



guide to

**YOUR 2018 BENEFITS
AND SERVICES**



kaiserpermanente.org

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

**GROUP
EVIDENCE OF COVERAGE**

MARYLAND

SIGNATURE CARE DELIVERY SYSTEM



This plan has Excellent accreditation from the NCQA
See 2018 NCQA Guide for more information on Accreditation



KAISER PERMANENTE®

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

IMPORTANT INFORMATION ABOUT YOUR PLAN

Under current IRS rules for high deductible health plans (HDHPs), only preventive care benefits can be provided without a deductible. Maryland law requires all plans to cover male sterilization without a deductible, but the IRS does not list male sterilization as one of the preventive care benefits for HDHPs. The Maryland Insurance Administration is aware of this issue and has sought clarification from the IRS. If you fund an HSA with this plan, you may be subject to tax penalties if the IRS does not recognize male sterilization as a preventive care benefit. Please contact your tax professional if you have further questions.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call **1-800-777-7902** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

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

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-777-7902** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**)።

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**).

Bàsòò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̀ Bàsòò-wùdù-po-nyò jũ ní, níí, à wùdù kà kò d̀ò po-poò b́éin m̀ gbo kpáa. Đá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-777-7902** (TTY: **711**)।

中文 (Chinese) 注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-777-7902** (TTY: **711**)。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: 711) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: 711).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-777-7902** (TTY: 711).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: 711).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: 711).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: 711) पर कॉल करें।

Igbo (Igbo) NRUBAMA: O bụrụ na i na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dijiri gi. Kpọọ **1-800-777-7902** (TTY: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (TTY: 711).

日本語 (Japanese) 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-777-7902** (TTY: 711) まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-777-7902** (TTY: 711) 번으로 전화해 주십시오.

Naabeehó (Navajo) D77 baa ak0 n7n7zin: D77 saad bee yln7[ti'go Diné Bizaad, saad bee 1kl'ln7da'lwo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih **1-800-777-7902** (TTY: 711.)

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: 711).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: 711).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (TTY: 711).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-777-7902** (TTY: 711).

ไทย (Thai) เรียน: ถ้าวัดคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: 711).

اردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں **1-800-777-7902** (TTY: 711)۔

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-777-7902** (TTY: 711).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-777-7902** (TTY: 711).

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Definitions

YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

SECTION 1: INTRODUCTION

This Evidence of Coverage (EOC) describes Kaiser Permanente SignatureSM health care coverage provided under the Agreement between Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and your Group. In this EOC, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. is sometimes referred to as “Health Plan,” “we” or “us.” Members are sometimes referred to as “you.” Some capitalized terms have special meanings in this EOC. Please see the Definitions Appendix of this EOC for terms you should know.

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

The Health Plan provides health care Services directly to its Members through an integrated medical care system, rather than reimburse expenses on a fee-for-service basis. The EOC should be read with this direct-service nature in mind. Under our Agreement with your Group, we have assumed the role of a named fiduciary, which is a party responsible for determining whether you are entitled to benefits under this EOC. Also, as named fiduciary, we have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC.

IF YOU ARE ENROLLED IN A HEALTH SAVINGS ACCOUNT QUALIFIED PLAN

The health care coverage described in this Agreement has been designed to be a High Deductible Health Plan (HDHP) qualified for use with a Health Savings Account (HSA). An HSA is a tax-exempt account established under Section 223(d) of the Internal Revenue Code for the exclusive purpose of paying current and future qualified medical expenses. Contributions to such an account are tax deductible, but in order to qualify for and make contributions to an HSA, you must be enrolled in a qualified HDHP.

Enrollment in a HSA-qualified HDHP is only one of the eligibility requirements for establishing and contributing to an HSA. Other requirements include that you must not be:

1. Covered by another health plan (for example, through your Spouse’s employer) that is not also an HSA-qualified plan, with certain exceptions;
2. Enrolled in Medicare; and/or
3. Able to be claimed as a dependent on another person’s tax return.

Please note that the tax references contained in this document relate to federal income tax only. The tax treatment of HSA contributions and distributions under your state’s income tax laws may differ from the federal tax treatment, and differs from state to state. Kaiser Permanente does not provide tax advice. Contact your financial or tax advisor for more information about your eligibility for an HSA or to obtain tax advice.

IF YOU ARE ENROLLED IN A KAISER PERMANENTE DEDUCTIBLE HMO PLAN WITH HEALTH REIMBURSEMENT ARRANGEMENT

The health care coverage described in this Agreement has been designed as a health benefit plan for Members with an employer-sponsored health reimbursement arrangement, a non-federally qualified health benefit plan. Your Group plan administrator will provide you with information about your health reimbursement arrangement, including the amount of your funds, how to access your funds and the specific expenses for which the funds may be used.

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KAISER PERMANENTE SIGNATURESM

Kaiser Permanente SignatureSM provides health care benefits to Members using Plan Providers located in our Plan Medical Centers and through affiliated Plan Providers located throughout our Service Area, which is described in the Definitions Appendix of this EOC.

To make your health care easily accessible, the Health Plan provides conveniently located Plan Medical Centers and medical offices throughout the Washington, DC and Baltimore Metropolitan Areas. We have placed an integrated team of specialists, nurses and technicians alongside our network physicians; all working together at our state-of-the-art Plan Medical Centers. Additionally, we include pharmacy, optical, laboratory and X-ray facilities at most of our Plan Medical Centers.

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

1. Emergency Services;
2. Urgent Care Services outside of our Service Area;
3. Authorized Referrals; and
4. Covered Services received in other Kaiser Permanente Regions or Group Health Cooperative Service Areas.

Through our medical care system, you have convenient access to all of the covered health care Services you may need, such as routine care with your own Plan Physician, hospital care, nurses, laboratory and pharmacy Services and supplies, and other benefits described in Section 3: Benefits.

WHO IS ELIGIBLE

General

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

1. Your Group's eligibility requirements that we have approved (your Group is required to inform Subscribers of the Group's eligibility requirements) and meet the Subscriber or Dependent eligibility requirements below.
2. Live or work in our Service Area (our Service Area is described in the Definitions Appendix).

However, you or your Spouse's or Domestic Partner's eligible children who live outside our Service Area are eligible for coverage for certain limited Services. Specifically, coverage is limited to only Emergency Services and Urgent Care Services provided outside of our Service Area, and Services received in connection with an approved referral, unless you elect to bring the Dependent within our Service Area to receive covered Services from Plan Providers.

3. You may not enroll under this EOC until you pay all amounts owed by you and your Dependents if you were ever a Subscriber in this or any other plan who had entitlement to receive Services through us terminated for failure:
 - a. Of you or your Dependent to pay any amounts owed to us, Kaiser Foundation Hospitals, or Medical Group;
 - b. To pay your Cost Share to any Plan Provider; and/or
 - c. To pay non-group Premium.

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Subscribers

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

Dependents

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

1. Your Spouse or Domestic Partner;
2. Your or your Spouse's or Domestic Partner's child who is under the age limit specified in the Summary of Services and Cost Shares section of the Appendix, including:
 - a. A natural child,
 - b. A stepchild,
 - c. An adopted child,
 - d. A grandchild of the Subscriber or Subscriber's Spouse or Domestic Partner, who is:
 - i. Unmarried;
 - ii. Is in the court-ordered custody of the Subscriber;
 - iii. Resides with the Subscriber;
 - iv. Is the dependent of the Subscriber; and has not attained the limiting age under the terms of the policy or contract;
3. A child who is: (a) under the testamentary or court-appointed guardianship, other than temporary guardianship of less than twelve (12) months duration, of the Subscriber or Subscriber's Spouse or Domestic Partner, (b) resides with the Subscriber and (c) is a dependent of the Subscriber or the Subscriber's Spouse or Domestic Partner; or
4. A child for whom the Subscriber or Subscriber's Spouse or Domestic Partner has received a child support order or other court order.

Currently enrolled Dependents who meet the Dependent eligibility requirements, except for the age limit, may be eligible as a disabled dependent if they meet all of the following requirements:

1. They are incapable of self-sustaining employment because of a mental or physical incapacity that occurred prior to reaching the age limit for Dependents;
2. They receive 50 percent or more of their support from you or your Spouse or Domestic Partner; and
3. You provide us proof of their incapacity and dependency at the time that the individual has been certified as a disabled dependent. (See the "Disabled Dependent Certification" section, immediately below, for additional eligibility requirements).

Disabled Dependent Certification

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

1. If your Dependent is incapacitated, we require you to provide your Dependent's documentation of his or her incapacity and dependency at the time that the individual reaches the dependent age

YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

limit. Upon receipt of the documentation, we will determine if the individual is eligible as a disabled Dependent.

2. If we determine that your Dependent does not meet the eligibility requirements as a disabled Dependent, we will notify you that he or she is not eligible and let you know the membership termination date.
3. If we determine that your Dependent is eligible as a disabled Dependent, there will be no lapse in coverage. Also, beginning two (2) years after the date that your Dependent reached the age limit, you must provide us documentation of his or her incapacity and dependency annually within sixty (60) days after we request it so that we can determine if he or she continues to be eligible as a disabled Dependent. Documentation of your Dependent's incapacity and dependency may be requested less than once per year; however, such documentation must be provided within sixty (60) days after we request it.

Genetic Information

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

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

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Membership begins at 12 a.m. ET (the time at the location of the administrative office of Health Plan at 2101 East Jefferson Street, Rockville, Maryland 20852) on the membership effective date. Eligible individuals may enroll as follows:

New Employees and Their Dependents

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within thirty-one (31) days after you become eligible. Check with your Group to see when new employees become eligible.

Your Group shall notify its employees and their enrolled dependents of their effective date of membership if such date is different than the effective date of the Group Agreement as specified on the Face Sheet, or is different than the dates specified under "Special Enrollment Due to New Dependents," below.

Special Enrollment

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

1. You become eligible as described in this "Special enrollment" section.
2. You did not enroll when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is no later than the 1st day

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of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application from the Subscriber.

Special enrollment due to new Dependents

You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, within thirty-one (31) days after marriage, Domestic Partnership, birth, adoption, or placement for adoption by submitting to your Group a Health Plan-approved enrollment application.

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

1. **For new Spouse or Domestic Partner**, no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber.
2. **For newborn children, the moment of birth.** If payment of additional Premium is required to provide coverage for the newborn child then, in order for coverage to continue beyond thirty-one (31) days from the date of birth, notification of birth and payment of additional Premium must be provided within thirty-one (31) days of the date of birth, otherwise coverage for the newborn will terminate thirty-one (31) days from the date of birth.
3. **For children, stepchildren, grandchildren, or adopted children who become eligible through Subscriber’s marriage, the date of the marriage.** If payment of additional Premium is required to provide coverage for the child(ren) then, in order for coverage to continue beyond thirty-one (31) days from the date of eligibility, notification of eligibility and payment of additional Premium must be provided within thirty-one (31) days of the date of eligibility, otherwise coverage for the newly eligible child(ren) will terminate thirty-one (31) days from the date of eligibility.
4. **For children, stepchildren, grandchildren, or adopted children who become eligible through Subscriber’s new Domestic Partner arrangement, the date of the signed Affidavit of Domestic Partnership.** If payment of additional Premium is required to provide coverage for the child(ren) then, in order for coverage to continue beyond thirty-one (31) days from the date of eligibility, notification of eligibility and payment of additional Premium must be provided within thirty-one (31) days of the date of eligibility, otherwise coverage for the newly eligible child(ren) will terminate thirty-one (31) days from the date of eligibility.
5. **For newly adopted children (including children newly placed for adoption),** the “date of adoption.” The “date of adoption” means the earlier of: (1) a judicial decree of adoption, or (2) the assumption of custody or placement with the Subscriber or Subscriber’s Spouse or Domestic Partner, pending adoption of a prospective adoptive child by a prospective adoptive parent.

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

6. **For a newly eligible grandchild, the date the grandchild is placed in your or your Spouse’s or Domestic Partner’s custody.** If payment of additional Premium is required to provide

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coverage for the child then, in order for coverage to continue, notification of the court ordered custody and payment of additional Premium must be provided within thirty-one (31) days of the date of the court ordered custody, otherwise coverage terminates thirty-one (31) days from the date of the court ordered custody.

7. **For children who are newly eligible for coverage as the result of guardianship granted by court or testamentary appointment, the date of court or testamentary appointment.** If payment of additional Premium is required to provide coverage for the child, notification of the court or testamentary appointment may be provided at any time but, payment of Premium must be provided within thirty-one (31) days of the enrollment of the child, otherwise, enrollment of the child terminates thirty-one (31) days from the date of court or testamentary appointment.

Special Enrollment due to court or administrative order

If you are enrolled as a Subscriber and you are required under a court or administrative order to provide coverage for a Dependent child, you may enroll the child at any time pursuant to the requirements specified by §15-405(f) of the Maryland Insurance Article. You must submit a Health Plan-approved enrollment application along with a copy of the order to your employer.

If you are not enrolled at the time we receive a court or administrative order to provide coverage for a Dependent child, we shall enroll both you and the child, without regard to any enrollment period restrictions, pursuant to the requirements and time periods specified by §15-405(f) and (g) of the Maryland Insurance Article.

The membership effective date for children who are newly eligible for coverage as the result of a court or administrative order received by you or your Spouse or Domestic Partner, will be the date specified in the court or administrative order.

If payment of additional Premium is required to provide coverage for the child, notification of the court or administrative order may be provided at any time but, payment of additional Premium must be provided within thirty-one (31) days of enrollment of the child, otherwise, enrollment of the child will be void. Enrollment for such child will be allowed in accordance with Section 15-405(c) of the Insurance Article which provides for the following:

1. An insuring parent is allowed to enroll in family member's coverage and include the child in that coverage regardless of enrollment period restrictions;
2. A non-insuring parent, child support agency, or Department of Health and Mental Hygiene is allowed to apply for health insurance coverage on behalf of the child and include the child in the coverage regardless of enrollment period restrictions; and
3. The Health Plan may not terminate health insurance coverage for a child eligible under this subsection unless written evidence is provided that the:
 - a. Court or administrative order is no longer in effect;
 - b. Child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;
 - c. Employer has eliminated family member's coverage for all of its employees; or
 - d. Employer no longer employs the insuring parent, except the parent elects to enroll in COBRA, coverage shall be provided for the child consistent with the employer's plan for postemployment health insurance coverage for dependents.

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Special enrollment due to loss of other coverage

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

1. The Subscriber or at least one (1) of the Dependents had other coverage when he or she previously declined Health Plan coverage;
2. The loss of the other coverage is due to one of the following:
 - a. Exhaustion of COBRA coverage;
 - b. Termination of employer contributions for non-COBRA coverage; however the special enrollment period is still applicable even if the other coverage continues because the enrolling person is paying the amounts previously paid by the employer;
 - c. Loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (non-group) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, reaching the age limit for dependent children, or the Subscriber's death, termination of employment, or reduction in hours of employment;
 - d. Loss of eligibility for Medicaid coverage or Child Health Insurance Program (CHIP) coverage, but not termination for cause; or
 - e. Reaching a lifetime maximum on all benefits.

Note: If you are enrolling yourself as a Subscriber along with at least one (1) eligible Dependent, only one (1) of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Health Plan-approved enrollment or change of enrollment application to your Group within thirty-one (31) days after loss of other coverage, except that the timeframe for submitting the application is sixty (60) days if you are requesting enrollment due to loss of eligibility for Medicaid or CHIP coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the 1st day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special enrollment due to reemployment after military service

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

Special enrollment due to eligibility for premium assistance under Medicaid or CHIP

You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, if the Subscriber or at least one of the enrolling Dependents becomes eligible to receive premium assistance under Medicaid or CHIP. To request enrollment, the Subscriber must submit a Health Plan-approved enrollment or change of enrollment application to your Group within sixty (60) days after the Subscriber or Dependent is determined eligible for premium assistance. The effective date of an enrollment resulting from eligibility for the premium assistance under Medicaid or CHIP is no later than the 1st day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

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OPEN ENROLLMENT

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

PREMIUM

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

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SECTION 2: HOW TO OBTAIN SERVICES

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

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

1. Emergency Services, in Section 3: Benefits;
2. Urgent Care Outside our Service Area, in Section 3: Benefits;
3. Continuity of Care for New Members as described in this section;
4. Approved Referrals, as described in this section under “Getting a Referral,” including referrals for Clinical Trials as described in Section 3: Benefits; and
5. Authorized Referrals.

YOUR PRIMARY CARE PLAN PHYSICIAN

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

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

You may also access our Provider Directory online at: www.kp.org

To learn how to choose or change your primary care Plan Physician, contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

CONTINUITY OF CARE FOR NEW MEMBERS

At the request of a new member, or a new member’s parent, guardian, designee or health care provider, the Health Plan shall:

1. Accept a preauthorization issued by the member’s prior carrier, managed care organization or third party administrator; and
2. Allow a new enrollee to continue to receive health care Services being rendered by a non-Plan provider at the time of the member’s enrollment under this Agreement. If this Agreement is an Added Choice Point of Service (POS) plan the cost share will be covered at the In-Plan level as shown in the Summary of Services and Cost Shares.

As described below, the Health Plan will accept the preauthorization; and allow a new member to continue to receive Services from a non-Plan Provider for:

1. The lesser of the course of treatment or ninety (90) days; and
2. The duration of up to three trimesters of a pregnancy and the initial postpartum visit.

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GETTING A REFERRAL

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

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

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

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

1. The initial consultation for treatment of mental illness, emotional disorders, drug or alcohol abuse provided by a Plan Provider. Contact the Behavioral Health Access Unit at 1-866-530-8778.
2. Obstetric and gynecological Services provided by an obstetrician/gynecologist, a certified nurse-midwife, or any other Plan Provider authorized to provide obstetric and gynecological Services, if the care is Medically Necessary, including routine care and the ordering of related obstetrical and gynecological Services that are covered under the Agreement;
3. Optometry Services; and
4. Urgent Care Services provided within our Service Area.

For the most up-to-date list of Plan Medical Centers and other Plan Providers, visit our website at www.kp.org. To request a provider directory, please contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

STANDING REFERRALS TO SPECIALISTS

If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires specialized health care Services or medical care, your primary care Plan Physician may determine, in consultation with you and the specialist, that you need continuing care from the specialist. In such instances, your primary care Plan Physician will issue a standing referral to the specialist.

The standing referral shall be made in accordance with a written treatment plan for covered Services developed by the specialist, your primary care Plan Physician and you. The treatment plan may limit the number of visits to the specialist; limit the period of time in which visits to the specialist are authorized; and require the specialist to communicate regularly with your primary care Plan Physician regarding the treatment and your health status.

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REFERRALS TO NON-PLAN SPECIALISTS AND NON-PLAN NON-PHYSICIAN SPECIALISTS

A Member may request a referral to a non-Plan specialist or a non-Plan Non-Physician Specialist, if:

1. The Member has been diagnosed with a condition or disease that requires specialized health care Services or medical care; and
2. The Health Plan does not have a Plan specialist or a Non-Physician Specialist with the professional training and expertise to treat or provide health care Services for the condition or disease; or
3. Health Plan cannot provide reasonable access to a specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care Services for the condition or disease without unreasonable delay or travel.

You must have an approved oral or written referral to the non-Plan specialist or non-Plan Non-Physician Specialist in order for us to cover the Services. Any additional radiology studies, laboratory Services or Services from any professional who is not named in the referral are not authorized and will not be reimbursed. If the non-Plan Provider recommends Services not indicated in the approved referral, your primary care Plan Physician will work with you to determine whether those Services can be provided by a Plan Provider. Copayments, Coinsurance and Deductibles for approved referral Services are the same as those required for Services provided by a Plan Provider.

