, VANCOUVER, WASHOUGAL, YACOLT	WA
COWLITZ	ARIEL, CARROLLS, CASTLE ROCK, COUGAR, KALAMA, KELSO, LONGVIEW, RYDERWOOD, SILVERLAKE, TOUTLE, WOODLAND	WA
LEWIS	TOLEDO, VADER, WINLOCK	WA
SKAMANIA	NORTH BONNEVILLE, STEVENSON	WA
WAHKIAKUM	CATHLAMET, SKAMOKAWA	WA

Service Areas for Washington and Idaho

COUNTY	CITY	STATE
LATAH	BOVILL, DEARY, GENESEE, HARVARD, JULIAETTA, KENDRICK, MOSCOW, POTLATCH, PRINCETON, TROY, VIOLA,	ID
BENTON	BENTON CITY, KENNEWICK, PATERSON, PLYMOUTH, PROSSER, RICHLAND, WEST RICHLAND	WA
COLUMBIA	DAYTON, STARBUCK	WA
FRANKLIN	CONNELL, ELTOPIA, KAHLOTUS, MESA, PASCO	WA
ISLAND	CAMANO ISLAND, CLINTON, COUPEVILLE, FREELAND, GREENBANK, LANGLEY, OAK HARBOR	WA
KING	AUBURN, BARING, BELLEVUE, BLACK DIAMOND, BOTHELL, BURTON, CARNATION, DUVALL, ENUMCLAW, FALL CITY, FEDERAL WAY, HOBART, ISSAQUAH, KENMORE, KENT, KIRKLAND, MAPLE VALLEY, MEDINA, MERCER ISLAND, NORTH	WA

	BEND, PACIFIC, PRESTON, RAVENSDALE, REDMOND, RENTON, SAMMAMISH, SEAHURST, SEATTLE, SKYKOMISH, SNOQUALMIE, SNOQUALMIE PASS, VASHON, WOODINVILLE	
KITSAP	BAINBRIDGE ISLAND, BREMERTON, BURLEY, HANSVILLE, INDIANOLA, KEYPORT, KINGSTON, MANCHESTER, OLALLA, PORT GAMBLE, PORT ORCHARD, POULSBO, RETSIL, ROLLINGBAY, SEABECK, SILVERDALE, SOUTH COLBY, SOUTHWORTH, SUQUAMISH, TRACYTON	WA
KITTITAS	CLE ELUM, EASTON, ELLENSBURG, KITTITAS, RONALD, ROSLYN, SOUTH CLE ELUM, THORP, VANTAGE	WA
LEWIS	ADNA, CENTRALIA, CHEHALIS, CINEBAR, CURTIS, DOTY, ETHEL, GALVIN, GLENOMA, MINERAL, MORTON, MOSSYROCK, NAPAVINE, ONALASKA, PACKWOOD, PE ELL, RANDLE, SALKUM, SILVER CREEK, TOLEDO, VADER, WINLOCK	WA
MASON	ALLYN, BELFAIR, GRAPEVIEW, HOODSPORT, LILLIWAUP, MATLOCK, SHELTON, TAHUYA, UNION	WA
PIERCE	ANDERSON ISLAND, ASHFORD, BONNEY LAKE, BUCKLEY, CAMP MURRAY, CARBONADO, DUPONT, EATONVILLE, ELBE, FOX ISLAND, GIG HARBOR, GRAHAM, KAPOWSIN, LA GRANDE, LAKEBAY, LAKEWOOD, LONGBRANCH, LONGMIRE, MCCHORD AFB, MCKENNA, MILTON, ORTING, PARADISE INN, PUYALLUP, ROY, SOUTH PRAIRIE, SPANAWAY, STEILACOOM, SUMNER, TACOMA, UNIVERSITY PLACE, VAUGHN, WAUNA, WILKESON	WA
SAN JUAN	BLAKELY ISLAND, DEER HARBOR, EASTSOUND, FRIDAY HARBOR, LOPEZ ISLAND, OLGA, ORCAS, SHAW ISLAND, WALDRON	WA
SKAGIT	ANACORTES, BOW, BURLINGTON, CLEARLAKE, CONCRETE, CONWAY, HAMILTON, LA CONNER, LYMAN, MARBLEMOUNT, MOUNT VERNON, ROCKPORT, SEDRO WOOLLEY	WA
SNOHOMISH	ARLINGTON, BOTHELL, DARRINGTON, EDMONDS, EVERETT, GOLD BAR, GRANITE FALLS, INDEX, LAKE STEVENS, LYNNWOOD, MARYSVILLE, MILL CREEK, MONROE, MOUNTLAKE TERRACE, MUKILTEO, NORTH LAKEWOOD, SILVANA, SNOHOMISH, STANWOOD, STARTUP, SULTAN	WA
SPOKANE	AIRWAY HEIGHTS, CHATTAROY, CHENEY, COLBERT, DEER PARK, ELK, FAIRCHILD AIR FORCE BASE, FAIRFIELD, FOUR LAKES, GREENACRES, LATAH, LIBERTY LAKE, MARSHALL, MEAD, MEDICAL LAKE, MICA, NEWMAN LAKE, NINE MILE FALLS, OTIS ORCHARDS, ROCKFORD, SPANGLE, SPOKANE, VALLEYFORD, VERADALE, WAVERLY	WA
THURSTON	BUCODA, EAST OLYMPIA, LACEY, LITTLEROCK, OLYMPIA, RAINIER, ROCHESTER, TENINO, TUMWATER, YELM,	WA
WALLA WALLA	BURBANK, COLLEGE PLACE, DIXIE, PRESCOTT, TOUCHET, WAITSBURG, WALLA WALLA, WALLULA,	WA
WHATCOM	ACME, BELLINGHAM, BLAINE, CUSTER, DEMING, EVERSON, FERNDALE, LUMMI ISLAND, LYNDEN, MAPLE FALLS, NOOKSACK, POINT ROBERTS, SUMAS	WA
WHITMAN	ALBION, BELMONT, COLFAX, COLTON, ENDICOTT, FARMINGTON, GARFIELD, HAY, HOOPER, LACROSSE, LAMONT, MALDEN, OAKESDALE, PALOUSE, PULLMAN, ROSALIA, SAINT JOHN, STEPTOE, TEKOA, THORNTON, UNIONTOWN	WA
YAKIMA	BROWNSTOWN, BUENA, COWICHE, GRANDVIEW, GRANGER, HARRAH, MABTON, MOXEE, NACHES, OUTLOOK, PARKER, SELAH, SUNNYSIDE, TIETON, TOPPENISH, WAPATO, WHITE SWAN, YAKIMAL, ZILLAH	WA

