guide to

YOUR 2018 BENEFITS AND SERVICES

kaiserpermanente.org

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

GROUP
EVIDENCE OF COVERAGE

VIRGINIA

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 REGARDING YOUR INSURANCE

This company is subject to regulation in this Commonwealth by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and by the Virginia Department of Health pursuant to Title 32.1.

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact Kaiser Permanente at the following address and telephone number:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Box 6831
2101 East Jefferson Street
Rockville, MD 20852

(301) 468-6000 or toll-free 711

We recommend that you familiarize yourself with our Getting Assistance; Claims and Appeal Procedures; and Customer Satisfaction Procedure as described in Section 5 of Your Group Evidence of Coverage, and make use of it before taking any other action.

If you have been unable to contact or obtain satisfaction from the company or your agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

Consumer Services: (804) 371-9741 or toll-free (800) 552-7945

National toll-free (877) 310-6560

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, Kaiser Permanente or the Bureau of Insurance, have your policy number available.

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 ሊያግዝዎት ተዘጋጀተዋል፡ 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**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓέìn m̀ gbo kpáa. Đá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুনঃ 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) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. 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 y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'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: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (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**).

Table of Contents

SECTION 3: BENEFITS **3.1**

SECTION 1: INTRODUCTION

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

Please note that the Health Plan is subject to the regulations of the Commonwealth of Virginia by both the State Corporation Commission Bureau of Insurance, as well as the Virginia Department of Health.

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

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

KAISER PERMANENTE SIGNATURE[SM]

Kaiser Permanente Signature[SM] provides health care Services to Members using Plan Providers located in our Plan Medical Centers and through affiliated Plan Providers located throughout our Service Area, which is defined 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 physicians, all working together at our state-of-the-art Plan Medical Centers. Additionally, pharmacy, optical, laboratory and x-ray facilities are included in 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 our Service Area;
3. Authorized Referrals; and
4. Covered Services received in other Kaiser Permanente Regions

Through our medical care system, you have convenient access to all of the covered health care Services

you may need, such as routine care with your own Plan Physician, hospital care, nurses, laboratory and pharmacy Services, and other benefits described in 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 eligible children who live outside our Service Area may be eligible to enroll if you are required to cover them pursuant to a Qualified Medical Child Support Order (QMCSO).

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

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, the following persons may be eligible to enroll as your Dependents:

1. Your Spouse;
2. Your or your Spouse's children, who are under the age limit specified on the Summary of Services and Cost Shares section;
3. Other Dependent persons who meet all of the following requirements:
   a. They are under the age limit specified on the Summary of Services and Cost Shares section; and
   b. You or your Spouse is the child's court-appointed guardian (or was when the person reached age 18).

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 physically- or mentally-disabling injury, illness or condition that occurred prior to reaching the age limit for Dependents;
2. They receive 50 percent or more of their support and maintenance from you or your Spouse; and
3. You provide us proof of their intellectual disability or physical handicap and dependency within sixty (60) days after we request it. (See "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 intellectual disability or physical handicap and Dependency as follows:

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

   If you provide us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that your Dependent does not meet the eligibility requirements as a disabled Dependent, we will notify you that he or she is not eligible and let you know the membership termination date. If we determine that your Dependent is eligible as a disabled Dependent, there will be no lapse in coverage. Also, beginning two (2) years after the date that your Dependent reached the age limit, you must provide us documentation of his or her intellectual disability or physical handicap 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.

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

   If we determine that your Dependent is eligible as a disabled Dependent, you must provide us documentation of his or her intellectual disability or physical handicap 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.

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 the 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 on the membership effective date. Eligible people may enroll as follows:

New Employees and Their Dependents

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health

Plan-approved enrollment application to your Group within thirty-one (31) days after you become eligible. (Check with your Group to see when new employees become eligible). Your memberships will become effective as determined by Group.

Special Enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment, unless one of the following is true:

1. You become eligible as described in this "Special enrollment" section
2. You did not enroll in any coverage through your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is no later than the 1st day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application from the Subscriber.

Special Enrollment Due to New Dependents

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

The effective date of an enrollment resulting from marriage is no later than the 1st day of the month following the date your Group receives an enrollment application from the Subscriber.

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

1. **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.

2. **For newly adopted children, the date of adoptive or parental placement with a Subscriber or Subscriber's Spouse, for the purpose of adoption.** If a child is placed with the Subscriber within thirty-one (31) days of birth, such child will be considered a newborn of the Subscriber as of the date of adoptive or parental placement.

   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.

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

3. **For children who are newly eligible for coverage as the result of foster care placement or**

guardianship granted by court or testamentary appointment, the date of court or testamentary appointment. If payment of addition 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

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

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

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

Special Enrollment Due to Loss of Other Coverage

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

1. The Subscriber or at least one of the Dependents had other coverage when he or she previously declined all coverage through your Group.
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;
   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 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 first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

OPEN ENROLLMENT

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

PREMIUM

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

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. Getting a Referral, as described in this section;
4. Receiving Care in Another Kaiser Foundation Health Plan Service Area, as described in this section; and
5. Services Received from Non-Plan Providers at Non-Plan Facilities without a Referral, as described in this section.

YOUR PRIMARY CARE PLAN PHYSICIAN

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

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

You may also access our Provider Directory online at: 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

Member may request to continue to receive health care services for a period of ninety (90) days from the date of the Plan Provider's notification of termination from the Health Plan's provider panel, except when terminated for cause.

In addition, under the following special situations, Health Plan will continue to provide benefits for Plan Provider's care beyond a period of ninety (90) days when the Member:

1. Has entered at least the 2nd trimester of pregnancy at the time of the provider's termination, except when terminated for cause. Such treatment may continue, at the Member's option, through the provision of postpartum care; or
2. Is determined to be terminally ill at the time of the Plan Provider's termination, except when terminated for cause. Such treatment may continue, at the Member's option, for the remainder of the Member's life.

GETTING A REFERRAL

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

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

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

If your primary care Plan Physician decides that you require covered Services not available from us, he or she will refer you to a non-Plan Provider inside or outside our Service Area. You must have an approved written referral to the non-Plan Provider in order for us to cover the Services. Any additional radiology studies, laboratory Services or Services from any other professional 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. When prior authorization is the responsibility of an in-network provider, any reduction or denial of benefits will not affect the enrollee.

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. Female Members do not need a referral or prior authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology;
3. Optometry services; and
4. Urgent Care services provided within our Service Area.

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

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).

SERVICES RECEIVED FROM NON-PLAN PROVIDERS AT NON-PLAN FACILITIES WITHOUT A REFERRAL

There may be circumstances where the Health Plan determines that it is responsible for payment to a non-Plan Provider. In these circumstances, the Health Plan will send to a Member the payment amount determined, in the Health Plan's discretion, to be the appropriate payment for services furnished by a Non-Plan Provider where such services require prior authorization. Application of the payment from the Health Plan to the Non-Plan Provider's charges is the Member's responsibility. This provision does not affect a Member's obligations to pay applicable Cost-sharing, including Copayments and/or Coinsurance.

STANDING REFERRALS TO SPECIALISTS

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

If a Member has been diagnosed with cancer, the Health Plan will allow for the Member's primary care Plan Physician to issue a standing referral to any Health Plan-authorized oncologist or board-certified physician in pain management, as the Member chooses.

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

SECOND OPINIONS

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

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

If you 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.) if you had received them from Plan Providers.

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 may require Urgent Care Services (for example: a sudden rash, high fever, severe vomiting, ear infection, or a sprain), you may call our advice nurses at:

Inside the Washington, 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 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 (1) Medical Record Number, please let us know by contacting Member Services 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 Health Plan ID card that will serve as evidence of your Membership status. In addition to your Health Plan ID card, you may be asked to show a valid photo ID at your medical appointments. Allowing another person to use your Membership card will result in forfeiture of your card and may result in termination of your membership.

RECEIVING CARE IN ANOTHER KAISER FOUNDATION HEALTH PLAN SERVICE AREA

You may receive covered Services from another Kaiser Foundation Health Plan, if the Services are provided, prescribed, or directed by that other plan, and if the Services would have been covered under this EOC. Covered Services are subject to the terms and conditions of this EOC, including prior authorization requirements, the applicable Copayment, Coinsurance and shown in the "Summary of Services and Cost Shares" and in Section 4: Exclusions, Limitations and Reductions. For more information about receiving care in other Kaiser Foundation Health Plan service areas, including availability of Services, and provider and facility locations, please contact Member Services at 1-800-777-7902 or 711 (TTY) or our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

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

The following visiting member care is covered when it is provided or arranged by a Plan Physician in the service area you are visiting. Certain Services, such as transplant Services or infertility Services, are not

covered for visiting members. Visiting member benefits may not be the same as those you receive in your home Service Area.

Hospital Inpatient Care:

1. Physician Services;
2. Room and board;
3. Necessary Services and supplies;
4. Maternity Services; and
5. Prescription drugs.

Outpatient Care:

1. Office visits;
2. Outpatient surgery;
3. Physical, speech and occupational therapy (up to twenty (20) visits for physical therapy per incident; up to two (2) months for occupational and speech therapy);
4. Allergy tests and allergy injections; and
5. Dialysis care.

Laboratory and X-Ray:

1. Covered in or out of the hospital.

Outpatient Prescription Drugs:

1. Covered only if you have an outpatient prescription drug benefit within your home Service Area. Copayments, Coinsurance and Deductibles; exclusions and limitations apply.

Mental Health Services other than for Emergency or Urgent Care Services:

1. Outpatient visits and inpatient hospital days.

Substance Abuse Treatment other than for Emergency or Urgent Care Services:

1. Outpatient visits and inpatient hospital days.

Skilled Nursing Facility Care:

1. Up to one-hundred (100) days per calendar year.

Home Health Care:

1. Home health care Services inside the visited Service Area.

Hospice Care:

1. Home-based hospice care inside the visited Service Area.

Pre-Authorization Required for Certain Services

1. Inpatient physical rehabilitation services covered in your home region may also be available to you as a visiting member. Pre-authorization from your home region is required.
2. Services that require pre-authorization in your home region may also be available to you when you are visiting a different Kaiser Foundation Health Plan or allied plan service area, once you have obtained pre-authorization from your home region or allied plan service area.

Also, some services require pre-authorization from the region or Service Area you are visiting. Please contact Member Services in the region or allied plan service area you plan to visit for more information.

Visiting Member Service Exclusions

The following Services are not covered under your visiting member benefits. Note: Services include equipment and supplies. However, some of these Services, such as Emergency Services, may be covered under your home Service Area benefits, and applicable Copayments, Coinsurance and/or Deductibles will apply. For coverage information, refer to Section 3: Benefits.

