



guide to
YOUR 2013 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 2013 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 20849



KFHP-EOC COVER(01/10)VA

DHMO

THIS IS NOT A FEDERALLY QUALIFIED PRODUCT

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 (800) 777-7902

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.

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SECTION 1 – Introduction

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

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,” 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 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.

Kaiser Permanente SignatureSM

Kaiser Permanente SignatureSM 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 described in the “Definitions” section of this EOC.

To make your health care easily accessible, Health Plan provides conveniently located Plan Medical Centers and medical offices throughout the Washington 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. In addition, we have added pharmacy, optical, laboratory, and x-ray facilities at most of our Plan Medical Centers.

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

- Emergency Services
- Urgent Care Services outside our Service Area
- Authorized Referrals
- 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 the “Benefits” section.

Who is Eligible

General

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

- A. You must meet your Group's eligibility requirements that we have approved (your Group is required to inform Subscribers of the Group's eligibility requirements) and meet the Subscriber or Dependent eligibility requirements below.
- B. You must live or work in our Service Area (our Service Area is described in the “Definitions” section).

However, your 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 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.

- C. Neither you nor any member of your family may enroll under this EOC if you or any dependent have ever had entitlement to Services through Health Plan terminated for:
 - (1) If you or any Dependent have ever had entitlement to receive Services through us terminated for any of the reasons listed under “Termination for Cause” in the “Termination of Membership” section, neither you nor any member of your family is eligible to enroll under this EOC.
 - (2) You may not enroll under this EOC until you pay all amounts owed by you and your Dependents if you were ever a subscriber in

this or any other plan who had entitlement to receive Services through us terminated for:

- (a) failure of you or your Dependent to pay any amounts owed to us, Kaiser Foundation Hospitals, or Medical Group, or
- (b) failure to pay your Cost Share to any Plan Provider, or
- (c) failure to pay non-group Premium.

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 (for example, 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:

- A. Your Spouse;
- B. Your or your Spouse's children, who are under the age limit specified on the Summary of Services and Cost Shares section;
- C. Other Dependent persons (but not including foster children) who meet all of the following requirements:
 - (1) they are under the age limit specified on the Summary of Services and Cost Shares section; and
 - (2) 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:

- A. they are incapable of self-sustaining employment because of physically- or mentally-disabling injury, illness, or condition that occurred prior to reaching the age limit for Dependents;
- B. they receive 50 percent or more of their support and maintenance from you or your Spouse;
- C. you provide us proof of their incapacity and dependency within 60 days after we request it (see "Disabled Dependent Certification" section below for additional eligibility requirements).

Disabled Dependent Certification

A Dependent who meets the Dependent eligibility requirements except for the age limit may be eligible as a disabled Dependent as described in this section.

You must provide us documentation of your dependent's incapacity and Dependency as follows:

- 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 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 incapacity and dependency within 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, two years after the date that your Dependent reached the age limit, you must provide us documentation of his or her incapacity and dependency annually within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled Dependent.
- If your Dependent is not a Member and you are requesting enrollment, you must provide us documentation of his or her incapacity and dependency within 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 incapacity and dependency annually within 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 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 12:00 a.m. 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 31 days after you become eligible (you should 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:

- A. You become eligible as described in this "Special enrollment" section
- B. 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 first day of the month following the date your Group receives a Health Plan-approved enrollment or change of enrollment application from the Subscriber.

Special enrollment due to new Dependents

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

The effective date of an enrollment resulting from marriage is no later than the first 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:

- A. 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 31 days from the date of birth, notification of birth and

payment of additional Premium must be provided within 31 days of the date of birth, otherwise coverage for the newborn will terminate 31 days from the date of birth.

- B. 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 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 31 days from the date of adoption, notification of adoption and payment of additional Premium must be provided within 31 days of the date of adoption, otherwise coverage for the newly adopted child will terminate 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.

- C. For children who are newly eligible for coverage as the result of guardianship granted by court or testamentary appointment, the date of court or testamentary appointment.

If payment of additional Premium is required to provide coverage for the child, notification of the court or testamentary appointment may be provided at any time but, payment of Premium must be provided within 31 days of the enrollment of the child, otherwise, enrollment of the child terminates 31 days from the date of court or testamentary appointment.

Special Enrollment due to court or administrative order

Within 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 disenrolled 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:

- A. The Subscriber or at least one of the Dependents had other coverage when he or she previously declined all coverage through your Group
- B. The loss of the other coverage is due to one of the following:
 - (1) exhaustion of COBRA coverage;
 - (2) termination of employer contributions for non-COBRA coverage;
 - (3) loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, reaching the age limit for dependent children, or the Subscriber's death, termination of employment, or reduction in hours of employment ;
 - (4) loss of eligibility for Medicaid coverage or Child Health Insurance Program coverage, but not termination for cause; or
 - (5) reaching a lifetime maximum on all benefits

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

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 31 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for Medicaid or Child Health Insurance Program coverage. The effective date of an enrollment resulting from loss of other coverage is no later than

the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special enrollment due to 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 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 (through payroll deduction, for example).

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:

- Emergency Services, in the “Benefits” section
- Urgent Care Outside our Service Area, in the “Benefits” section
- Getting a Referral, in this section
- Visiting Other Kaiser Permanente Regions or Group Health Cooperative Service Areas, in this section
- Visiting Member Services, in the “Benefits” section
- Services Received from Non-Plan Providers at Non-Plan Facilities Without a Referral.

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 the following website address:

www.kp.org

To learn how to choose or change your primary care Plan Physician, please call our Member Services Department at:

Inside the Washington, D.C., Metropolitan area
(301) 468-6000
TTY (301) 879-6 380

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

Our Member Services Representatives are available to assist you Monday through Friday from 7:30 a.m. until 5:30 p.m.

Continuity of Care

Member may request to continue to receive health care services for a period of 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 90 days when the Member:

- (1) Has entered at least the second 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 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 Plan 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.

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. For continued treatment, you or your Plan Provider must contact the Behavioral Health Access Unit for assistance with arranging for and scheduling of covered Services. The Behavioral Health Access Unit may be reached 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.
- (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 "Getting a Referral" 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 call our Member Services Department at the number listed on your Health Plan identification card.

Services Received from Non-Plan Providers at Non-Plan Facilities Without a Referral

There may be circumstances where Health Plan determines that it is responsible for payment to a non-Plan Provider. In these circumstances, Health Plan will send to a Member the payment amount determined, in 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 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, Health Plan will allow for the Member's Primary Care 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 have an Emergency Medical Condition, call 911 (where available) or go to the nearest emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non-Plan Providers anywhere in the world, as long as the Services would have been covered under the "Benefits" section (subject to the "Exclusions, Limitations, and Reductions" section) if you had received them from Plan Providers.

Emergency Services are available from Plan Hospital emergency departments 24 hours a day, seven 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, D.C. Metropolitan Area
(703) 359-7878
TTY (703) 359-7616

Outside the Washington, D.C. Metropolitan Area
1-800-777-7904
TTY at 1-800-700-4901

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

Inside the Washington, D.C. Metropolitan Area
(703) 359-7878
TTY (703) 359-7616

Outside the Washington, D.C. Metropolitan Area
1-800-777-7904
TTY at 1-800-700-4901

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

Missed Appointment Fee

If you cannot keep a scheduled medical appointment, please notify your health care professional's office at least one day prior to the appointment. If you fail to cancel your appointment, you may be responsible for the payment of an administrative fee for the missed appointment. The fee for a missed appointment at a Plan Medical Center is shown in the Appendix - Summary of Services and Cost Shares section of this EOC. This will not count toward your Deductible or Out-of-Pocket maximum, if applicable.

Using Your Identification Card

Each Member has a Health Plan ID card with a Medical Record Number on it to use when you call for advice, make an appointment, or go to a Plan Provider for care. The Medical Record Number is used to identify your medical records and membership information. You should always have

the same Medical Record Number. If you need to replace your card, or if we ever inadvertently issue you more than one Medical Record Number, please let us know by calling our Member Services Department in the Washington, D.C., Metropolitan area at 301-468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902. Our TTY is 301-879-6380.

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.

Visiting Other Kaiser Permanente Regions or Group Health Cooperative Service Areas

If you visit a different Kaiser Permanente Region or Group Health Cooperative service area temporarily (not more than 90 days), you can receive visiting member care from designated providers in that area. The covered Services, Copayments, Coinsurance and Deductibles may differ from those in this Service Area, and are governed by the Kaiser Permanente program for visiting members. This program does not cover certain Services, such as transplant Services or infertility Services. Also, except for Out-of-Plan Emergency Services, your right to receive covered Services in the visited service area ends after 90 days unless you receive prior written authorization from us to continue receiving covered Services in the visited service area. The 90-day limit on visiting member care does not apply to Members who attend an accredited college or accredited vocational school.

To receive more information about visiting member Services, including facility locations across the United States, you may call our Member Services Department:

Inside the Washington, D.C. Metropolitan Area
(301) 468-6000
TTY (301) 816-6344

Outside the Washington, D.C. Metropolitan Area
1-800-777-7902

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 visited service area. The benefits may not be the same as those you receive in your home Service Area. Except for outpatient prescription drugs, these

benefits are provided at no charge to you.

Hospital Inpatient Care:

- Physician Services
- Room and board
- Necessary Services and supplies
- Maternity Services
- Prescription drugs

Outpatient Care:

- Office visits
- Outpatient surgery
- Physical, speech and occupational therapy (up to 20 visits for physical therapy per incident; up to two months for occupational and speech therapy)
- Allergy tests and allergy injections
- Dialysis care

Laboratory and X-Ray:

- Covered in or out of the hospital

Outpatient Prescription Drugs:

- Covered only if you have an outpatient prescription drug benefit (regular home Service Area Copayments, Coinsurance, Deductibles, exclusions and limitations apply)

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

- Outpatient visits and inpatient hospital days

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

- Inpatient and outpatient medical detoxification and other outpatient visits

Skilled Nursing Facility Care:

- Up to 100 days per calendar year

Home Health Care:

- Home health care Services inside the visited service area

Hospice Care:

- Home-based hospice care inside the visited service area

Pre-Authorization Required for Certain Services

The following Services require preauthorization from your home Service Area while you are visiting another Kaiser Permanente Region or Group Health Cooperative service area:

- Inpatient physical rehabilitation
- Mental health hospital services
- Residential facility admissions for chemical dependency
- Outpatient mental health or chemical dependency benefits

Visiting Member Service Exclusions

The following Services are not covered under your visiting member benefits. (“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 the “Benefits” section of this EOC.

- Services that are not Medically Necessary
- Physical examinations and related Services for insurance, employment, or licensing
- 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 IVF and GIFT
- Experimental Services and all clinical trials
- Cosmetic surgery or other Services primarily to change appearance
- Custodial care and care provided in an intermediate care facility
- Services related to sexual reassignment
- Transplants and related care
- Complementary and alternative medicine Services, such as chiropractic Services
- Services received as a result of a written referral from a Plan provider in your home Service Area
- Emergency Services, including emergency ambulance Services
- 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

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 our Member Services Department at:

Inside the Washington, D.C., Metropolitan area
(301) 468-6000
TTY (301) 879-6 380

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

Our Member Services Representatives are available to assist you Monday through Friday from 7:30 a.m. until 5:30 p.m.