Service Areas for Georgia

COUNTY	ZIP
BARROW	BOGART, AUBURN, BRASELTON, HOSCHTON, BETHLEHEM, STATHAM, WINDER, MONROE
BARTOW	ADAIRSVILLE, ARAGON, CARTERSVILLE, CASSVILLE, EMERSON, KINGSTON, ROME, RYDAL, WALESKA, WHITE, ACWORTH, CARTERSVILLE, DALLAS, TAYLORSVILLE, FAIRMOUNT
BUTTS	FLOVILLA, FORSYTH, JENKINSBURG, JACKSON, MCDONOUGH, GRIFFIN, LOCUST GROVE, GRIFFIN
CARROLL	BOWDON JUNCTION, CARROLLTON, MOUNT ZION, WHITESBURG, WINSTON, VILLA RICA, BREMEN, WACO, BOWDON, TEMPLE, ROOPVILLE
CHEROKEE	CANTON, HOLLY SPRINGS, LEBANON, NELSON, WOODSTOCK, MARIETTA, WOODSTOCK, ROSWELL, CUMMING, DAWSONVILLE, JASPER, CUMMING, ALPHARETTA, BALL GROUND
CLARKE	ATHENS, ATHENS, HULL, WINTERVILLE, WATKINSVILLE
CLAYTON	ATLANTA, FOREST PARK, JONESBORO, LOVEJOY, MORROW, RIVERDALE, CONLEY, ELLENWOOD, FAYETTEVILLE, JONESBORO, REX, STOCKBRIDGE, HAMPTON
COBB	AUSTELL, POWDER SPRINGS, ATLANTA, DALLAS, HIRAM
COWETA	HARALSON, MORELAND, NEWNAN, SARGENT, SHARPSBURG, TURIN, SENOIA, PALMETTO, NEWNAN, HOGANSVILLE, GRANTVILLE
DAWSON	ELLIJAY, DAHLONEGA, MARBLE HILL
DEKALB	ATLANTA, AVONDALE ESTATES, CLARKSTON, DECATUR, LITHONIA, PINE LAKE, REDAN, SCOTTDALE, STONE MOUNTAIN, TUCKER, SNELLVILLE, CONYERS
DOUGLAS	DOUGLASVILLE, LITHIA SPRINGS
FAYETTE	PEACHTREE CITY, TYRONE, FAYETTEVILLE, BROOKS
FORSYTH	CUMMING, ALPHARETTA, DULUTH, SUWANEE, GAINESVILLE
GWINNETT	BUFORD, DULUTH, GRAYSON, LAWRENCEVILLE, LILBURN, NORCROSS, NORTH METRO, SNELLVILLE, BUFORD, LOGANVILLE, DACULA
HALL	ALTO, CHESTNUT MOUNTAIN, CLERMONT, CORNELIA, FLOWERY BRANCH, GAINESVILLE, GILLSVILLE, LULA, MURRAYVILLE, OAKWOOD, PENDERGRASS, TALMO
HARALSON	BUCHANAN, CEDARTOWN, FELTON, TALLAPOOSA, ROCKMART
HEARD	FRANKLIN, LAGRANGE
HENRY	MCDONOUGH
LAMAR	BARNESVILLE, CULLODEN, YATESVILLE, MEANSVILLE, MILNER, THE ROCK, ZEBULON
MADISON	CARLTON, COLBERT, COMER
MERIWETHER	GAY, GREENVILLE, LUTHERSVILLE, MANCHESTER, PINE MOUNTAIN, WARM SPRINGS, WOODBURY
NEWTON	COVINGTON, MANSFIELD, NEWBORN, PORTERDALE, CONYERS, COVINGTON, OXFORD, SOCIAL CIRCLE
OCONEE	BISHOP, FARMINGTON, HIGH SHOALS, ARNOLDSVILLE
OGLETHORPE	CRAWFORD, LEXINGTON, MAXEYS, RAYLE, STEPHENS, UNION POINT
PICKENS	RANGER, TALKING ROCK, TATE
PIKE	CONCORD, MOLENA, WILLIAMSON
SPALDING	EXPERIMENT, ORCHARD HILL, SUNNY SIDE,
WALTON	GOOD HOPE, JERSEY, MADISON, MONROE, RUTLEDGE

Customer Service Phone Numbers

General Customer Service

Northern California Region	800-663-1771
Southern California Region	800-533-1833
Colorado Region	877-883-6698
Mid-Atlantic States Region	877-740-4117
Northwest Region	866-800-3402
Georgia Region	866-800-1486
Washington & Eastern Idaho	877-721-2199

Utilization Management for Out-of-Network Emergency Services

Northern California Region	800-225-8883
Southern California Region	800-225-8883
Colorado Region	303-338-3800
Mid-Atlantic States Region	800-810-4766
Northwest Region	866-813-2437
Georgia Region	800-221-2412
Washington & Eastern Idaho	800-289-1363

Advice Nurses

Northern California Region	866-454-8855
Southern California Region	888-576-6225
Colorado Region	866-311-4464
Mid-Atlantic States Region	703-359-7878
(Outside Washington Metro Area)	800-777-7904
Northwest Region	503 813-2000
Outside Portland	800 813-2000
Georgia Region	800-611-1811
Washington & Eastern Idaho	800-297-6877

Interpreter Services

Northern California Region	800-663-1771
Southern California Region	800-533-1833
Colorado Region	877-883-6698
Mid-Atlantic States Region	877-740-4117
Northwest Region	866-800-3402
Washington & Eastern Idaho	866-213-3062

TTY 771 or 877-870-0283

Pharmacy Benefit Information

All Regions 866-427-7701

Claims Administrator:

KPIC Self-Funded Claims Administrator
P.O. Box 30547
Salt Lake City, UT 84130-0547
Payor ID # 94320

Pharmacy Claim Form

PRESCRIPTION REIMBURSEMENT REQUEST FORM

Use this form to request reimbursement for covered medications purchased at retail cost. Complete one form per member. **Please print clearly. Additional information and instructions on back, please read carefully.**

1 Member Information

RxGroup *(see ID card)* Member ID *(see ID card)*

Last Name First Name MI

Mailing Street Address Apt. #

City State ZIP

Prescription is for: O Self O Spouse O Dependent O Domestic Partner O Other______________________ Gender O M O F