- Services that are not Medically Necessary;
- Physical examinations for insurance, employment or licensing and any related services;
- Drugs for the treatment of sexual dysfunction disorders;
- Dental care and dental X-rays;
- Services to reverse voluntary infertility;
- Infertility services;
- Services related to conception by artificial means, such as in vitro fertilization (IVF) and gamete intrafallopian tube transfer (GIFT);
- Cosmetic surgery or other Services performed mainly to change appearance;
- Custodial ("at home") care, and care provided in a nursing home;
- Services related to sexual reassignment surgery and treatment;
- Organ transplants and related Services;
- Alternative medicine and complementary care, such as chiropractic services;
- Experimental Services and all clinical trials;
- Services related to bariatric surgery and treatment;
- Services that require a written referral from a Plan provider in your home Service Area; and
- Services that are excluded or limited in your home Service Area.

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 may not be the same in the other service area. You should contact your Group's employee benefits coordinator before you move.

VALUE ADDED SERVICES

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

For information concerning these Services, including which ones are available to you, you may contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

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

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

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

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 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.

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;
2. You have met any Deductible requirement described in the "Deductible" 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 provided by a Plan Provider (unless the Service is to be provided by a non-Plan Provider subject to an approved referral as described in Section 2) in accordance with the terms and conditions within this EOC including but not limited to the requirements, if any, for prior approval (authorization);
5. The Services are Medically Necessary; and
6. You receive the Services from a Plan Provider except as specifically described in this EOC.

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

1. Emergency Services;
2. Urgent Care outside of our Service Area;
3. Authorized referrals to non-Plan Providers (as described in Section 2: How to Obtain Services); and
4. Receiving Care in Another Kaiser Foundation Health Plan Service Area as described in Section 2: How to Obtain Services.

Exclusions and Limitations:
Exclusions and limitations that apply only to a particular benefit are described in this section. Other exclusions, limitations and reductions that generally affect benefits are described in Section 4: Exclusions, Limitations and Reductions.

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

A. OUTPATIENT CARE

We cover the following outpatient care:

1. Primary care visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics/gynecology (OB/GYN) 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 not limited to:
5. Diagnostic examinations, including digital rectal exams and prostate antigen (PSA) tests provided in accordance with American Cancer Society guidelines to:
    a. Persons age 50 or older and
    b. Persons age 40 or older who are at high risk for prostate cancer, according to the most recent

published guidelines of the American Cancer Society;

6. Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;
7. Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A "qualified individual" means an individual:
   a. Who is estrogen deficient individual 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;
8. Outpatient surgery;
9. Anesthesia, including Services of an anesthesiologist;
10. Chemotherapy and radiation therapy;
11. Respiratory therapy;
12. Medical social Services;
13. House calls when care can best be provided in your home as determined by a Plan Provider;
14. 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
15. Equipment, supplies, complex decongestive therapy and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care professional legally authorized to prescribe or provide such items under law.

Refer to "Preventive Health 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;
8. Chemotherapy and radiation therapy;
9. Respiratory therapy; and
10. 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.

Minimum Stay for Hysterectomy

We cover a minimum stay in a hospital of not less than 23 hours laparoscopy-assisted vaginal hysterectomy; and a minimum stay in a hospital of not less than 48 hours coverage for a vaginal hysterectomy including as provided in this section. A shorter period of hospital stay may be determined appropriate between you and your physician.

C. ACCIDENTAL DENTAL INJURY SERVICES

We cover Medically Necessary dental Services as a result of accidental injury, regardless of the date of such injury. Coverage is provided when all of the following conditions have been satisfied:

1. A Plan Provider provides the restorative dental Services.
2. 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.
3. The covered Services must be requested within sixty (60) days of the injury, for injuries occurring on or after the effective date of coverage.

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.

Accidental Dental Injury Services Exclusions:

- Services provided by non-Plan Providers.

D. ALLERGY SERVICES

We cover the following allergy Services:

1. Evaluations, and treatment; and
2. Injections and serum.

E. AMBULANCE SERVICES

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

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

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

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

G. AUTISM SPECTRUM DISORDER (ASD)

We cover Services for the diagnosis and treatment of Autism Spectrum Disorder (ASD) for a dependent child from age 2 through age 10. Autism Spectrum Disorder or (ASD) means any pervasive developmental disorder, including: (1) autistic disorder; (2) Asperger's Syndrome; (3) Rett Syndrome; (4) childhood disintegrative disorder; or (5) Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

For the purposes of this benefit, diagnosis of ASD means Medically Necessary assessments, evaluations, or tests to diagnose whether an individual has ASD. The diagnosis of ASD shall be made by a Plan Provider or a licensed psychologist who determines the care, including behavioral health treatments and therapeutic care to be Medically Necessary.

Treatment for ASD shall be identified in a treatment plan and include the following care prescribed or

ordered for an individual diagnosed with ASD by a Plan Provider who determines the care to be Medically Necessary: (1) behavioral health treatment; (2) pharmacy care; (3) psychiatric care; (4) psychological care; (5) therapeutic care; and (6) Applied Behavior Analysis (ABA), when provided or supervised by a board-certified behavior analyst licensed by the Virginia Board of Medicine. Applied Behavior Analysis (ABA) is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior; including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The prescribing practitioner shall be independent of the provider of applied behavior analysis.

A treatment plan means a plan for the treatment of ASD developed by a Plan Provider pursuant to a comprehensive evaluation or re-evaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

H. 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 prescribed whole blood and blood products are also covered.

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

Blood, Blood Products and Their Administration Limitations:

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

Blood, Blood Products and Their Administration Exclusions:

- Directed blood donations.

I. CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES

We cover the treatment of mental illnesses including, but not limited to, Biologically Based Mental Illness, emotional disorders, and Drug and Alcohol Misuse.

For the purposes of this benefit provision:

1. Drug and Alcohol Misuse 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;
2. Biologically Based Mental Illness means any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's ability to function. Specifically, the following diagnoses are defined as Biologically Based Mental Illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.

While you are hospitalized, we cover all medical Services of physicians and other health professionals as

performed, prescribed or directed by a Physician including:

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.

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

Partial hospitalization is defined as the provision of medically directed intensive or intermediate short-term treatment for mental illness, emotional disorders, and drug and alcohol misuse 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 necessary Services of physicians and other health care professionals as performed, prescribed, or directed by a physician including, but not limited to:

1. Evaluations;
2. Crisis intervention;
3. Individual therapy;
4. Group therapy;
5. Psychological testing;
6. Medical treatment for withdrawal symptoms; and
7. Visits for the purpose of monitoring drug therapy.

Chemical Dependency and Mental Health Exclusions:

- Services in a facility whose primary purpose is to provide treatment for alcoholism, drug misuse, or drug addiction, except as described above.
- Services provided in a psychiatric residential treatment facility, except as described above.
- Services for Members who, in the opinion of the Plan Provider, are seeking Services for non-therapeutic purposes.
- Psychological testing for ability, aptitude, intelligence or interest.
- Services on court order or as a condition of parole or probation, unless determined by the Plan Provider to be necessary and appropriate.
- Evaluations that are primarily for legal or administrative purposes, and are not medically indicated.

J. CLEFT LIP, CLEFT PALATE OR ECTODERMAL DYSPLASIA

We cover inpatient and outpatient Services when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia. Coverage includes orthodontics, oral surgery, otologic, audiological and speech/language treatment, and dental Services and dental appliances furnished to a newborn child.

K. 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 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 conducted under an investigational new drug application reviewed by the FDA;
   b. The study or investigation is a drug trial that is exempt from having an investigational new drug application;
   c. 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; or
   d. 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. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
      vii. 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 though 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.

For covered Services related to a clinical trial, the same Cost Sharing applies that would apply if the Services were not related to a clinical trial.

Clinical trials Exclusions:

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

L. 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 both prescribed by and purchased from a Plan Provider 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 covered under the "Outpatient Prescription Drug Rider" attached to this EOC, if applicable. If the Outpatient Prescription Drug Rider does not apply, insulin is covered under this benefit.

Diabetic Equipment and Supplies Limitation:

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

M. 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.
2. Services of the Plan Provider who is conducting your self-dialysis training.
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 of the Service area for a limited time period may receive pre-planned dialysis Services in accordance to prior authorization requirements.

N. DRUGS, SUPPLIES, AND SUPPLEMENTS

We cover the following during a covered stay in a Plan Hospital or Skilled Nursing Facility, or if they require administration or observation by medical personnel and are administered to you in a Plan Medical Office or during home visits:

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. Standard Reference Compendia means: (a) American Hospital Formulary Service Drug Information; (b) National Comprehensive Cancer Network's Drugs & Biologics Compendium; or (c) Elsevier Gold Standard's Clinical Pharmacology;
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, splints, casts, hypodermic needles, syringes or any other Medically Necessary supplies provided at the time of treatment;
5. Vaccines and immunizations approved for use by the FDA that are not considered part of routine preventive care;
6. Any drug prescribed to treat a covered condition, even those typically used as a customary treatment for another condition, so long as the drug has been approved by the FDA and is recognized for treatment of the covered condition in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature;
7. Any drug approved by the FDA for use in the treatment of cancer, even if that drug has not been approved by the FDA for treatment of the specific type of cancer for which the drug has been prescribed, as long as the drug has been recognized as safe and effective for treatment of the

member's type of cancer; and

8. Any drug approved by the FDA for cancer pain in excess of the recommended dosage when the excess dosage is determined to be Medically Necessary by a Plan Provider for a patient with intractable cancer pain.

Note: Dispensing limitations for FDA-approved prescription drugs used in the treatment of cancer pain management for patients with intractable cancer pain will be waived.

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

Drugs, Supplies and Supplements Exclusions:

- Drugs, supplies, and supplements which can be self-administered or do not require administration or observation by medical personnel.
- Drugs for which a prescription is not required by law.
- Drugs for the treatment of sexual dysfunction disorders.
- Drugs for the treatment of infertility.
- Contraceptive drugs, unless otherwise covered under an Outpatient Prescription Drug Rider attached to this EOC.

O. DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment is defined as equipment that: (1) is intended for repeated use; (2) is primarily and customarily used to serve a medical purpose; (3) is generally not useful to a person in the absence of illness or injury; and (4) meets the Health Plan criteria for being Medically Necessary.