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.

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.

SECTION 3 – Benefits

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

- You are a Member on the date the Services are rendered;
- You have met any Deductible requirement described in the "Deductible" section of the Summary of Cost Shares section of the Appendix.
- You have not met the maximum benefit for the Service, if any. A maximum benefit applies per Member per contract year.
- 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 of this EOC including but not limited to the requirements, if any, for prior approval (authorization);
- The Services are Medically Necessary; and
- 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:

- Emergency Services
- Urgent Care outside our Service Area
- Authorized referrals to non-Plan Providers (as described in Section 2)
- Visiting Member Services as described in Section 2

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 the “Exclusions, Limitations, and Reductions” section of this EOC.

Note: The “Summary of Services and Cost Shares” section of the 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:

- Primary care visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics/gynecology Services (refer to “Preventive Health Care Services” for coverage of preventive care Services);

- Specialty care visits (refer to Section 2 “How to Obtain Services” for information about referrals to Plan specialists);
- Consultations and immunizations for foreign travel (refer to the “Outpatient Prescription Drugs Rider,” attached to this EOC, for coverage of self-administered travel vaccines) ;
- 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:
 - Diagnostic examinations, including digital rectal exams and prostate antigen (PSA) tests provided in accordance with American Cancer Society guidelines to:
 - i. persons age fifty and over and
 - ii. persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society; ;
 - 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.
 - 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 estrogen deficient individual at clinical risk for osteoporosis;
 - an individual with a specific sign suggestive of spinal osteoporosis, including roentgeno-graphic 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;
 - an individual receiving long-term gluco-corticoid (steroid) therapy;
 - an individual with primary hyperparathyroidism; or

- an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy (Refer to “Preventive Health Services” for coverage of preventive care tests and screening Services);

- Outpatient surgery;
- Anesthesia;
- Chemotherapy and radiation therapy;
- Respiratory therapy;
- Medical social Services;
- House calls when care can best be provided in your home as determined by a Plan Provider;
- 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
- 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.

Additional outpatient Services are covered, but only as specifically described in this “Benefits” 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:

- Room and board, including private room when deemed Medically Necessary;
- Specialized care and critical care units;
- General and special nursing care;
- Operating and recovery room;
- Plan Physicians’ and surgeons’ Services, including consultation and treatment by specialists;
- Anesthesia;
- Medical supplies;
- Chemotherapy and radiation therapy;
- Respiratory therapy; and
- Medical social Services and discharge planning.

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

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:

- A Plan Provider provides the restorative dental Services.
- 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.
- The covered Services must be requested within 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:

- Evaluations, and treatment
- 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.

We will not cover ambulance transportation Services in any other circumstances, even if no other transportation is available. We cover ambulance Services only inside our Service Area, except as covered under the “Emergency Services” provision in this section of the EOC.

Ambulance Services Exclusions:

- Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan

Provider.

F. Anesthesia for Dental Services

We cover Services to a Member who is determined by a licensed dentist in consultation with the Member's treating physician to require general anesthesia and admission to a hospital or ambulatory surgical center to effectively and safely provide dental care and:

- Who are 7 years of age or younger or are severely disabled;
- For whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition; and
- For whom a superior result can be expected from dental care provided under general anesthesia; or
- Who are 17 years of age or younger who is extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred; and
- Whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity; or
- For adults age 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 surgical center charges will be covered only for dental care that is provided by:

- A fully accredited specialist in pediatric dentistry; or
- A fully accredited specialist in oral and maxillofacial surgery; and
- For whom hospital privileges has been granted.

Anesthesia for Dental Services Exclusions:

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

G. Blood, Blood Products and Their Administration

We cover blood, 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.

H. 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 abuse.

For the purposes of this benefit provision:

- Drug and Alcohol Abuse means a disease that is characterized by a pattern of pathological use of a drug and/or alcohol with repeated attempts to control its use and with significant negative consequences in at least one the following areas of life: medical, legal, financial, or psycho-social;
- 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:

- Individual therapy
- Group therapy
- Shock therapy
- Drug therapy

- Education
- Psychiatric nursing care
- Appropriate hospital Services

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

We cover treatment in a structured multidisciplinary program as an alternative to inpatient psychiatric hospitalization.

Partial hospitalization is defined as the provision of medically directed intensive or intermediate short term treatment for mental illness, emotional disorders, drug and alcohol abuse for a period of less than 24 hours but more than 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:

- Evaluations
- Crisis intervention
- Individual therapy
- Group therapy
- Psychological testing
- Medical treatment for withdrawal symptoms
- 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 abuse, 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
- Cognitive Behavior Therapy (CBT)
- 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

I. Cleft Lip, Cleft Palate or Both

We cover inpatient and outpatient Services arising from orthodontics, oral surgery and otologic, audiological and speech/language treatment as the

result of the congenital defect known as cleft lip, cleft palate, or both.

J. Clinical Trials

We cover the patient costs you incur for clinical trials provided on an inpatient and an outpatient basis as the result of treatment studies on cancer. "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:

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

We cover the patient costs incurred for clinical trials if:

- (a) The treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer.
- (b) The treatment is being provided in a clinical trial approved by:
 - the National Cancer Institute (NCI);
 - an NCI cooperative group or an NCI center;
 - the FDA in the form of an investigational new drug application;
 - the federal Department of Veterans Affairs; or
 - 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;
- (c) 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;
- (d) There is no clearly superior, noninvestigational treatment alternative; and
- (e) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative.

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

Off-Label use of Drugs or Devices. We also cover patient costs incurred for drugs and devices that have

been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor or provider of that drug or device.

K. Diabetic Equipment, Supplies, and Self-Management

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

- insulin-using diabetes;
- insulin-dependent diabetes;
- non-insulin using diabetes; or
- 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 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.

L. Dialysis

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

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

We cover the following renal dialysis Services:

- 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.

- Inpatient maintenance dialysis if you are admitted to a Plan Hospital because your medical condition requires specialized hospital Services on an inpatient basis.
- Plan Provider Services related to inpatient and outpatient dialysis.

We cover the following self-dialysis Services:

- Training for self-dialysis including the instructions for a person who will assist you with self-dialysis.
- Services of the Plan Provider who is conducting your self-dialysis training.
- Retraining for use of new equipment for self-dialysis.

We cover home dialysis, which includes:

- Hemodialysis;
- Home intermittent peritoneal dialysis (IPD);
- Home continuous cycling peritoneal dialysis (CCPD); and
- Home continuous ambulatory peritoneal dialysis (CAPD).

M. 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:

- 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;
- Injectable devices;
- The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
- Dressings and casts; and
- Vaccines and immunizations approved for use by the federal Food and Drug Administration (FDA), that are not considered part of routine preventive care.

Note: Additional Services that require administration or observation by medical personnel are covered. See the "Outpatient Prescription Drugs", if applicable, for coverage of self-administered outpatient prescription drugs, including self-

administered travel vaccines. “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.

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.

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 a Prescription Drug Rider attached to this EOC.

N. Durable Medical Equipment

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

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 Devices” for coverage of internal prosthetic devices, ostomy and urological supplies and breast prosthesis. Additional coverage for external prosthesis and orthotic devices is only covered if a Prosthetic and Orthotic Devices Rider is attached to this EOC.

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 price 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.

1. Oxygen and Equipment

We cover oxygen and equipment when prescribed by a Plan Provider and your medical condition meets Health Plan’s criteria for medical necessity. A Plan Provider must certify the continued medical need for oxygen and equipment every 30 days.

2. Positive Airway Pressure Equipment

We cover continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BIPAP) equipment when prescribed by a Plan Provider and your medical condition meets Health Plan’s criteria for medical necessity. A Plan Provider must certify the continued medical need every 30 days.

3. Apnea Monitors

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

4. Asthma Equipment

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

- Spacers
- Peak-flow meters
- Nebulizers

5. Bilirubin Lights

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

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 “Diabetes Equipment, Supplies and Self Management”).

- Electronic monitors of the heart or lungs, except infant apnea monitors.
- Services not preauthorized by Health Plan.

O. Early Intervention Services

We cover Medically Necessary early intervention Services for Dependents from birth to age 3. As used here, “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.

Limitations:

- This benefit is limited to a maximum of \$5,000 per year for assistive technology Services and devices.

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.

P. Emergency Services

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

If you experience an Emergency Medical Condition you should contact 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, not to exceed forty-eight (48) hours or the next 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 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 our Service Area:

We cover reasonable charges for Emergency Services if you are injured or become ill while temporarily outside 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 end-stage renal disease, post-operative care following surgery, and treatment for continuing infections, unless we determine that you were temporarily outside our Service Area because of extreme personal emergency.

Continuing Treatment Following Emergency Services

Inside our Service Area

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

Inside another Kaiser Permanente Region:

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

Outside our Service Area:

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

Transport to a Service Area

If you obtain prior approval from us, or from the nearest Kaiser Foundation Health Plan Region, 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 48 hours of any hospital admission, or on the first working day following the admission, unless it was not reasonably possible to notify us within that time. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us, or if you choose not to be transferred, we will not cover any Services you receive after transfer would have been possible.

Filing Claims for Non-Plan Emergency Services

Keep all your receipts for Emergency Services provided by non-Plan Providers and verify that the non-Plan Provider has submitted the claims. All claims must be filed with us within six 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. If you do not notify us as provided herein, we will not cover the emergency room visit, or hospital care you receive 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 Health Plan. We cover only the out-of-Plan emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser 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.

Q. Family Planning Services

We cover the following:

- Family planning counseling, including pre-abortion and post-abortion counseling and information on birth control
- Insertion and removal, and any Medically Necessary examination associated with the use of contraceptive drugs and devices. Contraceptive devices (other than diaphragms) and implantable contraceptive drugs are supplied by the provider, and are covered under this benefit. Contraceptive drugs and diaphragms are covered only under an “Outpatient Prescription Drug Rider,” if applicable.
- Tubal ligations
- Vasectomies
- Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (i) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (ii) 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 covered, but not under this section (see “X-ray, Laboratory and Special Procedures”).

R. Hearing Services

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

Hearing Services Exclusions:

- Tests to determine an appropriate hearing aid; and
- Hearing aids or tests to determine their efficacy.

S. Home Health Services

Except as provided for 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:

- Skilled nursing care
- Home health aide Services
- 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 "Benefits" 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 48 hours of inpatient hospitalization following the surgery, are entitled to the following:

- One home visit scheduled to occur within 24 hours following his or her discharge; and
- One 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 hours, then each two-hour increment counts as a separate visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as two visits. Also, each person providing Services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two hours, that counts as two visits.

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

Home Health Care Exclusions:

- Custodial care (see definition under "Exclusions" in the "Exclusions, Limitations, and Reductions" section of this EOC).
- Routine administration of oral medications, eye drops, 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 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.