SECOND OPINIONS

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

GETTING THE CARE YOU NEED: EMERGENCY SERVICES, URGENT CARE, AND ADVICE NURSES

If you think you are experiencing an Emergency Medical Condition, call 911 (where available) or go to the nearest emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition we cover Emergency Services you receive from Plan Providers or Non-Plan Providers anywhere in the world, as long as the Services would have been covered under the Section 3: Benefits, subject to Section 4: Exclusions, Limitations, and Reductions.

Emergency Services are available from Plan Hospital emergency departments twenty-four (24) hours a day, seven (7) days a week.

Getting Advice from our Advice Nurses

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

Inside the Washington, DC Metropolitan Area: (703) 359-7878

Outside of the Washington, DC Metropolitan Area: 1-800-777-7904

711 (TTY)

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

Our advice nurses are registered nurses (RNs) specially trained to help assess medical problems and provide medical advice. They can help solve a problem over the phone and instruct you on self-care at

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home if appropriate. If the problem is more severe and you need an appointment, they will help you to get one.

MAKING APPOINTMENTS

When scheduling appointments it is important to have your identification card handy. If your primary care Plan Physician is located in a Plan Medical Center, please contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

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

USING YOUR IDENTIFICATION CARD

Each Member has a Health Plan ID card with a Medical Record Number on it to use when you call for advice, make an appointment, or go to a Plan Provider for care. The Medical Record Number is used to identify your medical records and membership information. You should always have the same Medical Record Number. If you need to replace your card, or if we ever inadvertently issue you more than one Medical Record Number, please let us know by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

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

MOVING TO ANOTHER KAISER PERMANENTE REGION OR GROUP HEALTH COOPERATIVE SERVICE AREA

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

PAYMENT TOWARD YOUR COST SHARE AND WHEN YOU MAY BE BILLED

In most cases, you will be asked to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services (such as Primary Care treatment and laboratory tests), you may be required to pay separate Cost Shares for each of those Services. In some cases, your provider may not ask you to make a payment at the time you receive Services and you may be billed for your Cost Share.

Keep in mind that your payment toward your Cost Share may cover only a portion of your total Cost Share for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay Cost Share amounts in addition to the amount you pay at check-in:

1. **You receive non-preventive Services during a preventive visit.** For example, you go in for a routine physical exam, and at check-in you pay your Cost Share for the preventive exam (your

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Cost Share may be "no charge"). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory tests). You may be asked to pay your Cost Share for these additional non-preventive diagnostic Services.

2. **You receive diagnostic Services during a treatment visit.** For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay your Cost Share for these additional diagnostic Services.
3. **You receive treatment Services during a diagnostic visit.** For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay your Cost Share for these additional treatment Services.
4. **You receive non-preventive Services during a no-charge courtesy visit.** For example, you go in for a blood pressure check or meet and greet visit and the provider finds a problem with your health and performs diagnostic or treatment Services. You may be asked to pay your Cost Share for these additional diagnostic or treatment Services.
5. **You receive Services from a second provider during your visit.** For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay your Cost Share for the consultation with the specialist.

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SECTION 3: BENEFITS

The Services described in this section are covered only when:

1. You are a Member on the date the Services are rendered, except as provided for “Extension of Benefits” as described in Section 6: Termination of Membership;
2. You have met any Deductible requirement described in the "Deductibles" section of the Summary of Services and Cost Shares Appendix;
3. You have not met the maximum benefit for the Service, if any. A maximum benefit applies per Member per contract year;
4. The Services are Medically Necessary; and
5. You receive the Services from a Plan Provider, except as specifically described within this EOC.

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

1. Emergency Services, as described in this section;
2. Urgent Care outside our Service Area, as described in this section;
3. Continuity of Care for New Members, as described in Section 2: How to Obtain Services; and
4. Authorized referrals to non-Plan Providers, as described in Section 2: How to Obtain Services under “Getting a Referral,” including referrals for Clinical Trials as described in this section.

Exclusions and Limitations: Exclusions and limitations that apply only to a particular benefit are described in this section. Other exclusions, limitations and reductions that affect benefits are described in Section 4: Exclusions, Limitations and Reductions and the Summary of Services and Cost Shares Appendix.

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

A. OUTPATIENT CARE

We cover the following outpatient care for preventive medicine, diagnosis and treatment:

1. Primary care visits for internal medicine, family practice, pediatrics and routine preventive obstetrics and gynecology Services. (Refer to “Preventive Health Care Services” for coverage of preventive care Services);
2. Specialty care visits. (Refer to Section 2: How to Obtain Services for information about referrals to Plan specialists);
3. Consultations and immunizations for foreign travel;
4. Diagnostic testing for care or treatment of an illness, or to screen for a disease for which you have been determined to be at high risk for contracting, including, but limited not to:
 - a. Diagnostic examinations, including digital rectal exams and prostate antigen (PSA) tests provided:
 - i. For men who are between 40 and 75 years of age;
 - ii. When used for male patients who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society;
 - iii. When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; or
 - iv. When used for staging in determining the need for a bone scan in patients with prostate

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cancer.

5. Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances, radiological imaging, for persons who are at high risk of cancer in accordance with the most recently published guidelines of the American Cancer Society;
6. Bone mass measurement for the prevention, diagnosis and treatment of osteoporosis is provided when the bone mass measurement is requested by a health care provider for a qualified individual. A “qualified individual” means an individual:
 - a. Who is estrogen deficient and at clinical risk for osteoporosis;
 - b. With a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
 - c. Receiving long-term glucocorticoid (steroid) therapy;
 - d. With primary hyperparathyroidism; or
 - e. Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
7. Outpatient surgery;
8. Anesthesia, including Services of an anesthesiologist;
9. Respiratory therapy;
10. Medical social Services;
11. House calls when care can best be provided in your home as determined by a Plan Provider;
12. After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to the Urgent Care provision for covered Services; and
13. Smoking cessation counseling program.

Note: As described here, diagnostic testing is not preventive care and may include an office visit, outpatient surgery, diagnostic imaging, or x-ray and lab. The applicable Cost Share will apply based on the place and type of Service provided.

Refer to “Preventive Health Care Services” for coverage of preventive care tests and screening Services.

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

B. HOSPITAL INPATIENT CARE

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

1. Room and board (includes bed, meals and special diets), including private room when deemed Medically Necessary);
2. Specialized care and critical care units;
3. General and special nursing care;
4. Operating and recovery room;
5. Plan Physicians’ and surgeons’ Services, including consultation and treatment by specialists;
6. Anesthesia, including Services of an anesthesiologist;
7. Medical supplies;

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8. Respiratory therapy; and
9. Medical social Services and discharge planning.

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

C. ACCIDENTAL DENTAL INJURY SERVICES

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

1. The accident has been reported to your primary care Plan Physician within seventy-two (72) hours of the accident;
2. A Plan Provider provides the restorative dental Services;
3. The injury occurred as the result of an external force that is defined as violent contact with an external object, not force incurred while chewing;
4. The injury was sustained to sound natural teeth;
5. The covered Services must begin within sixty (60) days of the injury; and
6. The covered Services are provided during the twelve (12) consecutive month period commencing from the date that treatment for the injury occurred.

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

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

Accidental Dental Injury Services Exclusions:

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

D. ALLERGY SERVICES

We cover the following allergy Services:

1. Evaluations and treatment; and
2. Injection visits and serum.

E. AMBULANCE SERVICES

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

Ambulance transportation from an emergency room to a Plan Facility or from a hospital to a Plan Facility

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that is both Medically Necessary and ordered by a Plan Provider is covered at no charge.

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

We will not cover emergency ambulance or ambulette (non-emergent transportation) Services in any other circumstances, even if no other transportation is available. We cover licensed ambulance and ambulette (non-emergent transportation) Services ordered by a Plan Provider only inside our Service Area, except as covered under the “Emergency Services” provision.

Ambulance Services Exclusions:

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

F. ANESTHESIA FOR DENTAL SERVICES

We cover general anesthesia and associated hospital or ambulatory facility Services for dental care provided to Members who are age:

1. 7 or younger or are developmentally disabled and for whom a:
 - a. Superior result can be expected from dental care provided under general anesthesia; and
 - b. Successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition.
2. 17 or younger who are extremely uncooperative, fearful or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred, and for whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity
3. 17 and older when the Member’s medical condition requires that dental Service be performed in a hospital or ambulatory surgical center for the safety of the Member (e.g., heart disease and hemophilia).

General anesthesia and associated hospital and ambulatory facility charges will be covered only for dental care that is provided by a fully accredited specialist for whom hospital privileges have been granted.

Anesthesia for Dental Services Exclusions:

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

G. BLOOD, BLOOD PRODUCTS AND THEIR ADMINISTRATION

We cover blood and blood products, both derivatives and components, including the collection and storage of autologous blood for elective surgery, as well as cord blood procurement and storage for approved Medically Necessary care, when authorized by a Plan Provider. The administration of blood and blood products are also covered.

In addition, benefits shall be provided for the purchase of blood products and blood infusion equipment

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required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.

Blood, Blood Products and their Administration Limitations:

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

Blood, Blood Products and their Administration Exclusions:

- Directed blood donations.

H. CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES

Mental Illness, Emotional Disorders, Drug and Alcohol Abuse Services

We cover the treatment of mental illnesses, emotional disorders, drug abuse and alcohol abuse for conditions that in the opinion of a Plan Provider would be Medically Necessary and treatable. For the purposes of this benefit provision, drug and alcohol abuse means a disease that is characterized by a pattern of pathological use of a drug and/or alcohol with repeated attempts to control its use and with significant negative consequences in at least one the following areas of life: medical, legal, financial or psycho-social.

We cover inpatient in a licensed or certified facility or program, including a licensed or certified residential treatment center. Covered Services include all medical Services of physicians and other health professionals as performed, prescribed or directed by a Physician including, but not limited to:

1. Individual therapy;
2. Group therapy;
3. Shock therapy;
4. Drug therapy;
5. Education;
6. Psychiatric nursing care; and
7. Appropriate hospital Services.

Medical Services for detoxification are limited to the removal of the toxic substance or substances from the system.

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

In an outpatient setting, we cover all Medically Necessary Services of physicians and other health care professionals to treat mental illness, emotional disorders, drug abuse and alcohol abuse, and opioid treatment Services as performed, prescribed or directed by a physician including, but not limited to:

1. Diagnostic evaluations;
2. Crisis intervention;
3. Individual therapy;
4. Group therapy;
5. Medication evaluation and management visits;
6. Psychological and neuropsychological testing for diagnostic purposes;

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7. Medical treatment for withdrawal symptoms; and
8. Visits for the purpose of monitoring drug therapy.

Chemical Dependency and Mental Health Services Exclusions:

- Services for Members who, in the opinion of the Plan Provider, are seeking services and supplies for other than therapeutic purposes.
- Psychological and neuropsychological testing for ability, aptitude, intelligence or interest.
- Services on court order or as a condition of parole or probation, unless determined by the Plan Provider to be necessary and appropriate.
- Evaluations that are primarily for legal or administrative purposes and are not Medically Necessary.

Psychiatric Residential Crisis Services

We cover residential crisis Services that are:

1. Provided to a Member with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the individual's ability to function in the community;
2. Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay;
3. Provided out of the Member's residence on a short-term basis in a community-based residential setting; and
4. Provided by entities that are licensed by the Department of Health and Mental Hygiene to provide residential crisis Services.

Psychiatric Residential Crisis Services Exclusion:

- Long-term residential treatment Services.

I. CLEFT LIP, CLEFT PALATE OR BOTH

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

J. CLINICAL TRIALS

We cover the patient costs you incur for clinical trials provided on an inpatient and an outpatient basis. "Patient costs" mean the cost of a Medically Necessary Service that is incurred as a result of the treatment being provided to the member for purposes of the clinical trial. "Patient costs" do not include:

1. The cost of an investigational drug or device, except as provided below for off-label use of an United States Food and Drug Administration (FDA) approved drug or device;
2. The cost of non-health care Services that may be required as a result of treatment in the clinical trial; or
3. Costs associated with managing the research for the clinical trial.

We cover Services received in connection with a clinical trial if all of the following conditions are met:

1. The Services would be covered if they were not related to a clinical trial;
2. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the

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following ways:

- a. A Plan Provider makes this determination;
 - b. You provide us with medical and scientific information establishing this determination;
3. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside of the state in which you live;
4. The clinical trial is a phase I, phase II, phase III or phase IV clinical trial related to the prevention, detection or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
- a. The study or investigation is approved or funded by at least one (1) of the following:
 - i. The National Institutes of Health;
 - ii. The Centers for Disease Control and Prevention;
 - iii. The Agency for Health Care Research and Quality;
 - iv. The Centers for Medicare & Medicaid Services;
 - v. A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs;
 - vi. The study or investigation is conducted under an investigational new drug application reviewed by the FDA;
 - vii. The study or investigation is a drug trial that is exempt from having an investigational new drug application;
 - viii. An institutional review board of an institution in the state which has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the National Institutes of Health;
 - ix. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
 - x. The Department of Veterans Affairs, Department of Defense or the Department of Energy; but only if the study or investigation has been reviewed and approved through a system of peer review that the United States Secretary of Health and Human Services determines meets all of the following requirements:
 - (a) It is comparable to the National Institutes of Health system of peer review of studies and investigations; and
 - (b) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.
5. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise;
6. There is no clearly superior, non-investigational treatment alternative; and
7. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.

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

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

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manufacturer, distributor or provider of that drug or device.

Clinical Trials Exclusions:

- The investigational Service.
- Services provided solely for data collection and analysis and that are not used in your direct clinical management.

K. DIABETIC EQUIPMENT, SUPPLIES, AND SELF-MANAGEMENT

We cover diabetes equipment, diabetes supplies, and in-person diabetes outpatient self-management training and educational Services, including medical nutrition therapy, when prescribed by a Plan Provider and purchased from a Plan preferred vendor, for the treatment of:

1. Insulin-using diabetes;
2. Insulin-dependent diabetes;
3. Non-insulin using diabetes; or
4. Elevated blood glucose levels induced by pregnancy, including gestational diabetes.

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

Diabetic Equipment, Supplies and Self-Management Limitation:

Diabetic equipment and supplies are limited to Health Plan preferred equipment and supplies unless the equipment or supply (1) was prescribed by a Plan Provider and (2) (a) there is no equivalent preferred equipment or supply available or (b) an equivalent preferred equipment or supply (i) has been ineffective in treating the disease or condition of the Member or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member. “Health Plan preferred equipment and supplies” are those purchased from a Plan preferred vendor. To obtain information about Plan preferred vendors, contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

L. DIALYSIS

If the following criteria are met, we cover dialysis Services related to acute renal failure and chronic end-stage renal disease (ESRD):

1. You satisfy all medical criteria developed by Medical Group and by the facility providing the dialysis;
2. The facility (when not provided in the home) is certified by Medicare; and
3. A Plan Physician provides a written referral for care at the facility.

We cover the following renal dialysis Services:

1. Outpatient maintenance dialysis treatments in a Plan dialysis facility. Coverage includes the cost of laboratory tests, equipment, supplies and other Services associated with your treatment;
2. Inpatient maintenance dialysis if you are admitted to a Plan Hospital because your medical condition requires specialized hospital Services on an inpatient basis; and
3. Plan Provider Services related to inpatient and outpatient dialysis.

We cover the following self-dialysis Services:

1. Training for self-dialysis including the instructions for a person who will assist you with self-dialysis;

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2. Services of the Plan Provider who is conducting your self-dialysis training; and
3. Retraining for use of new equipment for self-dialysis.

We cover home dialysis, which includes:

1. Hemodialysis;
2. Home intermittent peritoneal dialysis (IPD);
3. Home continuous cycling peritoneal dialysis (CCPD); and
4. Home continuous ambulatory peritoneal dialysis (CAPD).

Members requiring dialysis outside the Service Area for a limited time period, may receive pre-planned dialysis Services in accordance to prior authorization requirements.

M. DRUGS, SUPPLIES AND SUPPLEMENTS

We cover drugs, supplies and supplements during a covered stay in a Plan Hospital, Skilled Nursing Facility and outpatient settings, or if they require administration or observation by medical personnel and are administered to you in a Plan Medical Center or during a home health visit:

1. Oral, infused or injected drugs and radioactive materials used for therapeutic purposes, including chemotherapy. This includes off-label use of a drug when the drug is recognized in Standard Reference Compendia or certain medical literature as appropriate in the treatment of the diagnosed condition;
 - a. **Note:** If a drug covered under this benefit meets the criteria for a Specialty Drug, then the Member's cost for the drug will not exceed \$150 in accordance with §15-847 of the Insurance Article. If this benefit is subject to the Deductible, as shown in the Summary of Services and Cost shares, the Deductible must be met first.
 - b. **Note:** As permitted under §15-846 of the Insurance Article, oral chemotherapy drugs will be provided at the same or better level than intravenous or injectable chemotherapy drugs.
2. Injectable devices;
3. The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
4. Medical and surgical supplies including dressing, casts, hypodermic needles, syringes or any other Medically Necessary supplies provided at the time of treatment; and
5. Vaccines and immunizations approved for use by the FDA that are not considered part of routine preventive care.

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

Drugs, Supplies and Supplements Exclusions

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

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- Drugs for the treatment of infertility. Refer to Infertility Services for coverage of administered drugs necessary for in vitro fertilization.

N. DURABLE MEDICAL EQUIPMENT

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

Durable Medical Equipment does not include coverage for Prosthetic Devices, such as artificial eyes or legs or Orthotic Devices, such as braces or therapeutic shoes. Refer to “Prosthetic and Orthotic Devices” for coverage of Prosthetic and Orthotic Devices.

Basic Durable Medical Equipment

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

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

Note: Diabetes equipment and supplies are not covered under this section. Refer to “Diabetes Equipment, Supplies and Self-Management”

Supplemental Durable Medical Equipment

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

Oxygen and Equipment

We cover oxygen and equipment when prescribed by a Plan Provider and your medical condition meets Health Plan’s criteria for Medical Necessity. A Plan Provider must certify the continued medical need for oxygen and equipment.

Positive Airway Pressure Equipment

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

Apnea Monitors

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

Asthma Equipment

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

1. Spacers;
2. Peak-flow meters; and

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3. Nebulizers.

Bilirubin Lights

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

International Normalized Ratio (INR) Home Testing Machines

INR home testing machines when deemed Medically Necessary by a Plan Physician.

Durable Medical Equipment Exclusions:

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

O. EMERGENCY SERVICES

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

If you think you are experiencing an Emergency Medical Condition, you should call 911 immediately. If you are not sure whether you are experiencing an Emergency Medical Condition, please contact us at the number listed on the reverse side of your ID card for immediate medical advice. You or your representative should notify Health Plan as soon as possible, and not to exceed forty-eight (48) hours or the 1st business day, whichever is later, after you receive care at a hospital emergency room (ER) to ensure coverage, unless it was not reasonably possible to notify us within that time frame. If the emergency room visit was not due to an “Emergency Medical Condition,” as defined in the Definitions Appendix, and was not authorized by the Health Plan, you will be responsible for all charges.

We cover Emergency Services as follows:

Inside our Service Area:

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

Outside of our Service Area:

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

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

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Continuing Treatment Following Emergency Services

Inside our Service Area

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

Inside another Kaiser Permanente Region

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

Outside our Service Area

Except for Emergency Services received for emergency surgery described below, all other continuing or follow-up care for Emergency Services received outside our Service Area must be authorized by us, until you can safely return to the Service Area.

Continuing Treatment Following Emergency Surgery

If we authorize, direct, refer or otherwise allow you to access a hospital emergency facility or other urgent care facility for a medical condition that requires emergency surgery, we will reimburse the physician, oral surgeon, periodontist or podiatrist who performed the surgical procedure for follow-up care that is:

1. Medically Necessary;
2. Directly related to the condition for which the surgical procedure was performed; and
3. Provided in consultation with the Member's primary care Plan Physician.