Durable Medical Equipment does not include coverage for Prosthetic Devices, such as implants, artificial eyes or legs, or Orthotic Devices, such as braces or therapeutic shoes. Refer to "Prosthetic and Orthotic Devices" for coverage of Prosthetic Devices 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 the 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 the Health Plan's criteria for medical necessity. 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 through a Plan Provider:

1. Spacers
2. Peak-flow meters
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.

P. EARLY INTERVENTION SERVICES

We cover Medically Necessary early intervention Services for Dependents from birth to age 3. Early intervention Services means speech and language therapy, occupational therapy, physical therapy and assistive technology Services and devices for Dependents who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for Services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

Medically Necessary early intervention Services means those Services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, and shall

include Services that enhance functional ability without affecting a cure. These Services are provided in addition to the "Physical, Occupational, Speech Therapy and Multidisciplinary Rehabilitation Services" described in this EOC.

Early Intervention Services Exclusions:

- Care which has been provided under federal, state or local early intervention programs, including school programs, at no cost to the member.

Q. 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 must notify the Health Plan as soon as possible, and not to exceed forty-eight (48) hours or the 1st business day, whichever is later, if you receive care at a hospital emergency room (ER) to ensure coverage. If the emergency room visit was not due to an "Emergency Medical Condition," as defined in the Definitions Appendix of this EOC, and was not authorized by the Health Plan, you will be responsible for all charges.

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 of our Service Area because of extreme personal emergency.

Continuing Treatment Following Emergency Services

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

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

Outside of our Service Area
All other continuing or follow-up care for Emergency Services received outside of our Service Area must

be authorized by us, until you can safely return to the Service Area.

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

Continued Care in Non-Plan Facility Limitation
If you are admitted to a non-Plan Hospital, you or someone on your behalf must notify us within the later of 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, of if you choose not to be transferred, we will not cover any Services you receive after transfer would have been possible.

Filing Claims for Non-Plan Emergency Services
Keep all your receipts for Emergency Services provided by non-Plan Providers and verify that the non-Plan Provider has submitted the claims. All claims must be filed with us within six (6) months of the date of the Service, or as soon as reasonably possible in order to assure payment.

Emergency Services Limitations:

- **Notification:** If you receive care at a hospital emergency room or are admitted to a non-Plan hospital, you, or someone on your behalf, must notify us as soon as possible, but not later than 48 hours after the emergency room visit or hospital admission, or the next business day, whichever is later, 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. Once your emergency condition has been stabilized, all continuing and follow-up treatment must be authorized by us. If you do not notify us and obtain authorization for a continued hospital stay once your condition has stabilized, we will not cover the inpatient hospital charges you incur after transfer would have been possible.

- **Continuing or Follow-up Treatment:** Except as provided for under "Continuing Treatment Following Emergency Surgery," we do not cover continuing or follow-up treatment after Emergency Services unless authorized by the 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 of our Service Area or in another Kaiser Foundation Health Plan or allied plan Service area.

- **Hospital Observation:** Transfer to an observation bed or observation status does not qualify as an admission to a hospital. Your emergency room visit copayment, if applicable, will not be waived.

R. 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; and
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 (i.e., vasectomies); 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.

Voluntary termination of pregnancy limitations:

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

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.

S. HEARING SERVICES

Hearing Exams

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

Hearing Services Exclusions:

- 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.

T. HOME HEALTH SERVICES

Except as provided for under Visiting Member Services, 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
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

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

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

Home Health Care Limitations:

- Home HealthCare 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 (2) hours, then each two (2)-hour increment counts as a separate visit. For example, if a nurse comes to your home for three (3) hours and then leaves, that counts as two (2) 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 (2) hours that counts as two (2) visits.

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

Home Health Care Exclusions:

- Custodial care (see definition 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 appropriately provided in a Plan Facility or Skilled Nursing 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, drugs, medical supplies and supplements to the home.

U. 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 Care 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 Provider 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 Care 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 and appliances;

7. Palliative drugs in accord with our drug formulary guidelines;
8. Physician care;
9. General hospice inpatient Services for acute symptom management including pain management;
10. Respite Care that may be limited to five (5) consecutive days for any one inpatient stay up to four (4) times in any contract year;
11. Counseling Services for the Member and his Family Members, including dietary counseling for the Member; and bereavement counseling for the Member's Family Members, for a period of one (1) year after the Member's death; and
12. Services of hospice volunteers.

Definitions:

1. **Family Member** means a relative by blood, marriage or adoption who lives with or regularly participates in the care of the terminally ill Member.
2. **Hospice Care** means a coordinated, interdisciplinary 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 counseling following the death of the Member.
3. **Respite Care** means temporary care provided to the terminally ill Member to relieve the Member's Caregiver from the daily care of the Member.
4. **Caregiver** means an individual primarily responsible for the day to day care of the Member during the period in which the Member receives Hospice Services.

V. INFERTILITY SERVICES

We cover the following:

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

Notes:

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

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

Infertility Services Exclusions:

- Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member's eggs and/or male Member's sperm for future attempts.
- Assisted reproductive procedures and any related testing or Service that includes the use of donor sperm, donor eggs or donor embryos.
- Any charges associated with obtaining donor eggs, donor sperm or donor embryos.
- Infertility Services when the member does not meet medical guidelines established by the American Society of Reproductive Medicine and the American Society for Reproductive

Endocrinology.

- Services not preauthorized by the Health Plan.
- Services to reverse voluntary, surgically induced infertility.
- Infertility Services when the infertility is the result of an elective male or female surgical procedure.
- Assisted reproductive technologies and procedures, including, but not limited to: artificial insemination; in vitro fertilization; gamete intrafallopian transfers (GIFT); zygote intrafallopian transfers (ZIFT); assisted hatching; and prescription drugs related to such procedures.

W. 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. The Health Plan covers birthing classes and breastfeeding support, supplies, and counseling from trained providers during pregnancy and/or in the postpartum period.

"Non-routine obstetrical care" includes (a) Services provided for a condition not usually associated with pregnancy; (b) Services provided for conditions existing prior to pregnancy; (c) Services related to the development of a high-risk condition(s) during pregnancy; and (d) Services provided for the medical complications of pregnancy.

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

We cover inpatient hospitalization Services for you and your 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 health visits upon release, when prescribed by the attending provider.

In consultation with your physician, you may request a shorter length of stay. In such cases, we will cover one home health visit scheduled to occur within 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.

X. 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;
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.

Y. MORBID OBESITY

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

Morbid obesity is defined as:

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

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

Morbid Obesity Services Exclusion:

- Services not preauthorized by the Health Plan.

Z. 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 nutritional deficit; and
2. Based on examination of the Member by a Plan Provider.

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 and ectodermal dysplasia under a separate benefit. Please see "Cleft Lip, Cleft Palate or Ectodermal Dysplasia" 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.

AA. PREVENTIVE HEALTH CARE SERVICES

In addition to any other preventive benefits described in the group contract or certificate, the Health Plan shall cover the following preventive Services and shall not impose any cost-sharing requirements, such as Deductibles, Copayment amounts or Coinsurance amounts to any Member receiving any of the following benefits for Services from Plan Providers:

1. Evidenced-based items or Services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009. (To see an updated list of the "A" or "B" rated USPSTF 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), except for those Services excluded in Section 4.

The Health Plan shall update new recommendations to the preventive benefits listed above at the schedule 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. Low dose screening mammograms to determine the presence of breast disease is covered as follows:
   a. One mammogram for persons age 35 through 39;
   b. One mammogram biennially for persons age 40 through 49; and
   c. One mammogram annually for person 50 or older;
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 screening guidelines issued by the American Cancer Society including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy;
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 (a) women under age 20 if they are sexually active; and (b) women age 20 or older, and men of any age, who have multiple risk factors, which include: (i) a prior history of sexually transmitted diseases; (ii) new or multiple sex partners; (iii) inconsistent use of barrier contraceptives; or (iv) cervical ectopy;
b. Human Papillomavirus Screening (HPS) as recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;

11. HIV tests;
12. TB tests;
13. Newborn hearing screenings that include follow up audiological examinations, as recommended by a physician or audiologist, and performed by a licensed audiologist to confirm the existence or absence of hearing loss when ordered by a Plan Provider;
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.

Preventive Health Care Services Limitations:
While treatment may be provided in the following situations, the following Services are not considered Preventive Health 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, based on factors determined by national standards.
- Services provided when you show signs or symptoms of a specific disease or disease process.
- Non-routine gynecological visits.
- Treatment of a medical condition or problem identified during the course of the preventive screening exam, such as removal of a polyp during a sigmoidoscopy.

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

BB. 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 standard device that adequately meets your medical needs.

Internally Implanted Devices
We cover Medically Necessary internal devices implanted during surgery, such as pacemakers, monofocal intraocular lens implants, artificial hips and joints, breast implants (see "Reconstructive Surgery") and cochlear implants, that are approved by the federal Food and Drug Administration 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 Limbs and Eyes

We cover Medically Necessary Prosthetic Devices to replace, in whole or in part, a limb or eye, their repair, fitting, replacement and components.

As used in this provision:
"Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

"Component" means the materials and equipment needed to ensure the comfort and functioning of a Prosthetic Device.

Ostomy and Urological Supplies and Equipment

We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets the Health Plan's criteria for medical necessity. 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.
- Therapeutic shoes and inserts are covered when deemed medically necessary by a Plan Provider, and are limited to individuals who have diabetic foot disease with impaired sensation or altered peripheral circulation.

Prosthetic Devices Exclusions:

- Internally implanted breast prosthesis for cosmetic purposes.
- Repair or replacement of prosthetic devices due to loss or misuse.
- Microprocessor and robotic-controlled external prosthetics that does not meet the Health Plan criteria as Medically Necessary.

- Multifocal intraocular lens implants.
- 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 but not limited to: jobst stockings; elastic garments and stockings; and garter belts.
- Comfort, convenience, or luxury equipment or features.

CC. RECONSTRUCTIVE SURGERY

We cover reconstructive surgery. This shall include plastic, cosmetic and related procedures required 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 significant improvement in physical function, and (3) treat congenital hemangioma known as port wine stains on the face.

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. 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, are not likely to result in significant improvement in physical function, and are not Medically Necessary. Examples of excluded cosmetic dermatology Services are:

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

DD. 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.

EE. 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");
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.

FF. TELEMEDICINE SERVICES

We cover telemedicine Services that would otherwise be covered under this Benefits 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.

GG. THERAPY AND REHABILITATION SERVICES

Physical, Occupational, and Speech Therapy Services

If, in the judgment of a Plan Physician, significant improvement is achievable within a ninety (90)-day period, we cover physical, occupational and speech therapy:

1. While you are confined in Plan Hospital; and
2. For up to thirty (30) visits per injury, incident or condition for each therapy in a Plan Medical Center, a Plan Provider's medical office, or a Skilled Nursing Facility, or as part of home health

care. This limit does not apply to necessary treatment of cleft lip, cleft palate, or ectodermal dysplasia.

