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YOUR GROUP AGREEMENT



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KAISER PERMANENTE®

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

2101 East Jefferson Street
Rockville, Maryland 20852

GROUP AGREEMENT KAISER PERMANENTE

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

GROUP AGREEMENT KAISER PERMANENTE

INTRODUCTION

This Group Agreement (Agreement), including the Face Sheet and Evidence of Coverage (EOC), all of which are incorporated herein by reference, constitutes the contract between the Group and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan).

The Health Plan is responsible for fulfilling its obligations under this Agreement with respect to itself and its product(s), as described in the EOC.

Pursuant to this Agreement, the Health Plan will provide covered Services and items to Members in accordance with the EOC.

The Group acknowledges acceptance of this Agreement by signing the Face Sheet and returning it to the Health Plan. If the Group does not return it to the Health Plan, the Group will be deemed to have accepted this Agreement if the Group pays the Health Plan any amount toward Premiums, or enrolls a person under this Agreement.

SECTION 1 - TERM OF AGREEMENT

This Agreement is effective from the date specified on the Face Sheet for twelve (12) consecutive months, unless terminated as set forth in the “Termination of Agreement” section below.

Unless this Agreement terminates pursuant to the “Termination of Agreement” section below, the Health Plan will either extend the term of this Agreement pursuant to the “Amendment of Agreement” section, immediately below, or offer the Group a new agreement to become effective immediately after termination of this Agreement.

Except as expressly provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m. Eastern Time on the termination date.

SECTION 2 - AMENDMENT OF AGREEMENT

Upon forty-five (45) days’ prior written notice to the Group, the Health Plan may amend this Agreement with regard to Premium, benefits, limitations, exclusions and/or conditions, to be effective on the Anniversary Date. “Anniversary Date” means the date on which this Agreement renews.

In addition, the Health Plan may, subject to government approval, amend this Agreement at any time by giving forty-five (45) days’ prior written notice to the Group in order to (a) comply with applicable law or (b) reduce or expand the Health Plan Service Area.

All amendments are deemed accepted by the Group unless the Group gives the Health Plan written notice of non-acceptance at least fifteen (15) days before the effective date of the amendment, in which event this Agreement terminates the date before the effective date of the amendment.

Changes to the Agreement will not be valid until approved by an executive of the Health Plan and the approval is either endorsed on the Agreement or attached to the Agreement.

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

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SECTION 3 - TERMINATION OF AGREEMENT

This Agreement will terminate under any of the conditions listed below.

Within seven (7) business days of issuing written notice of termination to the Group, the Health Plan will mail a legible copy of the notice to each Subscriber. Additionally, the Health Plan will mail to each Subscriber a written notification of his/her conversion rights, as defined within the EOC's "Conversion of Membership" provision, which can be found in Section 6: Termination of Membership.

Termination on Notice

The Group may terminate this Agreement effective at any time. If the Group notifies the Health Plan of its intent to terminate during the grace period, the Health Plan will hold the Group liable for the Premium for the period beginning on the first day of the grace period until the date on which the notice is received, or the date of termination stated in the notice, whichever is later.

The Health Plan will extend benefits for covered Services to Members, without premium, as defined in the EOC's "Extension of Benefits" provision, which can be found in Section 6: Termination of Membership.

Termination for Non-Payment of Premium

The Health Plan may terminate this Agreement for non-payment of Premium. Upon nonpayment of Premium, the Health Plan will notify the Group of the past-due amount and the effective date of termination, which will be thirty-one (31) days from the date of the written notice, unless the Health Plan does not intend to renew this Agreement beyond the period for which Premium have been accepted and notice of intention not to renew has been delivered to the Group at least forty-five (45) days before the Premium are due. The thirty-one (31) days from the written notice by the Health Plan through the termination date will constitute a grace period. This Agreement will remain in full force and effect throughout the grace period. If the Health Plan receives full payment within the grace period, this Agreement will remain effective according to the terms and conditions in the Agreement. If the Health Plan receives written notice from the Group to terminate this Agreement before the end of the grace period, the Health Plan shall collect Premium for the grace period, which shall be calculated beginning on the first day of the grace period until the date on which written notice was received, or the date of termination stated in the notice, whichever is later.

If the Health Plan does not receive full payment by the end of the grace period, this Agreement will be terminated without further extension or consideration. The Group will be liable for all unpaid amounts due through the date of termination.

If Premium for the thirty-one (31)-day grace period are paid after the grace period ends, the Health Plan may charge interest for the Premium. However, (a) interest may not begin to accrue during the thirty-one (31) day grace period and (b) the interest rate charged may not exceed an effective rate of 6 percent per year.

Termination for Fraud, Intentionally Furnishing Incorrect or Incomplete Information and/or Violation of Contribution or Participation Requirements

If the Group fails to (a) adhere to a material provision relating to the Health Plan's contribution or participation requirements, including those listed in the "Eligibility and Enrollment" section below, or (b) performs an act that constitutes fraud or intentional misrepresentation of material information to the Health

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Plan under the terms of coverage, the Health Plan will terminate this Agreement with thirty-one (31) days prior written notice to the Group.

Termination for Movement Outside of the Service Area

The Health Plan may terminate this Agreement upon thirty-one (31) days' prior written notice to the Group if no eligible person lives, resides or works in the Health Plan's Service Area as, defined in the EOC.

Discontinuance of Product or All Products within a Market

The Health Plan may terminate a particular product or all products offered in a large group market, as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If the Health Plan discontinues offering a particular product, the Health Plan may terminate this Agreement upon ninety (90) days' written notice prior to the date of nonrenewal to each affected Subscriber, plan sponsor, participant and beneficiary.

The Health Plan shall then offer the Group another product available at that time to groups in its respective market. The Health Plan shall act uniformly without regard to the claims experience of any affected plan sponsor, or any health status-related factor of any affected individual.

Health status-related factor means a factor related to (a) health status, (b) medical condition, (c) claims experience, (d) receipt of health care, (e) medical history, (f) genetic information, (g) evidence of insurability including conditions arising out of acts of domestic violence, or (h) disability.

If the Health Plan discontinues offering all products to large group markets, the Health Plan may terminate this Agreement upon one hundred-eighty (180) days' written notice to the Group. And, upon at least thirty (30) working days before that notice, the Health Plan shall give notice to the Commissioner, and may not write new business for groups in the state for a five (5)-year period beginning on the date of notice to the commissioner. No other product will be offered to the Group. For purposes of this Section, a "product" is a combination of benefits and Services provided to Members, each such product being defined by a distinct disclosure form or EOC.

SECTION 4 - PREMIUM AND PAYMENTS

The Group shall pay to the Health Plan, for each Subscriber and his or her Dependents, the Premium specified on the Face Sheet for each month no later than the first day the coverage period begins. These amounts are called the "Base Premium." "Base Premiums" means 100 percent of monthly Premiums for each enrolled Member, as set forth in this section.

Premium Payments for New Members

The Group will be billed the entire month's Premium for new Members whose effective date falls between the 1st and the 15th of the month. The Group will not be billed for the month's Premium when a new Member's effective date falls between the 16th and the end of the month. The Group shall continue to pay the Premium for each Subscriber and his or her enrolled Dependents covered under this Agreement until the later of the termination date or the date notice is received by the Health Plan.

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Premium Payments for Terminating Members

The Group will be billed the entire month's Premium for Members whose termination date falls between the 16th and the end of the month. The Group will not be billed for the month's Premium when a Member's termination date falls between the 1st and the 15th of the month.

The Group will continue to pay the Premium for each Member under this Agreement until the Group has provided written notice. The effective date of termination will be the date the Group's written notice is received by the Health Plan unless the Group's notice specifies a later date. Termination notices received by the Health Plan that request a later date will be terminated as of the date specified by the Group.

Change in Premium Based on Age

The Health Plan shall have the right to adjust Premium equitably in the event that the age of a Member has been misstated. The Health Plan shall provide written notice to the Group of the misstatement and the revised Premium.

Premium Increase Due to Tax or Other Charge

If a government agency or other taxing authority imposes or increases a tax or other charge (excluding a tax on or measured by net income) upon Health Plan or any of its contracting providers (or any of their activities), then beginning on the effective date of that tax or charge, the Health Plan may calculate the Group's Premium to include the Group's share of the new or increased tax or charge, subject to regulatory approval where required. The Group's share is determined by dividing the number of Members enrolled through the Group by the total number of Members enrolled in the applicable Service Area. The Health Plan shall provide written notice to Group at least forty-five (45) days before the change in Premium is proposed to become effective.

Premium Rebates

If state or federal law requires the Health Plan to rebate Premiums from this or any earlier contract year and the Health Plan rebates Premiums to the Group, those responsible to represent that the Group will use that rebate for the benefit of Members, in a manner consistent with the requirements of the Public Health Service Act, the Affordable Care Act and the obligations of a fiduciary under the Employee Retirement Income Security Act (ERISA).

Clerical Errors

If a clerical or administrative error made by the Group or Health Plan results in an eligible person being incorrectly enrolled or not enrolled, then such error will be rectified by the Group and Health Plan within ninety (90) days of the error being found.

If the Group's written notice to add an eligible person is received more than ninety (90) days from the eligible person's effective date, the Health Plan will only enroll the eligible person a maximum of ninety (90) days, retroactively from the date that the Health Plan received the written notice from the Group. Refunds or payments will be made accordingly by the Group or Health Plan, whichever is applicable.

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Cost Shares

Members must pay or arrange for payment of amounts they owe the Health Plan, Plan Hospitals or Medical Group. The Cost Share is the amount of Allowable Charge for a covered Service and is due at the time the Member receives a Service.

Limit on Cost Shares

There are limits to the total amount of Cost Shares paid by a Member in a contract year for certain Services covered under this EOC. The Copayment Maximum and the Out-of-Pocket Maximum, if applicable, are provided in the Summary of Services and Cost Shares in the EOC.

SECTION 5 - ELIGIBILITY AND ENROLLMENT

No change in the Group's eligibility or participation requirements is effective for purposes of this Agreement unless the Health Plan consents in writing.

The Group must:

1. Hold an Open Enrollment Period at least once a year. ("Open Enrollment Period" means a time period during which all eligible persons may enroll in the Health Plan or in any other health care plan available through the Group);
2. Offer enrollment in the Health Plan to all eligible persons on conditions no less favorable than those for any other health care plan available through the Group; and
3. Contribute to all health care plans available through the Group on a basis that does not financially discriminate against the Health Plan or against eligible persons who choose to enroll in the Health Plan. In no case will the Group's contribution be less than one-half the rate required for a single Subscriber for the plan in which the Subscriber is enrolled.

Eligible employees and their eligible Dependents may be added periodically in accordance with the terms of the contract.

SECTION 6 - MISCELLANEOUS PROVISIONS

Assignment

The Health Plan may assign this Agreement.

The Group may not assign this Agreement or any of the rights, interests, claims for money due, benefits, or obligations hereunder without prior written consent of the Health Plan.

This Agreement shall be binding on the successors and permitted assignees of the Health Plan and the Group.

Attorney Fees and Costs

If the Group or Health Plan institutes legal action against the other to collect any sums owed under this Agreement, the party that substantially prevails will be reimbursed for its reasonable litigation expenses, including attorneys' fees, by the other party, to the extent that the Health Plan may only collect premiums owed through the grace period and any interest that accrues after the grace period.

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

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Contestability

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

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

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

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

Delegation of Claims Review Authority

The Health Plan is a named fiduciary to review claims under this Agreement. The Group delegates to the Health Plan the discretion to determine whether a Member is entitled to benefits under this Agreement. In making these determinations, the Health Plan has the authority to review claims in accordance with the procedures contained herein, and to construe this Agreement to determine whether the Member is entitled to benefits.

Governing Law

Except as preempted by federal law, this Agreement will be governed in accordance with the laws of the State of Maryland, where Health Plan is licensed. Any provision required to be in this Agreement by federal or state law shall bind the Group and Health Plan, whether or not it is set forth herein.

Indemnification

The Health Plan will indemnify and hold harmless the Group and its agents, officers and employees, acting in their capacity as agents of the Group (collectively, "Group Parties"), against any claims, actions, costs (including reasonable attorneys' fees), damages or judgments, to the extent that they arise out of the Health Plan's acts or omissions under this Agreement.

The Group will give the Health Plan written notice of any claim that the Group at any time contends is subject to this provision within thirty (30) days after receiving notice of the claim, and will tender to the Health Plan the opportunity, at the Health Plan's expense, to arrange and direct the defense of any action or lawsuit related to the claim. If the Health Plan accepts the tender, then the Health Plan will have no obligation to Group Parties with respect to attorneys' fees incurred by Group Parties. Upon request, Group Parties will give the Health Plan all information and assistance reasonably necessary for defense of the claim. The foregoing indemnification applies only to claims or actions against Group Parties by third parties, including Members, and does not apply to any claim or action by the Health Plan that seeks to enforce the Health Plan's rights under this Agreement.

The Group will indemnify and hold harmless the Health Plan and its agents, officers and employees acting in their capacity as agents of the Health Plan (collectively, Health Plan Parties) against any claims, actions,

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costs (including reasonable attorneys' fees), damages or judgments, to the extent that they arise out of the Group's acts or omissions under this Agreement.

The Health Plan will give the Group written notice of any claim that the Health Plan at any time contends is subject to this provision within thirty (30) days after receiving notice of the claim, and will tender to the Group the opportunity, at the Group's expense, to arrange and direct the defense of any action or lawsuit related to the claim. If the Group accepts the tender, then the Group will have no obligation to Health Plan Parties with respect to attorneys' fees incurred by Health Plan Parties.

Upon request, Health Plan Parties will give the Group all information and assistance reasonably necessary for defense of the claim. The foregoing indemnification applies only to claims or actions against Health Plan Parties by third parties, including Members, and does not apply to any claim or action by the Group that seeks to enforce the Group's rights under this Agreement.

Legal Action

No legal action may be brought to recover on the contract (a) before the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the contract or (b) after the expiration of three (3) years after the written proof of loss is required to be furnished.

Member Information

The Group will inform Subscribers of eligibility requirements for Members and when coverage becomes effective and terminates. If the Health Plan gives the Group any information that is material to Members, the Group will disseminate that information to Subscribers by the next regular communication to them, but in no event no later than thirty (30) days after the Group receives the information. For purposes of this paragraph, "material" means information that a reasonable person would consider important in determining action to be taken.

The Group will provide electronic or paper summaries of benefits and coverage (SBCs) to participants and beneficiaries to the extent required by law, except that the Health Plan will provide SBCs to Members who make a request to the Health Plan.

No Waiver

The Health Plan's failure to enforce any provision of this Agreement will not constitute a waiver of that or any other provision, or impair Health Plan's right thereafter to require the Group's strict performance of any provision.

Notices

Notices from the Health Plan to the Group or from the Group to the Health Plan must be delivered in writing, except that the Group and Health Plan may each change its notice address by giving written notice to the other. Notices are deemed given when delivered in person or deposited in a United States Postal Service receptacle for the collection of U.S. mail.

If to the Health Plan:

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

P.O. Box 6831

2101 East Jefferson Street

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

GROUP AGREEMENT KAISER PERMANENTE

Rockville, Maryland 20849-6831

If to the Group:

To the address indicated on the Face Sheet.

If to a Member:

To the latest address provided to the Health Plan by the Member.

Right to Examine Records

Under reasonable notice, the Health Plan may examine the Group's records with respect to eligibility and payments provided under this Agreement.

Representation Regarding Waiting Periods

By entering into this Agreement, the Group hereby represents that the Group does not impose a waiting period exceeding ninety (90) days on its employees who meet the Group's substantive eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective, in accordance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

In addition, the Group represents that eligibility data provided by the Group to the Health Plan will include coverage effective dates for the Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

Certificates

Unless the Health Plan directly delivers a statement that summarizes the benefits and rights that pertain to Members covered under this Group Agreement to the employee or Member of the Group; the Health Plan will provide the aforementioned statement to the Group to distribute to each employee or member of the Group.

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

By: 

Mark Ruszczyk
Vice President, Marketing, Sales & Business Development

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



guide to
YOUR 2017 BENEFITS
AND SERVICES



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

**GROUP
EVIDENCE OF COVERAGE**

MARYLAND

SIGNATURE CARE DELIVERY SYSTEM



This plan has Excellent accreditation from the NCOA
See 2017 NCOA Guide for more information on Accreditation



KAISER PERMANENTE®

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



Kaiser Foundation Health Plan of the
Mid-Atlantic States, Inc. (KFHP-MAS)

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

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

If you need these services, call the number provided below.

District of Columbia	1-800-777-7902
Maryland	1-800-777-7902
Virginia	1-800-777-7902
TTY	711

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Kaiser Civil Rights Coordinator, 2101 East Jefferson Street, Rockville, MD 20852, telephone number: 1-800-777-7902. You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Cebuano (Bisaya): Anaa moy katungod nga mangayo og tabang sa inyo pinulongan ug kini walay bayad. Kung naa mo pangutana bahin sa inyo aplikasyon o coverage sa Kaiser Permanente, o kung kaning pahibalo nanginahanglan sa inyo paglihok sa dili pa usa ka pihon nga petsa, palihug lang pagtawag sa mga numero sa telepono nga gihatag sa imong estado ("state") o rehiyon ("region") para makigstorya sa usa ka interpreter.

中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的Kaiser Permanente申請或承保有任何疑問，或者如果本通知要求您在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。

Chuuk (Chukese): Mei wor omw pwuung omw kopwe angei aninis non foosun fonuomw (Chuukese), ese kamo. Ika mei wor omw kapas eis usun omw apilikeison me/ika policy fan nemenien Kaiser Permanente, are ika ei esinesin a erenuk pwe kopwe fori pwan ekoch fofor, ka tongeni omw kopwe kori ewe nampa mei kawor faniten omw state ika fonu (asan) iwe eman chon chiakku epwe anisuk non kapasen fonuomw.

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de votre demande d'inscription ou de la couverture par Kaiser Permanente, ou si cet avis vous demande de prendre des mesures à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutzes durch Kaiser Permanente haben oder falls Sie aufgrund dieser Benachrichtigung bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.