T. Hospice Care Services

Hospice Care Services are for terminally ill Members. If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is 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:

- Nursing care;
- Physical, occupational, speech, and respiratory therapy;
- Medical social Services;
- Home health aide Services;
- Homemaker Services;
- Medical supplies and appliances;
- Palliative drugs in accord with our drug formulary guidelines;
- Physician care;
- General hospice inpatient Services for acute symptom management including pain management;
- Respite Care that may be limited to 5 consecutive days for any one inpatient stay up to 4 times in any contract year;
- 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 year after the Member's death; and
- Services of hospice volunteers.

Definitions:

Family Member means a relative by blood, marriage, domestic partnership or adoption who lives with or regularly participates in the care of the terminally ill Member.

Hospice Care means a coordinated, inter-disciplinary program of hospice care Services for meeting the

special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health Services through home or inpatient care during the illness and bereavement counseling following the death of the Member.

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

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.

U. Infertility Services

We cover the following:

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

Notes:

- Involuntary infertility means the inability to conceive after 1 year of unprotected vaginal intercourse.
- 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 Prescription Drug Rider, if applicable, for coverage of outpatient infertility drugs.

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 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 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: in vitro fertilization; gamete intrafallopian transfers (GIFT); zygote interfallopian transfers (ZIFT); intracytoplasmic sperm injection (ICSI); assisted hatching; preimplantation genetic diagnosis (PGD); and prescription drugs related to such procedures.

V. Maternity Services

We cover Services for routine global maternity care and non-routine obstetrical care.

"Routine global maternity" means care provided after the first visit where pregnancy is confirmed, and includes all of the following as a single Service, subject to a single cost share: (a) the normal series of regularly scheduled preventive prenatal care exams; (b) labor and delivery, including cesarean section; and (c) routine postpartum follow-up consultations and exams.

"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 48 hours following an uncomplicated vaginal delivery; and at least 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 24 hours after discharge, and an additional home visit if prescribed by the attending provider.

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

W. Medical Foods

We cover medical foods and low protein modified food products for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry 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 enterally (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 (a) specially formulated to have less than one gram of protein per serving, and (b) 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.

X. Morbid Obesity

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

Morbid obesity is defined as:

- A weight that is at least 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
- A body mass index (BMI) that is equal to or greater than 35 kilograms per meter squared with a comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary condition, sleep apnea, or diabetes; or
- A BMI of 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 Health Plan.

Y. Oral Surgery

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

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

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

- the condition known as TMJ (temporal mandibular joint);
- fractures of the jaw or facial bones;
- removal of cysts of non-dental origin or tumors, including any associated lab fees prior to removal; and
- 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:

- evidenced through documented medical records showing significant impairment in speech or a nutritional deficit; and
- based on examination of the Member by a Plan Provider.

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

Health Plan provides coverage for cleft lip and cleft palate under a separate benefit. Please see the "Cleft Lip, Cleft Palate, or Both" section of this EOC for coverage.

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.

Z. Preventive Health Care Services

In addition to any other preventive benefits described in the group contract or certificate, 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:

- (a) 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;
- (b) 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;
- (c) 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; and
- (d) With respect to women, such additional preventive care and screenings, not described in paragraph (a) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Health Plan shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

Preventive Health Care Services Limitations:

While treatment may be provided in the following situations, the following Services are not considered Preventive Health Care Services. 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.

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

AA. Prosthetic 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 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. If we do not cover the prosthetic, 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, ocular lens implants, artificial hips and joints, breast implants (see “Reconstructive Surgery Benefits ” below) and cochlear implants, that are approved by the federal Food and Drug Administration for general use.

Artificial Limbs

We cover Medically Necessary prosthetic devices to replace, in whole or in part, a limb, 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

We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets Health Plan’s criteria for medical necessity.

Breast Prosthetics

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.

Breast Prosthetics Limitation:

- Coverage for mastectomy bras is limited to a maximum of two (2) per contract year.

Prosthetic Devices Exclusions:

- Internally implanted breast prosthetics for cosmetic purposes.
- External prosthetics, except as provided in this Section, or as provided under a “Prosthetic and Orthotic Devices Rider, if applicable.
- Repair or replacement of prosthetics due to loss, neglect, misuse, or abuse.
- Hair Prostheses.
- Artificial limbs designed primarily for an athletic purpose.
- Microprocessor and robotic controlled external prosthetics and orthotics.

BB. Reconstructive Surgery

We cover reconstructive surgery (a) to correct significant disfigurement resulting from an injury or Medically Necessary surgery, (b) to correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function, and (c) to treat congenital hemangioma known as port wine stains on the face for Members age 18 or younger.

Following mastectomy, we also 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 the two 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
- Pierced earlobe repairs, except for the repair of an acute bleeding laceration

CC. 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-day stay in an acute care hospital is not required.

We cover the following Services:

- Room and board;
- Physician and nursing care;
- Medical social Services;
- Medical and biological supplies; and
- Respiratory therapy.

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

- Blood (see “Blood, Blood Products and Their Administration);
- Drugs (see “Drugs, Supplies and Supplements”);
- Durable Medical Equipment ordinarily furnished by a Skilled Nursing Facility, including oxygen dispensing equipment and oxygen (see “Durable Medical Equipment”);
- Physical, occupational, and speech therapy (see “Therapy and Rehabilitation Services”); and
- X-ray, laboratory, and special procedures (see “X-ray, Laboratory and Special Procedures”).

Skilled Nursing Facility Care Exclusions:

- Custodial care (see definition under “Exclusions” in the “Exclusions, Limitations, and Reductions” section of this EOC).
- Domiciliary care.

DD. Therapy and Rehabilitation Services

Physical, Occupational, and Speech Therapy Services

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

1. while you are confined in Plan Hospital; and
2. for up to 90 consecutive days of treatment 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 or cleft palate.

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

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 consecutive months of treatment per injury, incident or condition.

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

Multidisciplinary Rehabilitation 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 12 weeks, or 36 sessions, whichever occurs first.

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

Therapy and Rehabilitation Services Exclusions:

- Long-term rehabilitative therapy.

EE. Telemedicine Services

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

FF. Transplant Services

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

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

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

- Unless otherwise authorized by Medical Group, transplants are covered only in our Service Area.
- 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.

- 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.
- 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.

GG. Urgent Care

As described below you are covered for Urgent Care Services anywhere in the world. "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." 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, as shown in the Summary of Services and Cost Shares section.

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:

- 1) If your primary care Plan Physician is located at a Plan Medical Office please call:

Inside the Washington, D.C. Metropolitan Area
(703) 359-7878
TTY (703) 359-7616

Outside the Washington, D.C. Metropolitan Area
1-800-777-7904
TTY 1-800-700-4901

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

Outside our Service Area

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

If you obtain prior approval from 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 our Service Area for conditions that, before leaving the Service Area, you should have known might require Services while outside our Service Area, such as dialysis for end-stage renal disease, post-operative care following surgery, and treatment for continuing infections, unless we determine that you were temporarily outside 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.

HH. 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.

We cover the following Services:

Eye Exams

Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses. Exams performed in an Optometry Department will be subject to the Primary Care Copayment. Exams performed in an Ophthalmology Department will be subject to the Specialty Care Copayment, if different.

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:

- Fitting of contact lenses;
- Initial pair of diagnostic lenses (to assure proper fit);
- Insertion and removal of contact lens training; and
- 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 jewellery.
- Low-vision devices.
- Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits.
- Orthoptic (eye training) therapy.

II. Visiting Member Services

We cover the same Medically Necessary Services that are covered under this plan in our Service Area, and your Cost Share will be the same, when you are temporarily (not more than 90 days) a visiting Member in a different Kaiser Permanente Region or Group Health Cooperative service area.

To receive more information about visiting member Services, including facility locations across the United States, you may call our Member Services Department:

Inside the Washington, D.C. Metropolitan Area
(301) 468-6000
TTY (301) 879-6380

Outside the Washington, D.C. Metropolitan Area
1-800-777-7902

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

Visiting Member Services Limitations:

- Access to Services in the visited service area will be subject to availability at the time you request the Service. Services may be unavailable due to temporary capacity constraints, inability to provide the Service generally, or other restrictions. If the Service is not available in the visited service area, you must call us for authorization to receive the Service.
- Except for Emergency Services, your right to receive covered Services in the visited service area ends after 90 days unless you receive prior written authorization from us to continue receiving covered Services in the visited service area. The 90-day limit on visiting member care does not apply to any Member who is a student attending an accredited college or accredited vocational school.

Visiting Member Service Exclusions

- All the terms and conditions, exclusions and limitations that apply to covered Services in our Service Area, will apply to Services received as a visiting Member in a different Kaiser Permanente Region or Group Health Cooperative service area.

JJ. X-ray, Laboratory, and Special Procedures

We cover the following Services only when prescribed as part of care covered in other parts of this “Benefits” 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”):

- Diagnostic imaging and interventional diagnostic tests;
- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
- Special procedures, such as electrocardiograms and electroencephalograms;

- Sleep lab and sleep studies; and
- Specialty imaging: including CT, MRI, PET Scans, and Nuclear Medicine studies.

SECTION 4 – Exclusions, Limitations, and Reductions

The following section provides you with information on what Services 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 the “Benefits” section. 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 Massage Therapist, unless otherwise covered under a Rider attached to this EOC.

Certain Exams and Services

Physical examinations and other Services (a) required for obtaining or maintaining employment or participation in employee programs, or (b) required for insurance, licensing, or disability determinations, or (c) on court-order or required for parole or probation.

Cosmetic Services

Services that are not medically necessary, and are intended primarily to improve your appearance and that are not likely to result in significant improvement in physical function, except for Services covered under “Reconstructive Surgery” or “Cleft Lip, Cleft Palate or Both” in the “Benefits” section.

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, dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any dental treatment involved in temporal mandibular joint (TMJ) pain dysfunction syndrome, 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 the “Benefits” section.

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 the “Benefits” section.

Durable Medical Equipment

Except for Services covered under “Durable Medical Equipment” in the “Benefits” section.

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” section of the “Benefits” section, 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:

- It cannot not be legally marketed in the United States without the approval of the Food and Drug Administration (“FDA”) and such approval has not been granted; or
- 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
- 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
- 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:

- your medical records,
- the written protocols or other documents pursuant to which the Service has been or will be provided,
- any consent documents you or your representative has executed or will be asked to execute, to receive the Service,
- the files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
- the published authoritative medical or scientific literature regarding the service, as applied to your illness or injury, and
- 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.

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

External Prosthetic and Orthotic Devices

Services and supplies for external prosthetic and orthotic devices, except as specifically covered under the "Benefits" section of this EOC, or unless otherwise covered under a Rider attached to this EOC.

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 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.

Sexual Reassignment

All Services related to sexual reassignment (also referred to as "sexual transformation").

Surrogacy Arrangements

Services related to conception, pregnancy or delivery in connection with a surrogacy arrangement. 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 our Service Area as described under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines.