Date of Birth *(mm/dd/yyyy)w* [|]/[|]/[| | |]

2 Physician and Pharmacy Information

Prescribing Physician Name Dispensing Pharmacy Name

Prescribing Physician Phone Number with Area Code Dispensing Pharmacy Phone Number with Area Code

3 Reason For Request

Select appropriate options for your request:

- O I did not use my Prescription Drug ID card
- O I used a non-participating pharmacy *(please explain)* ____
- O I filled a compound prescription *(your pharmacist must complete section B on the back of this form)*
- O Urgent/Emergency visit
- O Prescribed by Dentist
- O I purchased medication outside of the United States
  Country ______________________________________ Currency used ________________________
- O My primary coverage is with another insurance carrier *(coordination of benefits claim; see section C on back for details)*
  - O I am submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare
  - O I am submitting a copay receipt
- O I was waiting for a drug approval
- O I was retroactively enrolled with the plan
- O My pharmacy billed the wrong plan
- O Other *(please explain)* ____

4 Acknowledgement

I certify that the medication(s) for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medications received were not for treatment of an on-the-job injury. I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

Signature: ____

Date: ____________

ORX5262-KPI_170410

Instructions for Submitting Form

1. Include the original pharmacy receipt for each medication (not the register receipt). Pharmacy receipts must contain the information in Section A (below). If you do not have pharmacy receipts, ask your pharmacy to provide them to you.
2. Read the Acknowledgement (section 4) on the front of this form carefully. Then sign and date. Print page 2 of this form on the back of page 1.
3. Send completed form with pharmacy receipt(s) to: **OptumRx Claims Department, P.O. Box 29044, Hot Springs, AR 71903**

Note: Cash and credit card receipts are not proof of purchase. Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

Section A – Pharmacy Receipts for Reimbursement

Use the following checklist to ensure your receipts have all information required for your reimbursement request:

- O Date prescription filled
- O Name and address of pharmacy
- O Prescribing physician name or ID number
- O National Drug Code (NDC) number
- O Name of drug and strength
- O Prescription number (Rx number)
- O Quantity

Section B – Pharmacy Information *(for compound prescriptions ONLY)*

(Pharmacist must complete and sign)

- List VALID 11 digit NDC number (highest to lowest cost) in the box at right. Include EACH ingredient used in the compound prescription.
- For each NDC number, indicate the metric quantity expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL amount paid by the patient.
- Receipt(s) must be provided with this claim form.

* Individual quantities must equal the total quantity.
† Individual ingredient costs plus compounding fees must be equal to the total ingredient costs.

Rx#		Date Filled		Days Supply	

VALID 11 digit NDC#	Quantity*	Ingredient Cost†
Compounding Fee	X	
Total		

X ______________________________
Signature of Pharmacist

Section C – Coordination of Benefits

You must submit claims within one year of date of purchase or as required by your plan.

When submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare: If you have not already done so, submit the claim to the Primary Plan or Medicare. Once you receive the EOB, complete this form, submit the pharmacy receipts, and attach the EOB. The EOB must clearly indicate the cost of the prescription and amount paid by the Primary Plan or Medicare.

When submitting a copay receipt: If your Primary Plan requires you to pay a copayment or coinsurance to the pharmacy, then no EOB is needed. Just complete this form and submit the pharmacy receipts showing the amount you paid at the pharmacy. These receipts will serve as the EOB.

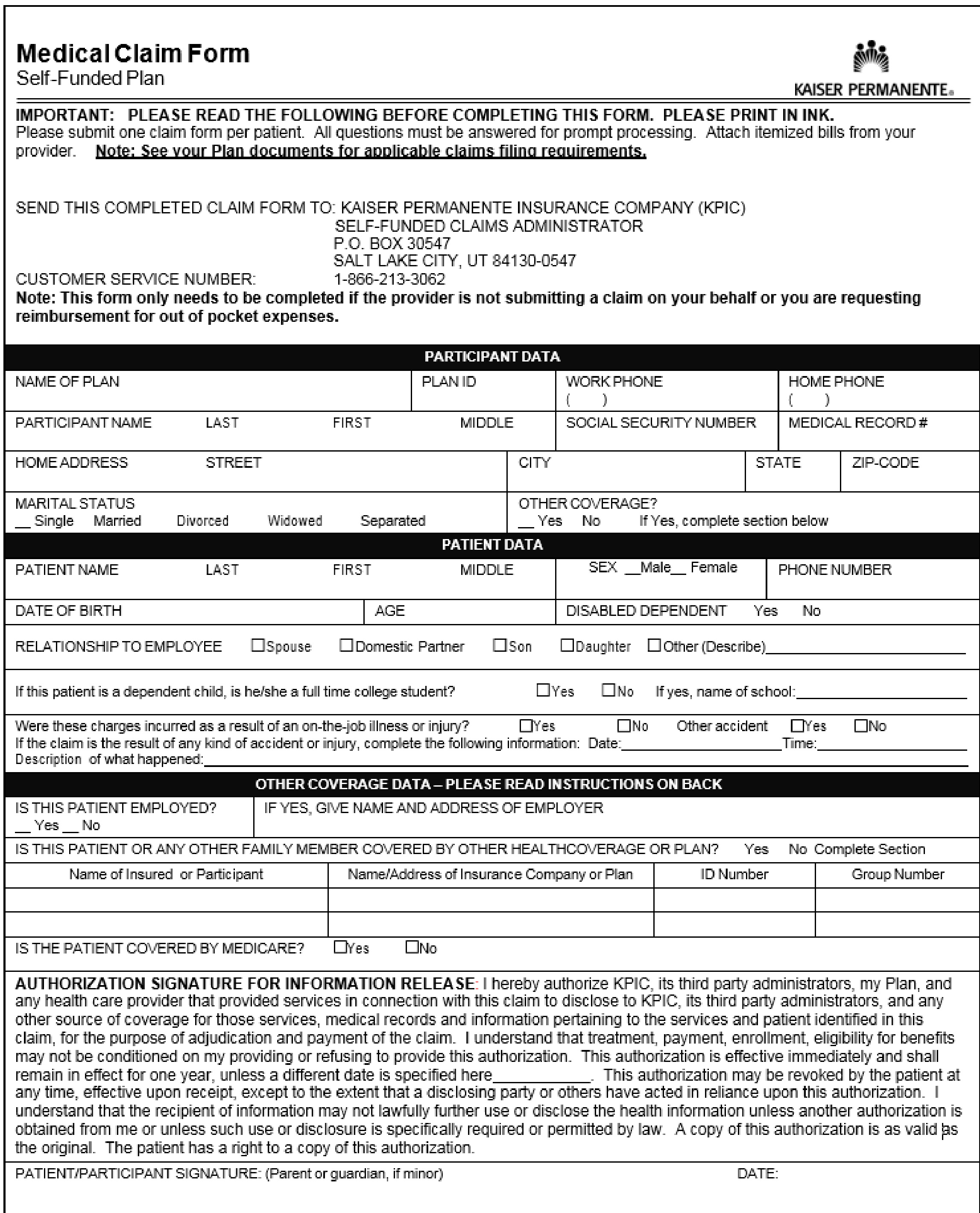
Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

***Arizona:** For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment or a loss is subject to criminal and civil penalties.