ગુજરાતી (Gujarati): તમને કોઈ પણ ખર્ચ વગર તમારી ભાષામાં મદદ મેળવવાનો અધિકાર છે. જો તમને Kaiser Permanente મારફતે તમારી અરજી અથવા કવરેજ વિશે પ્રશ્નો હોય, અથવા જો આ નોટિસ હોય જેમાં તમને કોઈ ચોક્કસ તારીખથી પગલાં લેવાની જરૂર હોય, તો દુભાષિયા સાથે વાત કરવા તમારા સ્ટેટ અથવા રીજીયન માટે પૂરા પાડવામાં આવેલ નંબર પર ફોન કરો.

Kreyòl Ayisyen (Haitian Creole): Ou gen dwa pou jwenn èd nan lang ou gratis. Si ou gen nenpòt kesyon sou aplikasyon ou an oswa asirans ou ak Kaiser Permanente, oswa si nan avni sa a gen bagay ou sipoze fè sa a avan yon sèten dat, rele nimewo nou mete pou Eta oswa rejyon ou a pou w ka pale ak yon entèprèt.

‘ōlelo Hawai‘i (Hawaiian): He pono a ua loa‘a no kekahi kōkua me kāu ‘ōlelo inā makemake a he manuahi no ho‘i. Inā he mau nīnau kāu e pili ana i kāu palapala noi ‘inikua ola kino a i ‘ole i kōkua ma‘ō ka polokalamu kōkua ola kino Kaiser Permanente, a i ‘ole inā ke ha‘i nei paha kēia leka nei iā‘oe e hana koke aku i kēia ma mua o kekahi lā i waiho ‘ia, e kelepona aku i ka helu i loa‘a ma kēia leka nei no kāu moku‘āina a i ‘ole pana‘āina no ka wala‘au ‘ana me kekahi kanaka unuhi ‘ōlelo.

हिन्दी (Hindi): आपको विना किसी कीमत चुकाए आपकी भाषा में सहायता पाने का अधिकार है। यदि आप आपके आवेदन पत्र के विषय में या Kaiser Permanente के कवरेज के विषय में कुछ पूछना चाहते हैं या यदि यह एक नोटिस है जिसके कारण आपको किसी विशेष तिथि तक कारवाई करनी पड़ेगी तो आपके राज्य या क्षेत्र के लिए दिए गए नंबर पर फोन करके किसी दुभाषिये से बात करें।

Hmoob (Hmong): Koj muaj cai kom tau txais kev pab uas hais koj hom lus yam tsis tau them nqi. Yog koj muaj lus nug txog koj daim ntawv thov los yog cov kev pab them nyiaj tim Kaiser Permanente, los yog tias daim ntawv no yog ib tsab ntawv ceebtoom uas yuav kom koj ua ib yam dabtsi raws li hnuv tau teev tseg, hu rau tus nab npawb xovtooj uas tau muab rau koj lub xeev lossis cheeb tsam kom tau tham nrog tus kws txhais lus.

Igbo (Igbo): ! nwere ikike inweta enyemaka n'asusụ gị na akwughị ugwo ọ bụla. Ọ bụrụ na ị nwere ajuju gbasara akwukwo anamachoihe gị ma ọ bụ mkpuchi si na Kaiser Permanente, ma ọ bụ ọ bụrụ na nke bụ ọkwa a choro ka ị mee ihe tupu otu ubochi, kpoọ nomba enyere maka steeti ma ọ bụ mpaghara gị iji kwukọta okwu n'etiti onye ọkwa okwu.

Iloko (Ilocano): Adda ti karbenganyo a dumawat iti tulong iti pagsasaoyo nga awan ti bayadanyo. No addaankayo kadagiti saludsod maipanggep ti aplikasionyo wenno coverage babaen ti Kaiser Permanente, wenno no daytoy ket maysa a pakdaar a kalikagumanna a rumbeng nga aramidenyo ti addang iti espesipiko a petsa, tawagan ti numero nga inpaay para ti estado wenno rehiyon tapno makipatang ti maysa mangipatarus iti pagsasao.

Italiano (Italian): Hai il diritto di ricevere assistenza nella tua lingua gratuitamente. In caso di domande riguardanti la tua richiesta o la copertura attraverso Kaiser Permanente, o se occorre intervenire entro una data specifica secondo quanto indicato in questa comunicazione, chiama il numero fornito per il tuo stato o la tua regione per parlare con un interprete.

日本語 (Japanese): あなたは、費用負担なしでご使用の言語で支援を受ける権利を保持しています。お申し込みまたはKaiser Permanenteの担保範囲に関してご質問があるか、または本通知により、あなたが特定の日付までに行動を起こすよう依頼されている場合、お住まいの州または地域に対して提供された電話番号に電話して、通訳とお話ください。

ខ្មែរ (Khmer): អ្នកមានសិទ្ធិទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ បើសិនអ្នកមានសំណួរណាមួយអំពីពាក្យស្នើសុំឬការធានារ៉ាប់រងតាមរយៈ Kaiser Permanente ឬប្រសិនបើជាលិខិតជូនដំណឹងដែលតម្រូវឱ្យអ្នកចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ សូមទូរស័ព្ទទៅលេខដែលបានផ្តល់ជូនសម្រាប់រដ្ឋឬតំបន់របស់អ្នកដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ។

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다. Kaiser Permanente를 통한 귀하의 보험 신청서나 보험 보장 범위에 관해 질문이 있을 경우 또는 이 통지서의 요구대로 어느 날짜까지 조치를 취해야만 하는 경우, 귀하의 주 및 지역의 제공된 전화번호로 연락해 통역사와 통화하십시오.

ລາວ (Laotian): ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັຽຄ່າ. ຖ້າວ່າ ທ່ານມີຄໍາຖາມກ່ຽວກັບການສະໝັກຂອງທ່ານ ຫຼື ການຄຸມຄອງຜ່ານ Kaiser Permanente, ຫຼື ຖ້າອັນນີ້ເປັນແຈ້ງການທີ່ຮຽກຮ້ອງໃຫ້ທ່ານດໍາເນີນການພາຍໃນວັນທີ່ເຈາະຈົງໃດໜຶ່ງ, ໃຫ້ໂທຕາມພາຍເລກທີ່ໃຫ້ໄວ້ສໍາລັບລັດ ຫຼື ເຂດຂອງທ່ານ ເພື່ອຂໍລິມັດຖານພາສາ.

Kajin Majōl (Marshallese): Ewōr jimwe eo aṃ in bōk jipañ ilo kajin eo aṃ ejjelōk wōṇāān. Ñe ewōr aṃ kajjitōk kōn peba in aplaiki eo aṃ ak insurance eo aṃ jān Kaiser Permanente, ak ñe enaan in kōjeļā in ej aikuj bwe kwōn ṃakūtūt ṃokta jān juon raan eo eṃōj an kallikkar, kaļok nōṃba eo ej leļok ñan state eo aṃ ak jikūṃ bwe kwōn maroñ kōnono ippān juon ri-ukōt.

Naabeehó (Navajo): T'áá ni nizaad bee níká i'doolwoł doo bik'é asíníááagóó éi bee náhaz'á. Kaiser Permanente áká aná'álwo' ná bik'é azláadoo yínikeedgo naaltsoos hadinílaa, éi bína'idílkid doogo, éi doodago díí naaltsoos haa'ida yookáalgo hait'áoda i'díilííł nílñiigo éi nitsaa hahoodzojí éi doodago t'áá aadi nahós'a'di ata' dahalne'ígíí bich'í' hólne'go bee bíł ahíł hodíílnih.

नेपाली (Nepali): तपाईंसँग कुनै शुल्क नदिए आफ्नो भाषामा सहायता पाउने अधिकार छ । तपाईंसँग आफ्नो आवेदन बारे वा Kaiser Permanente मार्फत कवरज बारेमा कुनै प्रश्नहरू भए, वा यो नोटिस अनुसार तपाईंले कुनै निर्धारित मितिमा कुनै कार्यवाही गर्नु पर्ने आवश्यकता भएमा, दोभाषेसंग कुराकानी गर्न तपाईंको राज्य वा क्षेत्रका लागि दिइएको नम्बरमा कल गर्नुहोस् ।

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa'ee iyyata keetii yookaan tajaajila Kaiser Permanente hammatu ilaalchisee gaaffii yoo qabaatte, yookaan yoo kun beeksisa guyyaa murtaa'e irratti tarkaanfii akka ati fudhattu gaafatu ta'e, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bilbiluudhaan turjumaana haasofsiisi.

فارسی (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره درخواست یا پوشش خود در Kaiser Permanente سوالی داشته یا بر اساس این اعلامیه باید تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.

lokaiahn Pohnpei (Pohnpeian): Komw anehki pwung en rapahki sounkawehwe en omw palien lokaia ni sohte isaihs. Ma mie iren owmi kalelapak ohng aplikeisin de iren audepe kan ohng Kaiser Permanente, de ma pakair wet me anahne komwi en mwekid ohng rahn me kileledi, ah komw anahne koahl nempe me sansalehr ohng owmi palien wehi pwe komwi en lokaiaie ng owmi tungoal soun kawehwe.

Português (Portuguese): Você tem o direito de obter ajuda em seu idioma sem nenhum custo. Se você tiver dúvidas sobre sua solicitação ou cobertura por meio da Kaiser Permanente, ou se este aviso exigir que você tome alguma medida até uma data específica, ligue para o número fornecido para seu estado ou região para falar com um intérprete.

ਪੰਜਾਬੀ (Punjabi): ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਸੁਲਕ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮਦਦ ਪਾਉਣ ਦਾ ਹੱਕ ਹੈ. ਜੇਕਰ ਤੁਹਾਡੇ ਆਪਣੀ ਅਰਜ਼ੀ ਜਾਂ Kaiser Permanente ਰਾਹੀਂ ਕਵਰੇਜ ਬਾਰੇ ਸਵਾਲ ਹਨ, ਜਾਂ ਇਸ ਨੋਟਿਸ ਵਜੋਂ ਤੁਹਾਨੂੰ ਕਿਸੇ ਨਿਸ਼ਚਿਤ ਮਿਤੀ ਤੱਕ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪਵੇ, ਤਾਂ ਦੁਬਾਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਆਪਣੇ ਰਾਜ ਜਾਂ ਇਲਾਕੇ ਲਈ ਮੁਹੱਈਆ ਕਰਵਾਏ ਗਏ ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ.

Română (Romanian): Aveți dreptul de a solicita ajutor care să vă fie oferit în mod gratuit în limba dumneavoastră. Dacă aveți întrebări legate de solicitarea dumneavoastră sau de acoperirea oferită de Kaiser Permanente sau dacă acest aviz vă solicită să luați măsuri până la o anumită dată, sunați la numărul de telefon furnizat pentru statul sau regiunea dumneavoastră pentru a sta de vorbă cu un interpret.

Русский (Russian): У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно вашего заявления или медицинского страхования в Kaiser Permanente, либо если такое уведомление требует от вас каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.

Faa-Samoa (Samoan): E iai lou 'aia e maua se fesoasoani i lou gagana e aunoa ma le tofogi. Afai e iai ni fesili e uiga i lou tusi apalai po o puipuiga e ala mai Kaiser Permanente, po o lenei tusi e manaomia ona e gaoioi i se taimi atofaina, vili le numera ua fuafuaina mo lou setete po o oganuu e fesoota'i i se faaliliu.

Español (Spanish): Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de su solicitud o cobertura a través de Kaiser Permanente, o si este es un aviso que requiere que usted tome alguna medida antes de una fecha determinada, llame al número de teléfono que se proporciona para su estado o región para hablar con un intérprete.

Tagalog (Tagalog): Mayroon kang karapatang humingi ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong aplikasyon o coverage sa pamamagitan ng Kaiser Permanente, o kung ito ay abisong nangangailangan ng iyong aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap sa isang interpreter.

ไทย (Thai): ท่านมีสิทธิที่จะได้รับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย หากท่านมีคำถามเกี่ยวกับการสมัครของท่าน หรือความคุ้มครองผ่าน Kaiser Permanente หรือหากนี่คือหนังสือที่ต้องการให้ท่านดำเนินการภายในวันที่กำหนดไว้ โปรดติดต่อหมายเลขที่ให้ไว้สำหรับรัฐหรือเขตพื้นที่ของท่านเพื่อคุยกับล่าม

Lea Faka-Tonga (Tongan): 'Oku 'ia ho totonu ke ke ma'u ha fakatonulea ta'etotongi. Kapau 'oku 'i ai ha'ofehu'i ki ho tohi kole na'e fakafonu ki he malu'i 'inisua 'a e Kaiser Permanente, pea kapau ko e tohina 'oku fiema'u keke fai ha me'a ki ai pe ko ha 'aho na'e tuku pau atu ke fai ia, taa ki he fika kuo 'oatu ki ho siteiti pe ko e vahefonua 'oku ke 'i ai ke talanoa mo ha tokotaha tene fakatonu lea atu kiate koe.

Українська (Ukrainian): У Вас є право на отримання допомоги безкоштовно на Вашій рідній мові. Якщо Ви маєте питання стосовно Вашого звернення чи страхового покриття в Kaiser Permanente, чи якщо відповідно до такого повідомлення Вам треба буде здійснити певну дію до конкретної дати, подзвоніть по номеру, що відповідає Вашій країні чи регіону, щоб поговорити з перекладачем.

اردو (Urdu): آپ کو کوئی بھی قیمت ادا کرنے سے بغیر اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ اگر آپ کے ذہن میں اپنی درخواست یا Kaiser Permanente کے ذریعہ کوریج کے متعلق کوئی بھی سوالات ہیں، یا اگر اس نوٹس کی وجہ سے آپ کو کسی مخصوص تاریخ تک عمل انجام دینے کی ضرورت ہوگی تو، کسی مترجم سے بات چیت کرنے کے لئے آپ کی ریاست یا علاقہ کے لئے فراہم کئے گئے نمبر پر کال کریں۔

Tiếng Việt (Vietnamese): Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về mẫu đơn hoặc mức bảo hiểm của mình thông qua Kaiser Permanente, hoặc đây là thông báo yêu cầu quý vị thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.

Yorùbá (Yoruba): O ní ẹ̀tọ́ láti rí irànlọ́wọ́ gbà nípa èdè rẹ láisan owó. Bí o bá ní ibèèrè nípa iwé tí o kọ tàbí ìsedéédé nípaşẹ Kaiser Permanente, tàbí ifitonilétí yí jẹ èyí o nílò láti igbésẹ kan ní ojọ kan patọ, pé nọmbà tí a pèsè fún ipínlẹ tàbí agbègbè rẹ láti bá òngbifọ kan sọrọ.

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APPENDICES

Definitions

YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

SECTION 1: INTRODUCTION

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

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

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

KAISER PERMANENTE SIGNATURESM

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

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

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

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

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

WHO IS ELIGIBLE

General

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

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

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

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

Subscribers

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

Dependents

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

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

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

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

Disabled Dependent Certification

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

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

Genetic Information

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

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

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

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

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New Employees and Their Dependents

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

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

Special Enrollment

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

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

Special enrollment due to new Dependents

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

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

1. **For new Spouse or Domestic Partner**, no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber.
2. **For newborn children, the moment of birth.** If payment of additional Premium is required to provide coverage for the newborn child then, in order for coverage to continue beyond thirty-one (31) days from the date of birth, notification of birth and payment of additional Premium must be provided within thirty-one (31) days of the date of birth, otherwise coverage for the newborn will terminate thirty-one (31) days from the date of birth.
3. **For children, stepchildren, grandchildren, or adopted children who become eligible through Subscriber’s marriage, the date of the marriage.** If payment of additional Premium is required to provide coverage for the child(ren) then, in order for coverage to continue beyond thirty-one (31) days from the date of eligibility, notification of eligibility and payment of additional Premium must be provided within thirty-one (31) days of the date of eligibility, otherwise coverage for the newly eligible child(ren) will terminate thirty-one (31) days from the date of eligibility.
4. **For children, stepchildren, grandchildren, or adopted children who become eligible through Subscriber’s new Domestic Partner arrangement, the date of the signed Affidavit of Domestic Partnership.** If payment of additional Premium is required to provide coverage for the child(ren) then, in order for coverage to continue beyond thirty-one (31) days from the date of

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eligibility, notification of eligibility and payment of additional Premium must be provided within thirty-one (31) days of the date of eligibility, otherwise coverage for the newly eligible child(ren) will terminate thirty-one (31) days from the date of eligibility.

5. **For newly adopted children (including children newly placed for adoption),** the “date of adoption.” The “date of adoption” means the earlier of: (1) a judicial decree of adoption, or (2) the assumption of custody or placement with the Subscriber or Subscriber’s Spouse or Domestic Partner, pending adoption of a prospective adoptive child by a prospective adoptive parent.

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

6. **For a newly eligible grandchild, the date the grandchild is placed in your or your Spouse’s or Domestic Partner’s custody.** If payment of additional Premium is required to provide coverage for the child then, in order for coverage to continue, notification of the court ordered custody and payment of additional Premium must be provided within thirty-one (31) days of the date of the court ordered custody, otherwise coverage terminates thirty-one (31) days from the date of the court ordered custody.

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

Special Enrollment due to court or administrative order

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

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

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

If payment of additional Premium is required to provide coverage for the child, notification of the court or administrative order may be provided at any time but, payment of additional Premium must be provided within thirty-one (31) days of enrollment of the child, otherwise, enrollment of the child will be void.

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Enrollment for such child will be allowed in accordance with Section 15-405(c) of the Insurance Article which provides for the following:

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

Special enrollment due to loss of other coverage

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

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

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

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

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Special enrollment due to reemployment after military service

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

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

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

OPEN ENROLLMENT

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

PREMIUM

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

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SECTION 2: HOW TO OBTAIN SERVICES

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

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

1. Emergency Services, in Section 3: Benefits;
2. Urgent Care Outside our Service Area, in Section 3: Benefits;
3. Continuity of Care for New Members as described in this section;
4. Approved Referrals, as described in this section under “Getting a Referral,” including referrals for Clinical Trials as described in Section 3: Benefits;
5. Authorized Referrals; and
6. Visiting Other Kaiser Permanente Regions or Group Health Cooperative Service Areas, as described in this section.