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:

- Any source providing a Financial Benefit or from whom a Financial Benefit is due; or
- 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 Health

Plan, Kaiser Foundation Hospitals, or Medical Group. However, in these circumstances 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 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.

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)

Member's with HSA's: Please note that if you have other health care coverage in addition to the coverage under this EOC, in most instances you will not be eligible to establish or contribute to an HSA unless both plans qualify as High Deductible Health Plans. Consult with your financial or tax advisor for tax advice or more information about your eligibility for an HSA.

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

1. The Primary Plan then provides benefits as it would in the absence of any other coverage.
2. The Plan that pays benefits second (Secondary Plan) coordinates with the Primary Plan, and pays the difference between what the Primary Plan paid, or the value of any benefit or service provided, and 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 call our Member Services Call Center.

Inside the Washington, D.C., Metropolitan area
(301) 468-6000

Outside the Washington, D.C. Metropolitan area
1-800-777-7902
TTY (301) 816-6344

Order of Benefit Determination Rules

Coordination of Benefits ("COB") applies when a Member has health care coverage under more than one Plan. "Plan" and "Health Plan" are defined below.

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% of the total Allowable Expenses.

Definitions

"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.

"Health Plan": Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., providing services or benefits for health care. Health Plan is a Plan.

"Allowable Expense" means 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 the "benefits" section.

"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.

Order of Benefit Determination Rules

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 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 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 or Domestic Partner 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 Health Plan is the Primary Plan, COB has no effect on the benefits or services provided under this Agreement. When Health Plan is a Secondary Plan as to one 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 Health Plan. At the Member's request, Health Plan will provider or arrange for covered services and then seek coordination with a Primary Plan.

1. Coordination with This Plan's Benefits. 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 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 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. 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 Health Plan, 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 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, 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 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 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; Claims and Appeal Procedures; and Customer Satisfaction Procedure

Getting Assistance

Member Services representatives are available at our Plan Medical Offices and through our Call Center to answer any questions you have about your benefits, available services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace an ID card. These representatives can also help you file a claim for Emergency Services and Urgent Care Services outside 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 calling our Member Services Department.

Who to Contact

By Telephone

Member Services Department telephone numbers:

Inside the Washington, D.C., Metropolitan area
(301) 468-6000

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

TTY **(301) 879-6380**

In Writing

To contact us in writing, mail your correspondence to:

Kaiser Permanente
Member Services Department
2101 East Jefferson Street
Rockville, MD 20852

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

Definitions

Adverse Decision: Any Health Plan determination or decision (a) that a Service is not a covered benefit, or if it is a covered benefit, such Service does not meet Health Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore payment is not provided or made by Health Plan, in whole or in part, for the Service, thereby making the Member responsible for payment of such Service, in whole or in part, or (b) that 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.

Appellant: An appellant is a person eligible to file an Independent External Appeal. The Member or the following persons may be considered an Appellant: (1) an Authorized Representative; or (2) 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.

Authorized Representative: An individual appointed 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" shall include an Authorized Representative.

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.

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:

- care that the treating physician deems urgent in nature;
- 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
- 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.

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.

Pre-Service Claim: A request that 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.

Urgent Medical Condition: As used in this Section 5, 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.

Procedure for Making a Claim and Initial Claim Decisions

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 above.

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 Health Plan provide or pay for a Service that you have not yet received. We 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 our Member Services Department at the numbers listed above.

Procedure for Making a Non-Urgent Pre-Service Claim

1. Tell the Member Services Department that you want to make a claim for 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 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 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 45 days, we will then make a decision within 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 2 working days of the decision; or

(b) orally by telephone within 24 hours of the decision if the claim is for cancer pain medication.

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.

5. 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 we determine 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 72 hours after receiving your claim. We will send a written or electronic confirmation within 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 24 hours of receipt of your claim. You will have 48 hours from the time of notification by us to provide the missing information. We will make a decision 48 hours after the earlier of (a) our receipt of the requested information, or (b) the end of the 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, you 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, then 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 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 business day of receipt of all information necessary to make a decision, but no later than 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 24 hours before the end of the initially approved period, we will decide the claim within 24 hours of receipt.

If you filed a request for additional services at least 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, Health Plan will decide your request for review within a reasonable period of time

appropriate to the circumstances but in no event later than 30 calendar days from the date on which your claim was received.

1. If we determine 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 24 hours after we receive your claim. If we notify you orally, we will send you a written decision within 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, your 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 Section 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 our Service Area. If you have any questions about post-service claims or appeals, please call the Member Services Department 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 our Service Area or other Services received from non-Plan Providers must be filed on forms provided by Health Plan; such forms may be obtained by calling or writing to the Member Services Department.

1. You must send the completed claim form to us at the address listed on the claim form within 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 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 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 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 45 days, we will make a decision based on the information we have. We will issue our decision within 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 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.

Health Plan will render its decision regarding the reconsideration request and provide the decision to the treating provider and the Member, in writing, within 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 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).

1. 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
2101 East Jefferson Street
Rockville, MD 20849
Member Services Appeals and
Correspondence
301-816-6192 (FAX)

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 AM to 5:30 PM at 301-468-6000, if calling within the local area, or 301-816-6344 TTY (Telephonic Device for the Deaf).

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

If within 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:

- a) notify the Member that it cannot proceed with reviewing the appeal unless additional information is provided; and
- b) assist in gathering the necessary information without further delay.

2. Standard appeals will either be acknowledged within 5 working days of the filing date of the written appeal request. An acknowledgement letter will be sent as follows:

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: i) request additional information, if necessary; ii) inform the Member when there will be a decision on their appeal; and iii) state that written notice of the appeal decision will be sent within 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: i) requesting additional information, if necessary; ii) informing the Member when a decision will be made; and iii) that the Member will be notified of the decision within 60 days of the date the appeal was received.

3. 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.

4. 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 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. 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 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 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, Health Plan will notify the Member or the member's Authorized Representative. The notification shall include:

- (a) the specific factual basis for the decision in clear understandable language;
- (b) 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);
- (c) 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.

- (d) 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 30 days of the date of Health Plan's final Adverse Decision, as described below; and
- (e) A statement of your rights under section 502(a) of ERISA.
- (f) 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% 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 Health Plan fails to make an appeal decision for a non-urgent Pre-Service Appeal within 30 days or within 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.:

(a) During Regular Business Hours

Monday through Friday from 7:30am – 5:30pm – The Member should contact the Member Services Department.

Inside the Washington, D.C. Metropolitan area
(301) 468-6000

Outside the Washington, D.C. Metropolitan area
(800) 777-7902.

(b) During Non-Business Hours

The Member should call the Advice/Appointment Line.

Inside the Washington, D.C. Metropolitan area
(703) 359-7878

Outside the Washington, D.C. Metropolitan area
(800) 777-7904

2. Once an Expedited Appeal is initiated, clinical review 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, Health Plan will verbally notify the Member within 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.

If additional information is needed to proceed with the expedited review, 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.

4. A decision with respect to such Expedited Appeal shall be rendered no later than:

- (a) 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 24 hours after receipt of the claim.

5. If approval is recommended, Health Plan will immediately provide assistance in arranging the authorized treatment or benefit.

6. If Health Plan declines to review an appeal as an Expedited Appeal; or if the Expedited Appeal results in a denial, 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 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:

- (a) the specific factual basis for the decision in clear understandable language;
- (b) 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);
- (c) 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
- (d) A statement of your rights under section 502(a) of ERISA.

7. 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 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:

- a) all of the Health Plan's appeal procedures described above have been exhausted;
- b) the Member requested an Expedited Appeal and the Health Plan determined that the standard appeal timeframes should apply; or
- c) when an Expedited Appeal is reviewed and is denied.

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

- a) 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;
- b) an Expedited emergency review (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;
- c) 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
- d) 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 120 days of the decision 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 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 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 Mayland Drive, Suite 401
Richmond, VA 23233-1463

Complaint Hotline:
Local: 1-804-367-2106
Toll Free: 1-800-955-1819
Fax No.: 1-804-527-4503

Customer Satisfaction Procedure

In addition, 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 our Member Services Department 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 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. 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. 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 "Termination of Membership" section.

This "Termination of Membership" 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 the "Eligibility and Enrollment" section on the first 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.

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 31 days before the termination date if you anyone in your Family Unit commits any of the following acts:

- You knowingly (1) misrepresent membership status, (2) present an invalid prescription or physician order, (3) misuse (or let someone else misuse) a Member ID card, or (4) commit any other type of fraud in connection with your membership;

- 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
- You no longer live or work within Health Plan's Service Area.
- Your behavior with respect to 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 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 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 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:

- 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 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 “Extension of Benefits” 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:

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

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 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.

Conversion of Membership

You may be eligible to convert to a non-group plan if you no longer meet the eligibility requirements described under “Who is Eligible” in the “Eligibility and Enrollment” section, or if you enroll in COBRA or USERRA continuation of coverage and then lose eligibility for that COBRA or USERRA coverage; or

if you enroll in the state continuation of coverage and then lose eligibility for that state continuation of coverage. However, you may not convert to this non-group plan if:

- You continue to be eligible for coverage through your Group;
- You live in another Kaiser Foundation Health Plan or allied plan service area, except that the Subscriber's or the Subscriber's Spouse's otherwise eligible children are not ineligible to be covered dependents solely because they live in another Kaiser Foundation Health Plan or allied plan service area if: (1) they are attending an accredited college or accredited vocational school; or (2) you are required to cover them pursuant to a Qualified Medical Child Support Order (QMCSO);
- Your membership ends because our Agreement with your Group terminates; or
- We terminated your membership under “Termination for Cause” or “Nonpayment of other charges” in this "Termination of Membership" section.

You must apply to convert your membership within the later of 31 days after your Group coverage ends or the date we notify you of your conversion rights. During this period, no medical review is required, and your non-group coverage begins when your Group coverage ends. You will have to pay Premium, and the benefits and copayments under the non-group coverage may differ from those under this EOC.

For information about converting your membership or about other non-group plans, call our Member Services Call Center.

Inside the Washington, D.C., Metropolitan area
(301) 468-6000
TTY (301) 816-6344

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

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:

- *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.
- *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 our Member Services Call Center.

Inside Washington, D.C., Metropolitan area
(301) 468-6000, or in the Baltimore, Maryland
TTY (301) 816-6344

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

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 Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

Contracts with Plan Providers

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 call our Member Services Call Center in the Washington, D.C., Metropolitan area at (301) 468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902. Our TTY is (301) 816-6344.

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 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 accord with the law of the Commonwealth of Virginia and any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

Notice of Non-Grandfathered Coverage

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

Groups and Members not Health Plan's Agents

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

Member Rights and Responsibilities

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

MEMBER RIGHTS

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

1. Receive information that empowers you to be involved in health care decision making. This includes your right to:

- a. Actively participate in discussions and decisions regarding your health care options.
- b. Receive and be helped to understand information related to the nature of your health status or condition, including all appropriate treatment and non-treatment options for your condition and the risks involved - no matter what the cost is or what your benefits are.
- c. Receive relevant information and education that helps promote your safety in the course of treatment.
- d. Receive information about the outcomes of health care you have received, including unanticipated outcomes. When appropriate, family members or others you have designated will receive such information.
- e. Refuse treatment, providing you accept the responsibility and consequences of your decision.
- f. Give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself by completing and giving us an Advance Directive, a durable power of attorney for health, living will, or other health care treatment directive. You can rescind or modify these documents at any time.
- g. Receive information about research projects that may affect your health care or treatment. You have the right to choose to participate in research projects.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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,” a party responsible for determining whether you are entitled to benefits under this EOC. Also, as a named fiduciary, we have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC.