Physical, Occupational, and Speech Therapy Services Limitations:

- Physical therapy is limited to treatment to restore physical function that was lost due to injury or illness. It is not covered to develop physical function, except as provided for under "Early Intervention Services" in this section.
- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Speech therapy is limited to treatment for speech impairments due to injury or illness.

Multidisciplinary Rehabilitation Services

If, in the judgment of a Plan Physician, significant improvement is achievable within a two-month period, we cover multidisciplinary rehabilitation Services in a Plan Hospital, Plan Medical Center, Plan Provider's medical office, or a Skilled Nursing Facility. Coverage is limited to a maximum of two (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.

Multidisciplinary Rehabilitation Services Limitations:

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

Cardiac Rehabilitation Services

We cover outpatient cardiac rehabilitation Services that is Medically Necessary following coronary surgery or a myocardial infarction, for up to twelve (12) weeks, or thirty-six (36), 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:

- Long-term rehabilitative therapy.

HH. 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.

II. TRANSPLANT SERVICES

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. The 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.
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 Services Exclusions:

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

JJ. 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 Office 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 Kaiser Permanente identification card.

Outside of our Service Area

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

If you obtain prior approval from 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 Plan Medical Office in the Service Area, or in the nearest Kaiser Foundation Health Plan region for continuing or follow-up treatment.

Urgent Care Limitations:
We do not cover Services outside of our Service Area for conditions that, before leaving the Service Area, you should have known might require Services while outside of 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 of our Service Area because of an extreme personal emergency.

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

KK. VISION SERVICES

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

Eye Exams
We cover routine and necessary eye exams, including:
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 (1) routine eye exam per year, including:
   a. Routine tests such as eye health and glaucoma tests; and
   b. 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) for the first regular supply for that contact lens per year; 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 frames, and subsequent adjustment.

Contact Lenses

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

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:

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

LL. 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 electrocardiograms and electroencephalograms;
4. Sleep lab and sleep studies; and
5. Specialty imaging: including CT, MRI, PET Scans, and Nuclear Medicine studies; and interventional radiology.

SECTION 4: EXCLUSIONS, LIMITATIONS AND REDUCTIONS

The following section provides you with information on what Services 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 coordinated with other types of coverage.

EXCLUSIONS

The Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in 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 the 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.

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 (other than those which are medically necessary as a result of an accidental injury), dental appliances, dental implants, orthodontia, shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, unless otherwise covered under a Rider attached to this EOC. This exclusion does not apply to medically necessary dental care covered under "Accidental Dental Injury Services," "Cleft-Lip, Cleft-Palate or Both" or "Oral Surgery" in 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 not 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. The 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. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;
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.

The 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 that are not medically necessary. This exclusion does not exclude Services for

when you are under active treatment for a metabolic or peripheral vascular disease.

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

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

Travel and Lodging Expenses
Travel and lodging expenses, except that in some situations, if a Plan Physician refers you to a non-Plan Provider outside of our Service Area as described under "Getting a Referral" in Section 2: How to Obtain Services, we may pay certain expenses that we pre-authorize in accordance with our travel and lodging guidelines.

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

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

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

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, terrorist activity, civil insurrection, disability of a large share of personnel of a Plan Facility, complete or partial destruction of facilities, and labor disputes not involving the Health Plan, Kaiser Foundation Hospitals, or Medical Group. However, in these circumstances the Health Plan, Kaiser Foundation Hospitals, Medical Group, and Medical Group Physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving the Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying care is safe and will not result in harmful health consequences.

REDUCTIONS

Medicare and TRICARE Benefits

The value of your benefits are coordinated with 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)

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

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

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

Definition

"Plan": Any of the following that provides benefits or services for, or because of, medical care or treatment: Group insurance or group-type coverage, whether insured or uninsured. This includes prepaid group practice or individual practice coverage.

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. If another Plan does not have a COB provision, that Plan is the Primary Plan.
2. If another Plan has a COB provision, the first of the following rules that apply will determine which Plan is the Primary Plan:
    a. **Subscriber/Dependent.** A Plan that covers a person as a Subscriber is Primary to a Plan that covers the person as a dependent.
    b. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in subparagraph (b)(iii) below, when the Health Plan and another Plan cover the same child as a dependent of

different persons, called "parents":

i. The Plan of the parent whose birthday falls earlier in the year is Primary to the Plan of the parent whose birthday falls later in the year; but
ii. If both parents have the same birthday, the Plan that covered a parent longer is Primary; or
iii. If the rules in (i) or (ii) do not apply to the rules provided in the other Plan, then the rules in the other Plan will be used to determine the order of benefits.

c. **Dependent Child/Separated or Divorced Parents.** If two (2) or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   i. First, the Plan of the parent with custody of the child;
   ii. Then, the Plan of the spouse of the parent with custody of the child; and
   iii. Finally, the Plan of the parent not having custody of the child.
   iv. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the Plan obligated to pay or provide the benefits of that parent has actual knowledge of those terms, that Plan is primary. This paragraph (iv) does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payer has that actual knowledge.
d. **Active/Inactive Employee.** A Plan that covers a person as an employee who is neither laid off nor retired (or as such an employee's dependent) is Primary to a Plan which covers that person as a laid off or retired employee (or as such an employee's dependent).
e. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the Plan that has covered a Subscriber longer is Primary to the Plan which has covered the Subscriber for the shorter time.

Effect of COB on the Benefits of this Plan

When 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 provider 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 or more of the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim thereon is made; exceeds Allowable Expenses in a Claim Determination Period. In that case, the Health Plan benefits will be coordinated, or the reasonable cash value of any services provided by 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. Health Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under Health Plan must give Health Plan any information it needs.

3. **Facility of Payment.** If a payment made or service provided under another Plan includes an amount that should have been paid or provided by or through 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 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.

SECTION 5: GETTING ASSISTANCE, FILING CLAIMS AND THE APPEALS PROCEDURE

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 your Kaiser Permanente identification card. These representatives can also help you file a claim for Emergency Services and Urgent Care Services outside of our Service Area (see Post-Service Claims) or to initiate an appeal for any unresolved problem.

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

By Telephone
Inside the Washington, DC Metropolitan Area: (301) 468-6000
Outside of the Washington, DC Metropolitan Area: 1-800-777-7902
TTY: 711

In Writing
To contact us in writing, mail your correspondence to:

Kaiser Permanente
2101 East Jefferson Street
Rockville, MD 20852

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

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

By Facsimile
To fax us your correspondence, send it to:

(301) 816-6192

When you must file a claim for services inside or outside of the Plan's service area, please submit claims to the following address:

Kaiser Permanente National Claims Administration-
Mid-Atlantic States
Attention: Claims Department
P.O. Box 371860
Denver, CO 80237-9998

PROCEDURE FOR FILING A CLAIM AND INITIAL CLAIM DECISIONS

The Health Plan will review claims that you make for Services or payment, and we may use medical

experts to help us review claims and appeals. You may file a claim or an appeal on your own behalf or through an Authorized Representative. As used with respect to Pre-Service, Concurrent Care, or Post-Service Claims and appeals related thereto, the term "Member" or "you" shall include an Authorized Representative, as defined in the Definitions Appendix.

The Health Plan will also process for a Member, the Member's Authorized Representative or the prescribing physician (or other prescriber) to request a standard review of a decision that a drug is not covered by the plan.

The initial response of the Health Plan may be to request additional information from the prescribing provider in order to make a determination. The Health Plan will make its utilization review decision no later than two business days following receipt of all the information necessary to complete the review.

The Health Plan will provide coverage of the drug for the duration of the prescription, including refills if the Health Plan grants a standard exception.

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

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

A. PRE-SERVICE CLAIMS

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

Procedure for Making a Non-Urgent Pre-Service Claim

1. Tell Member Services that you want to make a claim for the Health Plan to provide or pay for a Service you have not yet received. Your written or oral request and any related documents you give us constitute your claim. You may write or call us at the address and number listed above.
2. We will review your claim, and if we have all the information we need we will communicate our decision within two (2) working days after we receive your claim. If we cannot make a determination because we do not have all the information we need, we will ask you for more information within fifteen (15) days of receipt of your claim. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within forty-five (45) days, we will then make a decision within fifteen (15) days of the due date or the receipt date, whichever is earlier, based on the information we have.
3. We will make a good faith attempt to obtain information from the treating provider before we

make any Adverse Decision. At any time before we make our decision, the provider shall be entitled to review the issue of medical necessity with a physician advisor or peer of the treating provider. A physician reviewer will review the issue of medical necessity with the provider prior to making any Adverse Decision relating to cancer pain medication.

4. If we make an Adverse Decision regarding your claim, we will notify the treating provider:
   a. In writing within two (2) working days of the decision; or
   b. Orally by telephone within twenty-four (24) hours of the decision if the claim is for cancer pain medication.
5. The notice will include instructions for the provider to seek a reconsideration of the Adverse Decision, on behalf of the covered person, including the name, address and telephone number of the person responsible for making the Adverse Decision.
6. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can appeal.

Expedited Procedure for an Urgent Medical Condition

1. If you or your treating provider feels that you have an Urgent Medical Condition, you may request an expedited review of your Pre-Service claim.
2. If our clinical peer determines your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Pre-Service Claim.
3. We will review your claim, and if we have all the information we need we will notify you of our decision as soon as possible taking into account your medical condition(s) but no later than seventy-two (72) hours after receiving your claim. We will send a written or electronic confirmation within three (3) days after making our decision. If we cannot make a decision because we do not have all the information we need, we will ask you for more information within twenty-four (24) hours of receipt of your claim. You will have forty-eight (48) hours from the time of notification by us to provide the missing information. We will make a decision forty-eight (48) hours after the earlier of (a) our receipt of the requested information or (b) the end of the forty-eight (48)-hour period we have given you to provide the specified additional information.
4. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can appeal.
5. When you or your Authorized Representative sends an appeal, you or your Authorized Representative may also request simultaneous external review of our initial adverse decision. If you or your Authorized Representative wants simultaneous external review, your or your Authorized Representative's appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, than you or your Authorized Representative may be able to request external review after we make our decision regarding the appeal. See Section C Bureau of Insurance Independent External Appeals for additional information about filing an external appeal.

B. CONCURRENT CARE CLAIMS

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

1. Determinations regarding a Concurrent Care Claim request will be made, and notice provided to the Member's provider, by telephone and in writing, within one (1) business day of receipt of all information necessary to make a decision, but no later than fifteen (15) calendar days of receipt of the request.
2. If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date of onset of services and the date of the next scheduled concurrent review of the case.
3. If we reduce or terminate coverage for an ongoing course of treatment that we already approved, we will notify the Member sufficiently in advance of the reduction or termination to allow the member to appeal the decision as described below.