YOUR PRIMARY CARE PLAN PHYSICIAN

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

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

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

To learn how to choose or change your primary care Plan Physician, contact Member Services:

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

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

TTY: 711

Our Member Services Representatives are available to assist you Monday through Friday from 7:30 a.m. until 9 p.m. ET.

CONTINUITY OF CARE FOR NEW MEMBERS

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

1. Accept a preauthorization issued by the member’s prior carrier, managed care organization or third party administrator; and
2. Allow a new enrollee to continue to receive health care Services being rendered by a non-Plan provider at the time of the member’s enrollment under this Agreement. If this Agreement is an

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Added Choice Point of Service (POS) plan the cost share will be covered at the In-Plan level as shown in the Summary of Services and Cost Shares.

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

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

GETTING A REFERRAL

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

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

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

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

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

For the most up-to-date list of Plan Medical Centers and other Plan Providers, visit our website at www.kp.org. To request a provider directory, please contact Member Services:

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

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

TTY: 711

STANDING REFERRALS TO SPECIALISTS

If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires specialized health care Services or medical care, your primary care Plan Physician may determine, in

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consultation with you and the specialist, that you need continuing care from the specialist. In such instances, your primary care Plan Physician will issue a standing referral to the specialist.

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

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

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

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

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

SECOND OPINIONS

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

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

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

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

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Getting Advice from our Advice Nurses

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

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

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

TTY: 711

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

Our advice nurses are registered nurses (RNs) specially trained to help assess medical problems and provide medical advice. They can help solve a problem over the phone and instruct you on self-care at home if appropriate. If the problem is more severe and you need an appointment, they will help you to get one.

MAKING APPOINTMENTS

When scheduling appointments it is important to have your identification card handy. If your primary care Plan Physician is located in a Plan Medical Center, please call:

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

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

TTY: 711

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

MISSED APPOINTMENT FEE

If you cannot keep a scheduled medical appointment, please notify your health care professional's office at least one (1) 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 Summary of Services and Cost Shares section of the Appendix. This fee will not count toward your Copayment 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 contacting Member Services:

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

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

TTY: 711

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

VISITING OTHER KAISER PERMANENTE REGIONS OR GROUP HEALTH COOPERATIVE SERVICE AREAS

As a Kaiser Permanente member visiting a different Kaiser Foundation Health Plan or allied plan Service Area, you can receive visiting member care from designated providers in that area. The covered Services, Copayments, Coinsurance and Deductibles may differ between your home region and the service area you are visiting, and are governed by the Kaiser Permanente visiting member program. This program does not cover certain Services, such as transplant Services or infertility Services. To receive more information about visiting member Services, and assistance with accessing care at Kaiser facilities across the United States, contact Member Services:

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

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

The following visiting member care is covered when it is provided or arranged by a Plan Physician in the service area you are visiting. Visiting member benefits may not be the same as those you receive in your home Service Area, and all services listed will be provided free of charge to you, with the exception of outpatient prescription drugs.

Hospital Inpatient Care:

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

Outpatient Care:

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

Laboratory and X-Ray:

1. Covered in or out of the hospital.

Outpatient Prescription Drugs:

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

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

1. Outpatient visits and inpatient hospital days.

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

1. Outpatient visits and inpatient hospital days.

Skilled Nursing Facility Care:

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

Home Health Care:

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

Hospice Care:

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

Pre-Authorization Required for Certain Services

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

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

Visiting Member Service Exclusions

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

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

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

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

PAYMENT TOWARD YOUR COST SHARE AND WHEN YOU MAY BE BILLED

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

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

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

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5. **You receive Services from a second provider during your visit.** For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay your Cost Share for the consultation with the specialist.

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SECTION 3: BENEFITS

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

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

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

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

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

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

A. OUTPATIENT CARE

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

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

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- iv. When used for staging in determining the need for a bone scan in patients with prostate cancer.
5. Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances, radiological imaging, for persons who are at high risk of cancer in accordance with the most recently published guidelines of the American Cancer Society;
6. Bone mass measurement for the prevention, diagnosis and treatment of osteoporosis is provided when the bone mass measurement is requested by a health care provider for a qualified individual. A “qualified individual” means:
 - a. An estrogen deficient individual at clinical risk for osteoporosis;
 - b. An individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
 - c. An individual receiving long-term gluco-corticoid (steroid) therapy;
 - d. An individual with primary hyper-parathyroidism; or
 - e. An individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
7. Outpatient surgery physician/surgical Services;
8. Anesthesia, including Services of an anesthesiologist;
9. Chemotherapy and radiation therapy;
10. Respiratory therapy;
11. Medical social services;
12. House calls when care can best be provided in your home as determined by a Plan Provider;
13. 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
14. Smoking cessation counseling program.

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

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

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

B. HOSPITAL INPATIENT CARE

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

1. Room and board (includes bed, meals and special diets), including private room when deemed Medically Necessary);
2. Specialized care and critical care units;
3. General and special nursing care;

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4. Operating and recovery room;
5. Plan Physicians' and surgeons' Services, including consultation and treatment by specialists;
6. Anesthesia, including Services of an anesthesiologist;
7. Medical supplies;
8. Chemotherapy and radiation therapy;
9. Respiratory therapy; and
10. Medical social Services and discharge planning.

Hospitalization and Home Health Visits Following Mastectomy

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

For a Member who remains in the hospital for at least forty-eight (48) hours following mastectomy, we cover the cost of a home visit if prescribed by the attending physician. Refer to the Home Health Care Benefit for home health visits covered following a mastectomy or removal of a testicle.

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

C. ACCIDENTAL DENTAL INJURY SERVICES

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

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

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

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

Accidental Dental Injury Services Exclusions:

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

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D. ALLERGY SERVICES

We cover the following allergy Services:

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

E. AMBULANCE SERVICES

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

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

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

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

Ambulance Services Exclusions:

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

F. ANESTHESIA FOR DENTAL SERVICES

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

1. For whom a superior result can be expected from dental care provided under general anesthesia; and
2. 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.

Additionally, we provide these Services to Members age:

1. 7 or younger or are developmentally disabled.
2. 17 or younger who is extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred, and for whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

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3. 17 and older when the Member's medical condition requires that dental service be performed in a hospital or ambulatory surgical center for the safety of the Member (e.g., heart disease and hemophilia).

General anesthesia and associated hospital and ambulatory facility charges will be covered only for dental care that is provided by:

1. A fully accredited specialist in pediatric dentistry; or
2. A fully accredited specialist in oral and maxillofacial surgery; and
3. For whom hospital privileges have been granted.

Anesthesia for Dental Services Exclusions:

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

G. BLOOD, BLOOD PRODUCTS AND THEIR ADMINISTRATION

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

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

Blood, Blood Products and their Administration Limitations:

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

Blood, Blood Products and their Administration Exclusions:

- Directed blood donations.

H. CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES

Mental Illness, Emotional Disorders, Drug and Alcohol Abuse Services

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

We cover inpatient in a licensed or certified facility or program, including a licensed or certified residential treatment center. Covered Services include all medical Services of physicians and other health professionals as performed, prescribed or directed by a Physician including:

1. Individual therapy;
2. Group therapy;

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

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

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

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

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

Chemical Dependency and Mental Health Services Exclusions:

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

Psychiatric Residential Crisis Services

We cover residential crisis Services that are:

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

Psychiatric Residential Crisis Services Exclusion:

- Long-term residential treatment Services.

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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 (1) treatment for a life-threatening condition; or (2) prevention, early detection and 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:

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

We cover the patient costs incurred for clinical trials if:

1. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III or Phase IV clinical trial for cancer or any other life-threatening condition;
2. The treatment is being provided in a clinical trial approved or funded by:
 - a. One of the National Institutes of Health (NIH);
 - b. An NIH cooperative group or an NIH center;
 - c. The United States Food and Drug Administration (FDA) in the form of an investigational new drug application, including drug trials that are exempt from having an investigational new drug application reviewed by the FDA;
 - d. The Federal Department of Veterans Affairs;
 - e. 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;
 - f. Centers for Disease Control and Prevention (CDC);
 - g. The Agency for Health Care Research and Quality;
 - h. The Centers for Medicare & Medicaid Services;
 - i. The Department of Defense;
 - j. A cooperative group or center for the four previously mentioned entities;
 - k. A cooperative group or center for the Department of Veterans Affairs;
 - l. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
 - m. The Department of Energy.
3. 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;
4. There is no clearly superior, non-investigational treatment alternative; and

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5. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.

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

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

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

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

Diabetic Equipment, Supplies and Self-Management Limitation:

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

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

L. DIALYSIS

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

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

We cover the following renal dialysis services:

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

We cover the following self-dialysis services:

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

We cover home dialysis, which includes:

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

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

M. DRUGS, SUPPLIES AND SUPPLEMENTS

We cover 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 Center or during home visits:

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

Note: Additional Services that require administration or observation by medical personnel are covered. See: the Outpatient Prescription Drug Rider, if applicable, for coverage of self-administered outpatient prescription drugs, "Preventive Health Services" for coverage of vaccines and immunizations that are part

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of routine preventive care; “Allergy Services” for coverage of allergy test and treatment materials; and “Family Planning Services” for the insertion and removal of contraceptive drugs and devices.

Drugs, Supplies and Supplements Exclusions

- Drugs for which a prescription is not required by law.
- Drugs, supplies, and supplements that can be self-administered or do not require administration or observation by medical personnel.
- Drugs for the treatment of sexual dysfunction disorders.
- Drugs for the treatment of infertility. Refer to Infertility Services for coverage of administered drugs necessary for in vitro fertilization.

N. DURABLE MEDICAL EQUIPMENT

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

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

Basic Durable Medical Equipment

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

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

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

Supplemental Durable Medical Equipment

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

Oxygen and Equipment

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

Positive Airway Pressure Equipment

We cover continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BIPAP) equipment when prescribed by a Plan Provider and your medical condition meets Health Plan’s criteria

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for being Medically Necessary. A Plan Provider must certify the continued medical need for positive airway pressure equipment.

Apnea Monitors

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

Asthma Equipment

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

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

Bilirubin Lights

We cover bilirubin lights for infants who are under age 3, for a period not to exceed six (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 the Health Plan.

O. EMERGENCY SERVICES

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

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

We cover Emergency Services as follows:

Inside our Service Area:

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

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Outside of our Service Area:

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

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

Continuing Treatment Following Emergency Services

Inside our Service Area

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

Inside another Kaiser Permanente Region

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

Outside our Service Area

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

Continuing Treatment Following Emergency Surgery

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

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

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

Transport to a Service Area

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

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

Continued Care in Non-Plan Facility Limitation

If you are admitted to a non-Plan Hospital, you or someone on your behalf must notify us within the later of forty-eight (48) hours of any hospital admission, or on the 1st business day following the admission, unless it was not reasonably possible to notify us within that time. We will decide whether to make

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arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us, or if you choose not to be transferred, we will not cover any Services you receive after transfer would have been possible.

Filing Claims for Non-Plan Emergency Services

Keep all your receipts for Emergency Services provided by non-Plan Providers and verify that the non-Plan Provider has submitted the claims. All claims must be filed with us within one (1) year of receipt of covered Services. Failure to submit such a request within one (1) year of receipt of the covered services will not invalidate or reduce the amount of the claim, if it was not reasonably possible to submit the request within the aforementioned time frame. If it is not reasonably possible to submit the claim within one (1) year after the date of service, it shall be sent to us no later than two (2) years from the time, proof is otherwise required. A Member's legal incapacity shall suspend the time to submit a claim. Such suspension period ends when legal capacity is regained.

Emergency Services Limitations:

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

P. FAMILY PLANNING SERVICES

We cover the following:

1. Women's Preventive Services (WPS), including:
 - a. Patient education and contraceptive method counseling for all women of reproductive capacity;
 - b. Coverage for FDA-approved contraceptive devices, hormonal contraceptive methods, the insertion or removal of contraceptive devices, including any Medically Necessary examination associated with the use of contraceptive drugs and devices;
 - c. Female sterilization;
 - i. Note: WPS are preventive care and are covered at no charge.
2. Additional family planning counseling, including pre-abortion and post-abortion counseling;

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3. Vasectomies; and
4. Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (1) the fetus suffers from a chromosomal, major metabolic or anatomic defect or (2) 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 (2) voluntary terminations of pregnancy during a contract year.

Note: Diagnostic procedures are not covered under this section (see “X-ray, Laboratory and Special Procedures”).

Q. HABILITATIVE SERVICES

Children under age 19

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

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

Habilitative Services Exclusions:

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

R. HEARING SERVICES

Hearing Exams

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

Hearing Aids for Children

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

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

Hearing Services Exclusions:

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

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

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- Replacement of lost or broken hearing aids.
- Comfort, convenience or luxury equipment or features.

S. HOME HEALTH CARE

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

1. Skilled nursing care;
2. Home health aide Services; and
3. Medical social services.

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

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

Home Health Visits Following Mastectomy or Removal of Testicle

For a Member who remains in the hospital for at least forty-eight (48) hours following mastectomy, we cover the cost of a home visit if prescribed by the attending physician.

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

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

If a visit maximum applies, the maximum will not include home visits following mastectomy or testicle removal; and home visits following mastectomy or testicle removal do not count toward the visit maximum.

Home Health Care Limitations:

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

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

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

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Home Health Care Exclusions:

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

T. HOSPICE CARE SERVICES

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

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

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

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U. INFERTILITY SERVICES

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

1. Artificial insemination; and
2. In vitro fertilization, if:
 - a. For a Member whose Spouse is of the opposite sex, the Member's oocytes are fertilized with the Member's spouse's sperm; unless:
 - i. The Spouse is unable to produce and deliver functional sperm; and the inability to produce and deliver functional sperm does not result from:
 - (a) A vasectomy; or
 - (b) Another method of voluntary sterilization.
 - b. The Member and the Member's spouse have a history of involuntary infertility, which may be demonstrated by a history of:
 - i. Intercourse of at least two (2) years' duration failing to result in pregnancy when the Member and the Member's Spouse are of opposite sexes; or
 - ii. If the Member and the Member's Spouse are of the same sex, six (6) attempts of artificial insemination over the course of two (2) years failing to result in pregnancy.
 - c. The infertility is associated with any of the following:
 - i. Endometriosis;
 - ii. Exposure in utero to diethylstilbestrol, commonly known as DES;
 - iii. Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
 - iv. Abnormal male factors, including oligospermia, contributing to the infertility.
 - d. The Member has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this EOC; and
 - e. The in vitro fertilization procedures are performed at medical facilities that conform to applicable guideline or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.
 3. Intracytoplasmic Sperm Injection (ICSI) if the Member meets medical guidelines;
 4. Preimplantation Genetic Diagnosis (PGD) if the Member meets medical guidelines.

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

Infertility Limitations:

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

Infertility Exclusions:

- Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member's eggs and/or male Member's sperm for future attempts.
- Any charges associated with donor eggs, donor sperm or donor embryos.
- Infertility Services, except for covered Services for in vitro fertilization, when the Member does not meet medical guidelines established by the American College of Obstetricians and Gynecologists.
- Services to reverse voluntary, surgically induced infertility.

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- Infertility Services when the infertility is the result of an elective male or female sterilization surgical procedure.
- Assisted reproductive technologies and procedures other than those described above, including, but not limited to: gamete intrafallopian transfers (GIFT); zygote intrafallopian transfers (ZIFT); and prescription drugs related to such procedures.

V. INFUSION THERAPY SERVICES

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

W. MATERNITY SERVICES

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

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

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

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

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

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

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

Comprehensive lactation (breastfeeding) education and counseling, by trained clinicians during pregnancy and/or postpartum period in conjunction with each birth, Breastfeeding equipment is issued,

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per pregnancy. The breast feeding pump (including any equipment that is required for pump functionality) is covered at no cost sharing to the member.

Maternity Services Exclusions:

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

X. MEDICAL FOODS

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

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

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

Medical Foods Exclusions:

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

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

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

1. Immunoglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins;
2. Severe food protein induced enterocolitis syndrome;
3. Eosinophilic disorders, as evidenced by the results of a biopsy; and
4. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

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

Amino Acid Based Elemental Formula Exclusions:

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

Y. MORBID OBESITY SERVICES

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

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

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

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

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

Z. ORAL SURGERY

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

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

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

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

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

1. Evidenced through documented medical records showing significant impairment in speech or a nutritional deficit; and
2. Based on examination of the Member by a Plan Provider.

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

The Health Plan provides coverage for cleft lip, cleft palate or both under a separate benefit. Please see "Cleft Lip, Cleft Palate or Both" in Section 3: Benefits.

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.
- Services for TMJ.
- Orthodontic services.
- Dental appliances.

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AA. PREVENTIVE HEALTH CARE SERVICES

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

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

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

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

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

1. Preventive care exams, including:
 - a. Routine physical examinations and health screening tests appropriate to your age and sex;
 - b. Well-woman examinations; and
 - c. Well child care examinations.
2. Routine and necessary immunizations (travel immunizations are not preventive and are covered under Outpatient Services in this section) for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;
3. An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
4. Breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society. The Deductible, if any, will not apply to this provision;
5. Bone mass measurement to determine risk for osteoporosis;
6. Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to men who are age 40 or older;

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7. Colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society;
8. Cholesterol test (lipid profile);
9. Diabetes screening (fasting blood glucose test);
10. Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis and HPS), subject to the following:
 - a. Annual chlamydia screening is covered for (1) women under age 20, if they are sexually active; and (2) women age 20 or older; and men of any age, who have multiple risk factors, which include: (1) a prior history of sexually transmitted diseases; (2) new or multiple sex partners, (3) inconsistent use of barrier contraceptives or (4) cervical ectopy;
 - b. Human Papillomavirus Screening (HPS) at the intervals recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists.
11. HIV tests;
12. TB tests;
13. Hearing loss screenings for newborns provided by a hospital prior to discharge; and
14. Associated preventive care radiological and lab tests not listed above.