No Waiver

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

Nondiscrimination

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

Notices

Our notices to you will be sent to the most recent address we have on file for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Services Call Center in the Washington, D.C., Metropolitan area at (301) 468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902 as soon as possible to give us their new address. Our TTY is (301) 816-6344.

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 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. Our *Notice of Privacy Practices, which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request.* To request a copy, please call our Member Service Call Center (see below). You can also find the notice at your local Plan Facility or on our Web site at www.kp.org.

Inside Washington, D.C., Metropolitan area
(301) 468-6000, or in the Baltimore, Maryland
TTY (301) 816-6344

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

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

By: 

Ruben J. Burnett
Vice President, Marketing, Sales & Business
Development

APPENDICES

Definitions

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

Allowable Charges (AC): means either:

- For Services provided by 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;
- 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;
- For all other Services,
 - the contracted amount;
 - the negotiated amount
 - the amount stated in the fee schedule that providers have agreed to accept as payment for those Services; or,
 - the amount that the Health Plan pays for those Services.

Basic Health Services

Basic Health Services include:

- Inpatient and outpatient physician Services
- Inpatient hospital Services
- Outpatient medical Services
- Diagnostic laboratory and radiology Services
- Preventive health Services
- Emergency health care Services
- Prosthetic devices that are artificial devices to replace, in whole or in part, a limb
- Inpatient and outpatient chemical dependency and mental health Services.

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 .

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 Deductible, 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:

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

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

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

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

Fee Schedule: A listing of procedure-specific fees developed by 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.

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: (i) medically required to prevent, diagnose or treat your condition or clinical symptoms; (ii) in accordance with generally accepted standards of medical practice; (iii) not solely for the convenience of you, your family and /or you provider; and (iv) the most appropriate level of Service which can safely be provided to you. For purposes of this definition, “generally accepted standards of medical practice” means (a) standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; (b) physician specialty society recommendations; (c) the view of physicians practicing in the 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 this Section 3) is Medically Necessary and our decision is final and conclusive subject to your right to appeal as set forth in Section 5.

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

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

Plan: Kaiser Permanente.

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

Plan Hospital: A hospital that (i) contracts to provide inpatient and/or outpatient Services to Members and (ii) 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 (1) contracts to provide Services and supplies to Members and (ii) 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 (i) is employed by or operated by an entity that participates in the Kaiser Permanente Medical Care Program, or (ii) contracts with an entity that participates in the Kaiser Permanente Medical Care Program.

Premium: Periodic membership charges paid by Group.

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 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 52 weeks of the disability. After the first 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.

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 Dependents 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 (AC*) for a covered Service that you must pay through Deductibles, Copayments and Coinsurance. Allowable Charge means:

- For Services provided by 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;
- 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.
- For all other Services,
 - the contracted amount;
 - the negotiated amount;
 - the amount stated in the fee schedule that providers have agreed to accept as payment for those Services; or,
 - the amount that the Health Plan pays for those Services

In addition to the monthly premium, you may be required to pay a Cost Share for some Services. The Cost Share is the Copay, Deductible and Coinsurance, if any listed in the “Summary of Services and Cost Share” for each Service. 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.

DEDUCTIBLE

The Deductible is the amount of Allowable Charges you must incur during a contract year for certain covered Services before Health Plan will provide benefits for those Services. The Deductible applies to all covered Services except Preventive Health Care Services as described in Section 3, Benefits.

For covered Services that are subject to a Deductible, you must pay the full charge 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 Cost Shares for these Services.

Family Deductible. After two or more Members of a 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.

Missed Appointment Fee

The amount you may be required to pay if you fail to keep a scheduled appointment and you do not notify us at least one day prior to the appointment. \$25 per missed appointment

Your Evidence of Coverage – Summary of Services and Cost Shares

Deductible

The amount you must pay each contract year for the Services indicated below before we provide benefits for those Services.	<p>Individual Deductible \$400 per individual per contract year</p> <p>Family Deductible \$800 per Family Unit per contract year</p>
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Copayments and Coinsurance

Covered Service	You Pay
Outpatient Care	
Office visits (for other than preventive health care Services)	
Primary care office visits	
For adults	\$15 per visit after Deductible
For children under 5 years of age	No charge after Deductible
For children 5 years of age or older	\$15 per visit after Deductible
Specialty care office visits	
	\$25 per visit after Deductible
Consultations and immunizations for foreign travel	
	\$15 per visit after Deductible
Outpatient surgery (other than in a Provider's office)	
	\$50 per visit after Deductible
Anesthesia	
	No charge after Deductible
Chemotherapy and radiation therapy	
	\$25 per visit after Deductible
Respiratory therapy	
	\$25 per visit after Deductible
Medical social Services	
	\$15 per visit after Deductible
House calls	
	No charge after Deductible
Hospital Inpatient Care	
All charges incurred during a covered stay as an inpatient in a hospital	
	\$500 per admission after Deductible
Accidental Dental Injury Services	
	Applicable Cost Shares will apply, based on type and place of Service
Allergy Services	
Allergy evaluation 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	
By a licensed ambulance Service, per encounter	
	\$50 per encounter after Deductible
Non-emergent transportation Service (ordered by a Plan Provider)	
	No charge after Deductible

Copayments and Coinsurance

Covered Service	You Pay
<p>Anesthesia for Dental Services Anesthesia and associated hospital or ambulatory Services for certain individuals only.</p>	Applicable Cost Shares will apply, based on type and place of Service
<p>Autism Spectrum Disorder Services Autism spectrum disorder benefit for children age 2 through age 6:</p> <ul style="list-style-type: none"> • Physical, speech and occupational therapy (unlimited visits) <p>Note: Coverage up to \$35,000 per contract yr for applied behavior analysis. Coverage for behavioral health treatment, psychiatric care and pharmacy care are covered same as any other illness</p>	\$25 per visit after Deductible
<p>Blood, Blood Products and Their Administration</p>	No charge after Deductible
<p>Chemical Dependency and Mental Health Services Inpatient psychiatric and substance abuse care, including detoxification</p> <p>Hospital alternative Services</p> <ul style="list-style-type: none"> Intensive outpatient psychiatric treatment programs Partial hospitalization <p>Outpatient psychiatric and substance abuse care</p> <ul style="list-style-type: none"> • Individual therapy • Group therapy <p>Medication management visits</p>	<p>Applicable inpatient Cost Shares will apply</p> <p>\$15 per visit after Deductible</p> <p>\$15 per visit after Deductible</p> <p>\$15 per visit after Deductible</p> <p>\$7 per visit after Deductible</p> <p>\$15 per visit after Deductible</p>
<p>Cleft Lip, Cleft Palate, or Both</p>	Applicable Cost Shares will apply, based on type and place of Service
<p>Clinical Trials</p>	Applicable Cost Shares will apply, based on type and place of Service
<p>Diabetic Equipment, Supplies and Self-Management Training Diabetic equipment and supplies</p> <p>Self-management training</p>	<p>No charge after Deductible</p> <p>Applicable Cost Shares will apply, based on place of Service</p>
<p>Dialysis Inpatient care</p> <p>Outpatient Care</p>	<p>Applicable inpatient care Cost Shares will apply</p> <p>\$25 per visit after Deductible</p>

Copayments and Coinsurance

Covered Service	You Pay
Drugs, Supplies, and Supplements Administered by or under the supervision of a Plan Provider	No charge after Deductible
Outpatient Durable Medical Equipment	
Outpatient Basic Durable Medical Equipment	No charge after Deductible
Outpatient Supplemental Durable Medical Equipment	
<ul style="list-style-type: none"> • Oxygen and Equipment (Must be certified every 30 days) • Positive Airway Pressure Equipment (Must be certified every 30 days) • Apnea Monitors (Infants under 3, not to exceed a period of 6 months) • Asthma Equipment • Bilirubin Lights (Infants under 3, not to exceed a period of 6 months) 	<p>No charge for 1st 3 months; 50% of AC* each month thereafter after Deductible</p> <p>No charge for 1st 3 months; 50% of AC* each month thereafter after Deductible</p> <p>No charge after Deductible</p> <p>No charge after Deductible</p> <p>No charge after Deductible</p>
Early Intervention Services Limited to a maximum benefit of \$5,000 per contract year for children from birth to age 3.	\$25 per visit after Deductible
Note: Essential Health Services are not subject to the \$5,000 annual early intervention Services maximum.	
Emergency Services Emergency Room Visits	
<ul style="list-style-type: none"> • Inside the Service Area • Outside the Service Area 	<p>\$150 per visit after Deductible; Copayment waived if immediately admitted as an inpatient</p> <p>\$150 per visit after Deductible; Copayment waived if immediately admitted as an inpatient</p> <p>Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit copayment will not be waived.</p>
Family Planning Office visits	
	\$25 per visit after Deductible
Tubal ligation, Vasectomy, Voluntary termination of pregnancy	Applicable Cost Share will apply based on place of Service
Hearing Services Hearing tests (newborn hearing screening tests are covered under preventive health care Services)	
	Applicable office visit Cost Share will apply based on place of service
Home Health Services See Section 3 for benefit limitations	
	No charge after Deductible
Hospice Care Services	
	No charge after Deductible

Copayments and Coinsurance

Covered Service	You Pay
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
Maternity Services	
Routine global maternity care	No charge after Deductible
Non-routine outpatient obstetrical care	\$25 per visit after Deductible
Inpatient obstetrical care and delivery, including cesarean section	\$500 per admission after Deductible
Medical Foods	25% of AC* after Deductible
Morbid Obesity Services	Applicable Cost Shares will apply based on type and place of Service.
Oral Surgery	\$25 per visit after Deductible
Note: applicable inpatient Cost Shares will also apply for Services provided in a hospital or other inpatient facility.	
Preventive Health Care Services	
Routine physical exams for adults	No charge; Deductible waived
Routine preventive tests for adults	No charge; Deductible waived
Well child care visits	No charge; Deductible waived
Routine immunizations for children and adults (No additional charge for immunization agent)	No charge; Deductible waived
Routine Preventive Care Screenings conducted in a Lab or Radiology	No charge; Deductible waived
Prosthetic Devices	
Internally implanted devices	Applicable inpatient care Cost Shares will apply
Artificial limbs	No charge after Deductible
Ostomy and urological supplies	No charge after Deductible
Breast prosthetics	No charge after Deductible
Reconstructive Surgery	Applicable Cost Shares will apply based on place and type of Service.
Skilled Nursing Facility Care	\$500 per admission after Deductible
Limited to a maximum benefit of 100 days per contract year	
Telemedicine Services	No charge after Deductible

Copayments and Coinsurance

Covered Service	You Pay
Therapy and Rehabilitation Services (Refer to Section 3 for benefit maximums)	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	\$25 per visit after Deductible
Note: All Services received in one day for multidisciplinary rehabilitation Services at a day treatment program will be considered one visit.	
Transplants	
	Applicable Cost Shares will apply based on place and type of Service
Urgent Care	
Office visit during regular office hours	Applicable office visit Cost Share will apply
After-Hours Urgent Care or Urgent Care Center	\$25 per visit after Deductible
Vision Services	
Eye exams	
• by an Optometrist	\$15 per visit after Deductible
• by an Ophthalmologist	\$25 per visit after Deductible
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
X-ray, Laboratory and Special Procedures	
Diagnostic imaging and laboratory tests	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	No charge after Deductible
Specialty Imaging (including CT, MRI, PET Scans, Nuclear Medicine and Interventional Radiology)	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	\$75 per test after Deductible
Sleep lab and sleep studies	\$75 per visit after Deductible
Note: Charges for covered outpatient diagnostic and laboratory tests performed in the physician’s office are included in the office visit Copayment.	