We will not impose any Copayment or other cost-sharing requirement for follow-up care that exceeds that which you would be required to pay had the follow-up care been rendered by Plan Providers within our Service Area.

Transport to a Service Area

If you obtain prior approval from us, or from the nearest Kaiser Foundation Health Plan Medical Center, we will cover necessary ambulance Services or other special transportation arrangements medically required to transport you to a Plan Hospital or Medical Office in our Service Area, or in the nearest Kaiser Foundation Health Plan Region, for continuing or follow-up treatment.

Note: All ambulance transportation is covered under the "Ambulance Services" benefit in this section.

Continued Care in Non-Plan Facility Limitation

If you are admitted to a non-Plan Hospital, you or someone on your behalf must notify us within the later of forty-eight (48) hours of any hospital admission, or on the 1st business day following the admission, unless it was not reasonably possible to notify us within that time. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us, or if you choose not to be transferred, we will not cover any Services you receive after transfer would have been possible.

Filing Claims for Non-Plan Emergency Services

Keep all your receipts for Emergency Services provided by non-Plan Providers and verify that the non-Plan Provider has submitted the claims. All claims must be filed with us within one (1) year of receipt of covered Services. Failure to submit such a request within one (1) year of receipt of the covered Services will not invalidate or reduce the amount of the claim, if it was not reasonably possible to submit the request within the aforementioned time frame. If it is not reasonably possible to submit the claim within

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one (1) year after the date of service, it shall be sent to us no later than two (2) years from the time, proof is otherwise required. A Member's legal incapacity shall suspend the time to submit a claim. Such suspension period ends when legal capacity is regained.

Emergency Services Limitations:

- **Notification:** If you are admitted to a non-plan hospital, you, or someone on your behalf, should notify us as soon as possible, but not later than forty-eight (48) hours or the end of the 1st business day, whichever is later, after the hospital admission unless it was not reasonably possible to notify us. If you are admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us as provided herein, we will not cover the hospital care you receive after transfer would have been possible. If possible, we urge you or your authorized representative to notify us of any emergency room visits to assist you in coordinating any necessary follow-up care.
- **Continuing or Follow-up Treatment:** Except as provided for under "Continuing Treatment Following Emergency Surgery," we do not cover continuing or follow-up treatment after Emergency Services unless authorized by Health Plan. We cover only the out-of-Plan emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Permanente Region or Group Health Cooperative Service Area.
- **Hospital Observation:** Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit Copayment will not be waived.

P. FAMILY PLANNING SERVICES

We cover the following:

1. Women's Preventive Services (WPS), including:
 - a. Patient education and contraceptive method counseling for all women of reproductive capacity;
 - b. Coverage for FDA-approved contraceptive devices, hormonal contraceptive methods, the insertion or removal of contraceptive devices, including any Medically Necessary examination associated with the use of contraceptive drugs and devices;
 - c. Female sterilization;
Note: WPS are preventive care and are covered at no charge;
2. Additional family planning counseling, including pre-abortion and post-abortion counseling;
3. Male sterilization; and
4. Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (a) the fetus suffers from a chromosomal, major metabolic or anatomic defect or (b) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.

Note: Deductibles, Copayments and/or Coinsurances do not apply to male sterilization Services.

Voluntary Termination of Pregnancy Limitations:

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

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Note: Diagnostic procedures are not covered under this section, refer to “X-ray, Laboratory and Special Procedures” for coverage of diagnostic procedures and other covered Services.

Q. HABILITATIVE SERVICES

Children under age 19

We cover Medically Necessary Habilitative Services with no visit limits for children up until end of the month in which they turn age 19. Medically Necessary Habilitative Services are those Services and devices, including occupational therapy, physical therapy, and speech therapy that help a child keep, learn, or improve skills and functioning for daily living.

Medical Necessary Services to treat autism and autism spectrum disorders shall include Applied Behavioral Analysis (ABA).

Habilitative Services Exclusions:

- Services provided through federal, state or local early intervention programs, including school programs.
- Services not preauthorized by the Health Plan.
- Services for a Member that has plateaued and is able to demonstrate stability of skills and functioning even when Services are reduced.

R. HEARING SERVICES

Hearing Exams

We cover hearing tests to determine the need for hearing correction, when ordered by a Plan Provider. Refer to “Preventive Health Care Services” for coverage of newborn hearing screenings.

Hearing Aids for Children up until the end of the month they turn age 19

We cover one hearing aid for each hearing impaired ear every thirty-six (36) months.

A hearing aid is defined as a device that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children, and is non-disposable.

Hearing Services Exclusions:

Except as listed above for hearing aids, the following exclusions apply:

- Tests to determine an appropriate hearing aid.
- Hearing aids or tests to determine their efficacy; except as specifically provided in this section, or as provided under a “Hearing Services Rider,” if applicable.
- Replacement parts and batteries.
- Replacement of lost or broken hearing aids.
- Comfort, convenience or luxury equipment or features.

S. HOME HEALTH CARE

We cover the following home health care Services only within our Service Area, only if you are substantially confined to your home, and only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home:

1. Skilled nursing care;
2. Home health aide Services; and

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3. Medical social Services.

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

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

Home Health Visits Following Mastectomy or Removal of Testicle

We cover the cost of inpatient hospitalization Services for a minimum of forty-eight (48) hours following a mastectomy. A Member may request a shorter length of stay following a mastectomy if the Member decides, in consultation with the Member's attending physician that less time is needed for recovery.

For a Member who remains in the hospital for at least forty-eight (48) hours following mastectomy, we cover the cost of a home visit if prescribed by the attending physician. For Members undergoing a mastectomy or removal of a testicle on an outpatient basis, as well as Members who receive less than forty-eight (48) hours of inpatient hospitalization following the surgery, we cover the following:

1. One home visit scheduled to occur within twenty-four (24) hours following his or her discharge from the hospital or outpatient facility; and
2. One additional home visit, when prescribed by the patient's attending physician.

Home Health Care Limitations:

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

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

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

Home Health Care Exclusions:

- Custodial care (see definition under "Exclusions" in Section 4: Exclusions, Limitations and Reductions).
- Routine administration of oral medications, eye drops and/or ointments.
- General maintenance care of colostomy, ileostomy and ureterostomy.
- Medical supplies or dressings applied by a Member or family caregiver.
- Corrective appliances, artificial aids and orthopedic devices.
- Homemaker Services.
- Services not preauthorized by the Health Plan.
- Care that a Plan Provider determines may be provided in a Plan Facility and we provide or offer to provide that care in one of these facilities.
- Transportation and delivery service costs of Durable Medical Equipment, medications and drugs, medical supplies and supplements to the home.

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T. HOSPICE CARE SERVICES

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

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

1. Nursing care;
2. Physical, occupational, speech and respiratory therapy;
3. Medical social Services;
4. Home health aide Services;
5. Homemaker Services;
6. Medical supplies, equipment and medication required to maintain the comfort and manage the pain of the terminally ill Member;
7. Palliative drugs in accordance with our drug formulary guidelines;
8. Physician care;
9. Short-term inpatient care; including care for pain management and acute symptom management as Medically Necessary;
10. Respite Care for up to fourteen (14) days per contract year, limited to five (5) consecutive days for any one inpatient stay;
11. Counseling Services for the Member and his Family Members, including dietary counseling for the Member; and bereavement counseling for the Member's Family for a period of one (1) year after the Member's death; and
12. Services of hospice volunteers.

U. INFERTILITY SERVICES

We cover the following Services for diagnosis and treatment of involuntary infertility:

1. Artificial insemination; and
2. In vitro fertilization, if:
 - a. For a Member whose Spouse is of the opposite sex, the Member's oocytes are fertilized with the Member's spouse's sperm; unless:
 - i. The Spouse is unable to produce and deliver functional sperm; and the inability to produce and deliver functional sperm does not result from:
 - (a) A vasectomy; or
 - (b) Another method of voluntary sterilization;
 - b. The Member and the Member's spouse have a history of involuntary infertility, which may be demonstrated by a history of:
 - i. Intercourse of at least two (2) years' duration failing to result in pregnancy when the Member and the Member's Spouse are of opposite sexes; or
 - ii. If the Member and the Member's Spouse are of the same sex, six (6) attempts of artificial insemination over the course of two (2) years failing to result in pregnancy; or
 - c. The infertility is associated with any of the following:
 - i. Endometriosis;

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- ii. Exposure in utero to diethylstilbestrol, commonly known as DES;
 - iii. Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
 - iv. Abnormal male factors, including oligospermia, contributing to the infertility;
 - d. The Member has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this EOC; and
 - e. The in vitro fertilization procedures are performed at medical facilities that conform to applicable guideline or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.
3. Intracytoplasmic Sperm Injection (ICSI) if the Member meets medical guidelines; and
 4. Preimplantation Genetic Diagnosis (PGD) if the Member meets medical guidelines.

Note: Diagnostic procedures and drugs administered by or under the direct supervision of a Plan Provider are covered under this provision.

Infertility Limitations:

- Coverage for in-vitro fertilization embryo transfer cycles, including frozen embryo transfer (FET) procedure, is limited to three attempts per live birth, not to exceed a maximum lifetime benefit of \$100,000.

Infertility Exclusions:

- Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member's eggs and/or male Member's sperm for future attempts.
- Any charges associated with donor eggs, donor sperm or donor embryos.
- Infertility Services, except for covered Services for in vitro fertilization, when the Member does not meet medical guidelines established by the American College of Obstetricians and Gynecologists.
- Services to reverse voluntary, surgically induced infertility.
- Infertility Services when the infertility is the result of an elective male or female sterilization surgical procedure.
- Assisted reproductive technologies and procedures, other than those described above: gamete intrafallopian transfers (GIFT); zygote intrafallopian transfers (ZIFT); and prescription drugs related to such procedures.

V. MATERNITY SERVICES

We cover Services for pre-and post-natal Services, which includes routine and non-routine office visits, x-ray, lab and specialty tests. Health Plan cover birthing classes and breastfeeding support, supplies, and counseling from trained providers during pregnancy and/or in the postpartum period.

We cover obstetrical care, which includes (1) Services provided for a condition not usually associated with pregnancy, (2) Services provided for conditions existing prior to pregnancy, (3) Services related to the development of a high risk condition(s) during pregnancy and (4) Services provided for the medical complications of pregnancy.

Services for non-routine obstetrical care are covered subject to the applicable Cost Share for specialty, diagnostic and/or treatment Services.

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Services for diagnostic and treatment services for illness or injury received during a non-routine maternity care visit are subject to the applicable Cost Share.

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

Outpatient delivery and associated Services (i.e., birthing centers, certified midwife) are covered, subject to the applicable Cost Share.

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

Up to four (4) days of additional hospitalization for the newborn is covered if the enrolled mother is required to remain hospitalized after childbirth for medical reasons.

Comprehensive lactation (breastfeeding) education and counseling, by trained clinicians during pregnancy and/or postpartum period in conjunction with each birth, Breastfeeding equipment is issued, per pregnancy. The breast feeding pump (including any equipment that is required for pump functionality) is covered at no cost sharing to the member.

Maternity Services Exclusions:

- Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.

W. MEDICAL FOODS

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

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

Low protein modified foods are food products that are (1) specially formulated to have less than one (1) gram of protein per serving, and (2) intended to be used under the direction of a Plan Provider for the dietary treatment of an inherited metabolic disease.

Medical Foods Exclusions:

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

Amino Acid-based Elemental Formula (Drugs, Supplies and Supplements)

We cover amino acid-based elemental formula, regardless of delivery method, for the diagnosis and treatment of:

1. Immunoglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins;

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2. Severe food protein induced enterocolitis syndrome;
3. Eosinophilic disorders, as evidenced by the results of a biopsy; and
4. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Coverage shall be provided if the ordering physician has issued a written order stating that amino acid-based elemental formula is Medically Necessary for the treatment of a disease or disorder listed above. The Health Plan, or a private review agent acting on behalf of the Health Plan, may review the ordering physician's determination of the Medical Necessity of the amino acid-based elemental formula for the treatment of a disease or disorders listed above.

Amino Acid Based Elemental Formula Exclusions:

- Amino-acid based elemental formula for treatment of any condition other than those listed above.

X. MORBID OBESITY SERVICES

We cover diagnosis and surgical treatment of morbid obesity that is:

1. Recognized by the National Institutes of Health (NIH) as effective for long-term reversal of morbid obesity; and
2. Consistent with guidelines approved by the NIH.

Such treatment shall be covered to the same extent as for other Medically Necessary surgical procedures under this EOC.

Morbid obesity means a body mass index that is (1) greater than forty (40) kilograms per meter squared; or (2) equal to or greater than thirty-five (35) kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

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

Y. ORAL SURGERY

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

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

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

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

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

1. Evidenced through documented medical records showing significant impairment in speech or a

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nutritional deficit; and

2. Based on examination of the Member by a Plan Provider.

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

Temporomandibular Joint Services

Coverage is provided for:

1. Orthognathic surgery, including inpatient and outpatient surgery to correct temporomandibular joint (TMJ) pain dysfunction syndrome and craniomandibular joint services, that are required because of a medical condition or injury that prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part;
2. Removable appliances for TMJ repositioning; and
3. Therapeutic injections for TMJ.

The Health Plan provides coverage for cleft lip, cleft palate or both under a separate benefit. Please see “Cleft Lip, Cleft Palate or Both” in this section.

Oral Surgery Exclusions:

- Oral surgery Services when the functional aspect is minimal and would not in itself warrant surgery.
- Lab fees associated with cysts that are considered dental under our standards.
- Orthodontic Services.
- Dental appliances.
- Fixed or removable appliances that involve movement or repositioning of the teeth.

Z. PREVENTIVE HEALTH CARE SERVICES

We cover the following preventive Services without any Cost Sharing requirements, such as Deductibles, Copayment amounts or Coinsurance amounts to any Member receiving any of the following benefits for Services from Plan Providers:

1. Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009 (To see an updated list of the USPSTF “A” or “B” rated services. Visit www.uspreventiveservicestaskforce.org);
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (Visit the Advisory Committee on Immunization Practices at <http://www.cdc.gov/vaccines/acip/index.html>);
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Visit HRSA at <http://mchb.hrsa.gov>); and
4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Visit HRSA at <http://mchb.hrsa.gov>).

The Health Plan shall update new recommendations to the preventive benefits listed above at the schedule

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established by the Secretary of Health and Human Services.

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

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

1. Preventive care exams, including:
 - a. Routine physical examinations and health screening tests appropriate to your age and sex;
 - b. Well-woman examinations; and
 - c. Well child care examinations.
2. Routine and necessary immunizations (travel immunizations are not preventive and are covered under Outpatient Services in this section) for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;
3. An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
4. Breast cancer screening (for which the Deductible, if any, will not apply):
 - a. In accordance with the latest screening guidelines issued by the American Cancer Society; and
 - b. Digital tomosynthesis, commonly referred to as three-dimensional “3-D” mammography will be covered when the treating Plan physician determines that it is Medically Necessary.
5. Bone mass measurement to determine risk for osteoporosis;
6. Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to men who are age 40 or older;
7. Colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society;
8. Cholesterol test (lipid profile);
9. Diabetes screening (fasting blood glucose test);
10. Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis and HPS), subject to the following:
 - a. Annual chlamydia screening is covered for (1) women under age 20, if they are sexually active; and (2) women age 20 or older; and men of any age, who have multiple risk factors, which include: (1) a prior history of sexually transmitted diseases; (2) new or multiple sex partners, (3) inconsistent use of barrier contraceptives or (4) cervical ectopy;
 - b. Human Papillomavirus Screening (HPS) at the intervals recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists.
11. HIV tests;
12. TB tests;
13. Hearing loss screenings for newborns provided by a hospital prior to discharge;
14. Associated preventive care radiological and lab tests not listed above; and
15. BRCA counseling and genetic testing is covered at no Cost Share. Any follow up Medically Necessary treatment is covered at the applicable Cost Share based upon type and place of Service.

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Preventive Health Care Services Limitations:

While treatment may be provided in the following situations, the following services are not considered Preventive Care Services. The applicable Cost Share will apply:

- Monitoring chronic disease.
- Follow-up Services after you have been diagnosed with a disease.
- Testing and diagnosis for specific diseases for which you have been determined to be at high risk for contracting.
- Services provided when you show signs or symptoms of a specific disease or disease process.
- Non-routine gynecological visits.

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

AA. PROSTHETIC AND ORTHOTIC DEVICES

We cover the devices listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or injured. Coverage includes fitting and adjustment of these devices, repair or replacement (unless due to loss or misuse), and Services to determine whether you need the Prosthetic Device. If we do not cover the Prosthetic Device, we will try to help you find facilities where you may obtain what you need at a reasonable price. Coverage is limited to the Prosthetic Device that is considered Medically Necessary by meeting the indications and limitations of coverage and medical necessity established under the Medicare Coverage Database.

Internally Implanted Devices

We cover Medically Necessary internal devices implanted during surgery, such as pacemakers, monofocal intraocular lens implants, artificial hips and joints, breast implants following mastectomy (see “Reconstructive Surgery” below), and cochlear implants, that are approved by the FDA for general use.

External Prosthetic & Orthotic Devices

We cover the following external Prosthetic and Orthotic Devices when prescribed by a Plan Provider:

1. External Prosthetic Devices (other than dental) that replace all or part of the function of a permanently inoperative or malfunctioning body part.
2. Rigid and semi-rigid external Orthotic Devices that are used for the purpose of supporting a weak or deformed body member, or for restricting or eliminating motion in a diseased or injured part of the body. Examples of covered Orthotic Devices include, but are not limited to, leg, arm, back and neck braces.
3. Fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and services to determine whether you need a Prosthetic or Orthotic Device.

Artificial Arms, Legs or Eyes

We cover:

1. Artificial devices to replace, in whole or in part, a leg, an arm or an eye;
2. Components of an artificial device to replace, in whole or in part, a leg, an arm or an eye; and
3. Repairs to an artificial device to replace, in whole or in part, a leg, an arm or an eye.

The artificial arm, leg, eye or component will be considered Medically Necessary if it meets the indications and limitations of coverage and medical necessity established under the Medicare Coverage

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Database.

Ostomy and Urological Supplies and Equipment

We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets Health Plan's criteria for being Medically Necessary. Covered equipment and supplies include, but is not limited to flanges, collection bags, clamps, irrigation devices, sanitizing products, ostomy rings, ostomy belts and catheters used for drainage of urostomies.

Breast Prosthetics and Hair Prosthesis

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

In addition, we cover one hair prosthesis required for a Member whose hair loss results from chemotherapy or radiation treatment for cancer.

Prosthetic Device Limitations:

- Coverage for mastectomy bras is limited to a maximum of two (2) per contract year.
- Coverage for hair prosthesis is limited to one (1) prosthesis per course of chemotherapy and/or radiation therapy, not to exceed a maximum benefit of \$350 per prosthesis.
- Standard Devices: Coverage is limited to standard devices that adequately meet your medical needs.
- Coverage of therapeutic shoes and inserts is limited to individuals with severe diabetic foot disease or other vascular disease.

Prosthetic Device Exclusions:

- Internally implanted breast prosthetics for cosmetic purposes.
- Repair or replacement of prosthetics due to loss or misuse.
- Microprocessor and robotic-controlled external prosthetics not covered under the Medicare Coverage Database.
- More than one piece of equipment or device for the same part of the body, except for replacements, spare devices or alternate use devices.
- Dental prostheses, devices and appliances, except as specifically provided in this section, or as provided under an "Adult Dental Plan Rider" or a "Pediatric Dental Plan Rider," if applicable.
- Hearing aids, except as specifically provided in this section, or as provided under a "Hearing Services Rider," if applicable.
- Corrective lenses and eyeglasses, except as specifically provided in this section.
- Orthopedic shoes or other supportive devices, unless the shoe is an integral part of a leg brace; or unless indicated above.
- Non-rigid appliances and supplies, including jobst stockings, elastic garments and stockings, and garter belts.
- Comfort, convenience, or luxury equipment or features.