Concurrent Care Claims for an Urgent Medical Condition

If your Concurrent Care Claim involves an Urgent Medical Condition, and the claim is submitted within twenty-four (24) hours before the end of the initially approved period, we will decide the claim within twenty-four (24) hours of receipt.

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 claim is under consideration. If your claim is 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 your claim was received.

1. If our clinical peer determines your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Concurrent Care Claim.
2. We will notify you of our decision orally or in writing within twenty-four (24) hours after we receive your claim. If we notify you orally, we will send you a written decision within three (3) days after that.
3. If we deny your claim or if we do not agree to continue approval of all the Services you requested, we will tell you in writing why we denied your claim and how you can appeal.
4. When you or your Authorized Representative sends the appeal, you or your Authorized Representative may also request simultaneous external review of our adverse decision. If you want simultaneous external review, you or your Authorized Representative's appeal must tell us this. You or your Authorized Representative will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you or your Authorized Representative do not request simultaneous external review in the appeal, then you or your Authorized Representative may be able to request external review after we make our decision regarding the appeal. See the section entitled "C. Bureau of Insurance Independent External Appeals" for additional information about filing an external appeal.

C. POST-SERVICE CLAIMS

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

Procedure for Making a Post-Service Claim

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

1. You must send the completed claim form to us at the address listed on the claim form within one-hundred eighty (180) days, or as soon as reasonably possible after the Services are rendered. You should attach itemized bills along with receipts if you have paid the bills. Incomplete claim forms will be returned to you. This will delay any payments which may be owed to you. Also, you must complete and submit to us any documents that we may reasonably need for processing your claim or obtaining payment from insurance companies or other payors.
2. We will review your claim, and if we have all the information we need we will send you a written decision within thirty (30) days after we receive your claim. If we tell you we need more time because of circumstances beyond our control, we may take an additional fifteen (15) days to send you our written decision. If we tell you we need more time and ask you for more information, you will have forty-five (45) days to provide the requested information. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within forty-five (45) days, we will make a decision based on the information we have. We will issue our decision within fifteen (15) days of the deadline for receiving the information.
3. If we deny your claim or if we do not pay for all the Services you requested, our written decision will tell you why we denied your claim and how you can appeal.

RECONSIDERATION OF AN ADVERSE DECISION

Reconsideration of an Adverse Decision is available only to the treating health care provider, to request a review, on behalf of a Member, of an Adverse Decision by the Health Plan. A request for reconsideration is optional. The treating provider may choose to skip this step and the Member or the Authorized Representative may file an appeal as described below. If the provider does request reconsideration, the Member still has a right to appeal.

The Health Plan will render its decision regarding the reconsideration request and provide the decision to the treating provider and the Member, in writing, within ten (10) working days of the date of receipt of the request. If we deny the claim, the notice will include the criteria used and the clinical reason for the Adverse Decision, the alternate length of treatment of any alternate treatment recommended, and the Member's right to appeal the decision as described below.

APPEALS OF CLAIM DECISIONS

The Appeal Procedures are designed by the Health Plan to assure that Member concerns are fairly and

properly heard and resolved. By following the steps outlined below, Member concerns can be quickly and responsively addressed.

A. STANDARD APPEAL

This procedure applies to decisions regarding non-urgent Pre-Service Claims and Concurrent Claims as well as for Post-Service Claims. Please note that the timeframe for our response differs for Post-Service Claims (it is longer).

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

Kaiser Permanente
Member Services Appeals and Correspondence
2101 East Jefferson Street
Rockville, MD 20849
By fax: (301) 816-6192

You or your Authorized Representative may request a standard appeal by contacting the Member Services Department. In addition, you or your 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 to Members how appeals are processed and resolved and to assist the Member with filing an appeal. The Member Service Representative can be contacted Monday through Friday from 7:30 a.m. to 9 p.m. ET at:

Inside the Washington, DC Metropolitan Area: (301) 468-6000
Outside of the Washington, DC Metropolitan Area: 1-800-777-7902
TTY: 711

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

If within five (5) working days after a Member files an appeal, the Health Plan does not have sufficient information to initiate its internal appeal process, the Health Plan shall:

1. Notify the Member that it cannot proceed with reviewing the appeal unless additional information is provided; and
2. Assist in gathering the necessary information without further delay.

Standard appeals will either be acknowledged within five (5) working days of the filing date of the written appeal request. An acknowledgement letter will be sent as described immediately below.

Appeal of a Non-urgent Pre-Service or Non-urgent Concurrent Care Claim

If the appeal is for a Service that the Member is requesting, the acknowledgment letter will: (a) request additional information, if necessary; (b) inform the Member when there will be a decision on their appeal; and (c) state that written notice of the appeal decision will be sent within thirty (30) days of the date the appeal was received.

Appeal of a Post-Service Claim

If the appeal is asking for payment for completed services, an acknowledgment letter is sent: (a) requesting additional information, if necessary; (b) informing the Member when a decision will be made; and (c) that the Member will be notified of the decision within sixty (60) days of the date the appeal was received.

If there will be a delay in concluding the appeal process in the designated time, the Member will be sent a letter requesting an extension of time during the original time frame for a decision. If the Member does not agree to this extension, the appeal will move forward to be completed by end of the original time frame. Any agreement to extend the appeal decision shall be documented in writing.

If the appeal is approved, a letter will be sent to the Member stating the approval. If the appeal is by an Authorized Representative, the letter will be sent to both the Member and the Authorized Representative.

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

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

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

Prior to the Health Plan rendering its final decision, it must provide you or your Authorized Representative, without charge, any new or additional evidence considered, relied upon, or generated (or at the direction of) by the Health Plan in connection with the informal appeal.

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

If the review results in a denial, the Health Plan will notify the Member or the member's Authorized Representative. The notification shall include:

1. The specific factual basis for the decision in clear understandable language;
2. References to any specific criteria or standards on including interpretive guidelines, on which the

appeal decision was based (including reference to the specific plan provisions on which determination was based);

3. A statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request. In addition, you or your Authorized representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of your or your Authorized representative's claim.
4. A description of the right of the Member to file an external appeal with the Bureau of Insurance, along with the forms for filing and a detailed explanation of how to file such an appeal. An external appeal must be filed within one-hundred twenty (120) days after the date of receipt of a notice of the right to an external review of a final adverse determination or an adverse determination if the internal appeal process has been deemed to be exhausted or waived, a covered person or his authorized representative may file a request for an external review in writing with the Commission of the date of the Health Plan's final Adverse Decision, as described below; and
5. A statement of your rights under section 502(a) of ERISA.
6. If we send you a notice of an adverse decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least 10 percent of the population is literate only in the same federally mandated non-English language. You or your Authorized Representative may request translation of the notice by contacting Member Services.

If the Health Plan fails to make an appeal decision for a non-urgent Pre-Service Appeal within thirty (30) days or within sixty (60) days for a Post-Service Appeal, the Member may file a complaint with the Bureau of Insurance.

B. EXPEDITED APPEAL

When an Adverse Decision or adverse reconsideration is made, and you, your Authorized Representative, or treating health care provider believes that such Adverse Decision or adverse reconsideration warrants an immediate Expedited Appeal, you, your Authorized Representative, or your treating health care provider shall have the opportunity to appeal the Adverse Decision or adverse reconsideration by telephone on an expedited basis.

An Expedited Appeal may be requested only when the regular reconsideration and appeal process will delay the rendering of Covered Services in a manner that would be detrimental to the Member's health.

1. You, your Authorized Representative, or your treating health care provider may initiate an Expedited Appeal by contacting Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.:

During Regular Business Hours
Monday through Friday from 7:30 a.m. – 9 p.m. – The Member should contact the Member Services Department.

Inside the Washington, DC Metropolitan Area: (301) 468-6000
Outside of the Washington, DC Metropolitan Area: 1-800-777-7902
TTY: 711

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

Inside the Washington, DC Metropolitan Area: (703) 359-7878
Outside of the Washington, DC Metropolitan Area: 1-800-777-7904
TTY: 711

2. Once an Expedited Appeal is initiated, our clinical peer will determine if the appeal involves an urgent Pre-Service or Concurrent Care Claim. If the appeal does not meet the criteria for an expedited appeal, the request will be managed as a standard appeal, as described above. If such a decision is made, the Health Plan will verbally notify the Member within twenty-four (24) hours.
3. If the request for appeal meets the criteria for an expedited appeal, the appeal will be reviewed by a Plan physician who is board certified or eligible in the same specialty as the treatment under review, and who is not the individual (or the individual's subordinate) who made the initial adverse decision.
4. If additional information is needed to proceed with the expedited review, the Health Plan and the provider shall attempt to share the maximum information by telephone, facsimile, or otherwise to resolve the expedited appeal in a satisfactory manner.
5. A decision with respect to such Expedited Appeal shall be rendered no later than:
   a. Seventy-two (72) hours after receipt of the claim, if we have all of the necessary information; or
   b. If the claim is for cancer pain medication, no later than twenty-four (24) hours after receipt of the claim.
6. If approval is recommended, the Health Plan will immediately provide assistance in arranging the authorized treatment or benefit.
7. If the Health Plan declines to review an appeal as an Expedited Appeal; or if the Expedited Appeal results in a denial, the Health Plan shall immediately take the following actions:
   a. Notify you, your Authorized Representative, or the provider who requested the expedited review, by telephone, fax, or electronic mail that the Member is eligible for an Expedited Appeal to the Bureau of Insurance without the necessity of providing the justification required for a standard appeal; and
   b. Within twenty-four (24) hours after the initial notice, provide a written notice to the provider and the Member clearly informing them of the right to appeal this decision to the Bureau of Insurance. The written notice will include the appropriate forms and instructions to file an appeal with the Bureau of Insurance, as described below.

The notification shall also include:

1. The specific factual basis for the decision in clear understandable language;
2. References to any specific criteria or standards, including interpretive guidelines, on which the decision was based (including reference to the specific plan provisions on which determination was based);
3. A statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request; and
4. A statement of your rights under section 502(a) of ERISA.

An Expedited Appeal may be further appealed through the standard appeal process described above unless all material information was reasonably available to the provider and to the Health Plan at the time of the expedited appeal, and the physician advisor reviewing the Expedited Appeal was a peer of the treating health care provider, was board certified or board eligible, and specialized in a discipline related to the issues of the Expedited Appeal.

C. BUREAU OF INSURANCE INDEPENDENT EXTERNAL APPEALS

A Member may file for an Independent External Appeal with the State Corporation Commission's Bureau of Insurance (Bureau) if:

1. All of the Health Plan's appeal procedures described above have been exhausted;
2. The Member requested an Expedited Appeal and the Health Plan determined that the standard appeal timeframes should apply; or
3. When an Expedited Appeal is reviewed and is denied.