** “Retail price” means the price that would otherwise be charged for the lenses, frames or contacts at the KP 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 for the Basic Health Services covered under this EOC. Once you or your Family Unit has met your Out-of-Pocket Maximum, you will not be required to pay any additional Cost Shares for Basic Health Services. After two or more Members of a 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.

Except as excluded below, the covered Services found in Section 3. Benefits are considered Basic Health Services and apply toward the Out-of-Pocket Maximum.

- Inpatient and outpatient physician Services
- Inpatient hospital Services
- Outpatient medical Services
- Preventive health care Services
- Emergency Services
- X-ray, laboratory and special procedures
- Inpatient and outpatient chemical dependency and mental health Services

Out-of-Pocket Maximum Exclusions:

The following Services, if covered, are not considered Basic Health Services and *do not* apply toward your Out-of-Pocket Maximum:

- Outpatient drugs, supplies and supplements, including blood, blood products, and medical foods
- Outpatient durable medical equipment and prosthetic and orthotic devices except for prosthetic device covered as a Basic Health Services
- Inpatient and outpatient infertility Services
- Eyeglass lenses and frames contact lenses

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.

<p>Annual Out-Of-Pocket Maximum Combined total of Deductible and allowable Copayments and Coinsurance</p>	<p>Individual Out-of-Pocket Maximum \$2,200 per individual per contract year</p> <p>Family Out-of-Pocket Maximum \$6,400 per Family Unit per contract year</p>
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**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 Evidence of Coverage (EOC) terminate.

The following benefit, limitations, and exclusions are hereby added to the “Benefits” Section 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 “Appendices - Definitions.”

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

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 by Health Plan that distributes prescription drugs to Members via mail. Certain drugs that require special handling are not provided through the mail-delivery service. This includes, but is 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.

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.

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

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

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.

Prescription Drug (“Rx”) Deductible: The amount you must pay in a contract year for covered outpatient prescription drugs before we will cover such drugs in that contract year.

Prescription Drug (“Rx”) Out-of-Pocket Maximum: The maximum amount of Rx Copayments and Rx Coinsurance that you are required to pay for covered outpatient prescription drugs during a contract year. Amounts in excess of Allowable Charge, payments for drugs not covered under this Rider, or any amounts other than a Rx Copayment and Rx Coinsurance shall not be counted towards the Rx Out-of-Pocket Maximum. Once the Rx Out-of-Pocket Maximum is met, you do not have to pay any additional Rx Copayments or Rx Coinsurance for covered outpatient prescription drugs.

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.

B. Benefit:

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.

- FDA-approved drugs for which a prescription is required by law, except when the drug is listed in our Preferred Drug List.
- 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.
- Insulin
- Contraceptive drugs, including contraceptive devices that are approved by the United States Food and Drug Administration (FDA) for use as contraceptives.
- Smoking-cessation drugs.
- 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.
- For any drug approved by FDA for treatment of cancer pain because the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with §§ 54.1-2971.01, 54.1-3303 and 54.1-3408.1 for a patient with intractable cancer pain.
- Growth hormone therapy (GHT) for treatment of children under age 18 with a growth hormone deficiency.
- 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 at:

Inside the Washington, D.C. Metropolitan Area
(301) 468-6000
TTY (301) 879-6380

Outside the Washington, D.C. Metropolitan Area
1-800-777-7902

Where to Purchase Covered Drugs

We cover prescribed drugs only when purchased at a Plan Pharmacy, a Participating Network Pharmacy or through Health Plan's Mail Service Delivery Program. Most non-refrigerated prescription medications ordered through the Health Plan's Mail Service Delivery Program can be delivered anywhere in the United States.

Members may obtain prescribed drugs and accessories from either a Participating Network Pharmacy or a Participating Network Pharmacy 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 Copayment and 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 only when: (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 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. The applicable Cost Share for Brand Name Drug will apply.

If a Member requests a Brand Name Drug, for which the prescribing provider has not indicated "dispense as written" (DAW), 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 only when: (1) prescribed by a Plan physician or by a dentist or a referral physician; and (2) (a) there is no equivalent drug in our Preferred Drug List, or (b) an equivalent Preferred drug (i) has been ineffective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member. The applicable Non- Preferred Drug Cost Share will apply.

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

If a Member requests a Non-Preferred Drug, for which the provider has not indicated "dispense as written" (DAW), 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: (a) the place of purchase, (b) the prescribed dosage, (c) Standard Manufacturers Package Size, and (d) specified dispensing limits provided, however, 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 but when 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: (a) the prescribed dosage; (b) Standard Manufacturer's Package Size; and (c) specified dispensing limits.

C. Prescriptions Covered Outside the Service Area; Obtaining Reimbursement

The Health Plan covers drugs prescribed by non-Plan Providers and purchased at non-Plan Pharmacies when the drug was prescribed during the course of an emergency care visit or an urgent care visit (see "Emergency Services" and "Urgent Care Services" sections of the Group Evidence of Coverage), or associated with a covered, authorized referral outside Health Plan's Service Area. To obtain reimbursement, the Member must submit a copy of the itemized receipts for the prescriptions to Health Plan. We may require proof that urgent or emergency care Services were provided. Reimbursement will be made at the Allowable Charge less the applicable Rx Copayment or Rx Coinsurance, 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 6233
Rockville, Maryland 20849-6233

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, 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 of your EOC.

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 of your EOC.
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 of your EOC.
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 of your EOC.
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 of your EOC.
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 Devices” in Section 3 – Benefits of your EOC.
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 of your EOC.
19. Bandages or dressings. Refer to “Drugs, Supplies, and Supplements” and “Home Health Services” in Section 3 – Benefits of your EOC.
20. Diabetic equipment and supplies. Refer to “Diabetic Equipment, Supplies, and Self-Management” in Section 3 – Benefits of your EOC.
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 of your EOC.
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/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	\$15	\$25	\$13
Preferred Brand Drugs	\$30	\$40	\$23
Non-Preferred Brand Drugs	\$50	\$55	\$38

90-day Supply of Maintenance Medication	Mail Delivery	Plan Pharmacy and Participating Network Pharmacy
Generic Drugs	2.5 Rx Copayment(s) shown above	3 Rx Copayment(s) shown above
Preferred Brand Drugs	2.5 Rx Copayment(s) shown above	3 Rx Copayment(s) shown above
Non-Preferred Brand Drugs	2.5 Rx Copayment(s) shown above	3 Rx Copayment(s) shown above

Smoking cessation drugs for 50% of the Allowable Charge.

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

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. Rx Deductible:

No Rx 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. Rx Out-of-Pocket Maximum:

No Rx Out-of-Pocket Maximum

Cost Shares set forth in this Rider do not apply toward the Out-of-Pocket Maximum set forth in the Summary of Services and Cost Shares in the EOC to which this Rider is attached. The Rx Copayment and Rx Coinsurance set forth above will continue to apply even after the Out-of-Pocket Maximum in the EOC has been met.

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: 

Ruben J. Burnett
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**

EXTERNAL PROSTHETIC AND ORTHOTIC DEVICES RIDER

GROUP EVIDENCE OF COVERAGE

This External Prosthetic and Orthotic Devices Rider (herein called “Rider”) is effective as of the date of your Group Agreement and Group Evidence of Coverage, and shall terminate as of the date your Group Agreement and Group Evidence of Coverage terminates.

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

External Prosthetic and Orthotic Devices

A. Definitions

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

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.

Prosthetic Device: An artificial substitute for a missing body part used for functional reasons. As used in this Rider, “Prosthetic Device” does not include any prosthetic device that is covered under the Benefits Section of your Group EOC such as artificial devices to replace, in whole or in part, a leg, arm, hand, or foot.

B. Benefits

External Prosthetic and Orthotic Devices are covered when prescribed by a Plan Provider as follows, subject to the Cost Share shown below. Note: The benefit described in this Rider is in addition to the Prosthetic Device benefit provided in the Group EOC.

We select the provider or vendor that will furnish the covered device. Coverage includes 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. If we do not cover the device, we will try to help you find facilities where you may obtain what you need at a reasonable price.

External Prosthetic Devices

We cover external Prosthetic Devices (other than dental) that replace all or part of the function of a permanently inoperative or malfunctioning body part. Examples of covered external Prosthetic Devices are prosthetic lenses and artificial eyes.

Orthotic Devices

We cover 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. This benefit includes coverage of therapeutic shoes and inserts for individuals with severe diabetic foot disease only.

C. Limitations

- Standard Devices: Coverage is limited to standard devices that adequately meet your medical needs.

D. Exclusions

- 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 covered under the Group EOC.
- Hearing aids, except as specifically covered under the Group EOC.
- Corrective lenses and eyeglasses, except as specifically covered under the Group EOC.
- Repair or replacement due to misuse or loss.
- Orthopedic shoes or other supportive devices, unless the shoe is an integral part of a leg brace, unless indicated above.
- Microprocessor and robotic controlled external prosthetics and orthotics.
- 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.
- Artificial limbs, including their repair and replacement, are not covered under this Rider. Coverage for artificial limbs, their repair and replacement, is found under Prosthetics in the Group EOC.

E. Your Cost Share

Covered Services under this Rider are not subject to the Deductible and the Out-of-Pocket Maximum in the Group EOC to which this Rider is attached. You pay the following copayment or coinsurance for each Service:

- No charge

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

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

By: 

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

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

HMO DENTAL RIDER

This HMO Dental 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 Evidence of Coverage (EOC) terminates.

The following dental services shall be added to the Group Evidence of Coverage (EOC) to which this HMO Dental Rider (Rider) is attached, in consideration of Group's application and payment of Premium for such Services.

I. DEFINITIONS

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

Covered Dental Services: A range of diagnostic, preventive, restorative, endodontic, periodontic, prosthetics, orthodontic and oral surgery services that are covered under this Rider.

Covered Preventive Care Dental Services includes, but is not limited to oral evaluation, cleaning and certain diagnostic X-rays.