***California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

ORX5262-KPI_161208

Medical Claim Form



Medical Claim Form
Self-Funded Plan

KAISER PERMANENTE

IMPORTANT: PLEASE READ THE FOLLOWING BEFORE COMPLETING THIS FORM. PLEASE PRINT IN INK.
Please submit one claim form per patient. All questions must be answered for prompt processing. Attach itemized bills from your provider. **Note: See your Plan documents for applicable claims filing requirements.**

SEND THIS COMPLETED CLAIM FORM TO: KAISER PERMANENTE INSURANCE COMPANY (KPIC)
SELF-FUNDED CLAIMS ADMINISTRATOR
P.O. BOX 30547
SALT LAKE CITY, UT 84130-0547

CUSTOMER SERVICE NUMBER: 1-866-213-3062

Note: This form only needs to be completed if the provider is not submitting a claim on your behalf or you are requesting reimbursement for out of pocket expenses.

PARTICIPANT DATA

NAME OF PLAN	PLAN ID	WORK PHONE ( )	HOME PHONE ( )
PARTICIPANT NAME LAST FIRST MIDDLE		SOCIAL SECURITY NUMBER	MEDICAL RECORD #
HOME ADDRESS STREET	CITY	STATE	ZIP-CODE

MARITAL STATUS __ Single Married Divorced Widowed Separated
OTHER COVERAGE? __ Yes No If Yes, complete section below

PATIENT DATA

PATIENT NAME LAST FIRST MIDDLE	SEX __Male__ Female	PHONE NUMBER
DATE OF BIRTH	AGE	DISABLED DEPENDENT Yes No

RELATIONSHIP TO EMPLOYEE ☐Spouse ☐Domestic Partner ☐Son ☐Daughter ☐Other (Describe)____________________

If this patient is a dependent child, is he/she a full time college student? ☐Yes ☐No If yes, name of school:____________________

Were these charges incurred as a result of an on-the-job illness or injury? ☐Yes ☐No Other accident ☐Yes ☐No
If the claim is the result of any kind of accident or injury, complete the following information: Date:________________Time:______________
Description of what happened:____

OTHER COVERAGE DATA – PLEASE READ INSTRUCTIONS ON BACK

IS THIS PATIENT EMPLOYED? __ Yes __ No	IF YES, GIVE NAME AND ADDRESS OF EMPLOYER

IS THIS PATIENT OR ANY OTHER FAMILY MEMBER COVERED BY OTHER HEALTHCOVERAGE OR PLAN? Yes No Complete Section

Name of Insured or Participant	Name/Address of Insurance Company or Plan	ID Number	Group Number

IS THE PATIENT COVERED BY MEDICARE? ☐Yes ☐No

AUTHORIZATION SIGNATURE FOR INFORMATION RELEASE: I hereby authorize KPIC, its third party administrators, my Plan, and any health care provider that provided services in connection with this claim to disclose to KPIC, its third party administrators, and any other source of coverage for those services, medical records and information pertaining to the services and patient identified in this claim, for the purpose of adjudication and payment of the claim. I understand that treatment, payment, enrollment, eligibility for benefits may not be conditioned on my providing or refusing to provide this authorization. This authorization is effective immediately and shall remain in effect for one year, unless a different date is specified here___________. This authorization may be revoked by the patient at any time, effective upon receipt, except to the extent that a disclosing party or others have acted in reliance upon this authorization. I understand that the recipient of information may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. A copy of this authorization is as valid as the original. The patient has a right to a copy of this authorization.

PATIENT/PARTICIPANT SIGNATURE: (Parent or guardian, if minor) DATE:

PROVIDER INFORMATION (OPTIONAL)

HAS UTILIZATION MANAGEMENT BEEN CONTACTED FOR PRECERTIFICATION? ☐Yes ☐No If yes, Authorization Number:_____________

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: RELATE ITEMS 1, 2, 3 OR 4 TO THE DIAGNOSIS CODE BELOW BY ENTERING THE ITEM NUMBER FOR EACH SERVICE
1. ________________________ 2. ________________________ 3. ________________________ 4. ________________________

DATE(S) OF SERVICE		PLACE OF SERVICE	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS/ MODIFIER	DIAGNOSIS CODE	FULL DESCRIPTION OF PROCEDURE/SERVICE	DAYS/ UNITS	CHARGE AMOUNT
FROM	THROUGH						
MO | DY | YR	MO | DY | YR						
| |	| |						
| |	| |						
| |	| |						

PROVIDER FEDERAL TAX I.D. NUMBER __SSN __EIN	PATIENT'S ACCT NUMBER	TOTAL CHARGES $	AMT PAID $	BALANCE DUE $

NAME, SIGNATURE, CREDENTIALS OF TREATING PHYSICIAN/SUPPLIER	PROVIDER BILLING NAME, ADDRESS, ZIP CODE AND PHONE#
PRINTED NAME:__________________________CREDENTIALS_____	
SIGNED:______________________________DATE:_____________	

HOW TO FILE YOUR CLAIM

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION, OR OMITTING A MATERIAL FACT, MAY BE SUBJECT TO CIVIL OR CRIMINAL PROSECUTION AND PENALTIES.

This form is designed to help you file a claim for health care services received by you or an enrolled family member. If a doctor, hospital or other healthcare provider has already filed a claim directly with KPIC on your behalf, please do not submit a Member Medical Claim Form for the same services. Please see your Plan documents for applicable claim filing requirements.