However a member may request an emergency review (ER) prior to exhausting our internal appeal process if:

An Adverse determination was based on a determination that services are experimental/investigational may be expedited with written certification by the treating physician that services would be less effective if not initiated promptly;

1. An Expedited ER for medical necessity, appropriateness, healthcare setting, level of care or effectiveness denials may be requested simultaneously with an expedited internal review; the Independent Review Organization (IRO) will review and determine if internal appeal should be completed prior to ER;

2. The Health Plan fails to render a standard internal appeal determination within thirty (30) or sixty (60) days and you, your Authorized Representative or Health Care provider has not requested or agreed to a delay; or

3. The Health Plan waives the exhaustion requirement.

The forms and instructions for filing an ER are provided to the Member along with the notice of a final Adverse Decision.

To file an appeal with the Bureau it must be filed in writing within one-hundred twenty (120) days from the date of receipt of your Health Plan decision letter using the forms required by the Bureau. The request is mailed to the following address:

Virginia State Corporation Commission
Bureau of Insurance
Life and Health Consumer Services Division
P. O. Box 1157
Richmond, VA 23218
(804) 371-9691
Website: www.scc.virginia.gov

The decision resulting from the external review will be binding on both the member and the Health Plan to the same extent to which we would have been bound by a judgment entered in an action of law or in equity, with respect to those issues which the external review entity may review regarding a final Adverse Decision of the Health Plan.

OFFICE OF THE MANAGED CARE OMBUDSMAN

The Office of the Managed Care Ombudsman is available to assist Health Plan Members to file an appeal.

If a Member has questions regarding an appeal or grievance concerning the health care services that he or she has been provided which have not been satisfactorily addressed by the Health Plan, he or she may contact the Office of the Managed Care Ombudsman for assistance at:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Local: 1-804-371-9032
Toll Free: 1-877-310-6560
E-Mail: ombudsman@scc.virginia.gov

THE OFFICE OF LICENSURE AND CERTIFICATION

If a Member has concerns regarding the quality of care he or she has received, he or she may contact The Office of Licensure and Certification at:

Complaint Intake
Office of Licensure and Certification
Virginia Department of Health
9960 Maryland Drive, Suite 401
Richmond, VA 23233-1463

Complaint Hotline:
Local: 1-804-367-2106
Toll Free: 1-800-955-1819
Fax: 1-804-527-4503

CUSTOMER SATISFACTION PROCEDURE

In addition, the Health Plan has established a procedure for hearing and resolving Complaints by Members. An oral Complaint may be made to any Health Plan employee or to any person who regularly provides health care Services to Members. A written Complaint must be given or sent to a Membership Services Representative located at a Medical Office or by sending a letter to Member Services at the following address:

Kaiser Permanente
Member Services Department
Appeals and Correspondence
2101 East Jefferson St.
Rockville, MD 20852

You or your Authorized Representative will receive a written response to your complaints within thirty (30) days unless you or your Authorized Representative is notified that additional time is required.

If you are dissatisfied with our response, you may file a complaint with the Bureau of Insurance (Bureau) at any time.

For information visit the Bureau's website at www.scc.virginia.gov or call the Life and Health Consumer Services Section at (804) 371-9691 or toll-free (877) 310-6560, to discuss your complaint or receive assistance on how to file a complaint. Written complaints may be mailed to:

State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Fax: (804) 371-9944

SECTION 6: TERMINATION OF MEMBERSHIP

Your group is required to inform the Subscriber of the date your coverage terminates. 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. In addition, Dependents' membership end at the same time as the Subscriber's membership ends.

You will be billed at non-Member rates for any Services you receive after your membership terminates. The 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.

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.

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who is Eligible" in Section 1, 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 your Group's benefits administrator to confirm your termination date.

Termination of Group Agreement

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

Termination for Cause

We may terminate the memberships of the Subscriber and all Dependents in your Family Unit by sending written notice to the Subscriber at least thirty-one (31) days before the termination date if you anyone in your Family Unit commits any of the following acts:

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

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.

Nonpayment of any other charges

We may terminate the memberships of a Subscriber and all Dependents in your Family Unit if any one of you fails to pay any amount he or she owes to the Health Plan or Medical Group, or fails to pay the applicable Cost Share to any Plan Provider. We will send written notice of the termination to the Subscriber at least thirty-one (31) days before the termination date.

EXTENSION OF BENEFITS

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

1. If you become Totally Disabled while enrolled under this Agreement and remain so at the time your coverage ends, we will continue to provide benefits for covered services. Coverage will continue for one-hundred eighty (180) days from the date of termination or until you no longer qualify as being Totally Disabled, or until such time as a succeeding health plan elects to provide coverage to you without limitations as to the disabling condition, whichever comes first.

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

Upon termination of the Extension of Benefits, the Member will have the right to convert his or her coverage as described below.

Limitation(s):

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

1. Members whose coverage ends because of failure to pay Premium; or
2. Members whose coverage ends because of fraud or material misrepresentation by the Member.

CONTINUATION OF COVERAGE

A member whose eligibility for coverage terminates under this group contract has the opportunity to continue coverage at their own expense under the group contract for a period no shorter than twelve (12) months. The continuation coverage period begins immediately after the member's termination date of eligibility for coverage under this group contract.

1. Continuation coverage is to be provided without additional evidence of insurability, and is subject to the following requirements:
   a. The application and payment for continued coverage is made to the group contract holder within thirty-one (31) days following issuance of the written notice required in number 3 of this section (below), but not beyond the sixty (60)-day period following the member's termination date, as indicated in the written notice provided by the group contract holder;
   b. Each premium payment for continued coverage is paid timely to the group contract holder on a monthly basis during the twelve (12)-month continuation coverage period (or longer, if offered by the group); and
   c. The premium for continuation coverage shall be at the Health Plan's current rate, as applicable to similarly situated individuals under the group contract, plus any applicable administrative fee not to exceed 2 percent of the current rate.
2. Continuation coverage is not be required to be made available by the group when the enrollee:
   a. Is covered by or eligible for Medicare;
   b. Is covered by substantially the same level of benefits under any policy, contract or plan for individuals in a group;

c. Has not been continuously covered during the three (3)-month period immediately preceding the enrollee's termination of coverage;
d. Was terminated by the Health Plan or coverage was rescinded for:
   i. Failure to pay the premium required by the contract as shown in the contract or Evidence of Coverage (EOC); and/or
   ii. The policyholder or contract holder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage.
e. Was terminated from a plan administered by the Department of Medical Assistance Services that provided benefits pursuant to Title XIX or XXI of the Social Security Act (42 USC § 1396 et seq. or § 1397aa et seq.).

3. The group contract holder shall provide each enrollee or other person covered under the group contract with written notice of the procedures and timeframes for obtaining continuation of coverage under the group contract. This notice shall be provided within fourteen (14) days of the group contract holder's knowledge of the enrollee's or other covered person's loss of eligibility under the group contract.

Note: This continuation coverage provision is not applicable when a group contract holder is required by federal law to provide Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits under its group health plan.

CONTINUATION OF GROUP COVERAGE UNDER FEDERAL LAW

COBRA

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

USERRA

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

COVERAGE AVAILABLE ON TERMINATION

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

Or 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

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. **A Durable Power of Attorney for Health Care** lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your views on life support and other treatments.
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 and instructions, 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.

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 refer to your *Provider Directory* 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

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

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

GROUPS AND MEMBERS NOT HEALTH PLAN'S AGENTS

Neither your Group nor any Member is the agent or representative of the 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 Physician, including the name, professional level, and credentials of the doctors assisting or treating you;
b. Receive information about Kaiser Permanente, our Services, our practitioners and providers, and the rights and responsibilities you have as a Member. You also can make recommendations regarding Kaiser Permanente's member rights and responsibility policies;
c. Receive information about financial arrangements with physicians that could affect the use of Services you might need;
d. Receive Emergency Services when you, as a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed;
e. Receive covered urgently needed services when traveling outside Kaiser Permanente's Service Area;
f. Receive information about what Services are covered and what you will have to pay and to examine an explanation of any bills for Services that are not covered; 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 Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics, or Family Practice as your Primary Care Physician;
c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you;
d. Work with us to help you understand your health problems and develop mutually agreed upon treatment goals;
e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment;
f. Do your best to improve your health by following the treatment plan and instructions your physician or health care professional recommends;
g. Schedule the health care appointments your physician or health care professional recommends; and
h. Keep scheduled appointments or cancel appointments with as much notice as possible.

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

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

NAMED FIDUCIARY

Under our Agreement with your Group, we have assumed the role of a "named fiduciary," 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 contact

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

NOTICE OF NON-GRANDFATHERED GROUP PLAN

Health Plan believes this coverage is a ‘‘non-grandfathered health plan’’ under the Patient Protection and Affordable Care Act (PPACA).

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.

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 care services you receive, or payment for your health care. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

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

This is only a brief summary of some of our key privacy practices. 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.

DEFINITIONS APPENDIX

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

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

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 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,
   a. The contracted amount;
   b. The negotiated amount;
   c. The amount stated in the fee schedule that providers have agreed to accept as payment for those Services; or,
   d. The amount that the Health Plan pays for those Services.

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.

Appellant: An appellant is a person eligible to file an Independent External Appeal. The Member or the following persons may be considered an Appellant: (a) an Authorized Representative or (b) the member's spouse, parent, committee, legal guardian or other individual authorized by law to act on the Member's behalf if the Member is not a minor, but is incompetent or incapacitated.

Applied Behavior Analysis: The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

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

respect to claims and appeals, the term “Member” or “you”, or “your” shall include an Authorized Representative.

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.

Complaint: A Complaint is an inquiry to the Member Services Department about Services, Member rights or other issues; or the communication of dissatisfaction about the quality of service or other issue which is not an Adverse Decision. Complaints do not involve utilization review decisions.

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

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.

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 the “Eligibility and Enrollment” section.)

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

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; or
3. Serious dysfunction of any bodily organ or part.

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

1. A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition.

2. Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act requires to Stabilize the patient.

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

Expedited (Urgent Care) Appeal: An appeal that must be reviewed under an expedited process because the application of non-expedited appeal time frames could seriously jeopardize a Member's life or health or the Member's ability to regain maximum function. In determining whether an appeal involves Urgent Care, Health Plan must apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine. An Expedited Appeal is also an appeal involving:

1. Care that the treating physician deems urgent in nature;
2. The treating physician determines that a delay in the care would subject the Member to severe pain that could not adequately be managed without the care or treatment that is being requested; or
3. When Health Plan covers prescription drugs and the requested services is a prescription for the alleviation of cancer pain, the Member is a cancer patient and the delay would subject the Member to pain that could not adequately be managed without the care or treatment that is being requested.