Preventive Health Services Limitations:

While treatment may be provided in the following situations, the following services are not considered Preventive 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.
- Services provided when you show signs or symptoms of a specific disease or disease process.
- Non-routine gynecological visits.

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

BB. 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 not ill or injured. Coverage includes fitting and adjustment of these devices, repair or replacement (unless due to loss or misuse), and Services to determine whether you need the prosthetic. 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 prosthetic that is considered Medically Necessary by meeting the indications and limitations of coverage and medical necessity established under the Medicare Coverage Database.

Internally Implanted Devices

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

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Artificial Arms, Legs or Eyes

We cover:

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

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

Ostomy and Urological Supplies and Equipment

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

Breast Prosthetics and Hair Prosthesis

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

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

Prosthetic Device Limitations:

- Coverage for mastectomy bras is limited to a maximum of two (2) per contract year.
- Coverage for hair prosthesis is limited to one (1) prosthesis per course of chemotherapy and/or radiation therapy, not to exceed a maximum benefit of \$350 per prosthesis.

Prosthetic Device Exclusions:

- Internally implanted breast prosthetics for cosmetic purposes.
- External prosthetics or orthotics, except as specifically provided in this section, or as provided under a "Prosthetic and Orthotic Devices Rider," if applicable.
- Repair or replacement of prosthetics due to loss or misuse.
- Microprocessor and robotic-controlled external prosthetics not covered under the Medicare Coverage Database.

CC. RECONSTRUCTIVE SURGERY

We cover reconstructive surgery (1) to correct significant disfigurement resulting from an injury or Medically Necessary surgery, (2) to correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function, and (3) to treat congenital hemangioma known as port wine stains on the face for Members age 18 or younger. Breast augmentation is covered only if determined to be Medically Necessary.

Following mastectomy, we cover reconstructive breast surgery and all stages of reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

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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, or are not likely to result in significant improvement in physical function. Examples of excluded cosmetic dermatology services are:

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

DD. SKILLED NURSING FACILITY CARE

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

We cover the following Services:

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

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

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

Skilled Nursing Facility Care Exclusions:

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

EE. TELEMEDICINE SERVICES

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

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

Telemedicine Services Exclusion:

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

FF. THERAPY AND REHABILITATION SERVICES

Physical, Occupational and Speech Therapy Services

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

1. While you are confined in Plan Hospital; and
2. For up to thirty (30) visits of physical therapy, ninety (90) consecutive days of occupational therapy, and ninety (90) consecutive days of speech therapy per contract year per injury, incident or condition in a Plan Medical Center, a Plan Provider's medical office, a Skilled Nursing Facility or as part of home health care. These limits do not apply to necessary treatment of cleft lip or cleft palate.

Physical, Occupational and Speech Therapy Limitations:

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

Multidisciplinary Rehabilitation Services

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

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

Cardiac Rehabilitation Services

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

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

Therapy and Rehabilitation Services Exclusions:

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

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GG. TRANSPLANTS

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

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

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

1. Unless otherwise authorized by Medical Group, transplants are covered only in our Service Area.
2. If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for transplant, we will pay only for covered Services you receive before that determination was made.
3. Health Plan, Plan Hospitals, Medical Group and Plan Providers are not responsible for finding, furnishing, or ensuring the availability of a bone marrow or organ donor.
4. We cover reasonable medical and hospital expenses as long as these expenses are directly related to a covered transplant for a donor, or an individual identified by Medical Group as a potential donor even if not a Member.

Transplant Exclusions:

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

HH. URGENT CARE

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

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

Inside our Service Area:

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

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

If your primary care Plan Physician is located at a Plan Medical Center please call:

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

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

TTY: 711

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

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Outside of our Service Area:

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

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

Follow-up Care for Emergency Surgery

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

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

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

Urgent Care Limitations:

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

Urgent Care Exclusions:

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

II. VISION SERVICES

Medical Treatment

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

Eye Exams

We cover routine and necessary eye exams, including:

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

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Pediatric Eye Exams

We cover the following for children under age 19:

One routine eye exam per year, including

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

Pediatric Lenses and Frames

We cover the following for children under age 19 at no charge:

1. One (1) pair of lenses per year;
2. One (1) pair of frames per year from a select group of frames;
3. Regular contact lenses (in lieu of lenses and frames) up to a three (3)-month supply per year; or
4. Medically Necessary contact lenses up to two (2) pair per eye per year.

In addition, we cover the following Services:

Eyeglass Lenses

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

Frames

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

Contact Lenses

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

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

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

Vision Exclusions:

- Sunglasses without corrective lenses unless Medically Necessary.
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures.
- Eye exercises.
- Non-corrective contact lenses.

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- Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section.
- Replacement of lost or broken lenses or frames.
- Orthoptic (eye training) therapy.

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 section (for example, diagnostic imaging and laboratory tests are covered for outpatient Services only to the extent the outpatient Services are covered under “Outpatient Care”):

1. Diagnostic imaging;
2. Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
3. Special procedures, such as:
 - a. Electrocardiograms;
 - b. Electroencephalograms; and
 - c. Bone mass measurement for the diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A “qualified individual” means:
 - i. An estrogen deficient individual at clinical risk for osteoporosis;
 - ii. An individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
 - iii. An individual receiving long-term gluco-corticoid (steroid) therapy;
 - iv. An individual with primary hyper-parathyroidism; or
 - v. An individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
4. Sleep lab and sleep studies; and
5. Specialty imaging, including CT, MRI, PET Scans, Nuclear Medicine studies and interventional radiology.

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

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SECTION 4: EXCLUSIONS, LIMITATIONS AND REDUCTIONS

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

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

IMPORTANT DEFINITIONS

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

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

EXCLUSIONS

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

Alternative Medical Services

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

Certain Exams and Services

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

Cosmetic Services

Services that 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 Section 3: Benefits.

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.

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Dental Care

Dental care and dental X-rays, including dental appliances, dental implants, orthodontia, shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any dental treatment involved in temporomandibular joint (TMJ) pain dysfunction syndrome, unless otherwise covered under a Rider attached to this EOC. This exclusion does not apply to medically necessary dental care covered under “Accidental Dental Injury Services,” “Cleft Lip, Cleft Palate or Both” or “Oral Surgery” in Section 3: Benefits.

Disposable Supplies

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

Durable Medical Equipment

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

Employer or Government Responsibility

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

Experimental or Investigational Services

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

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

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

1. Your medical records;
2. Written protocols or other documents pursuant to which the Service has been or will be provided;
3. Any consent documents you or your representative has executed or will be asked to execute, to receive the Service;

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

Health Plan consults the 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 Section 3: Benefits, 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. This exclusion does not exclude Services when you are under active treatment for a metabolic or peripheral vascular disease.

Services for Members in the Custody of Law Enforcement Officers

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

Surrogacy Arrangements

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

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

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

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

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

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

Travel and Lodging Expenses

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

Travel Immunizations

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

Vision Services

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

Workers’ Compensation or Employer’s Liability

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

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

LIMITATIONS

We will use our best efforts to provide or arrange for covered Services in the event of unusual circumstances that delay or render impractical the provision of Services such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel of a Plan Hospital or Plan Medical

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Center, complete or partial destruction of facilities, and labor disputes not involving the Health Plan, Kaiser Foundation Hospitals, or Medical Group. However, Health Plan, Kaiser Foundation Hospitals, Medical Group, and Medical Group Physicians shall be liable for reimbursement of the expenses necessarily incurred by a Covered Person in procuring the Services through other providers, to the extent prescribed by the Insurance Commissioner of Maryland.

REDUCTIONS

Injury or Illness Caused by Third Party

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

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

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

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

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

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

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

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

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

Medicare and TRICARE Benefits

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

Coordination of Benefits (COB)

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

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

Definition

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

If you have any questions about COB, please call Member Services:

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

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

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

TTY: 711

Order of Benefit Determination Rules

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

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

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

1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two (2) Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
2. **Dependent Child Covered Under More Than One (1) Plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one (1) Plan the order of benefits is determined as follows:
 - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
 - ii. If both parents have the same birthday, the Plan that has covered the parent the longest is Primary plan.
 - b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - i. If a court decree states that one (1) of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph a above shall determine the order of benefits;

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- iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph a above shall determine the order of benefits; or
- iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial parent;
 - (b) The Plan covering the spouse of the Custodial parent;
 - (c) The Plan covering the non-custodial parent; and then
 - (d) The Plan covering the spouse of the non-custodial parent.
- c. For a dependent child covered under more than one (1) Plan of individuals who are the parents of the child, the provisions of Subparagraph a or b above shall determine the order of benefits as if those individuals were the parents of the child.
- d. (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in item 2g applies; (ii) in the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in item 2a to the dependent child's parent(s) and the dependent's spouse.
- e. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if paragraph 1 can determine the order of benefits.
- f. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if paragraph 1 can determine the order of benefits.
- g. **Longer or Shorter Length of Coverage.** The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
- h. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

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Effect of COB on the Benefits of this Plan

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

1. **Coordination with This Plan's Benefits.** The Health Plan may coordinate benefits payable or may recover the reasonable cash value of Services it has provided when the sum of:
 - a. The benefits that would be payable for, or the reasonable cash value of, the Services provided as Allowable Expenses by the Health Plan in the absence of this COB provision; and
 - b. The benefits that would be payable for Allowable Expenses under one (1) or more of the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim thereon is made; exceeds Allowable Expenses in a Claim Determination Period. In that case, the Health Plan benefits will be coordinated, or a portion of the reasonable cash value of any Services provided by the Health Plan may be recovered, from the Primary Plan, so that they and the benefits payable under the other Plans do not total more than the Allowable Expenses.
2. **Right to Reserve and Release Needed Information.** Certain information is needed to apply these COB rules. The Health Plan will decide the information it needs, and may get that information from, or give it to, any other organization or person. The Health Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under the Health Plan must give the Health Plan any information it needs.
3. **Facility of Payment.** If a payment made or service provided under another Plan includes an amount that should have been paid or provided by or through the Health Plan, the Health Plan may pay that amount to the organization which made that payment. The amount paid will be treated as if it was a benefit paid by the Health Plan.
4. **Right of Recovery.** If the amount of payments by the Health Plan is more than it should have paid under this COB provision, or if it has provided Services that should have been paid by the Primary Plan, the Health Plan may recover the excess or the reasonable cash value of the Services, as applicable, from one or more of:
 - a. The persons it has paid or for whom it has paid;
 - b. Insurance companies; or
 - c. Other organizations.
5. **Benefit Reserve Account.** When the Health Plan does not have to pay full benefits, or recovers the reasonable cash value of the Services provided because of COB, the savings will be credited to the Member in a Benefit Reserve Account. These savings can be used by the Member for any unpaid Covered Expense during the calendar year. A Member may request detailed information concerning the Benefits Reserve Account from the Health Plan's Patient Accounting Department.

Military Services

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

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

GETTING ASSISTANCE

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

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

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

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

TTY: 711

IMPORTANT DEFINITIONS

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

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

THE HEALTH CARE SERVICE REVIEW PROGRAM

Pre-Service Reviews

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

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

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

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

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

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

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

Expedited Pre-Service Reviews

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

Concurrent Reviews

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

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

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

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

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

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

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

Filing for Payment/Reimbursement of a Post Service Claim

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

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

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

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

Post-Service Claim Reviews

Health Plan will make its determination on post-service review within thirty (30) days of receiving a claim. If we do not have the necessary information to make our decision, we will notify you or your Authorized Representative of the need for additional information within three calendar days of the initial

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request and explain in detail what information is required. You must respond to requests for additional information within thirty (30) calendar days or we will make our decision based upon the information we have available to us at that time.

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

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

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

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

INTERNAL GRIEVANCE AND APPEAL PROCESSES

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

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

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

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

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

MARYLAND INSURANCE COMMISSIONER

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

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

The Maryland Insurance Commissioner may be contacted at:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeal and Grievance
200 St. Paul Place
Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000

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Toll free/out-of-area: 1-800-492-6116

TTY: 1-800-735-2258

Fax: 410-468-2260 or 410-468-2270

INTERNAL GRIEVANCE PROCESS

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

Initiating a Grievance

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

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

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

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

Grievance Acknowledgment

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

Pre-service Grievance

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

Post-service Grievance

If the Grievance is asking for payment for Health Care Services already rendered, a retrospective acknowledgment letter will be sent requesting additional information that may be necessary within five

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(5) working days after the filing date. We will also inform you and your Authorized Representative that a decision will be made in writing and such written notice will be made within the earliest of forty-five (45) working days or sixty (60) calendar days of the filing date of the Grievance.

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

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

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

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

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

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

EXPEDITED GRIEVANCES FOR EMERGENCY CASES

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

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

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

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

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

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

NOTICE OF ADVERSE GRIEVANCE DECISION

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

1. The specific factual basis for the decision in clear understandable language;
2. References to any specific criteria or standards on which the decision was based, including but not limited to interpretive guidelines used by us;
3. A statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request. In addition, you or your Authorized Representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of your or your Authorized Representative's claim;
4. The name, business address and business telephone number of the medical director who made the Grievance Decision;
5. A description of your or your Authorized Representative's right to file a complaint with the Commissioner within four (4) months after receipt of our Grievance Decision;
6. The Commissioner's address and telephone and facsimile numbers;

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7. A statement that the Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a complaint about the Health Plan with the Commissioner;
8. The Health Education and Advocacy Unit's address, telephone and facsimile numbers and electronic mail address; and
9. The Health Plan must provide notice of an adverse decision in a non-English language if certain thresholds are met for the number of people who are literate in the same non-English language. A threshold language applies to a county if at least 10 percent of the population is literate only in the same foreign language that is identified as a federally mandated non-English language. If we send you a notice of an adverse decision to an address in a county where a federally-mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. You or your Authorized Representative may request translation of the notice by contacting Member Services.

INTERNAL APPEAL PROCESS

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

Initiating an Appeal

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

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

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

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

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

Along with your appeal, you may also send additional information including comments, documents or additional medical records which you believe supports your claim. If we had asked for additional information before and you did not provide it, you may still submit the additional information with your appeal. In addition, you may also provide testimony in writing or by telephone. Written testimony may be

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sent along with your appeal to the address listed above. To arrange to give testimony by telephone, you may contact the Member Services Appeal Unit. The Health Plan will add all additional information to your claim file and will revise all new information without regard to whether this information was submitted and/or considered in its initial decision.

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

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

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

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

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FILING COMPLAINTS ABOUT THE HEALTH PLAN

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

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

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SECTION 6: TERMINATION OF MEMBERSHIP

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

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

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

TERMINATION DUE TO LOSS OF ELIGIBILITY

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

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

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

TERMINATION OF GROUP AGREEMENT

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

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

TERMINATION FOR CAUSE

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

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

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

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

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

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

TERMINATION FOR NONPAYMENT

Nonpayment of Premium

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

EXTENSION OF BENEFITS

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

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

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

Limitations

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

1. Failure to pay Premium by the Member;
2. Members’ whose coverage ends because of fraud or material misrepresentation by the Member;
3. When coverage is provided by another health plan and that health plan’s coverage:

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- a. Is provided at a cost to the individual that is less than or equal to the cost to the individual of the extended benefit available under this EOC; and
- b. Will not result in an interruption of benefits to the Member.

Discontinuation of a Product or All Products

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

CONTINUATION OF GROUP COVERAGE UNDER FEDERAL LAW

COBRA

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

USERRA

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

CONTINUATION OF COVERAGE UNDER STATE LAW

Death of the Subscriber

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

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

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

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- c. Acceptance of coverage under any non-group health insurance plan or health maintenance organization; or
- d. Dependent Child that ceases to qualify as a as a dependent child under dependent eligibility requirements; or
- e. Expiration of eighteen (18) calendar months after the death of the Subscriber; or
- f. Termination by the Subscriber.

Divorce of the Subscriber and his/her Spouse

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

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

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

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

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

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

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- e. Expiration of eighteen (18) calendar months after the termination of Subscriber's employment; or
- f. Termination by the Subscriber.

Coverage under the Continuation Provision of Group's Prior Plan

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

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

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

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SECTION 7: MISCELLANEOUS PROVISIONS

ADMINISTRATION OF AGREEMENT

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

ADVANCE DIRECTIVES

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

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

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

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

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

TTY: 711

AMENDMENT OF AGREEMENT

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

APPLICATIONS AND STATEMENTS

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

ASSIGNMENT

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

ATTORNEY FEES AND EXPENSES

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

CONTESTABILITY

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

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

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

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

CONTRACTS WITH PLAN PROVIDERS

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

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

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

TTY: 711

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

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

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

GOVERNING LAW

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

NOTICE OF NON-GRANDFATHERED COVERAGE

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

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GROUPS AND MEMBERS NOT HEALTH PLAN'S AGENTS

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

MEMBER RIGHTS AND RESPONSIBILITIES

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

Member Rights

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

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

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

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

Member Responsibilities

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

1. Promote your own good health:

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

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2. Know and understand your plan and benefits:

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

3. Promote respect and safety for others:

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

NAMED FIDUCIARY

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

NO WAIVER

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

NONDISCRIMINATION

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

NOTICES

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

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

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

TTY: 711

OVERPAYMENT RECOVERY

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

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PRIVACY PRACTICES

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

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

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

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DEFINITIONS APPENDIX

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

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

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

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

Allowable Charges (AC): means either:

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

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

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

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

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

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

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

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

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

Commissioner: The Maryland Insurance Commissioner.

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

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

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

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

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

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

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

1. Are at least age 18;
2. Are not related to each other by blood or marriage within four (4) degrees of consanguinity under civil law rule;
3. Are not married or in a civil union or domestic partnership with another individual;
4. Have been financially interdependent for at least six (6) consecutive months prior to application in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely; and
5. Share a common primary residence.