1. Complete the Participant Data and Patient Data sections of the claim form.
2. See instructions below regarding the Other Coverage Data section.
3. Complete and sign the Authorization section.
4. Either have the provider complete the Provider Information section, or attach itemized bills provided by the provider. Each bill/receipt must include:
   - The name of the patient
   - Date expenses were incurred
   - Nature of encounter (i.e. office visit, x-ray, etc.)
   - Any other information your Plan requires.
5. For reimbursement of any out-of-pocket expenses you incurred, you must include a copy of a receipt from the provider, and evidence of your payment to the provider, such as a credit card receipt.
6. Send the completed claim form, itemized bills and attachments to:

   KAISER PERMANENTE INSURANCE COMPANY (KPIC)
   SELF-FUNDED CLAIMS ADMINISTRATOR
   P.O. BOX 30547
   SALT LAKE CITY, UT 84130-0547

Note: Please be aware that if the provider holds a contract to provide services for your Plan, payment of a claim will always be made to the provider, even if you paid the provider directly. In that circumstance, you will need to seek reimbursement from the provider.

INSTRUCTIONS FOR OTHER COVERAGE

If the patient has coverage under any other plan, in addition to the Plan administered by KPIC, you may be able to receive benefits under both plans. This may happen if both spouses or domestic partners (where applicable) work and both carry family coverage through their respective employers or have other coverage. If you filed a claim with the other coverage, you will need to submit the explanation of benefits or other communication from the other coverage showing their adjudication of the claim, in addition to this Claim Form and copies of itemized bills and receipts.

VERSION 5.2
LAST REVISION 9/11/08
CEL

Non-Discrimination Notice

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

- Provides no-cost aids and services to people with disabilities to communicate effectively with KPIC, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provides 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 866-213-3062; for TTY, 711.

If you believe that KPIC 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 with the KPIC Civil Rights Coordinator, 3701 Boardman-Canfield Rd, Canfield, OH 44406; telephone number 866-213-3062. You can file a grievance by mail or phone. If you need help filing a grievance, the KPIC Civil Rights Coordinator is able to help you.

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

Help in your Language

English: You have the right to get help in your language at no cost. If you have questions about your benefits, or you are required to take action by a specific date, call the number provided for your state or region to talk to an interpreter.

Northern California Region......	1-800-663-1771
Southern California Region......	1-800-533-1833
Colorado Region...............	1-877-883-6698
Mid-Atlantic States Region......	1-877-740-4117
Northwest Region..............	1-866-800-3402
Georgia Region................	1-866-800-1486
TTY..................................	711

አማርኛ (Amharic): ያለምንም ክፍያ በቋንቋዎ እርዳታ የማግኘት መብት አለዎ። ስለ ጥቅማጥቅሞችዎ ጥያቄዎች ካሉዎት፣ ወይም በተወሰነ ቀን እንዲያከናውኑ የሚጠበቅዎ ድርጊት ካለ፣ ስቴትዎ ወይም ክልልዎ ከተርጓሚ ጋር እንዲነጋገር በተሰጠዎ ስልክ ቁጥር ይደውሉ።

العربية (Arabic): لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن المزايا الخاصة بك أو قد طُلب منك اتخاذ إجراء خلال تاريخ محدد، يُرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.

Հայերեն (Armenian): Դուք ունեք Ձեր լեզվով անվճար օգնություն ստանալու իրավունք: Եթե Դուք հարցեր ունեք Ձեր նպաստների, կամ Դուք պարտադրված եք գործողություններ ձեռնարկել մինչև որոշակի ամսաթիվ, ապա զանգահարե՛ք Ձեր նահանգի կամ շրջանի համար տրամադրված հեռախոսահամարով՝ թարգմանչի հետ խոսելու համար:

Ɓǎsɔ́ɔ̀ - wùɖù (Bassa): Ɔ mɔ̀ ni kpé ɓɛ́ ṁ ké gbo-kpá-kpá dyé ɖé ṁ miɔ̀ùn niin ɓíɖí-wùɖù mú pídyi. Ɔ jǔ ké ṁ dyi dyi-diè-ɖɛ̀ ɓě ɓéɖé ɓá kpáná ɓě ṁ kɔ̃ ṁ ké dyéɛ jè dyí, mɔɔ ɔ jǔ ké wa dyi niin ṁ mɛ nyu ɖɛ ɖíɛ̀ ɓě ɓó wé jɛ̀ɛ̀ ɖò kɔ̃ɛɛ ní, nii, ṁ mɛ ɖá nɔ̀ɓà ɓɛ́ wa tòà ɓó ni ɓóɖɔ́ɔ̀ mɔɔ ɓó ni gbɛ̌ɛ̀ɔ̀ biìɛ, ɓɛ́ ṁ ké nyɔ-wuɖuún-zà-nyɔ̀ ɖò gbo wùɖù.

বাংলা (Bengali): বিনা খরচে আপনার নিজের ভাষায় সাহায্য পাওয়ার অধিকার আপনার আছে। আপনার সুবিধাগুলির সম্পর্কে আপনার যদি কোন প্রশ্ন থাকে, অথবা একটি নির্ধারিত দিনের মধ্যে যদি আপনার কোন পদক্ষেপ গ্রহণ করার প্রয়োজন হয়, তাহলে দোভাষীর সঙ্গে কথা বলতে আপনার রাজ্য বা অঞ্চলের জন্য প্রদত্ত নম্বরটিতে ফোন করুন।

Your health benefits are self-insured by your employer, union, or Plan sponsor. Kaiser Permanente Insurance Company provides certain administrative services for the Plan and is not an insurer of the Plan or financially liable for health care benefits under the Plan. • Kaiser Permanente Insurance Company (KPIC), Ordway Building, One Kaiser Plaza, Oakland, CA 94612

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Cebuano (Bisaya): Anaa moy katungod nga mangayo og tabang sa inyo pinulongan ug kini walay bayad. Kung naa mo pangutana bahin sa inyo benepisyo o may mga butang nga nanginahanglan sa inyo paglihok sa dili pa usa ka piho nga petsa, palihug lang pagtawag sa mga numero sa telepono nga gihatag sa imong estado ("state") o rehiyon ("region") para makigstorya sa usa ka interpreter.

中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的福利有任何疑問，或者您被要求在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。

Chuuk (Chuukese): Mei wor omw pwuung omw kopwe neuneu aninis non kapasen fonuomw (Chuukese), ese kamo. Ika mei wor omw kapas eis usun omw pekin insurance, are ika a men auchea omw kopwe fori pwan ekoch fofor mei namot ngeni omw plan, ke tongeni kori ewe nampa ren omw state ika neni (asan) pwe eman chon awewe epwe anisuk non kapasen fonuomw.