BB. RECONSTRUCTIVE SURGERY

We cover reconstructive surgery to (1) correct significant disfigurement resulting from an injury or Medically Necessary surgery, (2) correct a congenital defect, disease, or anomaly in order to produce

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significant improvement in physical function, and (3) treat congenital hemangioma known as port wine stains on the face. Breast augmentation is covered only if determined to be Medically Necessary.

Following mastectomy, we cover reconstructive breast surgery and all stages of reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Mastectomy is the surgical removal of all or part of a breast. Reconstructive breast surgery is surgery performed as a result of a mastectomy to reestablish symmetry between both breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

Reconstructive Surgery Exclusions:

Cosmetic surgery, plastic surgery or other Services, supplies, dermatological preparations and ointments, other than those listed above, that are intended primarily to improve your appearance, or are not likely to result in significant improvement in physical function. Examples of excluded cosmetic dermatology Services are:

- Removal of moles or other benign skin growths for appearance only;
- Chemical peels; and
- Pierced earlobe repairs, except for the repair of an acute bleeding laceration.

CC. ROUTINE FOOT CARE

Coverage is provided for Medically Necessary routine foot care for patients with diabetes or other vascular disease. See the benefit-specific limitations and exclusions immediately below for additional information.

Routine Foot Care Limitations:

- Coverage is limited to Medically Necessary treatment of patients with diabetes or other vascular disease.

Routine Foot Care Exclusions:

- Routine foot care is not provided to Members who do not meet the requirements of the limitations of this benefit.

DD. SKILLED NURSING FACILITY CARE

We cover skilled inpatient Services in a licensed Skilled Nursing Facility. The skilled inpatient Services must be those customarily provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required.

We cover the following Services:

1. Room and board;
2. Physician and nursing care;
3. Medical social Services;
4. Medical and biological supplies; and
5. Respiratory therapy.

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

1. Blood (see “Blood, Blood Products and Their Administration”);
2. Drugs (see “Drugs, Supplies and Supplements”);

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3. Durable Medical Equipment ordinarily furnished by a Skilled Nursing Facility, including oxygen dispensing equipment and oxygen (see “Durable Medical Equipment”);
4. Physical, occupational, and speech therapy (see “Therapy and Rehabilitation Services”); and
5. X-ray, laboratory, and special procedures (see “X-ray, Laboratory and Special Procedures”).

Skilled Nursing Facility Care Exclusions:

- Custodial care (see definition in Section 4: Exclusions, Limitations and Reductions).
- Domiciliary care.

EE. TELEMEDICINE SERVICES

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

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

Telemedicine Services Exclusion:

- Services delivered through audio-only telephones, electronic mail messages or facsimile transmissions. Not all medical services are conducive to telemedicine, as such the provider will make a determination whether the Member should instead be seen in a face-to-face medical office setting.

FF. THERAPY AND REHABILITATION SERVICES

Physical, Occupational and Speech Therapy Services

If, in the judgment of a Plan Physician, significant improvement is achievable within a two (2)-month period, we cover physical, occupational and speech therapy:

1. While you are confined in Plan Hospital; and
2. For up to thirty (30) visits of physical therapy, thirty (30) visits of occupational therapy, and thirty (30) visits of speech therapy per contract year per injury, incident or condition in a Plan Medical Center, a Plan Provider’s medical office, a Skilled Nursing Facility or as part of home health care. These limits do not apply to necessary treatment of cleft lip or cleft palate.

Physical, Occupational and Speech Therapy Limitations:

- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Speech therapy is limited to treatment for speech impairments due to injury or illness.
- Physical therapy is limited to the restoration of an existing physical function, except as provided in the “Habilitative Services” section of this benefit.

Multidisciplinary Rehabilitation Services

If, in the judgment of a Plan Physician, significant improvement is achievable within a two (2)-month period, we cover multidisciplinary rehabilitation Services in a Plan Hospital, Plan Medical Center, Plan Provider’s medical office or a Skilled Nursing Facility. Coverage is limited to a maximum of two (2) consecutive months of treatment per injury, incident or condition.

Multidisciplinary rehabilitation Service programs mean inpatient or outpatient day programs that incorporate more than one (1) therapy at a time in the rehabilitation treatment.

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Cardiac Rehabilitation Services

We cover Medically Necessary cardiac rehabilitation Services following coronary surgery or a myocardial infarction, for up to twelve (12) weeks, or thirty-six (36) sessions, whichever occurs first.

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

Therapy and Rehabilitation Services Exclusions:

- Except as provided for cardiac rehabilitation Services, no coverage is provided for any therapy that the Plan Physician determines cannot achieve measurable improvement in function within a two (2)-month period.
- Long-term therapy and rehabilitation Services.

GG. THERAPY: RADIATION, CHEMOTHERAPY AND INFUSION THERAPY

Coverage is provided for chemotherapy, radiation and infusion therapy visits.

We cover Services for infusion therapy, which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion Services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These Services include coverage of all medications administered intravenously and/or parentally. Infusion Services may be received at multiple sites of Service, including facilities, professional provider offices and ambulatory infusion centers and from home infusion providers. The Cost Share amount will apply based on the place and type of Service provided.

Coverage is also provided for oral chemotherapy drugs. For additional information on this benefit, see ***Drugs, Supplies and Supplements*** in this list of benefits.

Note: If a drug covered under this benefit meets the criteria for a Specialty Drug, then the Member's cost for the drug will not exceed \$150 in accordance with §15-847 of the Insurance Article. If this benefit is subject to the Deductible, as shown in the Summary of Services and Cost shares, the Deductible must be met first.

HH. TRANSPLANTS

If the following criteria are met, we cover stem cell rescue and transplants of organs, tissue or bone marrow:

1. You satisfy all medical criteria developed by Medical Group and by the facility providing the transplant;
2. The facility is certified by Medicare; and
3. A Plan Provider provides a written referral for care at the facility.

After the referral to a transplant facility, the following applies:

1. Unless otherwise authorized by Medical Group, transplants are covered only in our Service Area.
2. If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for transplant, we will pay only for covered Services you receive before that determination was made.
3. Health Plan, Plan Hospitals, Medical Group and Plan Providers are not responsible for finding, furnishing, or ensuring the availability of a bone marrow or organ donor.

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4. We cover reasonable medical and hospital expenses as long as these expenses are directly related to a covered transplant for a donor, or an individual identified by Medical Group as a potential donor even if not a Member.

Transplant Exclusions:

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

II. URGENT CARE

As described below, you are covered for Urgent Care Services anywhere in the world. Your Copayment or Coinsurance will be determined by the place of Service (i.e., at a Provider's office or at an after-hours urgent care center).

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

Inside our Service Area:

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

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

If your primary care Plan Physician is located at a Plan Medical Center please contact us at 1-800-777-7902 or 711 (TTY).

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

Outside of our Service Area:

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

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

Follow-up Care for Emergency Surgery

In those situations when we authorize, refer or otherwise allow you access to a hospital emergency facility or other urgent care facility for a medical condition that requires emergency surgery, we will reimburse the physician, oral surgeon, periodontist or podiatrist who performed the surgical procedure for any follow-up care that is:

1. Medically Necessary;
2. Directly related to the condition for which the surgical procedure was performed; and
3. Provided in consultation with your primary care Plan Physician.

We will not impose any Copayment or other cost-sharing requirement for follow-up care under this provision that exceeds that which you would be required to pay had the follow-up care been rendered by Plan Providers within our Service Area.

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Urgent Care Limitations:

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

Urgent Care Exclusions:

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

JJ. VISION SERVICES

Medical Treatment

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

Eye Exams for Adults

We cover routine and necessary eye exams, including:

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

Pediatric Eye Exams

We cover the following for children until the end of the month in which the child turns age 19:

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

Pediatric Lenses and Frames

We cover the following for children, until the end of the month in which the child turns age 19, at no charge:

1. One (1) pair of lenses per year;
2. One (1) pair of frames per year from a select group of frames;
3. Regular contact lenses (in lieu of lenses and frames) (based on standard packaging for type purchased); or
4. Medically Necessary contact lenses up to two (2) pair per eye per year.

In addition, we cover the following Services:

Eyeglass Lenses

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

Frames

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

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frame and subsequent adjustment.

Contact Lenses

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

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

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

Vision Exclusions:

- Sunglasses without corrective lenses unless Medically Necessary.
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example: radial keratotomy, photo-refractive keratectomy, and similar procedures).
- Eye exercises.
- Non-corrective contact lenses.
- Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section.
- Replacement of lost or broken lenses or frames.
- Orthoptic (eye training) therapy.

KK. X-RAY, LABORATORY, AND SPECIAL PROCEDURES

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

1. Diagnostic imaging;
2. Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
3. Special procedures, such as:
 - a. Electrocardiograms;
 - b. Electroencephalograms; and
 - c. Bone mass measurement for the diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A “qualified individual” means an individual:
 - i. Who is estrogen deficient and at clinical risk for osteoporosis;
 - ii. With a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;

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- iii. Receiving long-term glucocorticoid (steroid) therapy;
 - iv. With primary hyperparathyroidism; or
 - v. Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
- 4. Sleep lab and sleep studies; and
 - 5. Specialty imaging, including CT, MRI, PET Scans, Nuclear Medicine studies and interventional radiology.

Note: Refer to “Preventive Health Care Services” for coverage of preventive care tests and screening Services.

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SECTION 4: EXCLUSIONS, LIMITATIONS AND REDUCTIONS

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

It also provides information on how your benefits may be reduced as the result of other types of coverage.

IMPORTANT DEFINITIONS

Several terms used within this Section have special meanings. Please see the Definitions Appendix for an explanation of these terms. They include:

1. Allowable Expense;
2. Claim Determination Period; and
3. Health Plan

EXCLUSIONS

The Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in Section 3: Benefits. When a Service is excluded, all Services related to the excluded Service are also excluded, even if they would otherwise be covered under this EOC.

Alternative Medical Services

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

Certain Exams and Services

Physical examinations and other Services (1) required for obtaining or maintaining employment or participation in employee programs or (2) required for insurance, licensing, or disability determinations or (3) on court-order or required for parole or probation, except for Medically Necessary Services covered under Section 3: Benefits.

Cosmetic Services

Cosmetic Services, including surgery or related Services and other Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies. Examples of Cosmetic Services include but are not limited to cosmetic dermatology, cosmetic surgical services and cosmetic dental services.

Custodial Care

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

Dental Care

Dental care and dental X-rays, including dental appliances, dental implants, orthodontia, shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any dental treatment involved in temporomandibular joint (TMJ) pain dysfunction syndrome, unless otherwise covered under a

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Rider attached to this EOC. This exclusion does not apply to medically necessary dental care covered under “Accidental Dental Injury Services,” “Cleft Lip, Cleft Palate or Both” or “Oral Surgery” in Section 3: Benefits.

Disposable Supplies

Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices, not specifically listed as covered in Section 3: Benefits.

Durable Medical Equipment

Except for Services covered under “Durable Medical Equipment” in Section 3: Benefits.

Employer or Government Responsibility

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

Experimental or Investigational Services

Except as covered under “Clinical Trials” in Section 3: Benefits, a Service is experimental or investigational for your condition if any of the following statements apply to it as of the time the Service is, or will be, provided to you:

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

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

1. Your medical records;
2. Written protocols or other documents pursuant to which the Service has been or will be provided;
3. Any consent documents you or your representative has executed or will be asked to execute, to receive the Service;
4. Files and records of the IRB or a similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;
5. Published authoritative medical or scientific literature regarding the Service, as applied to your illness or injury; and
6. Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

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

Prohibited Referrals

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

Routine Foot Care Services

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

Services for Members in the Custody of Law Enforcement Officers

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

Surrogacy Arrangements

You must pay us charges for Services you receive related to conception, pregnancy or delivery in connection with a surrogacy arrangement (“Surrogacy Health Services”). Your obligation to pay us for Surrogacy Health Services is limited to the compensation you are entitled to receive under the surrogacy arrangement. A surrogacy arrangement is one in which you agree to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we also have a lien on those payments. Those payments shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within thirty (30) days of entering into a surrogacy arrangement, you must send written notice of the arrangement, including a copy of any agreement, the names and addresses of the other parties to the arrangement, to:

Kaiser Permanente
Other Party Liability and Recovery Unit
2101 E. Jefferson Street, 4 East
Rockville, MD 20852
Attn: Surrogacy Coordinator

You must complete and send us all consents, releases, authorizations, lien forms, assignments and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this section and to satisfy those rights. You must not take any action that prejudices our rights.

If your estate, parent, guardian, spouse, trustee or conservator asserts a claim against a third party based on the surrogacy arrangement, your estate, parent, guardian, spouse or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Travel and Lodging Expenses

Travel and lodging expenses, except that in some situations, if a Plan Physician refers you to a non-Plan Provider outside our Service Area as described under “Getting a Referral” in Section 2: How to Obtain

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Services, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines.

Travel Immunizations

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

Vision Services

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

Workers' Compensation or Employer's Liability

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

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

LIMITATIONS

We will use our best efforts to provide or arrange for covered Services in the event of unusual circumstances that delay or render impractical the provision of Services such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel of a Plan Hospital or Plan Medical Center, complete or partial destruction of facilities, and labor disputes not involving the Health Plan, Kaiser Foundation Hospitals, or Medical Group. However, Health Plan, Kaiser Foundation Hospitals, Medical Group, and Medical Group Physicians shall be liable for reimbursement of the expenses necessarily incurred by a Covered Person in procuring the Services through other providers, to the extent prescribed by the Insurance Commissioner of Maryland.

REDUCTIONS

Injury or Illness Caused by Third Party

Except for any covered Services that would be (1) payable under Personal Injury Protection (PIP) coverage and/or (2) payable under any capitation agreement the Health Plan has with a Participating Provider, if you become ill or injured through the fault of a third party and you collect any money from the third party or from his or her insurance company for medical expenses, the Health Plan will be subrogated for any Service provided by or arranged as a result of the occurrence that gave rise to the cause of action as follows: (1) per the Health Plan's fee schedule for Services provided or arranged by the Medical Group or (2) any actual expenses that were made for Services provided by Participating Providers.

Except for any covered Services that would be (1) payable under Personal Injury Protection (PIP) coverage and/or (2) payable under any capitation agreement the Health Plan has with a Participating

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Provider, when you recover for medical expenses in a cause of action, the Health Plan has the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program or other source of coverage for monetary damages, compensation or indemnification on account of the injury or illness allegedly caused by the third party. The Health Plan will also be subrogated as of the time it mails or delivers a written notice of its exercise of this option to you or to your attorney as follows: (1) per the Health Plan's fee schedule for Services provided by the Medical Group at one of our Medical Offices or (2) any actual expenses that were made for Services provided by a Participating Provider. The subrogated amount will be reduced by any attorney's fees incurred by the Member.

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

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

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

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

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

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

Medicare and TRICARE Benefits

Your benefits are reduced by any benefits to which you are entitled under Medicare, except for Members whose Medicare benefits are secondary by law. TRICARE benefits are usually secondary benefits by law.

Coordination of Benefits (COB)

Members with Health Savings Accounts (HSA)s: Please note that if you have other health care coverage in addition to the coverage under this EOC, in most instances you will not be eligible to establish or contribute to an HSA unless both plans qualify as High Deductible Health Plans (HDHP).

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Consult with your financial or tax advisor for tax advice or more information about your eligibility for an HSA. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage. The Plan that pays first (Primary Plan) is determined by using National Association of Insurance Commissioners (NAIC) and Medicare Secondary Payer (MSP) Order of Benefits Guidelines.

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

Definition

“Plan”: Any of the following that provides benefits or services for, or because of, medical care or treatment: Individual or group insurance or group-type coverage, whether insured or uninsured. This includes group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits group or individual automobile contracts (personal injury protection benefits are not required to be paid before benefits under this Plan will be paid) and Medicare or any other federal governmental plan, as permitted by law.. “Plan” does not include hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; intensive care policies; personal injury protection under a motor vehicle insurance policy; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law. “Health Plan”: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., providing services or benefits for health care. Health Plan is a Plan.

If you have any questions about COB, please contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Order of Benefit Determination Rules

Coordination of Benefits (COB) applies when a Member has health care coverage under more than one (1) Plan.

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

Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the

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Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two (2) Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

2. **Dependent Child Covered Under More Than One (1) Plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one (1) Plan the order of benefits is determined as follows:
- a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
 - ii. If both parents have the same birthday, the Plan that has covered the parent the longest is Primary plan.
 - b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - i. If a court decree states that one (1) of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph a above shall determine the order of benefits;
 - iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph a above shall determine the order of benefits; or
 - iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial parent;
 - (b) The Plan covering the spouse of the Custodial parent;
 - (c) The Plan covering the non-custodial parent; and then
 - (d) The Plan covering the spouse of the non-custodial parent.
 - c. For a dependent child covered under more than one (1) 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.
 - d. (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in item 2g applies; (ii) in the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in item 2a to the dependent child's parent(s) and the dependent's spouse.

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- e. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if paragraph 1 can determine the order of benefits.
- f. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if paragraph 1 can determine the order of benefits.
- g. **Longer or Shorter Length of Coverage.** The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
- h. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

Effect of COB on the Benefits of this Plan

When the Health Plan is the Primary Plan, COB has no effect on the benefits or Services provided under this Agreement. When the Health Plan is a Secondary Plan as to one (1) or more other Plans, its benefits may be coordinated with the Primary Plan carrier using the guidelines below. COB shall in no way restrict or impede the rendering of Services provided by the Health Plan. At the Member's request, the Health Plan will provide or arrange for covered Services and then seek coordination with a Primary Plan.

- 1. **Coordination with This Plan's Benefits.** The Health Plan may coordinate benefits payable or may recover the reasonable cash value of Services it has provided when the sum of:
 - a. The benefits that would be payable for, or the reasonable cash value of, the Services provided as Allowable Expenses by the Health Plan in the absence of this COB provision; and
 - b. The benefits that would be payable for Allowable Expenses under one (1) or more of the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim thereon is made; exceeds Allowable Expenses in a Claim Determination Period. In that case, the Health Plan benefits will be coordinated, or a portion of the reasonable cash value of any Services provided by the Health Plan may be recovered, from the Primary Plan, so that they and the benefits payable under the other Plans do not total more than the Allowable Expenses.
- 2. **Right to Reserve and Release Needed Information.** Certain information is needed to apply these COB rules. The Health Plan will decide the information it needs, and may get that information from, or give it to, any other organization or person. The Health Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under the Health Plan must give the Health Plan any information it needs.

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3. **Facility of Payment.** If a payment made or service provided under another Plan includes an amount that should have been paid or provided by or through the Health Plan, the Health Plan may pay that amount to the organization which made that payment. The amount paid will be treated as if it was a benefit paid by the Health Plan.
4. **Right of Recovery.** If the amount of payments by the Health Plan is more than it should have paid under this COB provision, or if it has provided Services that should have been paid by the Primary Plan, the Health Plan may recover the excess or the reasonable cash value of the Services, as applicable, from one or more of:
 - a. The persons it has paid or for whom it has paid;
 - b. Insurance companies; or
 - c. Other organizations.
5. **Benefit Reserve Account.** When the Health Plan does not have to pay full benefits, or recovers the reasonable cash value of the Services provided because of COB, the savings will be credited to the Member in a Benefit Reserve Account. These savings can be used by the Member for any unpaid Covered Expense during the calendar year. A Member may request detailed information concerning the Benefits Reserve Account from the Health Plan's Patient Accounting Department.

Military Services

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

For those members enrolled in a Health Savings Account (HSA) qualified plan, please note that if you have actually received Veterans Administration health benefits in the last three (3) months, you will not be eligible to establish or contribute to an HSA even if you are enrolled in a High Deductible Health Plan (HDHP). Consult with your financial or tax advisor for tax advice or more information about your eligibility for an HSA.