Dental Administrator means the entity that has entered into a contract with Health Plan to provide or arrange for the provision of Covered Dental Services. The name and information about the Dental Administrator can be found under General Provisions, see Section II, Paragraph F below.

Dental Fee means the discounted fees that a Participating Dental Provider charges you for a Covered Dental Service. Dental Fees are reviewed annually and subject to change effective January 1st of each year.

Dental Specialist means a Participating Dental Provider that is a dental specialist.

General Dentist means a Participating Dental Provider that is a general dentist.

Participating Dental Provider means a licensed dentist who has entered into an agreement with Dental Administrator to provide Covered Preventive Care Dental Services and/or other dental services at negotiated contracted rates.

II. GENERAL PROVISIONS

- A. Subject to the terms, conditions, limitations, and exclusions specified in the Group Evidence of Coverage and this Rider, you may receive Covered Preventive Care Dental Services from Participating Dental Providers.
- B. Health Plan has entered into an agreement with Dental Administrator to provide Covered Preventive Care Dental Services and certain other dental services through its Participating Dental Providers.
- C. You will receive a list of Covered Preventive Care Dental Services and other Covered Dental Services and the associated Dental Fees that you will be charged for each Service. You will pay a fixed copayment for each preventive care office visit during which Covered Preventive Care Dental Services are provided. You will pay Dental Fees for certain other Covered Dental Services you receive from Participating Dental Providers. You will pay the applicable Dental Fee directly to the Participating Dental Provider at the time services are rendered. The Participating Dental Provider has agreed to accept that Dental Fee as payment in full of the Member's responsibility for that procedure. Neither Health Plan nor Dental Administrator are responsible for payment of these fees or for any fees incurred as the result of receipt of non-Covered Dental Services or any other non-covered dental service.
- D. You will receive a list of Participating Dental Providers from the Health Plan or from Dental Administrator. You should select a Participating Dental Provider, who is a "General Dentist", from whom you and your covered family members will receive Covered Preventive Care Dental Services and other Covered Dental Services. Specialty care is also available should such care be required, however, you must be referred to a

Dental Specialist by your General Dentist. Your Dental Fees are usually higher for care received by a Dental Specialist.

- E. You may obtain a list of Participating Dental Providers, Covered Dental Services and Dental Fees by contacting Dental Administrator or the Health Plan's Member Services Department at the following telephone numbers:

Within the Washington DC Metropolitan Area: 301-468-6000)

Outside the Washington DC metropolitan area: 800-777-7902

TTY number is: 301-879-6380

- F. **Dental Administrator (DOMINION Dental Services USA, Inc. or "DOMINION"):** Health Plan has entered into an agreement with DOMINION to provide Covered Dental Services as described in this Rider. For assistance concerning dental coverage questions or for help finding a Participating Dental Provider, DOMINION Member Services specialists are available Monday through Friday from 7:30 a.m. to 6:00 p.m. (Eastern Time), or you may call the following numbers:

Within the Washington DC Metropolitan Service Area: 703-518-5338

Outside the Washington DC Metropolitan Service Area (toll free): 1-888-518-5338

TTY Line: 1-800-688-4889.

Hearing impaired members may also use the internet at www.IP-RELAY.com

DOMINION's Integrated Voice Response System is available 24 hours a day for information about Participating Dental Providers in your area, or to help you select a Participating Dental Provider. The most up-to-date list of Participating Dental Providers can be found at the following website:

www.DominionDental.com/kaiserdentists

DOMINION also provides many other secure features online at www.dominiondental.com

- G. **Missed Appointment Fee:** Participating Dental Providers may charge you an administrative fee if you miss a scheduled dental appointment without giving 24 hours advance notice. The fee may vary depending on the Participating Dental Provider, however in no event shall the missed appointment fee exceed \$30 for a single visit.

III. SPECIALIST REFERRALS

A. Participating Specialist Referrals

If, in the judgment of your General Dentist, you require the Services of a specialist, you may be referred to a Dental Specialist who will provide Covered Dental Services to you at the Dental Fee for each procedure rendered.

B. Non-Participating Specialist Referrals

Benefits may be provided for referrals to non-Participating Dental Provider specialists when:

1. You have been diagnosed by your General Dentist with a condition or disease that requires care from a dental specialist; and
2. Health Plan and Dental Administrator do not have a Participating Dental Provider specialist who possesses the professional training and expertise required to treat the condition or disease; or
3. Health Plan and Dental Administrator cannot provide reasonable access to a Dental Specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

The Member's cost share will be calculated as if the provider rendering the Covered Dental Services was a Participating Dental Provider.

C. Standing Referrals to Dental Specialists

1. If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires specialized care, your General Dentist may determine, in consultation with you and the Dental Specialist, that you would be best served through the continued care of a Dental Specialist. In such instances, the General Dentist will issue a standing referral to the Dental Specialist.
2. The standing referral will be made in accordance with a written treatment plan developed by the General Dentist, Dental Specialist, and you. The treatment plan may limit the number of visits to the Dental Specialist or the period of time in which visits to the Dental Specialist are authorized. Health Plan retains the right to require the Dental Specialist to provide the General Dentist with ongoing communication regarding your treatment and dental health status.

IV. EXTENSION OF BENEFITS

A. In those instances when your coverage with Health Plan has terminated, we will extend Covered Dental Services, without payment of premium, in the following instances:

1. If you are in the midst of a course of covered dental treatment at the time your coverage ends, we will continue to provide benefits, in accordance with the Group Evidence of Coverage and Dental Rider in effect at the time your coverage ended, for a period of 90 days following the date your coverage ended.
2. If you are in the midst of a course of covered orthodontic treatment at the time your coverage ends, we will continue to provide benefits, in accordance with the Group Evidence of Coverage and Dental Rider in effect at the time your coverage ended, for a period of:
 - a. 60 days following the date your coverage ended, if the orthodontist has agreed to or is receiving monthly payments; or
 - b. until the later of 60 days following the date your coverage ended, or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

To assist us, if you believe you qualify under this "Extension of Benefits" provision, please notify us in writing.

B. Extension of Benefit Limitations:

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

1. Coverage ends because of your failure to pay premium;
2. Coverage ends as the result of you committing fraud or material misrepresentation;
3. When coverage is provided by another health plan and that health plan's coverage:
 - a. is provided at a cost to you that is less than or equal to the cost to you of the extended benefit available under this Rider; and
 - b. will not result in an interruption of the Covered Dental Services you are receiving.

V. DENTAL EMERGENCIES OUTSIDE THE SERVICE AREA

When a dental emergency occurs outside the Service Area, Dental Administrator will reimburse you for the reasonable charges for Covered Dental Services that may be provided, less any discounted fee, upon proof of payment, not to exceed \$50 per incident. Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. You must receive all post-emergency care from your Participating Dental Provider.

VI. EXCLUSIONS AND LIMITATIONS

A. Exclusions

The following services are not covered under this Rider:

1. Services provided by dentists or other practitioners of healing arts not associated with Kaiser Permanente and/or Dental Administrator except upon referral arranged by a Participating Dental Provider and authorized by us, or when required in a covered emergency.
2. Services for injuries or conditions, which are covered under worker's compensation or Employer's Liability laws.
3. Services which are provided without cost to Member by any federal, state, municipal, county, or other political subdivision (with the exception of Medicaid).
4. Services, which, in the opinion of the attending dentist, are not necessary for the patient's dental health.
5. Cosmetic, elective or aesthetic dentistry.
6. Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan which is described in the Group Evidence of Coverage.
7. Drugs obtainable with or without a prescription, except as may be otherwise covered in your medical plan this is described in the Group Evidence of Coverage.
8. Hospitalization for any dental procedure.
9. Treatment for conditions resulting from major disaster, epidemic or war, including declared or undeclared war or acts of war.
10. Replacement due to loss or theft of prosthetic appliance.
11. Services that cannot be performed because of the general health of the patient.
12. Implantation and related restorative procedures.
13. Services not listed as a Covered Dental Service.
14. Services provided by a non-Participating Dental Provider or not pre-authorized by Dental Administrator (with the exception of out-of-area emergency dental services).
15. Services related to the treatment of TMD (Temporomandibular disorder).
16. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
17. Procedures relating to the change and maintenance of vertical dimension or major restoration of occlusion, or to alter the occlusion (bite) through full mouth adjustment/grinding of the teeth. This does not exclude minor occlusal adjustments on individual teeth to remove high spots or smooth out rough or sharp areas.
18. Dental expenses incurred in connection with any dental procedure that was started prior to your effective date of coverage. Examples include orthodontic work in progress, teeth prepared for crowns, and root canal therapy in progress.
19. Treatment of malignancies, neoplasm, or congenital malformations, except as may be otherwise covered in your medical plan which is described in the Group Evidence of Coverage.
20. Lab Fees for excisions and biopsies, except as may be otherwise covered in your medical plan that is described in the Group Evidence of Coverage.
21. Experimental procedures, implantations, or pharmacological regimens.
22. Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
23. Charges for second opinions, unless pre-authorized.
24. Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
25. Occlusal guards, except for the purpose of controlling habitual grinding.

B. Limitations

Covered Dental Services are subject to the following limitations:

1. Replacement of a bridge, crown or denture within five (5) years after the date it was originally installed.
2. Replacement of a filling within two (2) years after original date of placement.
3. Coverage for periodic oral exams, prophylaxes (cleanings) and fluoride applications is limited to twice per contract year.
4. Crown and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary, and Reasonable (UCR) fee, minus 25%.
5. Full mouth x-rays or panoramic film is limited to one set every three (3) years.
6. Retreatment of root canal within two (2) years of the original treatment.
7. Coverage for sealants (D1351) is limited to the first and second permanent molars for children under the age of 16 once every 24 months.
8. Coverage for periodontal surgery of any type, including any associated material (D4210, D4211, D4240, D4241, D4249, D4260, D4261, D4263, D4265, D4268, D4270, D4271, D4275, D4276) is covered once every 36 months per quadrant or surgical site.
9. Coverage for root planing or scaling (D4341, D4342) is limited to once every 24 months per quadrant.
10. Full mouth debridement (D4355) is limited to once every 36 months.
11. Periodontal maintenance after active therapy (D4910) is limited to twice per 12 months within 24 months after definitive periodontal therapy.
12. Coverage for relining of Dentures (D5730, D5731, D5740, D5741, D5750, D5751, D5760 and D5761) is limited to once every 12 months.

This Rider is subject to all the terms and conditions of the Group Agreement and Group Evidence of Coverage (EOC) 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: 

Ruben J. Burnett
Vice President, Marketing, Sales & Business Development



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: 

Ruben J. Burnett
Vice President, Marketing, Sales & Business Development



KAISER PERMANENTE®

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

2101 East Jefferson Street
Rockville, Maryland 20852

2012 AMENDMENT

This Amendment is effective as of the date of your Group Agreement and Evidence of Coverage, or January 1, 2012, whichever is later, and shall terminate on the date your Group Agreement and Group Evidence of Coverage terminates.