Such appeal may be made by telephone, facsimile or other available similarly expeditious method.

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.

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

Health Plan Region: Each of the specific geographic areas where Kaiser Foundation Health Plan, Inc., or an affiliated organization conducts a direct service health care program.

Independent External Review: If the Member receives an Adverse Decision of an appeal, the Member or the Member’s Authorized Representative, which may include the treating provider, may appeal the Adverse Decision to the Bureau of Insurance for an Independent External Review.

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: (1) medically required to prevent, diagnose or treat your condition or clinical symptoms; (2) in accordance with

generally accepted standards of medical practice; (3) not solely for the convenience of you, your family and /or you provider; and (4) the most appropriate level of Service which can safely be provided to you. For purposes of this definition, "generally accepted standards of medical practice" means (a) standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; (b) physician specialty society recommendations; (c) the view of physicians practicing in the 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: Benefits) is Medically Necessary and our decision is final and conclusive subject to your right to appeal as set forth in Section 5: Getting Assistance, Filing Claims and the Appeals Procedure.

Medicare: A federal health insurance program for people 65 or 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 Member as "you" or "your."

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.

Plan: Kaiser Permanente.

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

Plan Hospital: A hospital that (a) contracts to provide inpatient and/or outpatient Services to Members and (b) 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.

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 (a) contracts to provide Services and supplies to Members and (b) 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 (a) is employed by or operated by an entity that participates in the Kaiser Permanente Medical Care Program or (b) contracts with an entity that participates in the Kaiser Permanente Medical Care Program.

Premium: Periodic membership charges paid by Group.

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

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

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

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

Services: Health care services or items.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation Services, or other related health care Services and is certified by Medicare. The facility's primary business must be the provision of 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.

Spouse: Your legal husband or wife.

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

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

Totally Disabled:

For Subscribers and Adult Dependents: 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 require prompt attention, but are not of an emergent nature.

Urgent Medical Condition: As used in Section 5: Getting Assistance, Filing Claims and the Appeals Procedure, a medical condition for which care has not been rendered and which (a) could seriously jeopardize your life, health or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject the Member to severe pain that cannot be adequately managed without the Services which are the subject of the claim.

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, or to age 26 if a full-time student, 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 below in the schedule for each Service in this "Summary of Services and Cost Shares." Allowable Charge is defined in the Definitions Appendix.

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 the Services shown in the schedule below that have a Coinsurance, except Durable Medical Equipment, Preventive Health Care Services and Prosthetic and Orthotic Devices. Other Services may have a Copayment. Copayments do not apply toward the Deductible.

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 Copayment or 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, then either one covered Family Member must meet the Individual Deductible, or the entire family must meet the Family Deductible. Each Individual Deductible amount counts toward the Family Deductible amount. but no one family Member's medical expenses may contribute more than the Individual Deductible shown below. After an Individual Member of the Family Unit has met the Individual Deductible, his or her Deductible will be met for the rest of the contract year. Other family Members will continue to pay full charges for Services that are subject to the Deductible until the Family Deductible is met. After two or more covered Members of your Family Unit combined have met the Family Deductible, the Deductible will be met for all Members of the Family Unit for the rest of the contract year.

Keep Your Receipts. When you pay an amount toward your Deductible, we will give you a receipt. Keep your receipts. 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	$500 per individual per contract year
Family Deductible	$1,000 per Family Unit per contract year

Copayments and Coinsurance	
Covered Service	**You Pay**
Outpatient Care	
Office visits (for other than preventive health care Services)	
Primary care office visits	
For adults	$10 per visit
For children under 3 years of age	No charge
For children 3 years of age or older	$10 per visit
Specialty care office visits	$10 per visit
Consultations and immunizations for foreign travel	$10 per visit
Outpatient surgery	10% of AC* after Deductible
Anesthesia	Applicable Cost Shares will apply based on type and place of Service
Respiratory therapy	$10 per visit
Medical social Services	$10 per visit
House calls	No charge
Hospital Inpatient Care All charges incurred during a covered stay as an inpatient in a hospital	10% of AC* after Deductible
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)	$150 per encounter
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.	Applicable Cost Shares will apply based on type and place of Service
Autism Spectrum Disorder Services Autism spectrum disorder benefit for children age 2 through age 10.	
Physical, speech and occupational therapy	$10 per visit
Applied Behavioral Analysis (ABA)	$10 per visit

Copayments and Coinsurance	
Covered Service	**You Pay**
Blood, Blood Products and Their Administration	10% of AC* after Deductible
Chemical Dependency and Mental Health Services	
Inpatient treatment in a hospital or residential treatment center	10% of AC* after Deductible
Partial hospitalization	No charge
Outpatient office visits	
• Individual therapy	$10 per visit
• Group therapy	$5 per visit
• Intensive Outpatient Treatment	$10 per visit
• Medication management visits	$10 per visit
All other outpatient Services	
• Crisis intervention	No charge
• Electroconvulsive Therapy (ECT)	No charge
• Psychological and neuropsychological testing (for diagnostic purposes)	No charge
Cleft Lip, Cleft Palate, or Both	Applicable Cost Shares will apply based on type and place of Service
Clinical Trials	Applicable Cost Shares will apply based on type and place of Service
Diabetic Equipment, Supplies and Self-Management Training	
Diabetic equipment and supplies	10% of AC* after Deductible
Self-management training	Applicable Cost Shares will apply based on place of Service
Dialysis	
Inpatient care	Applicable inpatient care Cost Shares will apply
Outpatient Care	$10 per visit
Drugs, Supplies, and Supplements Administered by or under the supervision of a Plan Provider	Applicable Cost Shares will apply based on type and place of Service

Copayments and Coinsurance	
Covered Service	**You Pay**
Durable Medical Equipment – Outpatient	
Outpatient Basic Durable Medical Equipment	10% of AC* after Deductible
Outpatient Supplemental Durable Medical Equipment	
• Oxygen and Equipment	10% of AC* after Deductible
• Positive Airway Pressure Equipment	10% of AC* after Deductible
• Apnea Monitors (Infants under 3, not to exceed a period of 6 months)	10% of AC* after Deductible
• Asthma Equipment	10% of AC* after Deductible
• Bilirubin Lights (Infants under 3, not to exceed a period of 6 months)	10% of AC*
Early Intervention Services (from birth to age 3)	$10 per visit
Emergency Services	
Emergency Room Visits	
• Inside the Service Area	10% of AC*
• Outside the Service Area	10% of AC*
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.	
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.s	
Voluntary termination of pregnancy	Applicable Cost Share will apply based on type and place of Service
Male sterilization (i.e., vasectomies).	Applicable Cost Share will apply based on type and place of Service
Hearing Services	
Hearing tests (newborn hearing screening tests are covered under preventive health care Services at no charge)	Applicable office visit Cost Share will apply based on place of service
Home Health Care See Section 3 for benefit limitations	10% of AC* after Deductible
Hospice Care	10% of AC* after Deductible
Infertility Services	
Office visits	50% of AC* after Deductible
Inpatient Hospital Care	50% of AC* after Deductible
All other Services for treatment of infertility	50% of AC* after Deductible

Copayments and Coinsurance	
Covered Service	**You Pay**
Maternity Services	
Delivery and all inpatient Services	10% of AC* after Deductible
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; Deductible waived
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	
Medical Foods	10% of AC* after Deductible
Medical Nutrition Therapy & Counseling	$10 per visit
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 DME cost share will apply
Preventive Health Care Services	
Routine physical exams for adults	No charge
Routine preventive tests for adults	No charge
Well child care visits	No charge
Routine immunizations for children and adults (No additional charge for immunization agent)	No charge
Routine Preventive Care Screenings conducted in a Lab or Radiology	No charge

Copayments and Coinsurance	
Covered Service	**You Pay**
Prosthetic and Orthotic Devices External Orthotics	
• Rigid and semi-rigid orthotic devices (Limited to standard devices)	10% of AC* after Deductible
• Therapeutic shoes and inserts (Limited to individuals who have diabetic foot disease with impaired sensation or altered peripheral circulation)	10% of AC* after Deductible
External Prosthetics	
• Artificial eyes, legs, and arms	10% of AC*
• Breast prosthesis following a Medically Necessary mastectomy (Limited to two prosthetic bras per year)	10% of AC*
• Ostomy and urological supplies	10% of AC*
• 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	10% of AC* after Deductible
Reconstructive Surgery	Applicable Cost Shares will apply based on place and type of Service.
Skilled Nursing Facility Care Limited to a maximum benefit of 100 days per contract year	10% of AC* after Deductible
Telemedicine Services	No charge
Therapy and Rehabilitation Services (Refer to Section 3 for benefit maximums)	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	$10 per visit
Note: All Services received in one day for multidisciplinary rehabilitation Services at a day treatment program will be considered one visit.	
Therapy: Radiation/Chemotherapy/Infusion Therapy	
Chemotherapy and Radiation Therapy	$10 per visit
Infusion Therapy	Applicable Cost Shares will apply based on type and place of Service
Transplants	Applicable Cost Shares will apply based on place and type of Service

Copayments and Coinsurance	
Covered Service	**You Pay**
Urgent Care	
Office visit during regular office hours	Applicable office visit Cost Share will apply
After-Hours Urgent Care or Urgent Care Center	$10 per visit
Vision Services	
Adult Vision (for adults age 19 or older)	
Routine eye exams/refractions - Optometry Services	$10 per visit
Eye Care (Medical Treatment) - Ophthalmology Services	$10 per visit
Eyeglass lenses and frames	You receive a 25% discount off retail price** for eyeglass lenses and for eyeglass frames
Contact lenses	You receive a 15% discount off retail price** on initial pair of contact lenses
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	$10 per visit
Eye Care (Medical Treatment) - Ophthalmology Services	$10 per visit
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

Copayments and Coinsurance	
Covered Service	**You Pay**
X-ray, Laboratory and Special Procedures	
Diagnostic imaging and laboratory tests	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	$10 per visit
Specialty Imaging (including CT, MRI, PET Scans, Nuclear Medicine and Interventional Radiology)	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	$50 per test
Sleep lab	$50 per visit
Sleep studies	$10 per visit
Note: Charges for covered outpatient diagnostic and laboratory tests performed in a Plan Physician's office are included in the office visit Copayment.	

*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.

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 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 this EOC, your medical expenses apply toward the Self-Only Out-of-Pocket Maximum shown below.

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

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
- Adult routine eye exams
- In vitro fertilization

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 Out-of-Pocket Maximum from our Member Services Department.