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SECTION 5: GETTING ASSISTANCE, HEALTH CARE SERVICE REVIEW, AND THE GRIEVANCE AND APPEAL PROCESS

GETTING ASSISTANCE

Member Services representatives are available at most of our Plan Medical Centers and through our Call Center to answer any questions you have about your benefits, available services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace an ID card. These representatives can also help you submit a request for payment and/or reimbursement for Emergency Services and Urgent Care Services outside of our Service Area (see “Filing for Payment/Reimbursement of a Post Service Claim” for information) or to initiate an Appeal or a Grievance for any unresolved problem.

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

Inside the Washington, DC Metropolitan Area: (301) 468-6000

Outside of the Washington, DC Metropolitan Area: 1-800-777-7902

TTY: 711

IMPORTANT DEFINITIONS

Several terms used within this Section have special meanings. Please see the Definitions Appendix for an explanation of these terms. They include:

- | | |
|---|-------------------------------|
| 1. Adverse Decision; | 2. Appeal; |
| 3. Appeal Decision; | 4. Authorized Representative; |
| 5. Commissioner; | 6. Complaint; |
| 7. Coverage Decision; | 8. Emergency Case; |
| 9. Grievance; | 10. Grievance Decision; |
| 11. Health Education and Advocacy Unit; | 12. Health Care Provider; |
| 13. Health Care Service; | 14. Urgent Medical Condition. |

THE HEALTH CARE SERVICE REVIEW PROGRAM

Pre-Service Reviews

If you do not have an Urgent Medical Condition and you have not received the Health Care Service you are requesting, then within two (2) working days of receiving all necessary information, Health Plan will make its determination. If we do not have the necessary information to make our decision, we will notify you or your Authorized Representative of the need for additional information within three calendar days of the initial request and explain in detail what information is required. Necessary information includes, but is not limited to, the results of any face-to-face clinical evaluation or any second opinion that may be required. We must receive the information requested by the notice, within forty-five (45) calendar days from the receipt of the notice identifying the additional necessary information, or we will make our decision based upon the information we have available to us at that time.

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If the authorization procedures are not followed, we will notify you and/or your Authorized Representative of the failure to follow the procedures within three (3) calendar days of the request for authorization. The notice will include the proper procedures to be followed to request authorization.

If an admission, procedure or service is pre-authorized, Health Plan will:

1. Notify the provider by telephone within one (1) working day of pre-authorization; and
2. Confirm the pre-authorization with you and the provider in writing within five (5) working days of our decision.

If pre-authorization is denied, or an alternate treatment or service is recommended, Health Plan will:

1. Notify the provider by telephone within one (1) working day of making the denial or alternate treatment or service recommendation; and
2. Confirm the denial decision with you and your Authorized Representative in writing within five (5) working days of making our decision.

You or your Authorized Representative may then file an Appeal or Grievance as appropriate, as described below.

Expedited Pre-Service Reviews

If you have an Urgent Medical Condition and you have not received the Health Care Service for which you are requesting review, then within twenty-four (24) hours of your request, we will notify you if we need additional information to make a decision, or if you or your Authorized Representative failed to follow proper procedures which would result in a denial decision. If additional information is requested, you will have only forty-eight (48) hours in which to submit the requested information. We will make a decision for this type of claim within forty-eight (48) hours following the earlier of (1) receipt of the information from you; or (2) the end of the period for submitting the requested information. Decision regarding pre-service review if you have an urgent Medical Condition will be communicated to you by telephone within twenty-four (24) hours. Such decisions will be confirmed in writing within three (3) calendar days of our decision.

Concurrent Reviews

When you make a request for additional treatment, when we had previously approved a course of treatment that is about to end, the Health Plan will make concurrent review determinations within one (1) working day of receiving the request or within one working day of obtaining all the necessary information so long as the request for authorization of additional services is made prior to the end of prior authorized services. In the event that our review results in the end or limitation of Health Care Services, we will make a review determination with sufficient advance notice so that you can file a timely Grievance or Appeal of our decision. If you have an Urgent Medical Condition, then a request for concurrent review will be handled like any other pre-service request for review when an Urgent Medical Condition is involved, except that our decision will be made within one (1) working day.

If the Health Plan authorizes an extended stay or additional Health Care Services under the concurrent review, the Health Plan will:

1. Notify the provider by telephone within one (1) working day of the authorization; and

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2. Confirm the authorization in writing with you or your Authorized Representative within five (5) working days after the telephone notification. The written notification will include the number of extended days or next review date, or the new total number of Health Care Services approved.

If the request for extended stay or additional Health Care Services is denied, the Health Plan will:

1. Notify the provider and/or you or your Authorized Representative of the denial by telephone within one (1) working day of making the denial decision; and
2. Confirm the denial in writing with you or your Authorized Representative and/or the provider within five (5) working days after the telephone notification. Coverage will continue for Health Care Services until you or your Authorized Representative and the provider rendering the Health Care Service have been notified of the denial decision in writing.

You or your Authorized Representative may then file an Appeal or Grievance, as appropriate, as described below. If you filed a request for additional services at least twenty-four (24) hours before the end of an approved course of treatment, you may continue to receive those services during the time your Appeal or Grievance is under consideration. If your Appeal or Grievance is then denied, you will be financially responsible for the entire cost of those services. Otherwise, if your request for additional services was not timely filed, the Health Plan will decide your request for review within a reasonable period of time appropriate to the circumstances but, in no event, later than thirty (30) calendar days from the date on which the Appeal or Grievance was received.

Filing for Payment/Reimbursement of a Post Service Claim

When you receive an itemized bill from a hospital, physician, or ancillary provider not contracting with us, please forward that bill directly to us for processing. Simply indicate the medical record number of the patient on the bill and submit it directly to us.

A request for payment or reimbursement of the cost of covered services received from physicians, hospitals or other Health Care Providers not contracting with us must be submitted to the Health Plan within one (1) year of receipt of the covered services. Failure to submit such a request within one (1) year of receipt of the covered services will not invalidate or reduce the amount of the claim, if it was not reasonably possible to submit the request within the aforementioned time frame. If it is not reasonably possible to submit the claim within one (1) year after the date of service, it shall be sent to us no later than two (2) years from the time, proof is otherwise required. A Member's legal incapacity shall suspend the time to submit a claim. Such suspension period ends when legal capacity is regained.

You must notify us within the later of forty-eight (48) hours of any hospital admission or on the 1st working day following the admission unless it was not reasonably possible to notify us within that time.

Reimbursement for covered Services will be made to the applicable provider of the Services, or if the claim has been paid, to you or in the case of a child, to the parent who incurred the expenses resulting from the claim or the Department of Health and Mental Hygiene.

Post-Service Claim Reviews

Health Plan will make its determination on post-service review within thirty (30) days of receiving a claim. If we do not have the necessary information to make our decision, we will notify you or your Authorized Representative of the need for additional information within three calendar days of the initial request and explain in detail what information is required. You must respond to requests for additional

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information within thirty (30) calendar days or we will make our decision based upon the information we have available to us at that time.

We will send a notice to you or your Authorized Representative explaining that:

1. The claim was paid; or
2. The claim is being denied in whole or in part; or
3. Additional information is needed to determine if all or part of the claim will be reimbursed and what specific information must be submitted; or
4. The claim is incomplete and/or unclear and what information is needed to make the claim complete and/or clear.

Benefits payable for any claim will be paid not more than 30 days after we receive your claim.

If we deny payment of the claim, in whole or in part, you or your Authorized Representative may then file an Appeal or Grievance, as appropriate, as described below.

INTERNAL GRIEVANCE AND APPEAL PROCESSES

A Member may file a Grievance or an Appeal on their own behalf or through an Authorized Representative.

THE HEALTH EDUCATION AND ADVOCACY UNIT OF THE OFFICE OF THE ATTORNEY GENERAL

The Health Education and Advocacy Unit can help you or your Authorized Representative prepare a Grievance or an Appeal to file with the Health Plan as follows:

1. The Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a Grievance or Appeal under the internal grievance and appeals processes. However, the Health Education and Advocacy Unit is not available to represent or accompany you and/or your Authorized Representative during the proceeding of the internal grievance and appeals process;
2. The Health Education and Advocacy Unit can assist you and/or your Authorized Representative in mediating a resolution of the Adverse Decision or Coverage Decision with the Health Plan, but at any time during the mediation, you and/or your Authorized Representative may file a Grievance or Appeal; and
3. You and/or your Authorized Representative may file a Complaint with the Commissioner without first filing a Grievance or Appeal as explained below under Maryland Insurance Commissioner.
4. The Health Education and Advocacy Unit may be contacted at:

Office of the Attorney General
Consumer Protection Division
Health Education and Advocacy Unit
200 St. Paul Place
Baltimore, MD 21202
Phone: 410-528-1840
Toll-free: 877-261-8807
Fax: 410-576-6571

Website: www.oag.state.md.us

Email: consumer@oag.state.md.us

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YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

MARYLAND INSURANCE COMMISSIONER

You, your Authorized Representative, or a Health Care Provider must file a Grievance or Appeal with us and exhaust our internal grievance or internal appeals process as described in this section prior to filing a Complaint with the Insurance Commissioner except when:

1. The Coverage Decision involves an Urgent Medical Condition for which care has not been rendered;
2. You, your Authorized Representative, or a Health Care Provider provides sufficient information and supporting documentation in the Complaint that supports a compelling reason to not exhaust our internal process for resolving Grievances (protests regarding Adverse Decisions), such as, when a delay in receiving the Health Care Service could result in loss of life, serious impairment to bodily organ or part, or your remaining seriously mentally ill with symptoms that cause you to be in danger to self or others;
3. We failed to make a Grievance Decision for a pre-service Grievance within thirty (30) working days after the filing date, or the earlier of forty-five (45) working days or sixty (60) calendar days after the filing date for a post-service Grievance;
4. We or our representative failed to make a Grievance Decision for an expedited Grievance for an Emergency Case within twenty-four (24) hours after you or your Authorized Representative filed the Grievance;
5. We have waived the requirement that our internal grievance process must be exhausted before filing a Complaint with the Commissioner;
6. We have failed to comply with any of the requirements of the internal grievance process; or
7. The member, member's Authorized Representative or the health care provider provides sufficient information and documentation in the complaint that demonstrates a compelling reason to do so.

The Maryland Insurance Commissioner may be contacted at:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeal and Grievance
200 St. Paul Place
Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000
Toll free/out-of-area: 1-800-492-6116
TTY: 1-800-735-2258
Fax: 410-468-2260 or 410-468-2270

INTERNAL GRIEVANCE PROCESS

This process applies to a utilization review determination made by us that a proposed or delivered Health Care Service was not medically necessary, appropriate or efficient thereby resulting in non-coverage of the Health Care Service.

Initiating a Grievance

You or your Authorized Representative may initiate a Grievance by submitting a written request, including all supporting documentation that relates to the Grievance to:

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

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Member Services Appeals Unit
Kaiser Permanente
2101 East Jefferson Street
Rockville, MD 20852
Fax: 1-866-640-9826

The Grievance must be filed in writing within one-hundred eighty (180) calendar days from the date of receipt of the Adverse Decision notice. If the Grievance is filed after the one-hundred eighty (180) calendar days, we will send a letter denying any further review due to lack of timely filing.

If within five (5) working days after you or your Authorized Representative file a Grievance we need additional information to complete our internal Grievance process, we shall notify you or your Authorized Representative that we cannot proceed with review of the Grievance unless we receive the additional information. If assistance is needed and requested, we will assist you or your Authorized Representative in gathering the necessary additional information without further delay.

Grievance Acknowledgment

We will acknowledge receipt of a Grievance within five (5) working days of the filing date of the written Grievance notice. The filing date is the earliest of five (5) calendar days after the date of mailing (postmark) or the date of receipt.

Pre-service Grievance

If the Grievance is for a Health Care Service that the Member is requesting (that is, the Health Care Service has not been rendered), an acknowledgment letter will be sent requesting any additional information that may be necessary within five (5) working days after the filing date. We will also inform you and your Authorized Representative that a decision will be made regarding the Grievance in writing, and such written notice will be sent within thirty (30) working days of the filing date of the Grievance.

Post-service Grievance

If the Grievance is asking for payment for Health Care Services already rendered, a retrospective acknowledgment letter will be sent requesting additional information that may be necessary within five (5) working days after the filing date. We will also inform you and your Authorized Representative that a decision will be made in writing and such written notice will be made within the earliest of forty-five (45) working days or sixty (60) calendar days of the filing date of the Grievance.

For both pre-service and post-service Grievances, if there will be a delay in our concluding the Grievance in the designated period, we will send you and your Authorized Representative a letter requesting an extension. Such extension period shall not exceed more than thirty (30) working days. If you or your Authorized Representative do not agree to the extension, then the Grievance will be completed in the original designated period. Any agreement to extend the period for a Grievance decision will be documented in writing.

If the pre-service or post-service Grievance is approved, a letter will be sent to you and your Authorized Representative stating the approval. If the Grievance was filed by your Authorized Representative, then a letter stating the Grievance Decision will also be sent to you.

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If the pre-service or post-service Grievance results in a denial, we will notify you and your Authorized Representative of the decision within thirty (30) working days or no later than the last day of the extension period for a pre-service Grievance or the earlier of forty-five (45) working days or sixty (60) calendar days from the date of filing or no later than the last day of the extension period for a post-service Grievance.

We will communicate our decision to you or your Authorized Representative verbally and will send a written notice of such verbal communication within five (5) working days of the verbal communication to you and your Authorized Representative.

If we fail to make a Grievance Decision within the stated timeframes herein, or an extension of such timeframe, you or your Authorized Representative may file a Complaint with the Commissioner without waiting to hear from us.

Note: In cases which a complaint against the Health Plan's Grievance Decision is filed with the Commissioner, you or your Authorized Representative must authorize the release of medical records that may be required to assist the Commissioner with reaching a decision in the Complaint.

EXPEDITED GRIEVANCES FOR EMERGENCY CASES

You or your Authorized Representative may seek an expedited review in the event of an Emergency Case as that term is defined in this section. An expedited review of an Emergency Case may be initiated by calling 1-800-777-7902.

Once expedited review is initiated, clinical review will determine if you have a medical condition which meets the definition of an Emergency Case. A request for expedited review must contain the telephone number where we may reach you or your Authorized Representative in an effort to communicate regarding our review. In the event that additional information is necessary for us to make a determination regarding the expedited review, we will notify you or your Authorized Representative by telephone to inform him/her that review of the expedited review may not proceed unless certain additional information is received. Upon request, we will assist you or your Authorized Representative in gathering such information so that a determination may be made within the prescribed timeframes.

If the clinical review determines that you do not have the requisite medical condition, the request will be managed as a non-expedited Grievance pursuant to the procedure outlined above. If we determine that an urgent medical condition does not exist, we will verbally notify you or your Authorized Representative within twenty-four (24) hours, and inform you or the Authorized Representative of the right to file a Complaint with the Commissioner.

If we determine that an Emergency Case does exist, then the expedited review request will be reviewed by a physician who is board certified or eligible in the same specialty as the treatment under review and who is not the individual (or the individual's subordinate) who made the initial decision. If additional information is needed to proceed with the review, we will contact you or your Authorized Representative by telephone or facsimile.

Within twenty-four (24) hours of the filing date of the expedited review request, we will verbally notify you or your Authorized Person of our decision. We will send written notification to you or your Authorized Representative within one (1) calendar day after the decision is verbally communicated. If approval is recommended, then we will assist you in arranging the authorized treatment or benefit. If the

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expedited review results in a denial, we will notify you and your Authorized Representative within one (1) calendar day after the decision is verbally communicated.

If we fail to make a decision within the stated timeframes for an expedited review, you or your Authorized Representative may file a Complaint with the Commissioner without waiting to hear from us.

NOTICE OF ADVERSE GRIEVANCE DECISION

If our review of a Grievance, including an expedited Grievance, results in denial, we will send you and your Authorized Representative written notice of our Grievance Decision within the time frame stated above. This notification shall include:

1. The specific factual basis for the decision in clear understandable language;
2. References to any specific criteria or standards on which the decision was based, including but not limited to interpretive guidelines used by us;
3. A statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request. In addition, you or your Authorized Representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of your or your Authorized Representative's claim;
4. The name, business address and business telephone number of the medical director who made the Grievance Decision;
5. A description of your or your Authorized Representative's right to file a complaint with the Commissioner within four (4) months after receipt of our Grievance Decision;
6. The Commissioner's address and telephone and facsimile numbers;
7. A statement that the Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a complaint about the Health Plan with the Commissioner;
8. The Health Education and Advocacy Unit's address, telephone and facsimile numbers and electronic mail address; and
9. The Health Plan must provide notice of an adverse decision in a non-English language if certain thresholds are met for the number of people who are literate in the same non-English language. A threshold language applies to a county if at least 10 percent of the population is literate only in the same foreign language that is identified as a federally mandated non-English language. If we send you a notice of an adverse decision to an address in a county where a federally-mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. You or your Authorized Representative may request translation of the notice by contacting Member Services.

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INTERNAL APPEAL PROCESS

This process applies to our Coverage Decisions and you must exhaust our internal Appeal process prior to filing a Complaint with the Commissioner, except if our Coverage Decision involves an Urgent Medical Condition for which care has not been rendered.

Initiating an Appeal

These internal appeal procedures are designed by the Health Plan to assure that concerns are fairly and properly heard and resolved. These procedures apply to a request for reconsideration of a Coverage Decision rendered by the Health Plan regarding any aspect of the Health Plan's health care Service.

The Member or the Member's Authorized Representative must file an internal appeal within one-hundred eighty (180) calendar days from the date of receipt of the Coverage Decision. The Appeal should be sent to us at the following address:

Member Services Appeals Unit
Kaiser Permanente
2101 East Jefferson Street
Rockville, MD 20852
Fax: 1-866-640-9826

In addition, the Member or the Member's Authorized Representative may request an internal appeal by contacting Member Services. The Member or the Member's Authorized Representative, as applicable, may review the Health Plan's appeal file and provide evidence and testimony to support the appeal request.

Member Service Representatives are available by telephone each day during business hours to describe how internal appeals are processed and resolved and to assist with filing an internal appeal. The Member Service Representative can be contacted Monday through Friday from 7:30 a.m. to 9 p.m. ET within the local service area at 301-468-6000 or TTY 711.

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

In addition, prior to rendering its final decision, the Health Plan will provide the Member or Member's Authorized Representative, without charge, any new or additional evidence considered, relied upon, or generated by (or at the direction of) the Health Plan in connection with the Member or Member's Authorized Representative appeal. If during the Health Plan's review of the Member or Member's Authorized Representative appeal, it determines that an adverse coverage decision can be made based on a new or additional rationale, the Health Plan will provide the Member or Member's Authorized Representative with this new information prior to issuing its final coverage decision and explain how you can respond to the information if you choose to do so. The additional information will be provided to the Member or Member's Authorized Representative as soon as possible and sufficiently before the deadline

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to give the Member or Member's Authorized Representative a reasonable opportunity to respond to the new information.

Health Plan will respond in writing to an Appeal within thirty (30) calendar days for a pre-service claim, or sixty (60) calendar days for a post-service claim after our receipt of the Appeal.

If our review results in a denial, we will notify you and your Authorized Representative in writing within three (3) calendar days after the Appeal Decision has been verbally communicated. This notification will include:

1. The specific factual basis for the decision in clear understandable language;
2. Reference to the specific plan provision on which determination was based. In addition, you or your Authorized Representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of your or your Authorized Representative's claim;
3. A description of you or your Authorized Representative's right to file a Complaint with the Commissioner within four (4) months after receipt of our Appeals Decision;
4. The Commissioner's address and telephone and facsimile numbers;
5. A statement that the Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a complaint about the Health Plan with the Commissioner;
6. The Health Education and Advocacy Unit's address, telephone and facsimile numbers and electronic mail address; and
7. The Health Plan must provide notice of an appeal decision in a non-English language if certain thresholds are met for the number of people who are literate in the same non-English language. A threshold language applies to a county if at least 10 percent of the population is literate only in the same foreign language that is identified as a federally mandated non-English language. If we send you a notice of an appeal decision to an address in a county where a federally-mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. You or your Authorized Representative may request translation of the notice by contacting Member Services.