Emergency Case: A case in which an Adverse Decision was rendered pertaining to Health Care Services which have yet to be delivered and such Health Care Services are necessary to treat a condition or illness

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that, without medical attention would (1) seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function or (2) cause the Member to be in danger to self or others.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Non-Physician Specialist: A health care provider who:

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

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

Plan: Kaiser Permanente.

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

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

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

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

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

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

Premium: Periodic membership charges paid by Group.

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

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

Service Area: The areas of the District of Columbia; the following Virginia counties – Arlington, Fairfax, King George, Loudoun, Spotsylvania, Stafford, Prince William, and specific ZIP codes within Caroline, Culpeper, Fauquier, Hanover, Louisa, Orange and Westmoreland; the following Virginia cities – Alexandria, Falls Church, Fairfax, Fredericksburg, Manassas and Manassas Park; the following Maryland areas: the City of Baltimore; the following Maryland counties: Anne Arundel, Baltimore, Carroll, Harford, Howard, Montgomery, and Prince George’s, and specific ZIP codes within Calvert,

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YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

Charles, and Frederick counties. A listing of these ZIP codes may be obtained from any Health Plan office.

Services: Health Care Services or items.

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

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

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

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

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

Totally Disabled:

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

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

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

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

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

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Summary of Services and Cost Shares

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

DEPENDENT AGE LIMIT

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

MEMBER COST-SHARE

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

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

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
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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
For children under 5 years of age	No charge
For children 5 years of age or older	\$15 per visit
Specialty care office visits	\$25 per visit
Consultations and immunizations for foreign travel	\$15 per visit
Outpatient surgery physician/surgical Services	No charge
Diagnostic testing (not preventive screening) as described under Outpatient Care in Section 3	Applicable Cost Shares will apply based on type and place of Service
Anesthesia	No charge
Chemotherapy and radiation therapy	\$25 per visit
Respiratory therapy	\$25 per visit
Medical social services	\$15 per visit
House calls	No charge

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Copayments and Coinsurance

Covered Service	You Pay
Hospital Inpatient Care All charges incurred during a covered stay as an inpatient in a hospital	No charge
Accidental Dental Injury Services	Applicable Cost Shares will apply, based on type and place of Service
Allergy Services Evaluations and treatment Injection visits and serum	Applicable Cost Shares will apply, based on type and place of Service 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 Non-emergent transportation Services (ordered by a Plan Provider)	No charge
Anesthesia for Dental Services Anesthesia and associated hospital or ambulatory Services for certain individuals only	Applicable Cost Shares will apply, based on type and place of Service
Blood, Blood Products and their Administration	No charge
Chemical Dependency and Mental Health Services Treatment of mental illness, emotional disorders, drug and alcohol abuse described in the “Benefits” section Inpatient psychiatric and substance abuse care, including detoxification Partial hospitalization Outpatient psychiatric and substance abuse care <ul style="list-style-type: none"> • Individual therapy • Group therapy Medication management visits Methadone treatment Psychiatric Residential Crisis Services All other outpatient Services	Applicable inpatient Cost Shares will apply \$15 per visit \$15 per visit \$7 per visit \$15 per visit \$15 per week, but not to exceed 50% of the daily cost of the treatment Applicable inpatient Cost Shares will apply \$15 per visit
Cleft Lip, Cleft Palate, or Both	Applicable Cost Shares will apply, based on type and place of Service
Clinical Trials	Applicable Cost Shares will apply, based on

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Copayments and Coinsurance

Covered Service	You Pay
	type and place of Service
Diabetic Equipment, Supplies and Self-Management Training	
Diabetic equipment and supplies	No charge
Self-management training	Applicable Cost Shares will apply, based on place of Service
Dialysis	
Inpatient care	Applicable inpatient Cost Shares will apply
Outpatient Care	\$25 per visit
Drugs, Supplies, and Supplements	
Administered by or under the supervision of a Plan Provider.	Applicable Cost Shares will apply, based on place of Service
Durable Medical Equipment	
Note: Applicable inpatient hospital cost shares will apply to equipment provided while you are confined as an inpatient.	
Basic Durable Medical Equipment	No charge
Supplemental Durable Medical Equipment	
<ul style="list-style-type: none"> • Oxygen and Equipment 	No charge for 1st 3 months; 50% of AC* each month thereafter
<ul style="list-style-type: none"> • Positive Airway Pressure Equipment 	No charge for 1st 3 months; 50% of AC* each month thereafter
<ul style="list-style-type: none"> • Apnea Monitors (under age 3, not to exceed a period of 6 months) 	No charge
<ul style="list-style-type: none"> • Asthma Equipment 	No charge
<ul style="list-style-type: none"> • Bilirubin Lights (under age 3, not to exceed a period of 6 months) 	No charge
Emergency Services	
Emergency Room Visits	\$100 per visit; Copayment waived if immediately admitted
<ul style="list-style-type: none"> • Inside the Service Area 	\$100 per visit; Copayment waived if immediately admitted
<ul style="list-style-type: none"> • Outside the Service Area 	\$100 per visit; Copayment waived if immediately admitted
Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit Copayment will not be waived.	
Family Planning	
Office visits	\$25 per visit
Vasectomy, Voluntary termination of pregnancy	Applicable Cost Shares will apply, based on type and place of Service
Women's Preventive Services, including all Food and Drug	

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KAISER PERMANENTE**

Copayments and Coinsurance

Covered Service	You Pay
Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity are covered under Preventive Care at no charge	
Habilitative Services	
Physical, Occupational or Speech Therapy	\$25 per visit
Applied Behavioral Analysis (ABA)	\$15 per visit
All other Services	Applicable Cost Share will apply based on type and place of Service
Hearing Services	
Hearing tests (newborn hearing screening tests are covered under preventive health care Services at no charge)	Applicable office visit Cost Share will apply based on place of Service
Hearing aids for children under age 18	
<ul style="list-style-type: none"> • Hearing aid tests 	Applicable Cost Share will apply based on type and place of Service
<ul style="list-style-type: none"> • Hearing aids (Limited to a hearing aid per ear every 36 months.) 	No charge
Home Health Care	
The visit maximum does not apply to home visits following mastectomy or testicle removal; or postpartum home visits.	No charge
Hospice Care	
	No charge
Infertility Services	
Office visits	50% of AC*
Inpatient Hospital Care	50% of AC*
All other Services for treatment of infertility	50% of AC*
Note: Coverage for in vitro fertilization is limited to a maximum of three attempts per live birth, not to exceed a maximum lifetime benefit of \$100,000.	
Infusion Therapy Services	
	Applicable Cost Shares will apply, based on type and place of Service
Maternity Services	
Inpatient Services	No charge
Prenatal and postpartum visits (after confirmation of pregnancy), including diagnostic tests	No charge
Postpartum home health visits	No charge
Breast Pumps	No charge

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

Copayments and Coinsurance

Covered Service	You Pay
Maternity Services that are required by the Affordable Care Act are covered under Preventive Care Services at no charge.	
Medical Foods (including Amino Acid-based Elemental Formula)	25% of AC*
Medical Nutrition Therapy & Counseling	\$15 per visit
Morbid Obesity Services	Applicable Cost Shares will apply based on type and place of Service
Oral Surgery	Applicable Cost Shares will apply based on type and place of Service
Preventive Health Care Services	No charge
Prosthetic Devices	
Internally implanted devices	No charge
Replacements for legs, arms or eyes, and their components and repair	No charge
Ostomy and urological supplies	No charge
Breast prosthetics	No charge
Hair Prosthesis (Limited to a maximum of \$350 per course of chemotherapy and/or radiation therapy)	No charge
Reconstructive Surgery	Applicable Cost Shares will apply based on place and type of Service.
Skilled Nursing Facility Care Limited to a maximum benefit of 100 days per contract year	No charge
Telemedicine Services	No charge
Therapy and Rehabilitation Services (Refer to Section 3 for benefit maximums)	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	\$25 per visit
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	

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

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

Copayments and Coinsurance

Covered Service	You Pay
Office visit during regular office hours	Applicable office visit Cost Share will apply
After-Hours Urgent Care or Urgent Care Center	\$25 per visit

Vision Services

Eye exams (for adults age 19 or older)	
<ul style="list-style-type: none"> • By an Optometrist 	\$15 per visit
<ul style="list-style-type: none"> • By an Ophthalmologist 	\$25 per visit
Eyeglass lenses and frames	You receive a 25% discount off retail price for eyeglass lenses and for eyeglass frames
Contact lenses	You receive a 15% discount off retail price on initial pair of contact lenses

Note: A child may select any pair of glasses in lieu of, or in addition to, the eyeglasses or contact lenses available at no charge under Vision Services for children below and receive the discount at any Plan Vision Center.

Vision Services (for children under age 19)

Eye exams	
<ul style="list-style-type: none"> • by an Optometrist 	\$15 per visit
<ul style="list-style-type: none"> • by an Ophthalmologist 	\$25 per visit
Eyeglass lenses and frames (Limited to a select group)	No charge for one pair per contract year
Contact lenses (Limited to a select group)	No charge for initial fit and first purchase per contract year
Medically necessary contact lenses (Limited to a select group)	No charge
Low Vision Aids (Unlimited from available supply)	No charge

X-ray, Laboratory and Special Procedures

Diagnostic imaging and laboratory tests	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	No charge
Specialty Imaging (including CT, MRI, PET Scans and Nuclear Medicine); Interventional Radiology and Special Procedures	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	No charge
Sleep lab	No charge
Sleep studies	\$25 per visit

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

YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

Copayments and Coinsurance

Covered Service

You Pay

Note: charges for covered outpatient diagnostic and laboratory tests performed in a Plan Physician's office are included in the office visit Copayment.

Out-of-Pocket Maximum

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

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

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

Out-of-Pocket Maximum Exclusions:

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

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

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

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

Annual Out-Of-Pocket Maximum Combined total of allowable Copayments and Coinsurance	
Individual Out-of-Pocket Maximum	\$2,250 per individual per contract year
Family Out-of-Pocket Maximum	\$4,500 per Family Unit per contract year

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

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

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

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

**OUTPATIENT PRESCRIPTION DRUG RIDER
GROUP EVIDENCE OF COVERAGE**

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

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

A. DEFINITIONS

Allowable Charge: Has the same meaning as defined in your EOC. See “Appendices - Definitions.”

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

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

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

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

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

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

FDA: The United States Food and Drug Administration.

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

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

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

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

Nicotine Replacement Therapy: A product that:

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

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

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

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

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

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

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

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

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

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

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

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

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

B. BENEFITS

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, dentist, or any licensed psychiatrist, whether or not the psychiatrist is a Plan Physician. Each prescription refill is subject to the same conditions as the original prescription. Plan Providers prescribe drugs in accordance with Health Plan's Preferred Drug List. If the Allowable Charge of the drug is less than the Rx Copayment, the Member will pay the lesser amount. You must obtain these drugs from a Plan Pharmacy or a Participating Network Pharmacy. It may be possible for you to receive prescription drugs and refills using our Mail Service Delivery Program; ask for details at a Plan Pharmacy.

1. FDA-approved drugs for which a prescription is required by law.
2. Compounded preparations containing at least one ingredient requiring a prescription and the ingredient is listed in our Preferred Drug List.
3. Insulin
4. Drugs that are FDA-approved for use as contraceptives, including over-the-counter contraceptives for women when prescribed by a Plan Provider, and diaphragms. For coverage of other types of contraception, including contraceptive injections, implants and devices, refer to "Family Planning Services" in Section 3: Benefits.
5. Nicotine Replacement Therapy, including over-the counter Nicotine Replacement Therapy when prescribed by a Plan Provider, for up to two 90-day courses of treatment per contract year.
6. Smoking cessation drugs that are approved by the FDA for the treatment of tobacco dependence, including over-the-counter Smoking cessation drugs when prescribed by a Plan Provider.
7. Off label use of drugs when a drug is recognized in Standard Reference Compendia or certain Medical Literature as appropriate in the treatment of the diagnosed condition.
8. Growth hormone therapy (GHT) for treatment of children under age 18 with a growth hormone deficiency.
9. Non-prescription drugs when they are prescribed by a Plan Provider and are listed on the Preferred Drug List.

The Pharmacy and Therapeutics Committee sets dispensing limitations in accordance with therapeutic guidelines based on the Medical Literature and research. The Committee also meets periodically to consider adding and removing prescribed drugs and accessories on the Preferred Drug List. If you would like information about whether a particular drug or accessory is included in our Preferred Drug List, please visit us online at www.kp.org, or call the Member Services Call Center at:

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

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

TTY: 711

Where to Purchase Covered Drugs

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

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

Generic and Preferred Drug Requirements

Generic vs. Brand Name Drugs

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

1. The provider has prescribed a Brand Name Drug and has indicated “dispense as written” (DAW) on the prescription; or
2. The Brand Name Drug is listed on our Preferred Drug List or
3. The Brand Name Drug is (1) prescribed by a Plan physician or by a dentist or a referral physician; 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.

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

Preferred vs. Non-Preferred Drugs

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

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

Dispensing Limitations

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

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

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

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

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 inside or 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. Claims should be submitted to:

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

D. LIMITATIONS

Benefits are subject to the following limitations:

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

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

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

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

E. EXCLUSIONS

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

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

16. Alternative formulations or delivery methods that are (1) different from the Health Plan’s standard formulation or delivery method for prescription drugs and (2) deemed not Medically Necessary.
17. Durable medical equipment, prosthetic or orthotic devices, and their supplies, including: peak flow meters, nebulizers, and spacers; and ostomy and urological supplies. Refer to “Durable Medical Equipment” and “Prosthetic Devices” in Section 3: Benefits.
18. Drugs and devices provided during a covered stay in a hospital or Skilled Nursing Facility, or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits. This includes the equipment and supplies associated with the administration of a drug. Refer to “Drugs, Supplies, and Supplements” and “Home Health Care” in Section 3: Benefits.
19. Bandages or dressings. Refer to “Drugs, Supplies, and Supplements” and “Home Health Care” in Section 3: Benefits.
20. Diabetic equipment and supplies. Refer to “Diabetic Equipment, Supplies, and Self-Management” in Section 3: Benefits.
21. Growth hormone therapy (GHT) for treatment of adults age 18 or older.
22. Immunizations and vaccinations solely for the purpose of travel. Refer to “Outpatient Care” in Section 3: Benefits.
23. Any prescription drug product that is therapeutically equivalent to an over-the-counter drug, upon a review and determination by the Pharmacy and Therapeutics Committee, unless in the judgment of the authorized prescriber: (1) there is no equivalent prescription drug or device in the entity's formulary; or (2) an equivalent prescription drug or device in the entity's formulary: (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.
24. Contraceptive devices (except diaphragms), injections and implants. Refer to “Family Planning Services” in Section 3 – Benefits of your EOC.
25. Drugs for the treatment of sexual dysfunction disorders, such as erectile dysfunction.

F. COPAYMENTS AND COINSURANCE

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

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

30 Day Supply	Plan Pharmacy and Mail Delivery
Generic Drugs	\$10
Preferred Brand Drugs	\$20
Non-Preferred Brand Drugs	\$35
Specialty Drugs	Refer to the applicable Generic and Brand Drugs Cost Share above

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

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

Weight management drugs for 50% of the Allowable Charge.

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

Oral Cancer Chemotherapy Drugs for no charge.

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

Please visit the following websites for a list of these drugs:

https://healthy.kaiserpermanente.org/static/health/en-us/pdfs/nat/nat_preventive_services_under_health_reform.pdf

<http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

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

G. DEDUCTIBLE

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

H. OUT-OF-POCKET MAXIMUM

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

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

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



By: _____

Mark Ruszczyk
Vice President, Marketing, Sales & Business Development

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

**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.

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.

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.

A. Limitations

- Standard Devices: Coverage is limited to standard devices that adequately meet your medical needs.
- Coverage of therapeutic shoes and inserts is limited to individuals with severe diabetic foot disease only.

B. 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 covered under the Group EOC.
- Hearing aids, except as covered under the Group EOC.
- Corrective lenses and eyeglasses, except as 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; or 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.

C. Your Cost Share

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: _____

Mark Ruszczyk

Vice President, Marketing, Sales & Business Development

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COMPLEMENTARY ALTERNATIVE MEDICINE SERVICES RIDER

GROUP EVIDENCE OF COVERAGE

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

The following benefits, limitations, and exclusions are hereby added to the "Benefits" Section of the Group Evidence of Coverage (herein referred to as the Group EOC), in consideration of the Group application and payment of the additional Premium for the Services pursuant to this Rider.

A. Definitions

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

B. Benefits:

We cover Acupuncture Services for chronic pain management or chronic illness management for Members when deemed Medically Necessary and prescribed by a Plan Provider as outlined under "Getting a Referral" in Section 2 "How to Obtain Services."

We cover Chiropractic Services in accordance with Health Plan coverage guidelines when you are a Member on the date that you receive the Services or under the conditions outlined in the Extension of Benefits provision in the Termination of Membership Section of the EOC. You must receive the Services from a Plan Provider as outlined under "Getting a Referral" in Section 2 "How to Obtain Services."

C. Limitations:

The number of visits needed for the Member to reach the maximum level of recovery will be determined by the Plan Provider and shall not exceed a total of **20** visits per contract year.

D. Exclusions:

- Services requested by the Member that are deemed not Medically Necessary (as defined in the Group EOC to which this Rider is attached) for Acupuncture services by the Plan Provider.
- Any Services not provided by a Plan Provider or for which a Referral is not obtained.

E. Your Cost Share:

Covered Services under this Rider for Acupuncture Services are not subject to the deductible and do not apply toward the Out-of-Pocket Maximum shown in the Summary of Services and Cost Shares in the Group EOC.

Covered Services under this Rider for Chiropractic Services apply toward the Out-of-Pocket Maximum shown in the Summary of Services and Cost Shares in the Group EOC. You pay the following Cost Share for each visit.

- You pay **\$25** per visit.