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de vos avantages ou si vous devez prendre des mesure à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Leistungsanspruchs haben oder Sie bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.

ગુજરાતી (Gujarati): તમને કોઇ પણ ખર્ચ વગર તમારી ભાષામાં મદદ મેળવવાનો અધિકાર છે. જો તમને તમારા લાભો વિશે પ્રશ્નો હોય, અથવા કોઈ ચોક્કસ તારીખથી તમને પગલાં લેવાની જરૂર હોય, તો દુભાષિયા સાથે વાત કરવા તમારા સ્ટેટ અથવા રીજીયન માટે પુરો પાડવામાં આવેલ નબંર પર ફોન કરો.

Kreyòl Ayisyen (Haitian Creole): Ou gen dwa pou jwenn èd nan lang ou gratis. Si ou gen nenpòt kesyon sou aplikasyon ou an oswa asirans ou ak Kaiser Permanente, oswa si nan avi sa a gen bagay ou sipoze fè avan yon sèten dat, rele nimewo nou mete pou Eta oswa rejyon ou a pou w ka pale ak yon entèprèt.

ʻōlelo Hawaiʻi (Hawaiian): He pono a ua loaʻa no kekahi kōkua me kāu ʻōlelo inā makemake a he manuahi no hoʻi. Inā he mau nīnau kāu e pili ana i kāu pono keu i ka polokalamu ola kino, a i ʻole inā ke haʻi nei iāʻoe e hana koke aku i kēia ma mua o kekahi lā i waiho ʻia, e kelepona aku i ka helu i loaʻa nei no kāu mokuʻāina a i ʻole panaʻāina no ka walaʻau ʻana me kekahi kanaka unuhi ʻōlelo.

हिन्दी (Hindi): आपको बिना कोई कीमत चुकाए आपकी भाषा में मदद पाने का अधिकार है। यदि आप आपके लाभ के बारे में कोई सवाल पूछना चाहते हैं या आपको किसी निश्चित तारीख तक कोई कारवाई करने की आवश्यकता है,तो आप आपके राज्य या क्षेत्र के लिए दिये गए नंबर पर फोन करके किसी दुभाषिए से बात करें।

Hmoob (Hmong): Koj muaj cai tau txais kev pab txhais ua koj hom lus pub dawb. Yog koj muaj lus nug txog koj cov txiaj ntsig, lossis koj yuav tsum tau ua raws li hnub hais tseg ntawd, hu rau tus nab npawb xovtooj ntawm lub xeev lossis hauv ib cheeb tsam uas tau muab rau koj mus tham nrog ib tug kws txhais lus.

Igbo (Igbo): Ị nwere ikike ịnweta enyemaka n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ọ bụrụ na ị nwere ajụjụ gbasara elele gị, ma ọ bụ na achọrọ ka ị mee ihe tupu otu ụbọchị, kpọọ nọmba enyere maka steeti ma ọ bụ mpaghara gị i ji kwukọrịta okwu n'etiti onye ọkọwa okwu.

Iloko (Ilocano): Adda dda ti karbenganyo a dumawat iti tulong iti pagsasaoyo nga awan ti bayadanyo. No addaankayo kadagiti saludsod maipanggep kadagiti benepisioyo wenno, mangkalikagum kadakayo a rumbeng nga aramidenyo ti addang iti espesipiko a petsa, tawagan ti numero nga inpaay para ti estado wenno rehion tapno makipatang ti maysa mangipatarus iti pagsasao.

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Italiano (Italian): Hai il diritto di ricevere assistenza nella tua lingua gratuitamente.In caso di domande riguardanti le tue agevolazioni o se devi intervenire entro una data specifica, chiama il numero fornito per il tuo stato o la tua regione per parlare con un interprete.

日本語 (Japanese): あなたは、費用負担なしでご使用の言語で支援を受ける権利を保持しています。給付に関してご質問があるか、または、あなたが特定の日付までに行動を起こすよう依頼されている場合、お住まいの州または地域に対して提供された電話番号に電話して、通訳とお話ください。

ខ្មែរ (Khmer): អ្នកមានសិទ្ធិទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ បើសិនអ្នកមានសំណួរណាមួយអំពីអត្ថប្រយោជន៍របស់លោកអ្នក ឬត្រូវបានតម្រូវឲ្យអ្នក ចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ សូមទូរស័ព្ទទៅលេខដែលបានផ្តល់ជូនសម្រាប់រដ្ឋ ឬតំបន់របស់អ្នកដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ ។

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다. 귀하의 보험 혜택이나 이 통지서의 요구대로 어느 날짜까지 조취를 취해야만 하는 경우, 제공된 귀하의 주 및 지역 전화번호로 연락해 통역사와 통화하십시오.

ລາວ (Laotian): ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັຽຄ່າ. ຖ້າວ່າ ທ່ານມີຄໍາຖາມກ່ຽວກັບຜົນປະໂຫຍດຂອງທ່ານ, ຫຼື ທ່ານຈໍາເປັນຕ້ອງດໍາເນີນການພາຍໃນວັນທີທີ່ເຈາະຈົງໃດໜຶ່ງ, ໃຫ້ໂທຕາມໝາຍເລກທີ່ໃຫ້ໄວ້ສໍາລັບລັດ ຫຼື ເຂດຂອງທ່ານເພື່ອຂໍລົມກັບນາຍພາສາ.

Kajin Majōḷ (Marshallese): Ewōr jimwe eo aṃ in bōk jipañ ilo kajin eo aṃ ejjeḷọk wōṇāān. Ñe ewōr aṃ kajjitōk kōn jibañ ko aṃ, ak ñe kwoj aikuuj in ṃakūtkūt ṃokta jān juon raan eo eṃōj an kallikkar, kaḷọk nōṃba eo ej leḷọk ñan state eo aṃ ak jikūṃ bwe kwōn maroñ kōnono ippān juon ri-ukōt.

Naabeehó (Navajo): Doo bik'é asíníłáágo ata' hane' bee níká i'doolwoł. Bee naa áháyánígíí dóó bee níká aná'álwo'ígíí bína'ídílkidgo, éí doodago náás yoołkááłgi hait'éegoda í'díílííł ni'di'nígo, bik'ehgo béésh bee hane'í naaltsoos bikáá'íjį' hodíílnih nitsaa hahoodzojį' éí doodago aadi nahós'a'di áko ata' halne'í bich'į' hadíídzih.