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

Annual Out-Of-Pocket Maximum	
Combined total of Deductible and allowable Copayments and Coinsurance	
Self-Only Out-of-Pocket Maximum	$3,000 per individual per contract year
Family Out-of-Pocket Maximum	$6,000 per Family Unit per contract year

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

OUTPATIENT PRESCRIPTION DRUG RIDER

GROUP EVIDENCE OF COVERAGE

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

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.

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.

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.

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: The (a) American Hospital Formulary Service- Drug Information; (b) National Comprehensive Cancer Network's Drugs & Biologics Compendium; or (c) Elsevier Gold Standard's Clinical Pharmacology.

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

B. BENEFITS

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. Each prescription refill is subject to the same conditions as the original prescription. Plan Providers prescribe drugs in accordance with Health Plan's Preferred Drug List. If the price of the drug is less than the Rx Copayment, the Member will pay the lesser amount. You must obtain these drugs from a Plan Pharmacy or a Participating Network Pharmacy. It may be possible for you to receive 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, except when the drug is listed in our Preferred Drug List.
2. Compounded preparations that contain at least one ingredient requiring a prescription and are listed in our Preferred Drug List, if: (1) there is no medically appropriate alternative in our Preferred Drug List; and (2) the compound is prescribed for an appropriate FDA-approved indication.
3. Insulin

4. Drugs that are FDA-approved for use as contraceptives, including over-the-counter contraceptives for women when prescribed by a Plan Provider, and diaphragms. For coverage of other types of contraception, including contraceptive injections, implants and devices, refer to "Family Planning Services" in Section 3: Benefits.
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. Tobacco cessation drugs that are approved by the FDA for the treatment of tobacco dependence, including over-the-counter tobacco 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. For a patient with intractable cancer pain, any drug approved by the FDA for cancer pain in excess of the recommended dosage when the excess dosage is determined to be Medically Necessary by a Plan Provider.
9. Growth hormone therapy (GHT) for treatment of children under age 18 with a growth hormone deficiency.
10. Non-prescription drugs when they are prescribed by a Plan Provider and are listed on the Preferred Drug List.

The Pharmacy and Therapeutics Committee sets dispensing 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 on line 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.

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

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 unless the prescribing provider indicates "dispense as written" (DAW) on the prescription.

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

If a Member requests a Brand Name Drug, for which the prescribing provider has determined it does not meet one of the above criteria of the exception process, the Member will be responsible for the full Allowable Charge for that Brand Name Drug.

Preferred vs. Non-Preferred

Plan Pharmacies and Participating Network Pharmacies will dispense Preferred drugs unless the prescribing provider indicates "dispense as written" (DAW) on the prescription.

Non-Preferred Drugs will be covered following the formulary exception process when: (1) prescribed by a Plan Physician or by a dentist or a referral physician; when the enrollee has been receiving the Non-Preferred prescription drug for at least six months previous to the development or revision of the Preferred Drug List and (2) (a) there is no equivalent drug in our Preferred Drug List, or (b) an equivalent Preferred Drug (i) has not been effective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member. The applicable Preferred Drug Cost Share will apply.

The Health Plan, upon consultation with the prescribing provider, shall act on urgent requests within one business day of receipt of the request.

If a Member requests a Non-Preferred Drug, for which the provider has determined it does not meet one of the above criteria of the exception process, the Member will be responsible for the full cost for that drug.

Dispensing Limitations

Except for Maintenance Medications as described below, Members may obtain up to a 30 day supply and will be charged the applicable Rx Copayment or Rx Coinsurance based on: (1) the place of purchase, (2) the prescribed dosage, (3) Standard Manufacturers Package Size, and (4) specified dispensing limits. For contraceptive drugs, Members may obtain up to a 12-month supply at one time

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

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

Maintenance Medication Dispensing Limitations

Members may obtain up to a 90-day supply of Maintenance Medications in a single prescription, when authorized by the prescribing Plan Provider or by a dentist or a referral physician. This does not apply to the first prescription or change in a prescription. The day supply is based on (1) the prescribed dosage, (2) Standard Manufacturer's Package Size, and (3) 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 get reimbursed, you must submit a copy of the itemized receipts for the prescriptions to the Health Plan. We may require proof that Urgent Care or Emergency Services were provided. We will reimburse you at the Allowable Charge less the applicable Rx Copayment or Rx Coinsurance, 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.
2. In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with the Health Plan's emergency management department and/or our Pharmacy and Therapeutics Committee. If limited, the applicable Cost Share per prescription will apply.

E. EXCLUSIONS

The following are not covered under the Outpatient Prescription Drug Rider 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 when the drug is listed in our Preferred Drug List.
2. Compounded preparations that do not contain at least one ingredient requiring a prescription and are not listed in our Preferred Drug List; or for which: (1) there is a medically appropriate alternative in our Preferred Drug List; or (2) the compound was not prescribed for an appropriate FDA-approved indication.
3. Except as provided for in the "Where to Purchase Covered Drugs" provision above, drugs obtained from a non-Plan Pharmacy.
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. Except as specifically covered under this Outpatient Prescription Drug Rider, a drug (a) which can be obtained without a prescription, or (b) for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug.

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 retard 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 the EOC.
15. Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from the Health Plan's standard packaging for prescription drugs.
16. Alternative formulations or delivery methods that are: (1) different from the Health Plan's standard formulation or delivery method for prescription drugs; and (2) deemed not Medically Necessary.
17. Durable medical, 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 and Orthotic 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 Services" in Section 3: Benefits.
19. Bandages or dressings. Refer to "Drugs, Supplies, and Supplements" and "Home Health Services" 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, as determined by the Pharmacy and Therapeutics Committee.
24. Drugs for the treatment of sexual dysfunction disorders.

F. COPAYMENTS AND COINSURANCE

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

30 Day Supply	Plan Pharmacy	Participating Network Pharmacy	Mail Delivery
Generic Drugs	$10	$30	$10
Preferred Brand Drugs	$30	$50	$30
Non Preferred Brand Drugs	$50	$75	$50
Specialty Drugs	Refer to the applicable Generic and Brand Drugs Cost Share above	Refer to the applicable Generic and Brand Drugs Cost Share above	Refer to the applicable Generic and Brand Drugs Cost Share above

90-day Supply of Maintenance Medication	Mail Delivery	Plan Pharmacy and Participating Network Pharmacy
Generic Drugs	2 Rx Copayment(s) shown above	3 Rx Copayment(s) shown above
Preferred Brand Drugs	2 Rx Copayment(s) shown above	3 Rx Copayment(s) shown above
Non Preferred Brand Drugs	2 Rx Copayment(s) shown above	3 Rx Copayment(s) shown above
Specialty Drugs	2 Rx Copayment(s) shown	3 Rx Copayment(s) shown

Weight management drugs for 50% of the Allowable Charge

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

Tobacco Cessation Drugs for the treatment of tobacco dependence for no charge.

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

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

H. OUT-OF-POCKET MAXIMUM

Cost Shares set forth in this Rider 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 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, 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 Section 6: Termination of Membership. 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 20 visits per contract year.

D. ***Exclusions:***
- Services requested by the Member that are deemed not 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:***
Covered Services under this Rider for Acupuncture Services are not subject to the Deductible; and do not apply toward the Out-of-Pocket Maximum shown in the Summary of Services and Cost Shares in the Group EOC.

Covered Services under this Rider for Chiropractic Services are not subject to the Deductible; but apply toward the Out-of-Pocket Maximum shown in the Summary of Services and Cost Shares in the Group EOC. You pay the following Cost Share for each visit.

- You pay **$10** per visit.

This 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 PERMANENTE

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

DOMESTIC PARTNER RIDER

This Domestic Partner Rider is effective as of the date of your Group Agreement and Group Evidence of Coverage, and shall terminate the date your Group Agreement Group Evidence of Coverage terminates.

I. Definitions

Domestic Partner: An unmarried same or opposite sex adult who resides with the Subscriber and the Subscriber and the individual meet the following requirements:

A. The individual has lived with the Subscriber in a committed relationship for at least six consecutive months prior to eligibility for this coverage;
B. The individual must not have any blood relation to Subscriber;
C. The individual and the Subscriber must be at least 18 years of age;
D. Neither the Subscriber or the individual can be married, nor a member of another domestic partnership;
E. The individual and the Subscriber must agree to be jointly responsible for one another's basic living expenses and overall welfare;
F. Both the Subscriber and the individual must be mentally capable of consenting to the domestic partnership; and
G. The individual and the Subscriber must attest to the above in an Affidavit of Domestic Partnership provided by Health Plan.

II. Eligibility

Subject to the terms, conditions, limitations, and exclusions specified in the Group Evidence of Coverage and this Rider, the use of the term "Spouse" throughout the attached Group Evidence of Coverage shall also include Domestic Partner, except as provided in VI below. A Domestic Partner is not considered a legal spouse. As such, coverage is hereby extended to the Subscriber's eligible Domestic Partner and the Domestic Partner's eligible Dependent children.

Except as provided in VI below, a Domestic Partner and the Dependent children of a Domestic Partner are eligible for the same benefits provided to all other eligible Dependents under the Group Evidence of Coverage, including any applicable continuation of coverage provisions.

III. Enrollment and Effective Date of Coverage

In addition to submitting a Health Plan-approved enrollment application, as required under "Enrollment and Effective Date of Coverage" of Section 1 of the attached Group Evidence of Coverage, you and your Domestic Partner must complete and sign an "Affidavit of Domestic Partnership" form and submit it to Group within the same time frame as the enrollment application.

IV. Termination of Domestic Partner Coverage

You must notify Group within 30 days if the Domestic Partnership terminates by completing a "Statement of Termination of Domestic Partnership" form, which can be obtained from Group.

Except as provided for any extension of benefits provided under the Group Evidence of Coverage, coverage will terminate as follows:

A. If the Domestic Partnership ends for any reason other than death, the Domestic Partner's coverage will terminate on the last day of the month following receipt of notification by Health Plan. Coverage of the Domestic Partner's Dependents will terminate on the date the Domestic Partner's coverage terminates.
B. If coverage ends due to the death of a Domestic Partner, coverage will terminate as of the date of death. Coverage of the Domestic Partner's Dependents will terminate on the last day of the month following receipt of notification by Health Plan.

All other Termination provisions set forth in the attached Group Evidence of Coverage are applicable.

V. Addition of a Different Partner

You are required to wait six months from the date of notification of termination of a Domestic Partnership before enrolling a different partner, unless the Domestic Partnership ended because of the death of the Domestic Partner.

If the Domestic Partnership ended due to the death of the Domestic Partner, the Subscriber may add a new Domestic Partner in accord with the requirements stated in Section I of this Rider.

VI. Limitations

A Domestic Partner is not eligible for Infertility Services.

This 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

Notes

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