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

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

By: 

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

HEARING SERVICES RIDER

GROUP EVIDENCE OF COVERAGE

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

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

Hearing Services

A. Definitions

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

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

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

B. Benefits

We cover the following:

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

C. Limitations

- Your Hearing Aid Benefit Allowance is \$1,000.
- Coverage is provided for one Hearing Aid for each hearing impaired ear every 36 months. Two Hearing Aids are covered every 36 months only if both are required to provide significant improvement that is not obtainable with only one Hearing Aid, as determined by your Kaiser Permanente or Kaiser Permanente-designated audiologist or physician.
- You are not required to obtain Hearing Aids for both ears at the same time. The 36 month benefit period extends separately for each ear, and commences at the initial point of sale for each ear.
- The Hearing Aid Benefit Allowance must be used at the initial point of sale for each Hearing Aid. Any part of the Hearing Aid Benefit Allowance that is not exhausted at the initial point of sale may not be used at a later time.
- The type of Hearing Aid is limited to the models provided by Kaiser Permanente or the Kaiser Permanente-designated Hearing Aid vendor.
- You may apply the Hearing Aid Benefit Allowance toward a Hearing Aid upgrade. However, you must pay the difference in the Hearing Aid Benefit Allowance and the cost of the Hearing Aid upgrade.

D. Exclusions

- Replacement of parts and batteries

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

E. Your Cost Share

You pay the following copayment or coinsurance for each Service:

In-Plan Services:

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

Hearing Aids:

- You pay nothing so long as the cost of your Hearing Aid does not exceed your Hearing Aid Benefit Allowance. You pay any charges over and above the Hearing Aid Benefit Allowance.

Hearing Exams:

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

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

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

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

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



By: _____

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HMO ADULT DENTAL RIDER

This HMO Adult 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, for adults age 19 or older, shall be added to the Group Evidence of Coverage (EOC) to which this HMO Adult 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, periodontics, 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 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 and Covered 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 Covered 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. The fixed copayment does not apply to the following preventive Services: sealant (D1351), space maintainer (D1510, D1515, D1520, D1525), and re-cementation of space maintainer (D1550). 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.
- E. 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.
- F. 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: 711

- G. **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:

Toll Free: 1-855-733-7524

TTY Line: TTY 711.

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

- H. **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 \$50 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

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

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, which 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 Evidence of Coverage and Adult 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 Evidence of Coverage and Adult 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 the non-participating provider directly. If the member has already paid the charges, the Dental Administrator will reimburse the member (upon proof of payment) instead of paying the provider directly for Covered Dental Services that may have been provided. Reimbursement to the member is not to exceed \$50 per incident. Services are limited to those procedures not excluded under Plan Limitations and Exclusions. Proof of payment must be submitted to Dental Administrator by provider within one hundred eighty (180) days of treatment. The Dental Administrator will allow Members to submit claims up to one (1) year after the date of service. However, a Member’s legal incapacity shall suspend the time to submit a claim; and the suspension period ends when legal capacity is regained. Failure to submit a claim within one (1) year after the date of services does not invalidate or reduce the amount of the claim if it was not reasonably possible to submit the claim within one (1) year after the date of services; and the claim is submitted within two (2) years after the date of service. Proof of loss should be mailed to: Dominion Dental Services, Inc., 251 18th Street South, Suite 900, Arlington, Virginia 22202, ATTN: Accounting Dept.

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

VI. EXCLUSIONS AND LIMITATIONS

A. Exclusions

The following Services are not covered under this Rider:

1. Services which are covered under worker's compensation or Employer's Liability laws.
2. Services which are not necessary for the patient's dental health as determined by the Plan.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
4. Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan which is described in the Evidence of Coverage.
5. Services with respect to malignancies, cysts or neoplasms, hereditary congenital, anodontic, mandibular prognathism or development malformations where, in the opinion of the Plan, such Services should not be performed in a dental office.
6. Drugs obtainable with or without a prescription, except as may be otherwise covered in your medical plan this is described in the Evidence of Coverage.
7. Hospitalization for any dental procedure.
8. Treatment for conditions resulting from major disaster, epidemic or war, including declared or undeclared war or acts of war, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Procedures not listed as a covered benefits under this Plan.
11. Services obtained outside of the Participating Dental Provider's office that are not pre-authorized by such office or the Plan (with the exception of out-of-area emergency dental Services, or referrals to non-Participating Dental Provider specialists).
12. Services related to the treatment of TMD (Temporomandibular disorder).
13. Services related to procedures that are of such a degree of complexity as to not be normally performed by a Participating General Dentist. Listed copayments do not apply when performed by a Participating Specialist (with the exception of orthodontics). Participating Specialists, if available, have entered into an agreement to provide dental Services to members at a 25% reduction from their Usual, Customary and Reasonable (UCR) fees.
14. Elective surgery including, but not limited to extraction of non-pathologic, asymptomatic impacted teeth as determined by the Plan.
15. The Invisalign system and similar specialized braces are not a covered benefit. Patient copayments will apply to the routine orthodontic appliance portion of Services only. Additional costs incurred will become the patient's responsibility.

B. Limitations

Covered Dental Services are subject to the following limitations:

1. Two (2) evaluations are covered per calendar including a maximum of one (1) comprehensive evaluation.
2. One (1) problem focused exam is covered per calendar per patient.
3. Two (2) teeth cleanings (prophylaxis) are covered per calendar (one additional cleaning is covered during pregnancy and for diabetic patients)
4. One (1) topical fluoride or fluoride varnish is covered per calendar per patient.
5. Two (2) bitewing x-rays are covered per calendar per patient.
6. One (1) set of full mouth x-rays or panoramic film is covered every three (3) years per patient.
7. Replacement of a filling within two (2) years after original date of placement.
8. Replacement of a bridge, crown or denture within seven (7) years after the date it was originally installed.
9. 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%.
10. Relining and rebasing of dentures is covered once every 24 months per patient.
11. Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
12. Root planing or scaling is covered once every 24 months per quadrant per patient.
13. Full mouth debridement is covered once per lifetime per patient.
14. Procedure Code D4381 is limited to one (1) benefit per tooth for three teeth per quadrant or a total of 12 teeth for all four quadrants per twelve (12) months. Must have pocket depths of five (5) millimeters or greater.
15. Periodontal surgery of any type, including any associated material is covered once every 36 months per quadrant or surgical site per patient.
16. Periodontal maintenance after active therapy is covered twice per calendar within 24 months after definitive periodontal therapy.

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

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

By:  _____

Mark Ruszczyk
Vice President, Marketing, Sales & Business Development

PEDIATRIC DENTAL PLAN RIDER

This Pediatric Dental Plan 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 pediatric dental Services, for Members under age 19, shall be added to the Group Evidence of Coverage (EOC) to which this Pediatric 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, periodontics, prosthetics, orthodontic and oral surgery Services that are covered under this Pediatric Dental Plan Rider, and listed in the Pediatric Dental Plan Schedule of Dental Fees attached to the EOC.

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 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, Covered Dental Services and/or other dental Services at negotiated contracted rates.

Out-of-Pocket Maximum means the Out-of-Pocket Maximum listed in the Summary of Services and Cost Shares Appendix of the EOC to which this Rider is attached.

II. GENERAL PROVISIONS

- A.** Subject to the terms, conditions, limitations, and exclusions specified in this Rider, you may receive Covered Preventive Care Dental and Covered Dental Services from Participating Dental Providers. You may receive Covered Dental Services from a non-Participating Dental Provider for emergencies, urgent care received outside Health Plan's Service Area, and Services obtained pursuant to a referral to a non-participating specialist. Services received from non-Participating Dental Provider are not covered under this plan except for: (1) benefits provided under a referral to a non-Participating Dental Provider under Section III.B below; (2) dental emergencies as described in Section V. below; and (3) Continuity of Care for new Members, as described in Section 2.
- B.** Health Plan has entered into an agreement with Dental Administrator to provide Covered Preventive Care Dental Services and certain other Covered Dental Services through its Participating Dental Providers.
- C.** Attached is 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 office visit. The fixed copayment does not apply to certain preventive Services. 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

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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. Covered Dental Services are not subject to a Deductible. Copayments and Dental Fees set forth in the attached Pediatric Dental Plan Schedule of Dental Fees apply toward the Out-of-Pocket Maximum in the Summary of Services and Cost Shares of the EOC.

- 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.
- E. You may also obtain a list of Participating Dental Providers by contacting the 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: TTY 711

- 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:

Toll Free: 1-855-733-7524

TTY Line: TTY 711.

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:

DominionDental.com/kaiserdentists

Dominion also provides many other secure features online at 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 \$50 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. Please note that a referral is not required to receive Covered Dental Services from a participating pediatric dentist.

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

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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, which 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 Premiums, 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 EOC 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 EOC and Pediatric 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 Premiums;
2. Coverage ends as the result of you committing fraud or material misrepresentation;
3. When coverage is provided by a succeeding 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 the non-participating provider directly. If the member has already paid the charges, the Dental Administrator will reimburse the member (upon proof of payment) instead of paying the provider directly for Covered Dental Services that may have been provided. Reimbursement to the member is not to exceed \$50 per incident. Services are limited to those procedures not excluded under Plan Limitations and Exclusions. Proof of payment must be submitted to Dental Administrator. The Dental Administrator will allow Members to submit claims up to one (1) year after the date of service. However, a Member's legal incapacity shall suspend the time to submit a claim; and the suspension period ends when legal capacity is regained. Failure to submit a claim within one (1) year after the date of services does not invalidate or reduce the amount of the claim if it was not reasonably possible to submit the claim within one (1) year after the date of services; and the claim is submitted within two (2) years after the date of service. Proof of payment should be mailed to: Dominion Dental Services USA, Inc., 251 18th Street South, Suite 900, Arlington, VA 22202, ATTN: Accounting Dept. 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. PRE-AUTHORIZATION FOR MEDICALLY NECESSARY ORTHODONTIA

The Dental Administrator requires the treating orthodontist to submit a treatment plan prior to initiating Services. The Dental Administrator may request x-rays or other dental records prior to issuing the pre-authorization. The proposed Services will be reviewed and a pre-authorization will be issued to you or the orthodontist, specifying coverage. The pre-authorization is not a guarantee of coverage and is considered valid for 180 days.

VII. OUT-OF-POCKET MAXIMUM

All Dental Fees paid by the Member apply toward the Out-of-Pocket Maximum shown in the Summary of Services and Cost Shares Appendix of the EOC to which this Rider is attached.

VIII. SUBMISSION OF CLAIMS

When you receive Covered Dental Services from a Non-Participating Dental Provider, you are responsible for submitting a claim to us for payment and/or reimbursement.

The Dental Administrator will accept a recognized ADA claim form from the dental provider's office. Claims can be submitted to Dominion Dental Services USA, Inc., P.O. Box 1920, Bowie, MD 20717-1920. If you would like to request a claim form you may go online at www.dominiondental.com or please call Dental Administrator at the phone number listed above (See Section II.E) to request a claim form. Once you have completed the claim form, you must attach copies of all itemized bills and proof of payment, if any.

If Dental Administrator does not provide the claim form within 15 days, you may submit proof of loss by submitting, within the six-month time frame for filing proof of loss stated below, written proof of the occurrence, character, and extent of the loss for which the claim is made.

All itemized bills and/or proof of payment must be submitted within one (1) year of receipt of the covered Services. Failure to submit such a request within one (1) year of receipt of the covered Services will not invalidate or reduce the amount of the claim, if it was not reasonably possible to submit the request within the aforementioned time frame. If it is not reasonably possible to submit the claim within one (1) year after the date of service, it shall be sent to us no later than two (2) years from the time, proof is otherwise required. A Member's legal incapacity shall suspend the time to submit a claim. Such suspension period ends when legal capacity is regained.

Benefits payable under the Group Evidence of Coverage for any loss will be paid not more than 30 days after receipt of written proof of loss. If a claim is denied in whole or in part, the written notice of the denial will contain the reasons for denial and reference to the pertinent provisions of the Group Evidence of Coverage and this Rider.

If a claim is denied, you or your Authorized Representative may file an appeal in accordance with the "Getting Assistance, Health Care Service Review and Grievance and Appeal Process" section of the Group Evidence of Coverage.

IX. EXCLUSIONS AND LIMITATIONS

A. Exclusions

The following Services are not covered under this Pediatric Dental Plan Rider:

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not necessary for the patient's dental health as determined by the Plan.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where, in the opinion of the Plan, such Services should not be performed in a dental office.
6. Dispensing of drugs.
7. Hospitalization for any dental procedure.
8. Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Procedures not listed as covered benefits under this Rider, or the Pediatric Dental Plan Schedule of Dental Fees attached to the EOC.
11. Services obtained outside of the dental office in which enrolled and that are not preauthorized by such office or the Health Plan or Dental Administrator under Section III.B above (except for dental emergencies as described in Section V. above; and Continuity of Care for new Members, as described in Section 2 of the EOC).
12. Services performed by a Participating Specialist without a referral from a Participating General Dentist (with the exception of Orthodontics). A referral form is required. Participating dentists should refer to Specialty Care Referral Guidelines.
13. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by the Plan. The prophylactic removal of these teeth may be covered subject to review.
14. Any bill, or demand for payment, for a dental Service that the appropriate regulatory board determines was provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.
15. Non-medically necessary orthodontia and Phase I Treatment for Medically Necessary orthodontia are not covered benefits under this policy. The provider agreements create no liability for payment by the Plan, and payments by the member for these Services do not contribute to the Out-of-Pocket Maximum. The Invisalign system and similar specialized braces are not a covered benefit. See limitation #21 concerning Medically Necessary orthodontia.

B. Limitations

Covered Dental Services are subject to the following limitations:

1. One (1) evaluation (D0120, D0140, D0145, D0150, D0160, D0170, D0171 or D0180) is covered two (2) times per calendar year, per patient.
2. One (1) teeth cleaning (D1110 or D1120) is covered two (2) times per calendar year, per patient.
3. One (1) topical fluoride application is covered two (2) times per calendar year, per patient; four (4) fluoride varnish treatments are covered per calendar year, per patient for children age three (3) and above; eight (8) topical fluoride varnishes are covered per calendar year, per patient up to age two (2).
4. Two (2) bitewing x-rays are covered per calendar year, per patient.
5. One (1) set of full mouth x-rays or panoramic film is covered every three (3) years. Panoramic x-rays are limited to ages six (6) and above. No more than one (1) set of x-rays are covered per provider/location.
6. One (1) sealant per tooth is covered per lifetime, per patient (limited to occlusal surfaces of posterior permanent teeth without restorations or decay).
7. One (1) space maintainer (D1510, D1515, D1520 or D1525) is covered per 24 months, per patient, per arch.
8. Replacement of a filling is covered if it is more than three (3) years from the date of original placement.

9. Replacement of a crown or denture is covered if it is more than five (5) years from the date of original placement.
10. Replacement of a prefabricated resin and stainless steel crown (D2930, D2932, D2933, D2934) is covered if it is more than three (3) years from the date of original placement, per tooth, per patient.
11. Crown and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan.
12. Relining and rebasing of dentures is covered once per 24 months, per patient, only after six (6) months of initial placement.
13. Root canal treatment and retreatment of previous root canal are covered once per lifetime, per tooth.
14. Periodontal scaling and root planing (D4341 or D4342), osseous surgery (D4260 or D4261) and gingivectomy or gingivoplasmy (D4210 or D4212) are limited to one (1) per 24 months, per patient, per quadrant.
15. Full mouth debridement is covered once per 24 months, per patient.
16. Procedure Code D4381 is limited to one (1) benefit per tooth for three teeth per quadrant; or a total of 12 teeth for all four (4) quadrants per 12 months. Must have pocket depths of five (5) millimeters or greater.
17. Periodontal surgery of any type, including any associated material, is covered once every 24 months, per quadrant or surgical site.
18. Periodontal maintenance after active therapy is covered two (2) times per calendar year.
19. All dental Services that are to be rendered in a hospital setting require coordination and approval from both the Dental Administrator and the medical insurer before Services can be rendered. Services delivered to the patient on the date of service are documented separately using applicable procedure codes.
20. Anesthesia requires a narrative of medical necessity be maintained in patient records. A maximum of 60 minutes of Services are allowed for general anesthesia and intravenous or non-intravenous conscious sedation. General anesthesia is not covered with procedure codes D9230 or D9243. Intravenous conscious sedation is not covered with procedure codes D9223 or D9230. Non-intravenous conscious sedation is not covered with procedure codes D9223 or D9230. Analgesia (nitrous oxide) is not covered with procedure codes D9223 or D9243.
21. Orthodontics is only covered if Medically Necessary as determined by the Dental Administrator. There is a 24 months waiting period for medically necessary orthodontia. Patient copayments will apply to the routine orthodontic appliance portion of Services only. Additional costs incurred will become the patient's responsibility.

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

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



By: _____

Mark Ruszczyk

Vice President, Marketing, Sales & Business Development

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
\$0 Preventive Dental Plan
Schedule of Dental Fees – 2017

Procedures not shown in this list are not covered. Detailed dental benefits may be found in the *Evidences of Coverage* (plan material you will receive following your enrollment in our plan).

Fees quoted in the “Dentist Copay” column apply only when performed by a participating general dentist. If specialty care is required, your general dentist must refer you to a participating specialist. Services received from non-participating dentists are not covered under this plan, except for emergency services, out-of-area urgent care, and referrals to non-participating specialists.

Fixed Copayment \$0: You pay a combined FC of \$0 for any visit during which one or more of the following procedures are performed: (a) an oral exam (D0120, D0140, D0150, D0170 or D0180); (b) X-rays (D0220, D0230, D0240, D0250, D0260, D0270, D0272, D0273, D0274, D0277, D0340 or D0350); (c) a pulp vitality test (D0460); (d) a diagnostic cast (D0470); (e) a routine cleaning (D1110 or D1120); (f) fluoride application (D1206 or D1208); or (g) you are given oral hygiene or counseling instructions (D1310, D1320 or D1330). You pay a separate fee for any other procedure performed.

N/B: No benefit is provided.

NOTE: The Schedule of Dental Fees is reviewed annually and is subject to change at the renewal date each year. Contact Dominion for details at 855-733-7524 or TTY 711, Monday through Friday, 7:30 a.m. to 6 p.m.