नेपाली (Nepali): तपाईंले कुनै खर्च बिना आफ्नो भाषामा सहायता पाउने अधिकार छ। यदि सुविधाहरूका बारेमा तपाईंको कुनै प्रश्नहरू भए, अथवा कुनै निर्धारित मिति भित्र तपाईंले कुनै कारबाही गर्न आवश्यक भए, कुनै दोभाषेसँग कुरा गर्न तपाईंको राज्य वा क्षेत्रका लागि उपलब्ध नम्बरमा फोन गर्नुहोस्।

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa'ee tajaajila keetii ilaalchisee gaaffii yoo qabaatte, yookaan yoo guyyaa murtaa'e irratti tarkaanfii akka fudhattu gaafatamte, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bilbiluudhaan turjumaana haasofsiisi.

فارسی (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره مزایای خود سؤالی داشته یا لازم است تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.

lokaiahn Pohnpei (Pohnpeian): Komw anehki pwung en rapahki sounkawehwe en omw palien lokaia ni sohte isaihs. Ma mie iren owmi kalelapak ohng kosoandi me pid kamwau pe kan, de anahne komwi en mwekid ohng rahn me kileledi, ah komw anahne koahl nempe me sansalehr (insert number here) ohng owmi palien wehi pwe komwi en lokaiaieng owmi tungoal soun kawehwe.

Português (Portuguese): Você tem o direito de obter ajuda em seu idioma sem nenhum custo. Se você tiver dúvidas sobre seus benefícios, ou caso seja necessário que você tome alguma medida até uma data específica, ligue para o número fornecido para seu estado ou região para falar com um intérprete.

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ਪੰਜਾਬੀ (Punjabi): ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਸੁਲਕ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮਦਦ ਪਾਉਣ ਦਾ ਹੱਕ ਹੈ. ਜੇਕਰ ਤੁਹਾਡੇ ਆਪਣੇ ਫਾਇਦਿਆਂ ਬਾਰੇ ਸਵਾਲ ਹਨ, ਜਾਂ ਤੁਹਾਨੂੰ ਕਿਸੇ ਨਿਸ਼ਚਿਤ ਮਿਤੀ ਤੱਕ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪਵੇ, ਤਾਂ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਆਪਣੇ ਰਾਜ ਜਾਂ ਇਲਾਕੇ ਲਈ ਮੁਹੱਈਆ ਕਰਵਾਏ ਗਏ ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ.

Română (Romanian): Aveți dreptul de a solicita ajutor care să vă fie oferit în mod gratuit în limba dumneavoastră. Dacă aveți întrebări legate de beneficiile dumneavoastră sau vi se solicită să luați măsuri până la o anumită dată, sunați la numărul de telefon furnizat pentru statul sau regiunea dumneavoastră pentru a sta de vorbă cu un interpret.

Русский (Russian): У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно ваших преимуществ либо необходимо выполнение каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.

Faa-Samoa (Samoan): E iai lou 'aia e maua fua se fesoasoani i lou lava gagana. Afai e iai ni fesili e uiga i ou penefiti, pe e manaomia onae gaoioi a o le'i oo i se aso filifilia, vili le numera ua saunia atu mo lou setete po o vaipanoa e talanoa i se faaliliu.

Español (Spanish): Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de sus beneficios o si se le solicita que tome alguna medida antes de una fecha determinada, llame al número de teléfono que se proporciona para su estado o región para hablar con un intérprete.

Tagalog (Tagalog): Mayroon kang karapatang humingi ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong mga benepisyo o kinakailangan mong magsagawa ng aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap sa isang interpreter.

ไทย (Thai): ท่านมีสิทธิที่จะได้รับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย หากท่านมีคำถามเกี่ยวกับสิทธิประโยชน์ของท่าน หรือท่านจำเป็นต้องดำเนินการภายในวันที่ที่กำหนดไว้ โปรดติดต่อหมายเลขที่ให้ไว้สำหรับรัฐหรือเขตพื้นที่ของท่านเพื่อคุยกับล่าม

Lea Faka-Tonga (Tongan): 'Oku 'i ai ho totonu ke ma'u ha fakatonulea ta'etotongi. Kapau 'oku 'i ai ha'o fehu'i 'o fekau'aki mo ho ngaahi penefiti, pe ko ha me'a na'e fiema'u ke fai ki ha 'aho na'e tukupau atu ke fakahoko ia, taa ki he fika kuo 'oatu ki ho siteiti pe ko e vahefonua ke talanoa mo ha fakatonulea.

Українська (Ukrainian): У Вас є право на отримання допомоги на Вашій рідній мові безкоштовно. Якщо Ви маєте питання стосовно Ваших переваг, чи якщо Вам необхідно здійснити певну дію до конкретної дати, подзвоніть по номеру телефону, що відповідає Вашій країні чи регіону, щоб поговорити з перекладачем.

اُردو (Urdu): آپ کو کوئی بھی قیمت ادا کئے بغیر اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ اگر آپ کے ذہن میں اپنے فوائد کے متعلق کوئی سوالات ہیں، یا آپ کو ایک مخصوص تاریخ تک عمل انجام دینے کی ضرورت ہے تو، کسی مترجم سے بات چیت کرنے کے لئے آپ کی ریاست یا علاقہ کے لئے فراہم کئے گئے نمبر پر کال کریں۔

Tiếng Việt (Vietnamese): Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về các lợi ích của mình, hoặc quý vị được yêu cầu thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.

Yorùbá (Yoruba): O ní ẹ̀tọ́ láti gba ìrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Tí o bá ní ìbéèrè nípa àwọn ànfàní rẹ tàbí o ní láti gbé ìgbésẹ̀ kan ní ọjọ́ kan pàtó, pe nọ́mbà tí a pèsè fún ìpínlẹ̀ rẹ tàbí agbègbè láti bá ògbùfọ̀ kan sọ̀rọ̀.

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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.

"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 in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"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.

You're 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. 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 never 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.
- Base what you owe the provider or facility (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 out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the federal No Surprises Help Desk at 1-800-985-3059.

Visit *cms.gov/nosurprises/consumers* for more information about your rights under federal law.

PHI Disclosure Form

PLEASE RETURN THIS COMPLETED FORM TO:
Office of Clinical Management
The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016
(Confidential Fax: 212-251-8891)

AUTHORIZATION
FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. ***INDIVIDUAL AUTHORIZING USE OR DISCLOSURE***

____
____
____

[Print name and address of individual who is the subject of the information.]