FILING COMPLAINTS ABOUT THE HEALTH PLAN

If you have any complaints about the operation of the Health Plan or your care, you or your Authorized Representative may file a complaint with:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health
200 St. Paul Place
Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000
Toll-free/out-of-area: 1-800-492-6116
TTY: 1-800-735-2258
Fax: 410-468-2260 or 410-468-2270

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SECTION 6: TERMINATION OF MEMBERSHIP

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

If a Subscriber's membership ends, the Subscriber's Dependents' membership ends at the same time.

If your membership terminates, all rights to benefits end at 11:59 p.m. ET (the time at the location of the administrative office of Health Plan at 2101 East Jefferson Street, Rockville, MD 20852) on the termination date. You will be billed the applicable fee for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Extension of Benefits" in this section.

TERMINATION DUE TO LOSS OF ELIGIBILITY

Your membership will terminate if you no longer meet the conditions under which you became eligible to be enrolled, as described under "Who is Eligible" in Section 1.

If you are eligible on the 1st day of a month, but later in that month you no longer meet those eligibility requirements, your membership terminates on the last day of that month unless your Group has an arrangement with us to terminate at a time other than the last day of the month. Please check with the Group's benefits administrator to confirm your termination date.

If the Subscriber no longer lives or works within the Health Plan's Service Area, we may terminate the membership of the Subscriber and all Dependents in his or her Family Unit by sending notice of termination at least thirty (30) days prior to the termination date.

TERMINATION OF GROUP AGREEMENT

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

The Subscriber's Group is required to inform the Subscriber of the date your coverage terminates.

TERMINATION FOR CAUSE

We may terminate the memberships of the Subscriber and all Dependents in his or her Family Unit, by sending written notice to the Subscriber at least thirty (30) days before the termination date, if the Subscriber knowingly enrolls non-eligible persons as dependents, or intentionally fails to notify us that a Dependent is no longer eligible.

By sending written notice to the Subscriber at least thirty (30) days before the termination date, we may terminate you or your Dependent's membership for cause if:

1. You or your Dependent(s) knowingly perform an act, practice or omission that constitutes fraud, which under certain circumstances may include, but is not limited to, presenting a fraudulent prescription or physician order, selling your prescription or allowing someone else to obtain Services using your membership ID card; or
2. You or your Dependent(s) make an intentional misrepresentation of material fact.

If the fraud or intentional misrepresentation was committed by the Subscriber, we may terminate the memberships of the Subscriber and all Dependents in the Family Unit.

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If the fraud or intentional misrepresentation was committed by a Dependent, we may terminate the membership of only that Dependent.

We may report any Member fraud to the authorities for prosecution.

TERMINATION FOR NONPAYMENT

Nonpayment of Premium

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

EXTENSION OF BENEFITS

In those instances when your coverage with us has terminated, we will extend benefits for covered Services, without Premium, in the following instances:

1. If you are Totally Disabled at the time your coverage ends, we will continue to provide benefits for covered Services related to the condition causing the disability. Coverage will stop at the point you no longer qualify as being Totally Disabled, or up to twelve (12) months from the date your coverage ends, whichever comes first.
2. If you have ordered eyeglasses or contact lenses before the date your coverage ends, we will provide benefits for covered eyeglasses or contact lenses received within thirty (30) days following the date you placed the order.
3. If you are in the midst of a course of covered dental treatment at the time your coverage ends, we will continue to provide benefits, in accordance with the EOC in effect at the time your coverage ended, for a period of ninety (90) days following the date your coverage ended.
4. If you are in the midst of a course of covered orthodontic treatment at the time your coverage ends, we will continue to provide benefits, in accordance with the EOC in effect at the time your coverage ended, for a period of:
 - a. Sixty (60) days following the date your coverage ended if the orthodontist has agreed to or is receiving monthly payments; or
 - b. Until the latter of sixty (60) days following the date your coverage ended, or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

To assist us, if you believe you qualify under this “Extension of Benefits” provision, we encourage you to notify us in writing.

Limitations

The “Extension of Benefits” section listed above does not apply to the following:

1. Failure to pay Premium by the Member;
2. Members’ whose coverage ends because of fraud or material misrepresentation by the Member;
3. When coverage is provided by another health plan and that health plan’s coverage:
 - a. Is provided at a cost to the individual that is less than or equal to the cost to the individual of the extended benefit available under this EOC; and
 - b. Will not result in an interruption of benefits to the Member.

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

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Discontinuation of a Product or All Products

We may discontinue offering a particular product or all products in a market, as permitted by law. If we discontinue offering in a market the product described in this EOC, we will give ninety (90) days prior written notice to the Subscriber. If we discontinue offering all products to groups in a market, we will give one-hundred eighty (180) days prior written notice to the Subscriber.

CONTINUATION OF GROUP COVERAGE UNDER FEDERAL LAW

COBRA

You or your Dependents may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if permitted by the federal COBRA law. Members are not ineligible for COBRA continuation coverage solely because they live in another Kaiser Foundation Health Plan or allied plan service area. Please contact your Group to know whether you or your Dependents are eligible for COBRA coverage, how to elect COBRA coverage or how much you will have to pay your Group for it.

USERRA

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. Members are not ineligible for USERRA continuation coverage solely because they move or live outside our Service Area. You must submit a USERRA election form to your Group within sixty (60) days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

CONTINUATION OF COVERAGE UNDER STATE LAW

Death of the Subscriber

If you would otherwise lose coverage due to the Subscriber's death, you may continue uninterrupted coverage hereunder, upon arrangement with the Group in compliance with applicable Maryland law.

The election period for such coverage shall begin on the date on which there has been an applicable change in status, and end no sooner than forty-five (45) days after such date.

1. Group coverage under this section continues, for those Dependents who are eligible for state continuation coverage, only upon payment of applicable monthly charges, which may include an allowable reasonable administrative fee, not to exceed 2 percent of the entire cost to the employer, allocated predetermined amount to your Group's Premium charge, and terminates on the earliest of:
 - a. Termination of this Agreement; or
 - b. Eligibility of the Member under any other group health plan or entitlement to Medicare benefits; or
 - c. Acceptance of coverage under any non-group health insurance plan or health maintenance organization; or

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- d. Dependent Child that ceases to qualify as a as a dependent child under dependent eligibility requirements; or
- e. Expiration of eighteen (18) calendar months after the death of the Subscriber; or
- f. Termination by the Subscriber.

Divorce of the Subscriber and his/her Spouse

If you who would otherwise lose coverage due to divorce from the Subscriber, you may continue uninterrupted coverage hereunder, upon arrangement with the Group in compliance with applicable Maryland law.

The notification period for the applicable change in status provided under Maryland law shall begin with the date on which there has been a change in status and end no sooner than sixty (60) days after such date.

- 1. Group coverage under this section continues, for those Dependents who are eligible for state continuation coverage, only upon payment of applicable monthly charges to Group at the time specified by Group, and terminates on the earliest of:
 - a. Termination of this Agreement; or
 - b. Eligibility of the Member under any other group health plan or entitlement to Medicare benefits; or
 - c. Acceptance of coverage under any non-group health insurance plan or health maintenance organization; or
 - d. Ceasing to qualify as a dependent child; or
 - e. Marriage of the Member who is the divorced spouse of the Subscriber.

Voluntary or Involuntary Termination of a Subscriber's Employment for Reasons Other Than for Cause

If you would otherwise lose coverage due to the voluntary or involuntary termination of the Subscriber's employment, for any reason other than for cause, you may continue uninterrupted coverage hereunder, upon arrangement with Group in compliance with applicable Maryland law, if the Subscriber lives in Maryland.

- 1. Coverage under this section continues only upon payment of applicable monthly charges, which may include an allowable reasonable administrative fee not to exceed 2% of the entire cost to the employer, to your Group's Premium charge at the time specified by Group, and terminates on the earliest of:
 - a. Termination of this Agreement; or
 - b. Eligibility of the Subscriber under any other group health plan or entitlement to Medicare benefits; or
 - c. The Subscriber's acceptance of coverage under any non-group health plan or health maintenance organization; or
 - d. Dependent Child that ceases to qualify as a as a dependent child under dependent eligibility requirements; or
 - e. Expiration of eighteen (18) calendar months after the termination of Subscriber's employment; or
 - f. Termination by the Subscriber.

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Coverage under the Continuation Provision of Group's Prior Plan

An individual who previously had continued group coverage with a health benefits carrier or health maintenance organization other than the Health Plan and who becomes, by virtue of applicable Maryland law, eligible to continue group coverage with the Health Plan, may enroll in the Health Plan and continue coverage as set forth in this section.

For purposes of this section, "Member" includes a child born to a surviving or divorced spouse who is enrolled under this section.

Unless otherwise agreed to by Group, subject to these provisions, a person who is a Member hereunder on the 1st day of a month is covered for the entire month.

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SECTION 7: MISCELLANEOUS PROVISIONS

ADMINISTRATION OF AGREEMENT

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

ADVANCE DIRECTIVES

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

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

For additional information about Advance Directives, including how to obtain forms, including the information sheet developed by the Maryland Department of Health and Mental Hygiene and the Attorney General, and instructions, visit our website at kp.org or contact Member Services:

Inside the Washington, DC Metropolitan Area: (301) 468-6000

Outside of the Washington, DC Metropolitan Area: 1-800-777-7902

TTY: 711

AMENDMENT OF AGREEMENT

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

APPLICATIONS AND STATEMENTS

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

ASSIGNMENT

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

ATTORNEY FEES AND EXPENSES

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

CONTESTABILITY

The contract may not be contested, except for non-payment of Premiums, after it has been in force for two (2) years from the date of issue.

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A statement made by a Member covered under the contract relating to insurability may not be used in contesting the validity of coverage with respect to which the statement was made after coverage had been in force before the contest for a period of two (2) years during the Member's lifetime.

Absent of fraud, each statement made by an applicant, employer or Member is considered a representation and not a warranty. Therefore, a statement made to effectuate coverage may not be used to void coverage or reduce benefits under the contract unless:

1. The statement is contained in a written instrument signed by the applicant, employer or Member; and
2. A copy of the statement is provided to the applicant, employer or Member.

CONTRACTS WITH PLAN PROVIDERS

The Health Plan and Plan Providers are independent contractors. Your Plan Providers are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee for service and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call Member Services:

Inside the Washington, DC Metropolitan Area: (301) 468-6000

Outside of the Washington, DC Metropolitan Area: 1-800-777-7902

TTY: 711

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from Non-Plan Providers, except as provided in this EOC for:

1. Emergency Services;
2. Urgent Care outside our Service Area;
3. Authorized referrals; or
4. Care in other Health Plan Regions.

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

GOVERNING LAW

Except as preempted by federal law, this EOC will be covered in accordance with the law of the State of Maryland. Any provision that is required to be in this EOC by state or federal law shall bind Members and the Health Plan, whether or not it is set forth in this EOC.

NOTICE OF NON-GRANDFATHERED COVERAGE

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

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

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GROUPS AND MEMBERS NOT HEALTH PLAN'S AGENTS

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

MEMBER RIGHTS AND RESPONSIBILITIES

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

Member Rights

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

- 1. Receive information that empowers you to be involved in health care decision making. This includes your right to:**
 - a. Actively participate in discussions and decisions regarding your health care options;
 - b. Receive and be helped to understand information related to the nature of your health status or condition, including all appropriate treatment and non-treatment options for your condition and the risks involved - no matter what the cost is or what your benefits are;
 - c. Receive relevant information and education that helps promote your safety in the course of treatment;
 - d. Receive information about the outcomes of health care you have received, including unanticipated outcomes. When appropriate, family members or others you have designated will receive such information;
 - e. Refuse treatment, providing you accept the responsibility and consequences of your decision.
 - f. Give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself by completing and giving us an Advance Directive, a durable power of attorney for health, living will, or other health care treatment directive. You can rescind or modify these documents at any time;
 - g. Receive information about research projects that may affect your health care or treatment. You have the right to choose to participate in research projects; and
 - h. Receive access to your medical records and any information that pertains to you, except as prohibited by law. This includes the right to ask us to make additions or corrections to your medical record. We will review your request based on HIPAA criteria to determine if the requested additions are appropriate. If we approve your request, we will make the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. You, or your Authorized Representative, will be asked to provide written permission before your records are released, unless otherwise permitted by law.

- 2. Receive information about Kaiser Permanente and your plan. This includes your right to:**
 - a. Receive the information you need to choose or change your primary care Plan Physician, including the name, professional level, and credentials of the doctors assisting or treating you;
 - b. Receive information about Kaiser Permanente, our Services, our practitioners and providers, and the rights and responsibilities you have as a Member. You also can make recommendations regarding Kaiser Permanente's member rights and responsibility policies;

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- c. Receive information about financial arrangements with physicians that could affect the use of Services you might need;
 - d. Receive Emergency Services when you, as a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed;
 - e. Receive covered urgently needed Services when traveling outside Kaiser Permanente's Service Area;
 - f. Receive information about what Services are covered and what you will have to pay and to examine an explanation of any bills for Services that are not covered; and
 - g. File a complaint, grievance or appeal about Kaiser Permanente or the care you received without fear of retribution or discrimination, expect problems to be fairly examined, and receive an acknowledgement and a resolution in a timely manner.
- 3. Receive professional care and service. This includes your right to:**
- a. See Plan Providers, get covered health care Services and get your prescriptions filled within a reasonable period of time and in an efficient, prompt, caring, and professional manner;
 - b. Have your medical care, medical records and protected health information handled confidentially and in a way that respects your privacy;
 - c. Be treated with respect and dignity;
 - d. Request that a staff member be present as a chaperone during medical appointments or tests.
 - e. Receive and exercise your rights and responsibilities without any discrimination based on age, gender, sexual orientation, race, ethnicity, religion, disability, medical condition, national origin, educational background, reading skills, ability to speak or read English, or economic or health status including any mental or physical disability you may have;
 - f. Request interpreter Services in your primary language at no charge; and
 - g. Receive health care in facilities that are environmentally safe and accessible to all.

Member Responsibilities

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

1. Promote your own good health:

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

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2. Know and understand your plan and benefits:

- a. Read about your health care benefits in this EOC and become familiar with them. Call us when you have questions or concerns;
- b. Pay your plan premiums and bring payment with you when your visit requires a Copayment, Coinsurance or Deductible; and
- c. Let us know if you have any questions, concerns, problems or suggestions.

3. Promote respect and safety for others:

- a. Extend the same courtesy and respect to others that you expect when seeking health care Services; and
- b. Assure a safe environment for other members, staff and physicians by not threatening or harming others.

NAMED FIDUCIARY

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

NO WAIVER

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

NONDISCRIMINATION

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

NOTICES

Our notices to you will be sent to the most recent address we have on file for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call Member Services as soon as possible to give us their new address:

Inside the Washington, DC Metropolitan Area: (301) 468-6000

Outside of the Washington, DC Metropolitan Area: 1-800-777-7902

TTY: 711

OVERPAYMENT RECOVERY

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

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PRIVACY PRACTICES

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

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

This is only a brief summary of some of our key privacy practices. For a more detailed explanation of our privacy practices please refer to the *Notice of Privacy Practices*, which provides additional information about our privacy practices and your rights regarding your PHI. It is mailed with your enrollment materials or available on our website at www.kp.org.

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DEFINITIONS APPENDIX

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

Adverse Decision: A utilization review decision made by the Health Plan that:

1. A proposed or delivered Service is or was not Medically Necessary, appropriate or efficient; and
2. May result in non-coverage of the Health Care Service.

An Adverse Decision does not include a decision about the enrollment status as a Member under the Health Plan.

Allowable Charges (AC): means either:

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

For non-Plan Providers, the Allowable Charge shall not be less than the amount the Health Plan must pay pursuant to §19-710.1 of the Health General Article of the Annotated Code of Maryland.

Allowable Expense: A health care service or expense, including Deductibles, Coinsurance or Copayments that is covered in full or in part by any of the Plans covering the Member. This means that an expense or healthcare service or a portion of an expense or health care service that is not covered by any of the Plans is not an allowable expense. For example, if a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room usually is not an Allowable Expense. "Allowable Expense does not include coverage for dental care except as provided under "Accidental Dental Injuries" in Section 3: Benefits.

Appeal: A protest filed in writing by a Member or his or her Authorized representative with the Health Plan under its internal appeal process regarding a Coverage Decision concerning a Member. An Appeal does not include a verbal request for reconsideration of a benefit and/or eligibility determination.

Appeal Decision: A final determination by the Health Plan that arises from an Appeal filed with the Health Plan under its Appeal process regarding a Coverage Decision concerning a Member.

Authorized Representative: An individual authorized by the Member in writing or otherwise authorized by state law to act on the Member's behalf to file claims and to submit Appeals or Grievances to the Health Plan. A Health Care Provider (as defined below) may act on behalf of a Member with the Member's express consent, or without such consent in an Emergency Case.

Caregiver: An individual primarily responsible for the day-to-day care of the Member during the period in which the Member receives Hospice Care Services.

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

Coinsurance: The percentage of Allowable Charges that you must pay when you receive a covered Service as listed under "Copayments and Coinsurance" in the Summary of Services and Cost Shares section of the Appendix.

Commissioner: The Maryland Insurance Commissioner.

Complaint: A protest filed with the Commissioner involving a Coverage Decision or Adverse Decision as described in this section.

Complex or Chronic Medical Condition: A physical, behavioral, or developmental condition that: (1) may have no known cure; (2) is progressive; or (3) can be debilitating or fatal if left untreated or undertreated. Complex or Chronic Medical Condition includes, but is not limited to: Multiple Sclerosis, Hepatitis C, and Rheumatoid Arthritis.

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

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

Coverage Decision: An initial determination by the Health Plan or a representative of the Health Plan that results in non-coverage of a Health Care Service. Coverage Decision includes: a determination by a Health Plan that an individual is not eligible for coverage under the Health Plan's health benefit plan; any determination by the Health Plan that results in the rescission of an individual's coverage under a health benefit plan; or nonpayment of all or any part of a claim. A Coverage Decision does not include an Adverse Decision.

Deductible: The Deductible is an amount of Allowable Charges you must incur during a contract year for certain covered Services before we will provide benefits for those Services. Please refer to the Summary of Services and Cost Shares section of the Appendix, for the Services that are subject to Deductible and the amount of the Deductible.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements see "Who Is Eligible" in Section 1: Introduction).

Domestic Partner: An individual in a relationship with another individual of the same or opposite sex, provided both individuals:

1. Are at least age 18;
2. Are not related to each other by blood or marriage within four (4) degrees of consanguinity under civil law rule;
3. Are not married or in a civil union or domestic partnership with another individual;

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4. Have been financially interdependent for at least six (6) consecutive months prior to application in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely; and
5. Share a common primary residence.

Emergency Case: A case in which an Adverse Decision was rendered pertaining to Health Care Services which have yet to be delivered and such Health Care Services are necessary to treat a condition or illness that, without medical attention would (1) seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function or (2) cause the Member to be in danger to self or others.

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

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

Emergency Services: With respect to an Emergency Medical Condition, as defined above:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and,
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

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

Family Coverage: Any coverage other than Self-Only Coverage.

Family Member: A relative by blood, marriage, domestic partnership or adoption of the terminally ill Member.

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

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

Grievance: A protest filed by a Member or his or her Authorized Representative with Health Plan through our internal grievance process regarding an Adverse Decision concerning the Member. A Grievance does not include a verbal request for reconsideration of a Utilization Review determination.