ADA CODE	BENEFIT	DENTIST COPAY	SPECIALIST COPAY
DIAGNOSTIC/PREVENTIVE			
D0120	Periodic oral eval - established patient	FC \$0	N/B
D0140	Limited oral eval - problem focused	FC \$0	N/B
D0150	Comprehensive oral eval - new or established patient	FC \$0	N/B
D0170	Re-eval - limited, problem focused	FC \$0	N/B
D0180	Comp. periodontal eval - new or established patient	FC \$0	N/B
D0210	Intraoral - complete series (including bitewings)	54	69
D0220	Intraoral - periapical first film	FC \$0	14
D0230	Intraoral - periapical each add. film	FC \$0	11
D0240	Intraoral - occlusal film	FC \$0	21
D0250	Extraoral - first film	FC \$0	26
D0270	Bitewing x-rays - single film	FC \$0	14
D0272	Bitewing x-rays - two films	FC \$0	21
D0273	Bitewing x-rays - three films	FC \$0	28
D0274	Bitewing x-rays - four films	FC \$0	31
D0277	Vertical bitewings - 7 to 8 films	FC \$0	47
D0330	Panoramic film	43	55
D0340	Cephalometric film	FC \$0	55
D0350	Oral/facial photographic images	FC \$0	29
D0351	3D photographic image	FC \$0	32
D0460	Pulp vitality tests	FC \$0	35
D0470	Diagnostic casts	FC \$0	N/B
D1110	Prophylaxis (cleaning) - adult	FC \$0	N/B
D1110*	Additional cleaning (expecting mothers and Diabetics)	40	40
D1120	Prophylaxis (cleaning) - child	FC \$0	N/B
D1206	Topical fluoride varnish	FC \$0	N/B
D1208	Topical application of fluoride	FC \$0	N/B
D1310	Nutritional counseling for control of dental disease	FC \$0	N/B
D1320	Tobacco counseling for control and prev. oral disease	FC \$0	N/B
D1330	Oral hygiene instructions	FC \$0	N/B
D1351	Sealant - per tooth	30	N/B
D1352	Prev resin rest. mod/high caries risk – perm. tooth	30	N/B
D1510	Space maintainer - fixed - unilateral	200	N/B

D1515	Space maintainer - fixed - bilateral	278	N/B
D1520	Space maintainer - removable - unilateral	246	N/B
D1525	Space maintainer - removable - bilateral	278	N/B
D1550	Re-cementation of space maintainer	23	N/B

RESTORATIVE DENTISTRY (FILLINGS)

D2140	Amalgam - one surface, prim. or perm.	68	N/B
D2150	Amalgam - two surfaces, prim. or perm.	88	N/B
D2160	Amalgam - three surfaces, prim. or perm.	105	N/B
D2161	Amalgam - >=4 surfaces, prim. or perm.	126	N/B
D2330	Resin-based composite - one surface, anterior	83	N/B
D2331	Resin-based composite - two surfaces, anterior	105	N/B
D2332	Resin-based composite - three surfaces, anterior	129	N/B
D2335	Resin-based composite - >=4 surfaces, anterior	163	N/B
D2390	Resin-based composite crown, anterior	216	N/B
D2391	Resin-based composite - one surface, posterior	108	N/B
D2392	Resin-based composite - two surfaces, posterior	143	N/B
D2393	Resin-based composite - three surfaces, posterior	179	N/B
D2394	Resin-based composite - >=4 surfaces, posterior	204	N/B

CROWNS & BRIDGES*

D2510	Inlay- metallic - one surface	493	N/B
D2520	Inlay- metallic - two surfaces	556	N/B
D2530	Inlay - metallic - three or more surfaces	604	N/B
D2542	Onlay - metallic-two surfaces	641	N/B
D2543	Onlay - metallic - three surfaces	653	N/B
D2544	Onlay - metallic - four or more surfaces	657	N/B
D2610	Inlay - porcelain/ceramic - one surface	541	N/B
D2620	Inlay - porcelain/ceramic - two surfaces	576	N/B
D2630	Inlay - porcelain/ceramic - >=3 surfaces	665	N/B
D2642	Onlay - porcelain/ceramic - two surfaces	616	N/B
D2643	Onlay - porcelain/ceramic - three surfaces	666	N/B
D2644	Onlay - porcelain/ceramic - >=4 surfaces	710	N/B
D2650	Inlay - resin-based composite - one surface	498	N/B
D2651	Inlay - resin-based composite - two surfaces	538	N/B
D2652	Inlay - resin-based composite - >=3 surfaces	699	N/B
D2662	Onlay - resin-based composite - two surfaces	568	N/B
D2663	Onlay - resin-based composite - three surfaces	699	N/B
D2664	Onlay - resin-based composite - >=4 surfaces	662	N/B
D2710	Crown - resin based composite (indirect)	277	N/B
D2712	Crown - 3/4 resin-based composite (indirect)	255	N/B
D2720	Crown - resin with high noble metal	675	N/B
D2721	Crown - resin with predom. base metal	601	N/B
D2722	Crown - resin with noble metal	628	N/B
D2740	Crown - porcelain/ceramic substrate	741	N/B
D2750	Crown - porcelain fused to high noble metal	755	N/B
D2751	Crown - porcelain fused to predominantly base metal	653	N/B
D2752	Crown - porcelain fused to noble metal	679	N/B
D2780	Crown - 3/4 cast high noble metal	724	N/B
D2781	Crown - 3/4 cast predominantly base metal	566	N/B
D2782	Crown - 3/4 cast noble metal	611	N/B
D2783	Crown - 3/4 porcelain/ceramic	628	N/B
D2790	Crown - full cast high noble metal	675	N/B
D2791	Crown - full cast predominately base metal	601	N/B
D2792	Crown - full cast noble metal	628	N/B
D2794	Crown - titanium	679	N/B
D2910	Recement inlay	68	N/B
D2920	Recement crown	68	N/B
D2930	Prefab. stainless steel crown - prim. tooth	141	N/B
D2931	Prefab. stainless steel crown - perm. tooth	186	N/B
D2932	Prefabricated resin crown	254	N/B
D2940	Sedative filling	77	N/B

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D2941	Interim therapeutic rest., prim. dentition	49	N/B
D2950	Core buildup, including any pins	172	N/B
D2951	Pin retention - per tooth, in addition to restoration	40	N/B
D2952	Cast post and core in addition to crown	252	N/B
D2954	Prefab. post and core in addition to crown	224	N/B
D2955	Post removal (not in conj. w/ endo therapy)	194	N/B
D2980	Crown repair, by report	138	N/B

ENDODONTICS

D3110	Pulp cap - direct (excl. final restoration)	47	N/B
D3120	Pulp cap - indirect (excl. final restoration)	47	N/B
D3220	Therapeutic pulpotomy (excl. final restor.)	104	122
D3221	Pulpal debridement, prim. and perm. teeth	126	N/B
D3310	Endodontic therapy, anterior tooth	482	554
D3320	Endodontic therapy, bicuspid tooth	576	663
D3330	Endodontic therapy, molar	755	867
D3333	Internal root repair of perforation defects	N/B	225
D3346	Retreat of prev. root canal therapy, anterior	N/B	609
D3347	Retreat of prev. root canal therapy, bicuspid	N/B	812
D3348	Retreat of prev. root canal therapy, molar	N/B	1047
D3410	Apicoectomy/periradicular surgery, anterior	422	524
D3421	Apicoectomy/periradicular surgery, bicuspid (first root)	471	655
D3425	Apicoectomy/periradicular surgery, molar (first root)	518	687
D3426	Apicoectomy/periradicular surgery (each add. root)	314	371
D3427	Periradicular surg. w/o apicoectomy	402	504
D3430	Retrograde filling - per root	118	295
D3450	Root amputation - per root	205	330
D3920	Hemisection, not inc. root canal therapy	258	305
D3950	Canal prep/fitting of preformed dowel or post	154	216

PERIODONTICS

D4210	Gingivectomy or gingivoplasty - >3 cont. teeth, per quad.	372	439
D4211	Gingivectomy or gingivoplasty - <=3 teeth, per quad.	161	190
D4240	Gingival flap proc., inc. root planing - >3 cont. teeth, per quad	479	566
D4241	Gingival flap proc, inc. root planing - <=3 cont. teeth, per quad	121	239
D4260	Osseous surgery - >3 cont. teeth, per quad	709	836
D4261	Osseous surgery - <=3 cont. teeth, per quad	452	534
D4268	Surgical revision proc., per tooth	389	562
D4274	Distal or proximal wedge procedure	329	466
D4341	Perio scaling and root planing - >3 cont teeth, per quad.	137	194
D4342	Perio scaling and root planing - <= 3 teeth, per quad	99	117
D4355	Full mouth debridement	121	175
D4381	Localized delivery of chemotherapeutic agents	33	44
D4910	Periodontal maintenance	83	110

PROSTHETICS (DENTURES)

D5110	Complete denture - maxillary	845	N/B
D5120	Complete denture - mandibular	845	N/B
D5130	Immediate denture - maxillary	910	N/B
D5140	Immediate denture - mandibular	910	N/B
D5211	Maxillary partial denture - resin base	653	N/B
D5212	Mandibular partial denture - resin base	653	N/B
D5213	Maxillary partial denture - cast metal	906	N/B
D5214	Mandibular partial denture - cast metal	906	N/B
D5221	Immediate maxillary partial denture	653	N/B
D5222	Immediate mandibular partial denture	653	N/B
D5223	Immediate maxillary partial denture	906	N/B
D5224	Immediate mandibular partial denture	906	N/B
D5225	Maxillary partial denture - flexible base	904	N/B
D5226	Mandibular partial denture - flexible base	1004	N/B
D5281	Rem. unilateral partial denture - one piece cast metal	510	N/B

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D5410	Adjust complete denture - maxillary	79	N/B
D5411	Adjust complete denture - mandibular	79	N/B
D5421	Adjust partial denture - maxillary	79	N/B
D5422	Adjust partial denture - mandibular	79	N/B
D5510	Repair broken complete denture base	101	N/B
D5520	Replace missing or broken teeth - complete denture	77	N/B
D5610	Repair resin denture base	102	N/B
D5620	Repair cast framework	147	N/B
D5630	Repair or replace broken clasp	139	N/B
D5640	Replace broken teeth - per tooth	88	N/B
D5650	Add tooth to existing partial denture	131	N/B
D5660	Add clasp to existing partial denture	160	N/B
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	559	N/B
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	559	N/B
D5710	Rebase complete maxillary denture	344	N/B
D5711	Rebase complete mandibular denture	331	N/B
D5720	Rebase maxillary partial denture	265	N/B
D5721	Rebase mandibular partial denture	265	N/B
D5730	Reline complete maxillary denture (chairside)	214	N/B
D5731	Reline complete mandibular denture (chairside)	215	N/B
D5740	Reline maxillary partial denture (chairside)	212	N/B
D5741	Reline mandibular partial denture (chairside)	212	N/B
D5750	Reline complete maxillary denture (lab)	260	N/B
D5751	Reline complete mandibular denture (lab)	258	N/B
D5760	Reline maxillary partial denture (lab)	250	N/B
D5761	Reline mandibular partial denture (lab)	249	N/B
D5810	Interim compl. denture - maxillary	549	N/B
D5811	Interim compl. denture - mandibular	400	N/B
D5820	Interim partial denture - maxillary	424	N/B
D5821	Interim partial denture - mandibular	429	N/B
D5850	Tissue conditioning - maxillary	120	N/B
D5851	Tissue conditioning - mandibular	121	N/B

BRIDGES & PONTICS*

D6000-D6199 ALL IMPLANT SERVICES - 15% DISCOUNT

(incl. D0360-D0363 cone beam imaging w/ implants)

D6210	Pontic - cast high noble metal	610	N/B
D6211	Pontic - cast predominately base metal	624	N/B
D6212	Pontic - cast noble metal	586	N/B
D6214	Pontic - titanium	571	N/B
D6240	Pontic - porcelain fused to high noble metal	755	N/B
D6241	Pontic - porcelain fused to predominately base metal	653	N/B
D6242	Pontic - porcelain fused to noble metal	679	N/B
D6245	Pontic - porcelain/ceramic	741	N/B
D6549	Resin Retainer - for resin bonded fixed prost	270	N/B
D6250	Pontic - resin w/ high noble metal	745	N/B
D6251	Pontic - resin w/ predominately base metal	707	N/B
D6252	Pontic - resin w/ noble metal	717	N/B
D6545	Ret. - cast metal for resin bonded fixed prosthesis	270	N/B
D6548	Ret. - porc./ceramic for resin bonded fixed prosthesis	481	N/B
D6600	Inlay - porc./ceramic, two surfaces	400	N/B
D6601	Inlay - porc./ceramic, >=3 surfaces	426	N/B
D6602	Inlay - cast high noble metal, two surfaces	422	N/B
D6603	Inlay - cast high noble metal, >=3 surfaces	468	N/B
D6604	Inlay - cast predominantly base metal, two surfaces	422	N/B
D6605	Inlay - cast predominantly base metal, >=3 surfaces	404	N/B
D6606	Inlay - cast noble metal, two surfaces	384	N/B
D6607	Inlay - cast noble metal, >=3 surfaces	426	N/B

D6608	Onlay - porc./ceramic, two surfaces	437	N/B
D6609	Onlay - porc./ceramic, >=3 surfaces	458	N/B
D6610	Onlay - cast high noble metal, two surfaces	501	N/B
D6611	Onlay - cast high noble metal, >=3 surfaces	548	N/B
D6612	Onlay - cast predominantly base metal, two surfaces	431	N/B
D6613	Onlay - cast predominantly base metal, >=3 surfaces	478	N/B
D6614	Onlay - cast noble metal, two surfaces	454	N/B
D6615	Onlay - cast noble metal, >=3 surfaces	501	N/B
D6624	Inlay - titanium	468	N/B
D6634	Onlay - titanium	548	N/B
D6720	Crown - resin with high noble metal	747	N/B
D6721	Crown - resin with predom. base metal	666	N/B
D6722	Crown - resin with noble metal	696	N/B
D6740	Crown - porcelain/ceramic	741	N/B
D6750	Crown - porcelain fused to high noble metal	639	N/B
D6751	Crown - porcelain fused to predominately base metal	571	N/B
D6752	Crown - porcelain fused to noble metal	599	N/B
D6780	Crown - 3/4 cast high noble metal	724	N/B
D6781	Crown - 3/4 cast predominantly base metal	566	N/B
D6782	Crown - 3/4 cast noble metal	578	N/B
D6783	Crown - 3/4 porcelain/ceramic	808	N/B
D6790	Crown - full cast high noble metal	675	N/B
D6791	Crown - full cast predominately base metal	601	N/B
D6792	Crown - full cast noble metal	628	N/B
D6794	Crown - titanium	679	N/B
D6930	Recement fixed partial denture	88	N/B
D6940	Stress breaker	205	N/B

D6980	Fixed partial denture repair, by report	206	N/B
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ORAL SURGERY

D7111	Extraction, coronal remnants - deciduous tooth	72	85
D7140	Extraction, erupted tooth or exposed root	83	97
D7210	Surgical rem. of erupted tooth req. bone cut	149	176
D7220	Removal of impacted tooth - soft tissue	183	216
D7230	Removal of impacted tooth - partially bony	250	295
D7240	Removal of impacted tooth - completely bony	295	347
D7241	Removal of impacted tooth - completely bony w/ unusual surg. complications	363	429
D7250	Surgical removal of residual tooth roots	167	199
D7270	Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth	279	330
D7280	Surgical access of an unerupted tooth	312	369
D7282	Mobil. of erupted/malpositioned tooth to aid eruption	96	210
D7285	Biopsy of oral tissue - hard (bone, tooth)	196	231
D7286	Biopsy of oral tissue - soft (all others)	184	216
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	142	169
D7310	Alveoloplasty in conjunction with extractions - per quadrant	150	177
D7311	Alveoloplasty in conj. with extractions	130	154
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	193	227
D7321	Alveoloplasty not in conjunc w/ extractions	40	84
D7471	Removal of lateral exostosis	314	370
D7472	Removal of torus palatinus	263	311
D7473	Removal of torus mandibularis	271	320
D7485	Surgical reduction of osseous tuberosity	297	351
D7510	Incision and drainage of abscess - intraoral soft tissue	108	127
D7511	Incision/drainage of abscess - intra. soft tissue, comp.	226	260
D7910	Suture of recent small wounds up to 5 cm	246	290
D7960	Frenulectomy (frenectomy/frenotomy) - separate proc.	266	314
D7963	Frenuloplasty	99	245
D7970	Excision of hyperplastic tissue - per arch	456	539

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D7971	Excision of pericoronal gingiva	225	265
D7972	Surgical reduction of fibrous tuberosity	78	185
ORTHODONTICS – PRE-AUTHORIZATION REQUIRED			
D8070	Comp. ortho. treatment - transitional dentition	N/B	3304
D8080	Comp. ortho. treatment - adolescent dentition	N/B	3658
D8090	Comp. ortho treatment - adult dentition	N/B	3658
D8660	Pre-orthodontic treatment visit	N/B	413
D8670	Periodic ortho. treatment visit (as part of contract)	N/B	118
D8680	Ortho. retention (rem of appl./placement of retainers)	N/B	516
ADJUNCTIVE GENERAL SERVICES			
D9110	Palliative (emergency) treatment of dental pain	30	75
D9210	Local anesthesia not in conj. w/ operative/surg. procedures	0	N/B
D9211	Regional block anesthesia	0	N/B
D9212	Trigeminal division block anesthesia	0	N/B
D9215	Local anesthesia in conj. w/ operative/surg. procedures	0	N/B
D9223	Deep sedation/general anes - each 15 min incr	40	139
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	36	41
D9243	Intravenous moderate sedation/analgesia-15min	61	136
D9310	Consultation (diagnostic service by nontreating dentist)	59	96
D9439	Office visit not including an FC visit	10	10
D9440	Office visit after regularly scheduled hours	27	111
D9910	Application of desensitizing medicament	30	60
D9930	Treatment of complications, post-surgical	48	48
D9940	Occlusal guard, by report	338	519
D9950	Occlusion analysis, mounted case	169	169
D9951	Occlusal adjustment - limited	88	115
D9952	Occlusal adjustment - complete	372	597
D9986	Missed appointment	50	50

♦ All fees exclude the cost of noble and precious metals. An additional fee will be charged if these materials are used.