2. ***HEALTH PLAN(S) SPONSORED BY CHURCH PENSION GROUP SERVICES CORPORATION MAINTAINING THE RECORDS THAT ARE TO BE USED OR DISCLOSED (each Health Plan)***

____
____
____

[Print name and address of each health plan or other specific description.]

3. ***DESCRIPTION OF PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED****

____
____
____
____
____

[Specifically describe the information to be used or disclosed. Include meaningful details such as date of service, type of service provided, level of detail to be released, origin of information, etc. Attach additional sheets, if necessary.]

***IMPORTANT NOTE: Unless the authorization is expressly limited, this authorization grants the Health Plan(s) the right to use or disclose ALL of the protected health information identified, including information about any diagnosis or treatment for any medical health, substance abuse, infectious disease (such as HIV/AIDS), cancer, mental health and/or genetic condition, for the purposes described.**

4. ***PERSON(S) TO WHOM INFORMATION MAY BE DISCLOSED***

____
____
____

[Print name of individuals or organizations to receive information, if any.]

5. ***PURPOSE OF AUTHORIZATION TO USE OR DISCLOSE***

____
____
____
____

[List specific purposes here.]

6. DURATION OF AUTHORIZATION

____

____

____

[Specify when authorization will expire by listing (1) a date or (2) an event that relates to the patient or the purpose of the use or disclosure.]

7. TO REVOKE THIS AUTHORIZATION, CONTACT:

Office of Clinical Management
The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016
(Confidential Fax: 212.251.8891)

8. AUTHORIZATION AND ACKNOWLEDGEMENT OF PRIVACY RIGHTS

I authorize the Health Plan or Plans identified in item 2 to use and/or disclose the protected health information, as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, described in item 3 to the persons listed in item 4 for the purposes described in item 5. This authorization shall remain in force and effect until the date or event specified in item 6 unless I furnish written notice of revocation to the person specified in item 7.

I understand that:

- *a revocation is not effective to the extent that the parties named in this authorization have relied on the use or disclosure of the protected health information prior to the receipt of the revocation;*
- *information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law; and*
- *my health care provider(s) and health plan(s) may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure, except in certain circumstances. For example, if the purpose of a test or exam is to produce a record for my employment, I may be required to complete this authorization form before the test or exam is performed.*

______________________________________ ________________

Signature of Individual or Personal Representative *Date*

If a personal representative is signing the form on behalf of the individual whose protected health information is to be used or disclosed, please print the name of the personal representative and describe their authority to act on behalf of the individual.

____

*[Name of Personal Representative]**

____

____

[Authority of Personal Representative]

**Personal representative includes:*

- *Person who (1) has health care power of attorney, or (2) is the parent or legal guardian of a minor.*
- *If you are not (1) or (2) above, identify your relationship to the individual and your involvement in the individual's health care. The Plan Sponsor will determine whether disclosure to you is in the best interest of the individual.*

Note to Individual: The decision of whether to accept this authorization is made solely by the person or entity whom you are authorizing to disclose information.

For More Information

Here are some additional resources, should you have any questions after reviewing all of the information in this Plan Document Handbook.

THE EPISCOPAL CHURCH MEDICAL TRUST
cpg.org
800-480-9967
e-mail: *mtcustserv@cpg.org*
(Monday through Friday, 8:30 AM to 8:00 PM ET)

KAISER PERMANENTE
my.kp.org/ecmt

Colorado: 877-883-6698
Georgia: 866-800-1486
Mid-Atlantic States: 877-740-4117
Northwest: 866-800-3402
Northern California: 800-663-1771
Southern California: 800-533-1833
Washington 877-721-2199

TTY: 877-870-0283

(Monday through Friday, 7:00 AM to 9:00 PM ET)

EYEMED VISION CARE
eyemedvisioncare.com
866-723-0513
(Monday through Saturday, 8:00 AM to 11:00 PM ET, and Sunday, 11:00 AM to 8:00 PM ET)

CIGNA EMPLOYEE ASSISTANCE PROGRAM (EAP)
mycigna.com
866-395-7794
(24 hours a day, 7 days a week)

HEALTH ADVOCATE
healthadvocate.com/ecmt
866-695-8622
(24 hours a day, 7 days a week)
Normal business hours are Monday through Friday, 8:00 AM to 9:00 PM ET

UNITEDHEALTHCARE GLOBAL ASSISTANCE
members.uhcglobal.com
+1 410-453-6330 (collect calls accepted)
(24 hours a day, 7 days a week)

Church Pension Group Services Corporation ("CPGSC"), doing business as The Episcopal Church Medical Trust (the "Medical Trust"), maintains a series of health and welfare plans (the "Plans") for eligible employees (and their eligible dependents) of The Episcopal Church. The Medical Trust serves only eligible Episcopal employers. The Plans that are self-funded are funded by the Episcopal Church Clergy and Employees' Benefit Trust (the "ECCEBT"), a voluntary employees' beneficiary association within the meaning of Section 501(c)(9) of the Internal Revenue Code.

This Plan Document Handbook should not be viewed as an offer of coverage, or investment, tax, medical or other advice. By participating in and accepting benefits from the Plan, you agree to the terms of the Plan set forth in this Plan Document Handbook.

The Plan, and this Plan Document Handbook, are governed by, and the rights and obligations of the Medical Trust, the ECCEBT, KPIC, the Members and any person who is, or claims to be, eligible for participation in the Plan, shall be interpreted, construed and enforced in accordance with, the laws of the State of New York without regard to the conflict of law principles thereof.

The Church Pension Fund and its affiliates, including but not limited to CPGSC and the ECCEBT (collectively, "CPG"), retain the right to amend, terminate or modify the terms of the Plans, as well as any post-retirement health subsidy, at any time, for any reason and unless required by applicable law, without notice.

The Plans are church plans within the meaning of Section 3(33) of the Employee Retirement Income Security Act of 1974, as amended, and Section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States or outside the United States, and not all Plans are available on both a self-funded and fully insured basis. Additionally, the Plan may be exempt from federal and state laws that may otherwise apply to health insurance arrangements. The Plans do not cover all healthcare expenses, so Members should read this Plan Document Handbook carefully to determine which benefits are covered, as well as any applicable exclusions, limitations and procedures.

For purposes of determining the status of a Plan under state insurance laws, each Plan is deemed to be sponsored by a single employer under the Church Plan Parity and Entanglement Prevention Act.

CPG does not provide any healthcare services and therefore cannot guarantee any results or outcomes. Healthcare providers and vendors are independent contractors in private practice and are neither employees nor agents of CPG. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.