Autism Spectrum Disorder

SECTION 3 is amended to include the following benefit:

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 6. 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 licensed physician 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 licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment; (ii) pharmacy care; (iii) psychiatric care; (iv) psychological care; (v) therapeutic care; and (vi) applied behavior analysis when provided or supervised by a board certified behavior analyst licensed by the Virginia Board of Medicine. 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 licensed physician or a licensed psychologist 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.

Limitation:

- Coverage for Applied Behavior Analysis is limited to an annual maximum benefit of \$35,000. Applied Behavior Analysis 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.

APPENDICES - Definitions are amended to include the following:

Applied Behavior Analysis: means 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.

Autism Spectrum Disorder or (ASD): means any pervasive developmental disorder, including: (i) autistic disorder; (ii) Asperger's Syndrome; (iii) Rett Syndrome; (iv) childhood disintegrative disorder; or (v) 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.

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

By:  _____

Ruben J. Burnett

Vice President, Marketing, Sales & Business Development

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

2101 East Jefferson Street
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Women's Preventive Services Amendment

This Amendment is effective August 1, 2012, or the effective date of your Group Agreement and Evidence of Coverage (hereinafter collectively referred to as the "Evidence of Coverage") or Membership Agreement (Agreement), as applicable, and shall terminate the date your Evidence of Coverage or Agreement terminates.

Definitions

Cost Share: Has the same meaning as defined in your Evidence of Coverage or Agreement.

FDA: The United States Food and Drug Administration

Preventive Services

The following are additional preventive care and screenings that are covered Services as required by the Patient Protection and Affordable Care Act (ACA) of 2010, as amended, and are provided in accordance with the published guidelines supported by the Health Resources and Services Administration (HRSA). These guidelines are subject to change and can be found on the HRSA website at www.HRSA.gov/womensguidelines.

The Evidence of Coverage and Agreement are hereby amended, as applicable, to provide the preventive Services listed below, to women without Cost Share requirements, such as Deductibles, Copayment amounts or Coinsurance.

The preventive Services include the following:

- (1) Well-woman preventive care visit annually for adult women to obtain the recommended preventive Services that are age and developmentally appropriate, including preconception and routine prenatal care.
- (2) Screening for gestational (pregnancy-related) diabetes in pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
- (3) Annual screening and counseling on sexually transmitted infections for all sexually active women.
- (4) High-risk human papillomavirus DNA testing every three years for women age 30 years and over whether or not they have normal Pap test results.
- (5) Annual screening and counseling for human immune-deficiency virus (HIV) infection for all sexually active women.
- (6) Comprehensive lactation (breastfeeding) education and counseling, by trained clinicians during pregnancy and/or in the postpartum period in conjunction with each birth.
- (7) Breastfeeding equipment issued, per pregnancy and in accordance with Health Plan coverage guidelines.
- (8) Annual screening and counseling for interpersonal and domestic violence.
- (9) Patient education and contraceptive counseling for all women with reproductive capacity.
- (10) All prescribed FDA-approved contraceptive methods, including implanted contraceptive devices, hormonal contraceptive methods, barrier contraceptive methods, and female sterilization surgeries.

Note: Contraceptive methods that do not require clinical administration, such as birth control pills will not be covered if you have outpatient prescription drug coverage separate from your Health Plan coverage through another prescription drug provider.

Limitations

The following Services are not covered as preventive care. Applicable Cost Share will apply:

- Lab, imaging, and other ancillary Services not included in routine prenatal care.
- Non-preventive Services performed in conjunction with a sterilization.
- Lab, imaging, and other ancillary Services associated with sterilizations.
- Complications that arise after a sterilization procedure.

Exclusions

- Over-the-counter contraceptive pills, supplies, and devices.
- Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.
- Replacement or upgrades for breastfeeding equipment that is not rented Durable Medical Equipment.
- Prescription contraceptives that do not require clinical administration for certain group health plans that provide outpatient prescription drug coverage that includes FDA-approved contraception that is separate from Health Plan coverage and furnished through another prescription drug provider.

This Amendment is subject to all the terms and conditions of the Evidence of Coverage or Agreement to which this Amendment is attached. This Amendment does not change any of those terms and conditions, unless specifically stated in this Amendment.

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

By: 

Ruben J. Burnett
Vice President, Marketing, Sales & Business Development



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

This Amendment is effective as of the date of your Group Agreement and Group Evidence of Coverage, or January 1, 2013, whichever is later, and shall terminate on the date your Group Agreement and Group Evidence of Coverage terminates.

2013 GROUP AMENDMENT

SECTION 3 – Benefits are amended to include the following:

AMBULANCE SERVICES

The “Ambulance Services” subsection is replaced in its entirety with the following:

We cover ambulance Services provided by a licensed ambulance service only if: (1) your condition requires 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 air ambulance transport to the nearest hospital able to provide needed Services, provided during an encounter with an ambulance Service, as a result of a 911 call.

We cover medically appropriate non-emergent transportation Services when ordered by a Plan Provider.

We will not cover ambulance or non-emergent transportation Services in any other circumstances, even if no other transportation is available. We cover ambulance and medically appropriate non-emergent transportation Services only inside our Service Area, except as related to out of area Services covered under “Emergency Services” in this section. Your cost share will apply to each encounter whether or not transport was required.

Ambulance Services Exclusions:

- Transportation by car, taxi, bus, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider.
- Non-emergent transportation Services that are not medically appropriate and that have not been ordered by a Plan Provider.

MATERNITY SERVICES

The “Maternity Services” subsection is replaced in its entirety with the following:

We cover Services for routine global maternity care and non-routine obstetrical care.

“Routine global maternity” means care provided after the first visit where pregnancy is confirmed, and includes all of the following Services, subject to a cost share: (a) the normal series of regularly scheduled

preventive prenatal care exams; (b) physician charges for labor and delivery, including cesarean section; and (c) routine postpartum follow-up consultations and exams.

“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 48 hours following an uncomplicated vaginal delivery; and at least 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 24 hours after discharge, and an additional home visit if prescribed by the attending provider.

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

PROSTHETIC DEVICES

The “Internally Implanted Devices” provision under the “Prosthetic Devices” subsection is replaced in its entirety with the following:

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” following mastectomy” below) and cochlear implants, that are approved by the federal Food and Drug Administration for general use.

The “Prosthetic Device Exclusions” provision in the “Prosthetic Devices” subsection of Section 3 “Benefits” is replaced in its entirety with the following:

Prosthetic Device Exclusions:

- Internally implanted breast prosthesis for cosmetic purposes
- External Prosthesis, except as provided in this section under “Cleft-Lip, Cleft Palate, or Both”
- Repair or replacement of prosthetic devices due to loss or misuse
- Hair prosthesis
- Microprocessor and robotic-controlled external prosthetics not covered under the Medicare Coverage Database.
- Multifocal intraocular lens implants

RECONSTRUCTIVE SURGERY

The “Reconstructive Surgery” subsection is replaced in its entirety with the following:

We cover reconstructive surgery. This shall include plastic, cosmetic and related procedures required to: (a) to correct significant disfigurement resulting from an injury or Medically Necessary surgery, (b) to correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function, and (c) to treat congenital hemangioma known as port wine stains on the face for Members age 18 or younger.

Following mastectomy, we also 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 as a result of breast cancer. Reconstructive breast surgery is surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

Reconstructive Surgery Exclusions:

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

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

THERAPY AND REHABILITATION SERVICES

The “Cardiac Rehabilitation Services” provision under the “Therapy and Rehabilitation Services” subsection is replaced in its entirety with the following:

We cover outpatient cardiac rehabilitation Services that is Medically Necessary following coronary surgery or a myocardial infarction, for up to 12 weeks, or 36 sessions, whichever occurs first.

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

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

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

By:  _____

Ruben J. Burnett
Vice President, Marketing, Sales & Business Development

**KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.
AMENDMENT RIDER TO GROUP AGREEMENT AND EVIDENCE OF COVERAGE**

(Non-Grandfathered Group Plan)

Notice of Non-Grandfathered Group Plan

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

The Group Agreement and Evidence of Coverage (hereinafter severally and collectively referred to as the "Agreement") to which this amendment rider is attached are amended as described below.

SECTION 1 – Introduction is amended by deleting the provisions that define Dependents and replacing it with the following:

I. Dependents

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents:

- A. Your Spouse;
- B. Your or your Spouse's children, who are under age 26;
- C. Other Dependent persons (but not including foster children) who meet all of the following requirements:
 - (1) they are under age 26 and they are not eligible to enroll in an employer-sponsored plan (not including a plan that one of the child's parents is enrolled in); or
 - (2) you or your Spouse is the child's court-appointed guardianship

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

- A. 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;
- B. they receive 50 percent or more of their support and maintenance from you or your Spouse;
- C. you provide us proof of their incapacity and dependency within 60 days after we request it (see "Disabled Dependent Certification") below in this "Additional Eligibility Requirements" section.

Disabled Dependent Certification

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

- 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 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 incapacity and dependency within 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, two years after the date that your Dependent reached the age limit, you must provide us documentation of his or her incapacity and dependency annually within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled Dependent.

- If your Dependent is not a Member and you are requesting enrollment, you must provide us documentation of his or her incapacity and dependency within 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 incapacity and dependency annually within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled Dependent.

Prohibition on Pre-Existing Conditions for Children

We do not deny or reject coverage due to underwriting for a child under the age of 19.

SECTION 2 – How to Obtain Services is amended as follows:

A. Your Primary Care Plan Physician provision is amended by replacing the second paragraph with the following:

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

B. Getting a Referral – the third paragraph is amended by revising item (2) as follows:

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. For continued treatment, you or your Plan Provider must contact the Behavioral Health Access Unit for assistance with arranging for and scheduling of Covered Services. The Behavioral Access Unit may be reached at 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. 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 "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section.
- (3) Optometry services
- (4) Urgent care services provided inside our Service Area

C. Getting the Care You Need; Emergency Services, Urgent Care and Advice Nurses is replaced in its entirety with the following:

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

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

SECTION 3 – Benefits is amended as follows:

A. Early Intervention Services limitation provision is deleted and replaced with the following:

This benefit is limited to a maximum of \$5,000 per year for assistive technology Services and devices.

B. Emergency Services is amended to replace the first three paragraphs of the provision with the following language:

As described below you are covered if you have an emergency medical condition.

If you experience an emergency medical condition you should contact 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, not to exceed forty-eight (48) hours or the next 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, as defined, and was not authorized by Health Plan, you will be responsible for all charges.

C. Preventive Health Care Services is amended as follows:

In addition to any other preventive benefits described in the group contract or certificate, 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;
- (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;
- (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; 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.

Health Plan shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

The APPENDICES – Definition section is amended to include the following new definitions:

Capitalized terms shall have the meaning ascribed to them in the Agreement unless defined in this amendment rider. The following definitions have the following meanings in this amendment rider:

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:

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

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

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

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).

This amendment rider shall be effective the first day of the first Contract Year on or after September 23, 2010.

By: 

Ruben J. Burnett
Vice President, Marketing, Sales & Business Development