Only current ADA CDT codes are considered valid by Dominion Dental Services, Inc.
Current Dental Terminology © American Dental Association.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Pediatric Dental Plan
2017 Schedule of Dental Fees

Procedures not shown in this list are not covered. Refer to the Pediatric Dental Plan Rider for a complete description of the terms and conditions of your covered dental benefit.

Fees quoted in the "You pay to Dentist" column apply only when performed by a participating General Dentist or Dental Specialist. If specialty care is required, your general dentist must refer you to a participating specialist except as otherwise described in the Pediatric Dental Plan Rider.

NOTE: If you have any questions concerning this fee schedule, Contact Dominion for details at: 703-518-5338 or toll-free at 1-855-733-7524, Monday through Friday, 7:30 a.m. to 6 p.m., (TTY 711).

ADA CODE	DESCRIPTION OF SERVICES	YOU PAY TO DENTIST
D9439	Office visit	30
DIAGNOSTIC/PREVENTIVE		
D0120	Periodic oral eval - established patient	0
D0140	Limited oral eval - problem focused	0
D0145	Oral eval for a patient under 3 years of age	0
D0150	Comprehensive oral eval - new or established patient	0
D0160	Detailed and extensive oral eval - problem focused	0
D0170	Re-evaluation - limited, problem focused	0
D0210	Intraoral - complete series (including bitewings)	26
D0220/30	Intraoral - periapical first film	0
D0240	Intraoral - occlusal film	0
D0250	Extraoral – 2D projection radiographic image	0
D0270-74	Bitewing x-rays - 1 to 4 films	0
D0277	Vertical bitewings - 7 to 8 films	0
D0290	Posterior/anterior or lateral skull bone film	83
D0310	Sialography	370
D0320	Temporomandibular joint arthrogram, incl. injection	562
D0321	Other temporomandibular joint films, by report	120
D0330	Panoramic film	30
D0340	Cephalometric Film	0
D0350	Oral/facial photographic images	0
D0460	Pulp vitality tests	0
D0470	Diagnostic casts	0
D0486	Accession of Brush Biopsy Sample	0
D1110	Prophylaxis (cleaning) – adult	0

D1120	Prophylaxis (cleaning) – child	0
D1206	Topical fluoride varnish for mod/high risk caries patients	0
D1208	Topical application of fluoride	0
D1310	Nutritional counseling for control of dental disease	0
D1320/30	Oral hygiene instructions	0
D1351	Sealant - per tooth	21
D1352	Prev resin rest. mod/high caries risk – perm. tooth	21

SPACE MAINTAINERS

D1510/20	Space maintainer - fixed/removable - unilateral	143
D1515/25	Space maintainer - fixed/removable - bilateral	198
D1550	Re-cementation of space maintainer	34
D1555	Removal of fixed space maintainer, by non-originating dentist	44

RESTORATIVE DENTISTRY (FILLINGS)

D2140	Amalgam - one surface, prim. or perm.	41
D2150	Amalgam - two surfaces, prim. or perm.	51
D2160	Amalgam - three surfaces, prim. or perm.	64
D2161	Amalgam - >=4 surfaces, prim. or perm.	78

RESIN/COMPOSITE RESTORATIONS (TOOTH COLORED)

D2330	Resin-based composite - one surface, anterior	69
D2331	Resin-based composite - two surfaces, anterior	83
D2332	Resin-based composite - three surfaces, anterior	99
D2335	Resin-based composite - >=4 surfaces, anterior	119
D2390	Resin-based composite crown, anterior	192
D2391	Resin-based composite - one surface, posterior	73
D2392	Resin-based composite - two surfaces, posterior	87
D2393	Resin-based composite - three surfaces, posterior	102
D2394	Resin-based composite - >=4 surfaces, posterior	123
D2940	Sedative filling	39
D2941	Interim therapeutic restoration, primary dentition	31
D2950	Core buildup, including any pins	125
D2951	Pin retention - per tooth, in addition to restoration	22
D3110/20	Pulp cap - direct/indirect (excl. final restoration)	32

CROWNS & BRIDGES*

D2510	Inlay - metallic - one surface	407
D2520	Inlay - metallic - two surfaces	407
D2530	Inlay - metallic - three or more surfaces	425
D2542	Onlay - metallic-two surfaces	458
D2543	Onlay - metallic-three surfaces	524
D2544	Onlay - metallic-four or more surfaces	524
D2610	Inlay - porcelain/ceramic - one surface	427
D2620	Inlay - porcelain/ceramic - two surfaces	427

D2630	Inlay - porcelain/ceramic - >=3 surfaces	445
D2642	Onlay - porcelain/ceramic - two surfaces	479
D2643	Onlay - porcelain/ceramic - three surfaces	499
D2644	Onlay - porcelain/ceramic - >=4 surfaces	499
D2650	Inlay - resin-based composite - one surface	440
D2651	Inlay - resin-based composite - two surfaces	440
D2652	Inlay - resin-based composite - >=3 surfaces	440
D2662	Onlay - resin-based composite - two surfaces	444
D2663	Onlay - resin-based composite - three surfaces	444
D2664	Onlay - resin-based composite - >=4 surfaces	444
D2710	Crown - resin based composite (indirect)	272
D2712	Crown - 3/4 resin-based composite (indirect)	485
D2720/21/22	Crown - resin with metal	495
D2740	Crown - porcelain/ceramic substrate	560
D2750/51/52	Crown - porcelain fused metal	523
D2780/81/82	Crown - 3/4 cast with metal	478
D2783	Crown - 3/4 porcelain/ceramic	511
D2790-94	Crown - full cast metal	495
D2910/20	Recement inlay, onlay/crown or partial coverage rest.	43
D2930	Prefab. stainless steel crown - prim. tooth	110
D2931	Prefab. stainless steel crown - perm. tooth	121
D2932	Prefabricated resin crown	140
D2933	Prefab. stainless steel crown w/ resin window	271
D2934	Prefab. esthetic coated primary tooth	296
D2952	Cast post and core in addition to crown	186
D2954	Prefab. post and core in addition to crown	154
D2955	Post removal (not in conj. with endo. therapy)	105
D2960	Labial veneer (resin laminate) - chairside	434
D2961	Labial veneer (resin laminate) - laboratory	601
D2962	Labial veneer (porcelain laminate) - laborato	449
D2980	Crown repair, by report	102

PROSTHETICS (DENTURES)

D5110/20	Complete denture - maxillary/mandibular	697
D5130/40	Immediate denture - maxillary/mandibular	722
D5211/12	Maxillary/mandibular partial denture - resin base	649
D5213/14	Maxillary/mandibular partial denture - cast metal	750
D5221	Immediate maxillary partial denture	649
D5222	Immediate mandibular partial denture	649
D5223	Immediate maxillary partial denture	750
D5224	Immediate mandibular partial denture	750
D5225/26	Maxillary/mandibular partial denture - flexible base	750
D5281	Rem. unilateral partial denture - one piece cast metal	419
D5410/11	Adjust complete denture - maxillary/mandibular	38
D5421/22	Adjust partial denture - maxillary/mandibular	38

D5510/5610	Repair broken denture base (complete/resin)	87
D5520	Replace missing or broken teeth - complete denture	87
D5620	Repair cast framework	87
D5630/60	Clasp repaired, replaced or added	115
D5640	Replace broken teeth - per tooth	87
D5650	Add tooth to existing partial denture	87
D5670/71	Replace all teeth and acrylic on cast metal framework	287
D5710/11	Rebase complete maxillary/mandibular denture	260
D5720/21	Rebase maxillary/mandibular partial denture	260
D5730/31	Reline complete maxillary/mandibular denture (chairside)	159
D5740/41	Reline maxillary/mandibular partial denture (chairside)	155
D5750/51	Reline complete maxillary/mandibular denture (lab)	224
D5760/61	Reline maxillary/mandibular partial denture (lab)	224
D5810/11	Interim complete denture - maxillary/mandibular	362
D5820/21	Interim partial denture - maxillary/mandibular	362
D5850/51	Tissue conditioning - maxillary/mandibular	79
D5863	Overdenture - complete maxillary	1694
D5864	Overdenture - partial maxillary	1668
D5865	Overdenture - complete mandibular	1694
D5866	Overdenture - partial mandibular	1668
D5992	Adjustment of prosthetic appliance, by report	24
D5993	Cleaning and maintenance prosthetic appliance	18

BRIDGES & PONTICS*

D6058	Abutment supported porcelain/ceramic crown	560
D6059/60/61	Abutment porc/metal crown- metal	523
D6066	Implant porc/metal crown	523
D6210/11/12	Pontic – metal	495
D6240/41/42	Pontic - porcelain fused metal	523
D6245	Pontic - porcelain/ceramic	560
D6250/51/52	Pontic - resin with metal	495
D6545	Retainer - cast metal for resin bonded fixed prosthesis	251
D6548	Ret. - porc./ceramic for resin bonded fixed prosthesis	393
D6549	Resin retainer - for resin bonded fixed prosthesis	251
D6600	Inlay - porc./ceramic, two surfaces	427
D6601	Inlay - porc./ceramic, >=3 surfaces	445
D6602	Inlay - cast high noble metal, two surfaces	407
D6603	Inlay - cast high noble metal, >=3 surfaces	425
D6604	Inlay - cast predominantly base metal, two surfaces	407
D6605	Inlay - cast predominantly base metal, >=3 surfaces	425
D6606	Inlay - cast noble metal, two surfaces	407
D6607	Inlay - cast noble metal, >=3 surfaces	425
D6608	Onlay -porc./ceramic, two surfaces	479
D6609	Onlay - porc./ceramic, three or more surfaces	499

D6610	Onlay - cast high noble metal, two surfaces	458
D6611	Onlay - cast high noble metal, >=3 surfaces	524
D6612	Onlay - cast predominantly base metal, two surfaces	458
D6613	Onlay - cast predominantly base metal, >=3 surfaces	524
D6614	Onlay - cast noble metal, two surfaces	458
D6615	Onlay - cast noble metal, >=3 surfaces	524
D6720/21/22	Crown - resin with metal	495
D6740	Crown - porcelain/ceramic	560
D6750/51/52	Crown - porcelain fused metal	523
D6780	Crown - 3/4 cast high noble metal	430
D6781	Crown - 3/4 cast predominantly base metal	430
D6782	Crown - 3/4 cast noble metal	430
D6783	Crown - 3/4 porc./ceramic	511
D6790/91/92	Crown - full cast metal	495
D6930	Recement fixed partial denture	69
D6970	Post and core in addition to fixed part. dent. ret.	185
D6972	Prefab post and core in addition to fixed part. dent. ret.	154
D6973	Core build up for retainer, including any pins	125
D6976	Each add. indirectly fabricated post - same tooth	130
D6977	Each add. prefab post - same tooth	60
D6980	Fixed partial denture repair, by report	172

ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain	43
D9210/15	Local anesthesia	0
D9211/12	Regional block anesthesia	0
D9223	Deep sedation/general anes - each 15 min incr	103
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	37
D9243	Intravenous moderate sedation/analgesia-15min	103
D9248	Non-intravenous conscious sedation	145
D9310	Consultation (diagnostic service by nontreating dentist)	43
D9410	House/extended care facility call	200
D9420	Hospital call	350
D9910	Application of desensitizing medicament	31
D9930	Treatment of complications (post-surgical)	43
D9940	Occlusal guard, by report	272
D9941	Fabrication of athletic mouthguard	102
D9950	Occlusion analysis - mounted case	104
D9951	Occlusal adjustment – limited	66
D9952	Occlusal adjustment – complete	266
D9986	Missed appointment	50

ENDODONTICS

D3220	Therapeutic pulpotomy (excl. final restor.)	81
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D3221	Pulpal debridement, prim. and perm. teeth	94
D3230	Pulpal therapy - resorbable filling, anterior	160
D3240	Pulpal therapy - resorbable filling, posterior	164
D3310	Endodontic therapy, anterior tooth	341
D3320	Endodontic therapy, bicuspid tooth	418
D3330	Endodontic therapy, molar	512
D3332	Incomp endo. Therapy-inop. or fractured tooth	183
D3333	Internal root repair of perforation defects	105
D3346	Retreat of prev. root canal therapy, anterior	387
D3347	Retreat of prev. root canal therapy, bicuspid	465
D3348	Retreat of prev. root canal therapy, molar	558
D3351	Apexification/recalcification - initial visit	202
D3352	Apexification/recalcification - interim med. repl.	589
D3353	Apexification/recalcification - final visit	449
D3355	Pulpal regeneration - initial visit	202
D3356	Pulpal regeneration – interim medication replacement	589
D3357	Pulpal regeneration – completion of treatment	449
D3410	Apicoectomy/periradicular surgery, anterior	323
D3421	Apicoectomy/periradicular surgery, bicuspid (first root)	364
D3425	Apicoectomy/periradicular surgery, molar (first root)	418
D3426	Apicoectomy/periradicular surgery (each add. root)	152
D3427	Periradicular surgery w/o apicoectomy	266
D3428	Bone graft in conj. w/ periradicular surg., per tooth, single site	743
D3429	Bone graft in conj. w/ periradicular surg., add. contiguous tooth, same	582
D3430	Retrograde filling - per root	119
D3431	Biologic materials to aid soft/osseous tissue regen. in conj. w/ periradicular surg.	407
D3432	Guided tissue regen., resorbable barrier, per site, in conj. w/ periradicular surg	815
D3450	Root amputation - per root	234
D3470	Intentional reimplantation	718
D3920	Hemisection, not inc. root canal therapy	234
D3950	Canal prep/fitting of preformed dowel or post	136
PERIODONTICS		
D0180	Comp. periodontal eval - new or established patient	0
D4210	Gingivectomy or gingivoplasty - >3 cont. teeth, per quad.	279
D4211	Gingivectomy or gingivoplasty - <=3 teeth, per quad.	100
D4230	Anatomical crown exposure, >=4 teeth per quad.	454
D4231	Anatomical crown exposure, 1-3 teeth per quad.	424
D4240	Gingival flap proc., inc. root planing - >3 cont. teeth, per quad	345
D4241	Gingival flap proc, inc. root planing - <=3 cont. teeth, per quad	106
D4249	Clinical crown lengthening - hard tissue	576
D4260	Osseous surgery - >3 cont. teeth, per quad	499

D4261	Osseous surgery - <=3 cont. teeth, per quad	392
D4268	Surgical revision proc., per tooth	358
D4274	Distal or proximal wedge procedure	308
D4320	Provisional splinting – intracoronal	427
D4321	Provisional splinting – extracoronal	377
D4341	Perio scaling and root planing - >3 cont teeth, per quad.	109
D4342	Perio scaling and root planing - <= 3 teeth, per quad	63
D4355	Full mouth debridement	89
D4381	Localized delivery of chemotherapeutic agents	98
D4910	Periodontal maintenance	74
D4920	Unscheduled dressing change by non-treating dentist	84

ORAL SURGERY

D7111	Extraction, coronal remnants - deciduous tooth	56
D7140	Extraction, erupted tooth or exposed root	69
D7210	Surgical rem. of erupted tooth req. bone cut	133
D7220	Removal of impacted tooth - soft tissue	151
D7230	Removal of impacted tooth - partially bony	196
D7240	Removal of impacted tooth - completely bony	241
D7241	Removal of imp. tooth - completely bony, with unusual surg. Complications	217
D7250	Surgical removal of residual tooth roots	141
D7251	Coronectomy-intentional partial tooth removal	141
D7260	Oroantral fistula closure	578
D7270	Tooth reimplant/stabiliz. of acc. evulsed/displaced tooth	226
D7272	Tooth transplantation	615
D7280	Surgical access of an unerupted tooth	153
D7285	Biopsy of oral tissue - hard (bone, tooth)	387
D7286	Biopsy of oral tissue - soft (all others)	295
D7290	Surgical repositioning of teeth	407
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	60
D7310/20	Alveoloplasty, per quad	141
D7311/21	Alveoloplasty in conj. with/out extractions	141
D7340	Vestibuloplasty - ridge ext. sec. epithel.	923
D7350	Vestibuloplasty - ridge ext. inc. grafts, etc	1776
D7410	Excision of benign lesion up to 1.25 cm	278
D7440	Exc. of malignant tumor- lesion diam. <=1.25cm	608
D7450	Removal of benign odon cyst/tumor - diam <=1.25cm	354
D7451	Removal of benign odon cyst/tumor - diam >1.25cm	543
D7460	Removal of benign nonodon cyst/tumor-diam <=1.25cm	516
D7461	Removal of benign nonodon cyst/tumor-diam >1.25cm	718
D7471	Removal of lateral exostosis	351
D7472/73	Removal of torus palatinus/mandibularis	480
D7510	Incision and drainage of abscess - intraoral soft tissue	96
D7520	Incision/drainage of abscess -extra. soft tiss	116
D7550	Partial ostect/sequestrect non-vital bone rem.	336

D7960	Frenulectomy (frenectomy/frenotomy) - separate proc.	263
D7970	Excision of hyperplastic tissue - per arch	233
D7971	Excision of pericoronal gingiva	131

ORTHODONTICS - PRE-AUTHORIZATION REQUIRED

D8070	Comp. ortho. treatment - transitional dentition	3304
D8080	Comp. ortho. treatment - adolescent dentition	3422
D8090	Comp. ortho. treatment - adult dentition	3658
D8660	Pre-orthodontic treatment visit	413
D8670	Periodic ortho. treatment visit (as part of contract)	118
D8680	Orthodontic retention (rem. of appl. and placement of retainer(s))	413
D8692	Replacement of lost or broken retainer	179
D8693	Rebonding or recementing fixed dentures	174
D8694	Repair of fixed retainers, includes reattachment	174

* All fees exclude the cost of noble and precious metals. An additional fee will be charged if these materials are used.

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