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Grievance Decision: A final determination by the Health Plan that arises from a Grievance filed with us under our internal grievance process regarding an Adverse Decision concerning a Member.

Group – The entity with which we have entered into the Agreement that includes this Evidence of Coverage.

Habilitative Services: Services and devices, including occupational therapy, physical therapy, and speech therapy that help a child keep, learn, or improve skills and functioning for daily living.

Health Education and Advocacy Unit: The Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.

Health Care Provider: (1) An individual who is: licensed or otherwise authorized in this State to provide health care services in the ordinary course of business or practice of a profession and is the treating provider of the Member; or (2) a hospital.

Health Care Service: A health or medical care procedure or service rendered by a Health Care Provider that:

1. Provides testing, diagnosis, or treatment of a human disease or dysfunction; or
2. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction; or
3. Provides any other care, service or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well-being of human beings.

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

Health Savings Account (HSA): A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions made to a HSA by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified High Deductible Health Plan (HDHP) and meet other tax law requirements. Kaiser Permanente does not provide tax advice. Consult with your financial or tax advisor for more information about your eligibility for a HSA.

High Deductible Health Plan (HDHP): A health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. The health care coverage under this Agreement has been designed to be an HDHP qualified for use with a Health Savings Account (HSA).

Hospice Care Services: A coordinated, inter-disciplinary program of Hospice Care Services for meeting the special physical, psychological, spiritual and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing and other health Services through home or inpatient care during the illness and bereavement to (1) individuals who have no reasonable prospect of cure as estimated by a physician and (2) Family Members and Caregivers of those individuals.

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

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

Medically Necessary: Medically Necessary means that the Service is all of the following:

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1. Medically required to prevent, diagnose or treat the Member's condition or clinical symptoms;
2. In accordance with generally accepted standards of medical practice;
3. Not solely for the convenience of the Member, the Member's family and/or the Member's provider; and
4. The most appropriate level of Service which can safely be provided to the Member. For purposes of this definition, "generally accepted standards of medical practice" means:
 - a. Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
 - b. Physician specialty society recommendations;
 - c. The view of physicians practicing in the Kaiser Permanente Medical Care Program; and/or
 - d. Any other relevant factors reasonably determined by us. Unless otherwise required by law, we decide if a Service (described in Section 3) is Medically Necessary and our decision is final and conclusive subject to the Member's right to appeal, or go to court, as set forth in Section 5.

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

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

Non-Physician Specialist: A health care provider who:

1. Is not a physician;
2. Is licensed or certified under the Health Occupations Article; and
3. Is certified or trained to treat or provide Health Care Services for a specified condition or disease in a manner that is within the scope of the license or certification of the Health Care Provider.

Orthotic Device: An appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of movable parts of the body.

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

Plan: Kaiser Permanente.

Plan Facility: A Plan Medical Center, a Plan Hospital or another freestanding facility that (1) is operated by us or contracts to provide Services and supplies to Members and (2) is included in your Signature provider network.

Plan Hospital: A hospital that (1) contracts to provide inpatient and/or outpatient Services to Members and (2) is included in your Signature provider network.

Plan Medical Center: Medical office and specialty care facilities such as imaging centers operated by us in which Medical Group and other Health Care Providers including Non-Physician Specialists employed by us provide primary care, specialty care and ancillary care Services to Members.

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

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Plan Physician: Any licensed physician who is an employee of Medical Group, or any licensed physician (except for those physicians who contract only to provide Services upon referral) who (1) contracts to provide Services and supplies to Members and (2) is included in your Signature provider network.

Plan Provider: A Plan Physician, or other health care provider including but not limited to a Non-Physician Specialist, and Plan Facility that (1) is employed by or operated by an entity that participates in the Kaiser Permanente Medical Care Program or (2) contracts with an entity that participates in the Kaiser Permanente Medical Care Program.

Premium: Periodic membership charges paid by Group.

Prosthetic Device: An artificial substitute for a missing body part used for functional reasons.

Rare Medical Condition: A disease or condition that affects less than 200,000 individuals in the United States or approximately 1 in 1,500 individuals worldwide. Rare Medical Condition includes, but is not limited to: Cystic Fibrosis, Hemophilia, and Multiple Myeloma.

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

Self-Only Coverage: Coverage for a Subscriber only, with no Dependents covered under this Plan.

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

Services: Health Care Services or items.

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

Specialty Drugs: A prescription drug that: (1) is prescribed for an individual with a Complex or Chronic Medical Condition, or a Rare Medical Condition; (2) costs \$600 or more for up to a 30-day supply; (3) is not typically stocked at retail pharmacies; and (4) requires a difficult or unusual process of delivery to the Member in the preparation, handling, storage, inventory, or distribution of the drug; or requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug.

Spouse: The person to whom you are legally married under applicable law.

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to

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result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), “Stabilize” means to deliver (including the placenta).

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status (unless coverage is provided under a continuation of coverage provision) and who meets the eligibility requirements as a Subscriber. (For Subscriber eligibility requirements, see “Who is Eligible” in Section 1: Introduction).

Totally Disabled:

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

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

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

Urgent Medical Condition: As used in this section, a condition that satisfies either of the following:

1. A medical condition, including a physical, mental health or dental condition, where the absence of medical attention within seventy-two (72) hours could reasonably be expected by an individual, acting on behalf of the Health Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
 - a. Placing the Member's life or health in serious jeopardy;
 - b. The inability of the Member to regain maximum function;
 - c. Serious impairment to bodily function;
 - d. Serious dysfunction of any bodily organ or part; or
 - e. The Member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others; or
2. A medical condition, including a physical, mental health or dental condition, where the absence of medical attention within seventy-two (72) hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Coverage Decision.

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Summary of Services and Cost Shares

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

DEPENDENT AGE LIMIT

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

MEMBER COST-SHARE

Your Cost Share is the amount of the Allowable Charge for a covered Service that you must pay through Deductibles, Copayments and Coinsurance. The Cost Share, if any, is listed for each Service in this “Summary of Services and Cost Shares.” Allowable Charge is defined in the Definitions Appendix of this EOC.

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

DEDUCTIBLE

The Deductible is the amount of Allowable Charges you must incur during a contract year for certain covered Services before Health Plan will begin paying benefits for those Services. The Deductible applies to all covered Services except Preventive Health Care Services as described in Section 3, Benefits, and outpatient Prescription Drugs. Preventive Health Care Services may be subject to a Copayment as shown below.

For covered Services that are subject to a Deductible, you must pay the Allowable Charges for the Services when you receive them, until you meet your Deductible. The only amounts that count toward your Deductible are the Allowable Charges you incur for Services that are subject to the Deductible, but only if the Service would otherwise be covered. After you meet the Deductible, you pay the applicable Coinsurance for these Services for the rest of the contract year.

Self-Only Coverage Deductible. If you are covered as a Subscriber, and you do not have any Dependents covered under the plan, you must meet the Self-Only Deductible shown below.

Family Coverage Deductible. If you have one or more Dependents covered under this EOC, one or more covered Members of your Family Unit together must meet the Family Deductible shown below. After one or more covered Members of your Family Unit combined have met the Family Coverage Deductible, the Deductible will be met for all Members of the Family Unit for the rest of the contract year. The Individual Deductible shown below does not apply with Family Coverage. No one individual in a family will be required to pay more than the individual out-of-pocket maximum of \$7,350.

Keep Your Receipts. When you pay an amount toward your Deductible, we will give you a receipt. Keep your receipts. If you have an HSA account, you may need to prove to the IRS that distributions from your HSA were for qualified medical expenses. Also, if you have met your Deductible, and we have not received and processed all of your claims, you can use your receipts to prove that you have met your Deductible. You can also obtain a statement of the amounts that have been applied toward your Deductible from our Member Services Department.

Deductible

The amount you must pay each contract year for the Services indicated below before we provide benefits for those Services

Self-Only Deductible	\$1,500 per individual per contract year
Individual Deductible	per individual Family member per contract year
Family Deductible	\$3,000 per Family Unit per contract year

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Copayments and Coinsurance	
Covered Service	You Pay after Deductible
Outpatient Care	
Office visits (for other than preventive health care Services)	
Primary care office visits	20% of AC*
Specialty care office visits	20% of AC*
Consultations and immunizations for foreign travel	20% of AC*
Outpatient surgery	
• Outpatient surgery facility fee	20% of AC* after Deductible
• Outpatient surgery physician Services	20% of AC*
Diagnostic testing (not preventive screening) as described under Outpatient Care in Section 3	20% of AC*
Anesthesia	20% of AC* after Deductible
Respiratory therapy	20% of AC*
Medical social Services	20% of AC*
House calls	No charge
Hospital Inpatient Care	
All charges incurred during a covered stay as an inpatient in a hospital	20% of AC*
Accidental Dental Injury Services	
	Applicable Cost Shares will apply based on type and place of Service
Allergy Services	
Evaluations and treatment	Applicable Cost Shares will apply based on type and place of Service
Injection visit and serum	Applicable Cost Shares will apply, based on type and place of Service, not to exceed the cost of the serum plus administration
Ambulance Services	
Ambulance (Emergency transport by a licensed ambulance Service, per encounter)	20% of AC*
Ambulette (Non-emergent transportation Services ordered by a Plan Provider)	No charge
Anesthesia for Dental Services	
Anesthesia and associated hospital or ambulatory Services for certain individuals only.	20% of AC*
Blood, Blood Products and Their Administration	
	20% of AC*

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Covered Service	You Pay after Deductible
Chemical Dependency and Mental Health Services	
Treatment of mental illness, emotional disorders, drug and alcohol abuse described in Section 3: Benefits	
Inpatient treatment in a hospital or residential treatment center	20% of AC*
Partial hospitalization	20% of AC*
Outpatient office visits	
• Individual therapy	20% of AC*
• Group therapy	20% of AC*
• Intensive Outpatient Treatment	20% of AC*
• Medication evaluation and management	20% of AC*
• Methadone treatment	20% of AC* per week, but not to exceed 50% of the daily cost of the treatment
All other outpatient Services	
• Crisis intervention	20% of AC*
• Electroconvulsive Therapy (ECT)	20% of AC*
• Psychological and neuropsychological testing (for diagnostic purposes)	20% of AC*
Cleft Lip, Cleft Palate, or Both	Applicable Cost Shares will apply based on type and place of Service
Clinical Trials	Applicable Cost Shares will apply based on type and place of Service
Diabetic Equipment, Supplies and Self-Management Training	
Diabetic test strips	No charge
Diabetic equipment and supplies	20% of AC*
Self-management training	Applicable Cost Shares will apply based on type and place of Service
Dialysis	20% of AC*
Drugs, Supplies, and Supplements	Applicable Cost Shares will apply based on type and place of Service
Administered by or under the supervision of a Plan Provider	
Durable Medical Equipment	20% of AC*
Emergency Services	20% of AC*

**YOUR GROUP EVIDENCE OF COVERAGE (EOC)
KAISER PERMANENTE**

Covered Service	You Pay after Deductible
Family Planning	
Women's Preventive Services, including all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity are covered under Preventive Care at no charge.	
Voluntary termination of pregnancy	Applicable Cost Shares will apply based on type and place of Service
Male sterilization	No charge; Deductible waived
Habilitative Services	
Physical, Speech and Occupational therapy	20% of AC*
Applied Behavioral Analysis (ABA)	20% of AC*
Assistive Devices	Applicable DME cost share will apply
Hearing Services	
Hearing tests (newborn hearing screening tests are covered under preventive health care Services at no charge)	Applicable office visit Cost Share will apply based on type and place of Service
Hearing aids for children up until the end of the month they turn age 19	
<ul style="list-style-type: none"> • Hearing aid tests 	Applicable office visit Cost Share will apply based on type and place of Service
<ul style="list-style-type: none"> • Hearing aids (Limited to a hearing aid per ear, every 36 months.) 	No charge
Home Health Care	20% of AC*
See Section 3 for benefit limitations.	
Hospice Care	20% of AC*
Infertility Services	50% of AC*
Maternity Services	
Delivery and all inpatient Services	20% of AC*
Outpatient delivery and all Services (i.e., birthing centers, certified midwife)	Applicable Cost Shares will apply based on type and place of Service
Prenatal care and the first post-natal visit	No charge; Deductible waived
Postpartum home visits	No charge
Breast Pumps	No charge; Deductible waived
Note: Maternity Services that are required by the Affordable Care Act are covered under Preventive Care Services at no charge.	

**YOUR GROUP EVIDENCE OF COVERAGE (EOC)
KAISER PERMANENTE**

Covered Service	You Pay after Deductible
Medical Foods (including Amino Acid-based Elemental Formula)	20% of AC*
Medical Nutrition Therapy & Counseling	20% of AC*
Morbid Obesity Services	Applicable Cost Shares will apply based on type and place of Service
Oral Surgery	Applicable Cost Shares will apply based on type and place of Service
Temporomandibular Joint (TMJ) Services	Applicable Cost Shares will apply based on type and place of Service
TMJ Appliances	Applicable Cost Shares will apply based on type and place of Service
Preventive Health Care Services Not subject to Deductible	No Charge
Prosthetic and Orthotic Devices	
External Orthotics	
<ul style="list-style-type: none"> • Rigid and semi-rigid orthotic devices (Limited to standard devices) 	20% of AC*
<ul style="list-style-type: none"> • Therapeutic shoes and inserts (Limited to individuals who have diabetic foot disease with impaired sensation or altered peripheral circulation) 	20% of AC*
External Prosthetics	
<ul style="list-style-type: none"> • Artificial eyes, legs, and arms 	20% of AC*
<ul style="list-style-type: none"> • Breast prosthesis following a Medically Necessary mastectomy (Limited to two prosthetic bras per year) 	20% of AC* after Deductible
<ul style="list-style-type: none"> • Ostomy and urological supplies 	20% of AC*
<ul style="list-style-type: none"> • Hair prostheses (Limited to one prosthesis per course of chemotherapy and/or radiation therapy, not to exceed a maximum benefit of \$350 per prosthesis.) 	No charge
Internal Prosthetics	20% of AC*
Reconstructive Surgery	20% of AC*
Skilled Nursing Facility Care Limited to a maximum benefit of 100 days per contract year	20% of AC*
Telemedicine Services	No charge
Therapy and Rehabilitation Services (Refer to Section 3 for benefit maximums)	20% of AC*

**YOUR GROUP EVIDENCE OF COVERAGE (EOC)
KAISER PERMANENTE**

Covered Service	You Pay after Deductible
Therapy: Radiation/Chemotherapy/Infusion Therapy	
Chemotherapy and Radiation Therapy	20% of AC*
Infusion Therapy	Applicable Cost Shares will apply based on type and place of Service
Transplants	
	20% of AC*
Urgent Care	
	20% of AC*
Vision Services	
Adult Vision (for adults age 19 or older)	
Routine eye exams/refractions - Optometry Services	20% of AC* after Deductible
Eye Care (Medical Treatment) - Ophthalmology Services	20% of AC*
Eyeglass lenses and frames	You receive a 25% discount off retail price** for eyeglass lenses and for eyeglass frames
Contact lenses	You receive a 15% discount off retail price** on initial pair of contact lenses
Pediatric Vision (for children under age 19)	
Note: A child is covered until the end of the month in which the child attains age 19.	
Routine eye exams/refractions - Optometry Services	20% of AC* after Deductible
Eye Care (Medical Treatment) - Ophthalmology Services	20% of AC*
Eyeglass lenses and frames (Limited to one pair of lenses and frames per year from a select group. Lenses limited to single vision or bifocal lenses (ST28) in polycarbonate or plastic. Glasses not available if contacts are substituted for glasses.)	No charge for one pair per contract year
Contact lenses (Includes fitting fee and initial supply (based on standard packaging for type purchased) from a select group. Regular contacts may be substituted for pediatric lenses/frames once per calendar year.)	No charge for initial fit and first purchase per contract year
Medically necessary contact lenses (Limited to a select group)	No charge
Low Vision Aids (Unlimited from available supply)	No charge

YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

Covered Service	You Pay after Deductible
X-ray, Laboratory and Special Procedures	
Diagnostic Imaging and laboratory tests	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	20% of AC* after Deductible
Specialty Imaging (including CT, MRI, PET Scans, Nuclear Medicine); Interventional Radiology and Special Procedures	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	20% of AC*
Sleep lab	20% of AC*
Sleep studies	20% of AC*
<p>Note: Charges for covered outpatient diagnostic and laboratory tests performed in a Plan Physician's office are included in the office visit Copayment.</p>	

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the limit to the total amount of Deductible, Copayments and Coinsurance you must pay in a contract year. Once you or your Family Unit have met your Out-of-Pocket Maximum, you will not be required to pay any additional Cost Shares for most Services that are subject to the Out-of-Pocket Maximum for the rest of the contract year.

Self-Only Coverage Out-of-Pocket Maximum. If you are covered as a Subscriber, and you do not have any Dependents covered under the plan, your medical expenses apply toward the Self-Only Out-of-Pocket Maximum shown below.

Family Coverage Out-of-Pocket Maximum. If you have one or more Dependents covered under this EOC, the medical expenses of all Members of your Family Unit together apply towards the family Out-of-Pocket Maximum shown below. After one or more covered Members of your Family Unit combined have met the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be met for all Members of the Family Unit for the rest of the contract year. The Individual Out-of-Pocket Maximum shown below does not apply with family coverage.

Individual within Family Coverage Out-of-Pocket Maximum. There is a maximum to the total dollar amount of Copayments and Coinsurance that you must pay for covered Services that you receive within the same year. If you are the only Member in your Family, then you must meet the Self-Only within Family Out-of-Pocket Maximum. If you are a Member in a Family of two or more Members, then either you must each meet the Individual within Family Out-of-Pocket Maximum, or your entire Family must meet the Family Out-of-Pocket Maximum. Each Individual within Family Out-of-Pocket Maximum amount counts toward the Family Out-of-Pocket Maximum amount. The Self-Only Out-of-Pocket Maximum, Individual within Family Out-of-Pocket Maximum, and Family Out-of-Pocket Maximum amounts are shown below.

Out-of-Pocket Maximum Exclusions:

The following Services do not apply toward your Out-of-Pocket Maximum:

- Adult eyeglass lenses and frames, contact lenses that are available with a discount only
- Adult dental Services, if included by Rider attached to this plan
- Adult routine eye exams

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

**YOUR GROUP EVIDENCE OF COVERAGE (EOC)
KAISER PERMANENTE**

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

<p>Annual Out-of-Pocket Maximum Combined total of Deductible and allowable Copayments and Coinsurance</p>	
<p>Self-Only Out-of-Pocket Maximum</p>	<p>\$3,350 per individual per contract year</p>
<p>Individual Out-of-Pocket Maximum</p>	<p>per individual Family member per contract year</p>
<p>Family Out-of-Pocket Maximum</p>	<p>\$6,700 per Family Unit per contract year</p>

*Allowable Charge (AC) is defined in Definitions Appendix.

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

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

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

OUTPATIENT PRESCRIPTION DRUG RIDER

GROUP EVIDENCE OF COVERAGE

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

The following benefit, limitations, and exclusions are hereby added to the Section 3: Benefits of your EOC in consideration of the application and payment of the additional Premium for such Services.

A. DEFINITIONS

Allowable Charge: Has the same meaning as defined in your EOC. See Definitions Appendix.

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

Cancer Chemotherapy Drugs: A prescription drug that is prescribed by a licensed physician to kill or slow the growth of cancer cells.

Coinsurance: A percentage of the Allowable Charge that you must pay for each prescription or prescription refill.

Complex or Chronic Medical Condition: A physical, behavioral, or developmental condition that: (1) may have no known cure; (2) is progressive; or (3) can be debilitating or fatal if left untreated or undertreated. Complex or Chronic Medical Condition includes, but is not limited to: Multiple Sclerosis, Hepatitis C, and Rheumatoid Arthritis.

Contraceptive Drug: A drug or device that is approved by the United States Food and Drug Administration (FDA) for use as a contraceptive and requires a prescription.

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

FDA: The United States Food and Drug Administration.

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

Mail Service Delivery Program: A program operated or arranged by Health Plan that distributes prescription drugs to Members via mail. Some medications are not eligible for the Mail Service Delivery Program. These may include, but are not limited to, drugs that are time or temperature sensitive, drugs that cannot legally be sent by U.S. mail, and drugs that require professional administration or observation. The Mail Service Delivery Program can mail to addresses in MD, VA, DC and certain locations outside the service area.

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

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

Nicotine Replacement Therapy: A product that:

- (a) is used to deliver nicotine to an individual attempting to cease the use of tobacco products;
- (b) can be obtained only by a written prescription.

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

Participating Network Pharmacy: Any pharmacy that has entered into an agreement with Health Plan or the Health Plan's agent to provide pharmacy Services to its Members.

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

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

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

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

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

Rare Medical Condition: A disease or condition that affects less than 200,000 individuals in the United States or approximately 1 in 1,500 individuals worldwide. Rare Medical Condition includes, but is not limited to: Cystic Fibrosis, Hemophilia, and Multiple Myeloma.

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

Specialty Drugs: A prescription drug that: (1) is prescribed for an individual with a Complex or Chronic Medical Condition, or a Rare Medical Condition; (2) costs \$600 or more for up to a 30-day supply; (3) is not typically stocked at retail pharmacies; and (4) requires a difficult or unusual process of delivery to the Member in the preparation, handling, storage, inventory, or distribution of the drug; or requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug

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

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

B. BENEFITS

Subject to the Deductible and the Out-of-Pocket Maximum set forth in the Summary of Services and Cost Shares in the EOC to which this Rider is attached, and except as provided in the Limitations and Exclusions sections of this Rider, we cover drugs as described in this Section, in accordance with our Preferred Drug List guidelines, when prescribed by a Plan Physician or by a dentist or any licensed psychiatrist, whether or not the psychiatrist is a Plan Physician. Each prescription refill is subject to the same conditions as the original prescription. Plan Providers prescribe drugs in accordance with Health Plan's Preferred Drug List. If the Allowable Charge of the drug is less than the Rx Copayment, the Member will pay the lesser amount. You must obtain these drugs from a Plan Pharmacy or a Participating Network Pharmacy. It may be possible for you to receive prescription drugs and refills using our Mail Service Delivery Program; ask for details at a Plan Pharmacy.

We cover the following:

1. FDA-approved drugs for which a prescription is required by law.
2. Compounded preparations containing at least one ingredient requiring a prescription and the ingredient is listed in our Preferred Drug List.
3. Insulin
4. Drugs that are FDA-approved for use as contraceptives and diaphragms available by prescription or over-the-counter without a prescription. For coverage of other types of contraception, including contraceptive injections, implants and devices, refer to "Family Planning Services" in Section 3: Benefits.
5. Nicotine Replacement Therapy, including over-the counter Nicotine Replacement Therapy when prescribed by a Plan Provider, for up to two 90-day courses of treatment per contract year.
6. Smoking Cessation drugs that are approved by the FDA for the treatment of tobacco dependence, including over-the-counter Smoking Cessation drugs when prescribed by a Plan Provider.
7. Off label use of drugs when a drug is recognized in Standard Reference Compendia or certain Medical Literature as appropriate in the treatment of the diagnosed condition.
8. Growth hormone therapy (GHT) for treatment of children under age 18 with a growth hormone deficiency.
9. Non-prescription drugs when they are prescribed by a Plan Provider and are listed on the Preferred Drug List with the exception of the over-the counter contraceptives, which are available without a prescription and do not require authorization by a Plan Provider.

The Pharmacy and Therapeutics Committee sets dispensing limitations in accordance with therapeutic guidelines based on the Medical Literature and research. The Committee also meets periodically to consider adding and removing prescribed drugs and accessories on the Preferred Drug List. If you would like information about whether a particular drug or accessory is included in our Preferred Drug List, please visit us online at www.kp.org, or call the Member Services Call Center Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Where to Purchase Covered Drugs

Except for Emergency Services and Urgent Care Services, you must obtain prescribed drugs from a Plan Pharmacy, a Participating Network Pharmacy, or through Health Plan's Mail Service Delivery Program subject to the Cost Shares listed below under "Copayment/Coinsurance" Most non-refrigerated prescription medications ordered through the Health Plan's Mail Service Delivery Program can be delivered to addresses in MD, VA, DC and certain locations outside the service area.

Generic and Preferred Drug Requirements

Generic vs. Brand Name Drugs

Plan Pharmacies and Participating Network Pharmacies will substitute a generic equivalent for a Brand Name Drug when a generic equivalent is on our Preferred Drug List unless one of the following conditions is met:

1. The provider has prescribed a Brand Name Drug and has indicated “dispense as written” (DAW) on the prescription; or
2. The Brand Name Drug is listed on our Preferred Drug List or
3. The Brand Name Drug is (1) prescribed by a Plan physician or by a dentist or a referral physician; or (2) (a) there is no equivalent generic drug, or (b) an equivalent generic drug (i) has been ineffective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member or (3) a Non-Preferred contraceptive prescription drug or device which is Medically Necessary for the Member to adhere to appropriate use of the prescription drug or device.

If a Member requests a Brand Name Drug for which none of the above conditions has been met, the Member will be responsible for the full Allowable Charge for that Brand Name Drug.

Preferred vs. Non-Preferred Drugs

Plan Pharmacies and Participating Network Pharmacies will dispense Preferred Drugs unless the following criteria are met: (1) the Non-Preferred Drug is prescribed by a Plan Physician or by a dentist or a referral physician; and (2) (a) there is no equivalent drug in our Preferred Drug List, or (b) an equivalent Preferred Drug (i) has been ineffective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member or (3) a Non-Preferred contraceptive prescription drug or device which is Medically Necessary for the Member to adhere to appropriate use of the prescription drug or device.

If the criteria are met, the applicable Non-Preferred drug Cost Share will apply. If a Member requests a Non-Preferred drug and the criteria are not met, the Member will be responsible for the full Allowable Charge.

Dispensing Limitations

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

Members may obtain early refills of topical ophthalmic products at 70% of the predicted days of use or earlier if authorized by a Plan Physician.

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

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

For prescribed contraceptives, you may obtain up to a 2-month supply for the initial dispensing and up to 6-month supply for refills at a Plan pharmacy or through our mail-delivery program.

Maintenance Medication Dispensing Limitations

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

C. PRESCRIPTIONS COVERED OUTSIDE THE SERVICE AREA; OBTAINING REIMBURSEMENT

The Health Plan covers drugs prescribed by non-Plan Providers and purchased at non-Plan Pharmacies when the drug was prescribed during the course of an emergency care visit or an urgent care visit (see "Emergency Services" and "Urgent Care Services" sections of the Group Evidence of Coverage), or associated with a covered, authorized referral outside Health Plan's Service Area. To obtain reimbursement, the Member must submit a copy of the itemized receipts for the prescriptions to Health Plan. We may require proof that urgent or emergency care Services were provided. Reimbursement will be made at the Allowable Charge less the applicable Rx Copayment or Rx Coinsurance, subject to the Deductible, and the Out-of-Pocket Maximum set forth in the Summary of Services and Cost Shares in the EOC to which this Rider is attached. Claims should be submitted to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Claims Department
P.O. Box 371860
Denver, CO 80237-9998

D. LIMITATIONS

Benefits are subject to the following limitations:

1. For drugs prescribed by a dentist, coverage is limited to antibiotics and pain relief drugs that are included on our Preferred Drug List and purchased at a Plan Pharmacy or a Participating Network Pharmacy, unless the criteria for coverage of Non-Preferred Drugs under Section B. Preferred vs. Non-Preferred Drugs has been met.
2. In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with the Health Plan's emergency management department and/or our Pharmacy and Therapeutics Committee. If limited, the applicable Cost Share per prescription will apply. However, a Member may file a claim for the difference between the Cost Share for a full prescription and the pro-rata Cost Share for the actual amount received. Instructions for filing a claim can be found in Section 5 of the EOC to which this Rider is attached. Claims should be submitted to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Claims Department
P.O. Box 371860
Denver, CO 80237-9998

3. If the \$100,000 benefit limit for in vitro fertilization has been met by a Member under Section 3 of the EOC, drugs for the treatment of in vitro fertilization are no longer covered under this Rider for that Member.

E. EXCLUSIONS

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

1. Drugs for which a prescription is not required by law, except for non-prescription drugs that are prescribed by a Plan Provider and are listed in our Preferred Drug List and over-the-counter contraceptives, which are available without a prescription and do not require authorization by a Plan Provider.
2. Compounded preparations that do not contain at least one ingredient requiring a prescription or only contain ingredients that are excluded from coverage.
3. Drugs obtained from a non-Plan or non-Network Pharmacy, except when the drug is prescribed during an emergency or urgent care visit in which covered Services are rendered, or associated with a covered authorized referral outside the Service Area.
4. Take home drugs received from a hospital, Skilled Nursing Facility, or other similar facility. Refer to “Hospital Inpatient Care” and “Skilled Nursing Facility Care” in Section 3: Benefits.
5. Drugs that are not listed in our Preferred Drug List, except as described in this Rider.
6. Drugs that are considered to be experimental or investigational. Refer to “Clinical Trials” in Section 3: Benefits.
7. A drug (a) which can be obtained without a prescription (except over-the-counter contraceptives), or (b) for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug. Item b will not be excluded if, in the judgment of the authorized prescriber: (1) there is no equivalent prescription drug or device in the entity's Preferred Drug List; or (2) an equivalent prescription drug or device in the entity's Preferred Drug List: (i) has been ineffective in treating the disease or condition of the member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the member or (3) a Non-Preferred contraceptive prescription drug or device which is Medically Necessary for the Member to adhere to appropriate use of the prescription drug or device.
8. Drugs for which the Member is not legally obligated to pay, or for which no charge is made.
9. Blood or blood products. Refer to “Blood, Blood Products and their Administration” in Section 3: Benefits.
10. Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes, including but not limited to drugs used to slow or reverse the effects of skin aging or to treat nail fungus or hair loss.
11. Medical foods. Refer to “Medical Foods” in Section 3: Benefits.
12. Drugs for the palliation and management of terminal illness if they are provided by a licensed hospice agency to a Member participating in our hospice care program. Refer to “Hospice Care Services” in Section 3: Benefits.
13. Replacement prescriptions necessitated by damage, theft or loss.
14. Prescribed drugs and accessories that are necessary for Services that are excluded under your EOC.
15. Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from the Health Plan’s standard packaging for prescription drugs.

16. Alternative formulations or delivery methods that are (1) different from the Health Plan's standard formulation or delivery method for prescription drugs and (2) deemed not Medically Necessary.
17. Durable medical equipment, prosthetic or orthotic devices, and their supplies, including: peak flow meters, nebulizers, and spacers; and ostomy and urological supplies. Refer to "Durable Medical Equipment" and "Prosthetic Devices" in Section 3: Benefits.
18. Drugs and devices provided during a covered stay in a hospital or Skilled Nursing Facility, or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits. This includes the equipment and supplies associated with the administration of a drug. Refer to "Drugs, Supplies, and Supplements" and "Home Health Care" in Section 3: Benefits.
19. Bandages or dressings. Refer to "Drugs, Supplies, and Supplements" and "Home Health Care" in Section 3: Benefits.
20. Diabetic equipment and supplies. Refer to "Diabetic Equipment, Supplies, and Self-Management" in Section 3: Benefits.
21. Growth hormone therapy (GHT) for treatment of adults age 18 or older.
22. Immunizations and vaccinations solely for the purpose of travel. Refer to "Outpatient Care" in Section 3: Benefits.
23. Any prescription drug product that is therapeutically equivalent to an over-the-counter drug, upon a review and determination by the Pharmacy and Therapeutics Committee, unless in the judgment of the authorized prescriber: (1) there is no equivalent prescription drug or device in the entity's Preferred Drug List; or (2) an equivalent prescription drug or device in the entity's Preferred Drug List: (i) has been ineffective in treating the disease or condition of the member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the member or (3) a Non-Preferred contraceptive prescription drug or device which is Medically Necessary for the Member to adhere to appropriate use of the prescription drug or device.
24. Drugs for the treatment of sexual dysfunction disorders.

F. COPAYMENTS AND COINSURANCE

After you have met the Deductible set forth in the Summary of Services and Cost Shares in the EOC to which this Rider is attached, covered drugs are provided upon payment of the Rx Copayment or Rx Coinsurance per prescription or refill, subject to the Out-of-Pocket Maximum set forth in the Summary of Services and Cost Shares in the EOC to which this Rider is attached:

Payment amounts for a Plan Pharmacy also apply to the Health Plan's Mail Service Delivery Program.

30 Day Supply	Plan Pharmacy and Mail Delivery	Participating Network Pharmacy
Generic Drugs	20%	
Preferred Brand Drugs	20%	
Non-Preferred Brand Drugs	20%	
Specialty Drugs	Refer to the applicable Generic and Brand Drugs Cost Share above	Refer to the applicable Generic and Brand Drugs Cost Share above

	Mail Delivery, Plan Pharmacy and Participating Network Pharmacy
90-day Supply of Maintenance Medication	2 Rx Copayment(s) shown above

Weight management drugs for 50% of the Allowable Charge

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

Orally administered Cancer Chemotherapy Drugs for no charge.

Contraceptive Drugs (available by prescription or over-the-counter without a prescription) and preventive care drugs required to be covered by the Affordable Care Act (ACA) without Cost Sharing, including over-the-counter medications when prescribed by a Plan Provider, and obtained at a Plan Pharmacy, a Participating Network Pharmacy, or through the Mail Service Delivery Program are covered for no charge. This includes Smoking Cessation and Nicotine Replacement Therapy drugs. Please visit the following websites for a list of these drugs:

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

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

G. DEDUCTIBLE

Benefits set forth in this Rider are subject to the Deductible set forth in the Summary of Services and Cost Shares in the EOC to which this Rider is attached.

H. OUT-OF-POCKET MAXIMUM

Cost Shares set forth in this Rider apply toward the Out-of-Pocket Maximum set forth in the Summary of Services and Cost Shares in your EOC to which this Rider is attached.

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

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

By: 

Mark Ruszczyk
Vice President, Marketing, Sales & Business Development

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

2101 East Jefferson St., Rockville, MD 20849
301-816-2424

HEARING SERVICES RIDER

GROUP EVIDENCE OF COVERAGE

This Hearing Services Rider (herein called “Rider”) is effective as of the date of your Group Agreement and Group Evidence of Coverage and shall terminate as of the date your Group Agreement and Group Evidence of Coverage terminates.

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

Hearing Services

A. Definitions

Allowable Charge (AC): As defined in you Group Evidence of Coverage.

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

Hearing Aid Benefit Allowance: The maximum Health Plan payment toward cost of a covered Hearing Aid.

B. Benefits

We cover the following:

- Medically necessary Hearing Aids for adults and children. (The benefit described in this Rider is in addition to the Hearing Aid benefit described in the Group EOC).
- Hearing Aid evaluations and diagnostic procedures with Plan Providers to determine the Hearing Aid model which will best compensate for loss of hearing.
- Visits to verify that the Hearing Aid conforms to the prescription.
- Visits for fitting, counseling, adjustment, cleaning, and inspection.

C. Limitations

- Your Hearing Aid Benefit Allowance is \$1,000
- Coverage is provided for one Hearing Aid for each hearing impaired ear every 24 months. Two Hearing Aids are covered every 24 months only if both are required to provide significant improvement that is not obtainable with only one Hearing Aid, as determined by your Kaiser Permanente or Kaiser Permanente-designated audiologist or physician.
- The Hearing Aid Benefit Allowance must be used at the initial point of sale for each Hearing Aid. Any part of the Hearing Aid Benefit Allowance that is not exhausted at the initial point of sale may not be used at a later time.

- The type of Hearing Aid is limited to the models provided by Kaiser Permanente or the Kaiser Permanente-designated Hearing Aid vendor.
- You may apply the Hearing Aid Benefit Allowance toward a Hearing Aid upgrade. However, you must pay the difference in the Hearing Aid Benefit Allowance and the cost of the Hearing Aid upgrade.

D. Exclusions

- Replacement of parts and batteries
- Replacement of lost or broken Hearing Aid
- Repair of Hearing Aid beyond one year
- Comfort, convenience, or luxury equipment or features
- Hearing Aids prescribed and ordered prior to coverage or after termination of coverage

E. Your Cost Share

Covered Services under this Rider are subject to the Deductible and the Out-of-Pocket Maximum in the Group EOC to which this Rider is attached. After you meet the Deductible and before you reach the Out-of-Pocket Maximum as shown in the Summary of Benefits and Cost Shares in the Group EOC, you pay the following copayment or coinsurance for each Service:

(When the Service is received in accordance with an approved referral from a Plan Provider)

Hearing Aids:

You pay 20% of the Allowable Charge. The Health Plan pays remaining charges up to \$1000 per Hearing Aid.

Hearing Exams:

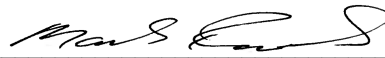
- You pay your Office Visit Copayment or Coinsurance amount indicated in your Group EOC.

Hearing Aid Tests, Fittings, and Follow-up Care:

- You pay your Office Visit Copayment or Coinsurance amount indicated in your Group EOC.

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

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

By: 

Mark Ruszczyk
Vice President, Marketing, Sales & Business Development

**KAISER FOUNDATION HEALTH PLAN
OF THE MID-ATLANTIC STATES, INC.
2101 East Jefferson St., Rockville, MD 20852
301-816-2424**

COMPLEMENTARY ALTERNATIVE MEDICINE SERVICES RIDER

GROUP EVIDENCE OF COVERAGE

This Complementary Alternative Medicine Services Rider (herein called "Rider") is effective as of the date of your Group Agreement and Group Evidence of Coverage and shall terminate as of the date that your Group Agreement and Group Evidence of Coverage terminate.

The following benefits, limitations, and exclusions are hereby added to the "Benefits" Section of the Group Evidence of Coverage (herein referred to as the Group EOC), in consideration of the Group application and payment of the additional Premium for the Services pursuant to this Rider.

A. Definitions

Allowable Charge (AC): As defined in your Group Evidence of Coverage.

B. Benefits:

We cover Acupuncture Services for chronic pain management or chronic illness management for Members when deemed Medically Necessary and prescribed by a Plan Provider as outlined under "Getting a Referral" in Section 2 "How to Obtain Services."

We cover Chiropractic Services in accordance with Health Plan coverage guidelines when you are a Member on the date that you receive the Services or under the conditions outlined in the Extension of Benefits provision in the Termination of Membership Section of the EOC. You must receive the Services from a Plan Provider as outlined under "Getting a Referral" in Section 2: How to Obtain Services.

C. Limitations:

The number of visits needed for the Member to reach the maximum level of recovery will be determined by the Plan Provider and shall not exceed a total of 30 visits per **contract** year.

D. Exclusions:

- Services requested by the Member that are not deemed Medically Necessary (as defined in the Group EOC to which this Rider is attached) for Acupuncture Services, by the Plan Provider
- Any Services not provided by a Plan Provider or for which a referral is not obtained.

E. Your Cost Share:

All covered Services under this Rider are subject to the Deductible and the Out-of-Pocket Maximum of the Group EOC to which this Rider is attached. After you meet the Deductible and before reaching the Out-of-Pocket Maximum, you pay the following Cost Share for each visit.

- You pay **20% of AC*** per visit.

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

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

By: _____



Mark Ruszczyk

Vice President, Marketing, Sales & Business Development



KAISER PERMANENTE

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