YOUR GROUP AGREEMENT

This plan has Excellent Accreditation from the NCQA. See 2018 NCQA Guide for more information on Accreditation.
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INTRODUCTION
This Group Agreement (Agreement), including the 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 accord 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, 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 expressively 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 Premiums, benefits, limitations, exclusions, and/or conditions, to be effective on the Anniversary Date.

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, (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.

SECTION 3 - TERMINATION OF AGREEMENT
This Agreement will terminate under any of the conditions listed below.

Within five (5) 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.

Termination on Notice
The Group may terminate this Agreement effective the day before any Anniversary Date by giving at

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
least ninety (90) days prior written notice to the Health Plan.

The Health Plan will extend benefits for covered Services to Members, with premium, as defined in the “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 non-payment of Premium, the Health Plan will notify the Group of the past-due amount and the effective date of termination, which will be fifteen (15) days from the date of the written notice.

The fifteen (15) days from the written notice by the Health Plan to 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 remain in effect according to the terms and conditions in the Agreement.

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.

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 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 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 Group if no eligible person lives, resides, or works in Health Plan’s Service Area as described 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 small or 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, 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 small and/or large group markets, the Health Plan may terminate this Agreement upon one-hundred eighty (180) days written notice to the Group. And,

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

DCLG-GRP-WRAP(01-18)
upon at least thirty (30) working days before that notice 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 Family Dependents, the Premium specified on the Face Sheet for each month on or before the agreed upon date in the preceding month. These amounts are called the "Base Premiums." "Base Premiums" means 100 percent of monthly Premiums for each enrolled Member, as set forth in this section.

A grace period of fifteen (15) days will be granted for the payment of each premium falling due after the 1st premium, during which grace period the policy shall continue in force.

Premium Payments for New Members
Premiums are payable for new Members for the entire month regardless of the membership effective date. The Group shall continue to pay the Premium for each Subscriber and his or her Family Dependents covered under this Agreement until the Group provides written notice to the Health Plan to terminate such coverage.

Premium Payments for Terminating Members
Premiums are payable for Members for the entire month regardless of the membership termination date. The Group shall continue to pay the Premium for each Subscriber and his or her Family Dependents covered under this Agreement until the Group provides written notice to the Health Plan to terminate such coverage.

The Health Plan will not terminate coverage until it has received the Group’s written notice. The effective date of termination will be the date the written notice is received by Health Plan.

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.

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.

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 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;

3. Contribute to all health care plans available through the Group on a basis that does not financially discriminate against 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.

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.

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 District of Columbia, 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 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, 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 the 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 action at law or in equity shall be brought to recover on this contract (a) prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this contract or (b) after the expiration of three (3) years after the time 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 given 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.
2101 East Jefferson Street
Rockville, Maryland 20852

If to the Group:
To the address indicated on the Face Sheet.

If to a Member:
To the latest address provided to 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
GROUP AGREEMENT
KAISER PERMANENTE

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, 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.

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

By: ____________________________
Mark Ruszczyk
Vice President, Marketing, Sales & Business Development
This plan has Excellent accreditation from the NCQA
See 2018 NCQA Guide for more information on Accreditation

KFHP-EOC COVER (01/14)DC
HMO
NONDISCRIMINATION NOTICE

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

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

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

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


HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ያስተር: የማካብ ምምር ከተለጠ ከቢትስ ከሚከተሉት እርዳታ ይቻቻታል፣ በወን ለማስረጥ የገኛባቸውዎቹ: መጽሃፍ መጋኛ ፈጥር ዋናታቸው መሠረታዊ ወለፋው መሠረታዊ 1-800-777-7902 (TTY: 711).

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

Ɓàsɔ́ ò-wùɖù-po-nyɔ̀ jǔ ké m̀ Ɓàsɔ́ ɔ̀ -wùɖù-po-nyɔ̀ jǔ ni, nìí, à wuɖu kà kò po-ro po-ro bëín m̩ gbo kpáa. Đà 1-800-777-7902 (TTY: 711)

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

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

توجه: اگر به زبان فارسی گفتگو گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌شود. تلفن: 1-800-777-7902 (TTY: 711).
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Definitions

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
DCLG-ALL-TOC(1/05)
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.

Please note that Health Plan is subject to the regulations of the District of Columbia Department of Insurance, Securities and Banking (“DISB”).

KAISER PERMANENTE SIGNATURESM

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

To make your health care easily accessible, the Health Plan provides conveniently located Plan Medical Centers and medical offices throughout the Washington, DC and Baltimore metropolitan areas. We have placed an integrated team of specialists, nurses, and technicians alongside our 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 our Service Area;
3. Authorized Referrals; and
4. Covered Services received in other Kaiser Permanente Regions and 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 other benefits described in the Section 3: Benefits.

WHO IS ELIGIBLE

General
To be eligible to enroll and to remain enrolled, you must meet the following requirements:
1. Your Group's eligibility requirements that we have approved (your Group is required to inform Subscribers of the Group's eligibility requirements) and meet the Subscriber or Dependent eligibility requirements below.

2. Live or work in our Service Area (our Service Area is described in the Definitions Appendix).
   However, you or your Spouse’s eligible children who live outside our Service Area may be eligible to enroll if you are required to cover them pursuant to a Qualified Medical Child Support Order (QMCSO).

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

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, or
   b. To pay your Cost Share to any Plan Provider, 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;
2. Your or your Spouse’s children (including adopted children or children placed with you for adoption) who are under the age limit specified on the Summary of Services and Cost Shares section of the Appendix;
3. Other Dependent persons who are under the age limit specified on the Summary of Services and Cost Shares section of the Appendix, (but not including foster children) who:
   a. Are in the court-ordered custody of you or your Spouse; or
   b. You or your Spouse have received a court or administrative order; or
   c. Are under testamentary or court-appointed guardianship.

Your Group determines which persons are eligible to be enrolled as your Dependents. Please contact your Group’s benefits administrator for questions regarding Dependent eligibility.

You or your Spouse’s 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 the following requirements:

1. They are incapable of self-sustaining employment because of a mentally- or physically-disabling injury, illness, or condition that occurred prior to reaching the age limit for Dependents;
2. They receive 50 percent or more of their support and maintenance from you or your Spouse; and

3. You give us proof of their incapacity and dependency within sixty (60) days after we request it (see “Disabled Dependent Certification” 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 above. You must provide us documentation of your Dependent's incapacity and dependency as follows:

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

If you provide us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination.

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.

If we determine that your Dependent is eligible as a disabled Dependent, there will be no lapse in coverage. Also, beginning two years after the date that your Dependent reached the age limit, you must provide us documentation of his or her incapacity and dependency annually within sixty (60) days after we request it so that we can determine if he or she continues to be eligible as a disabled Dependent.

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

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

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

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

Membership begins at 12a.m. ET on the membership effective date. Eligible people may enroll as follows:

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

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

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

Special Enrollment Due to New Dependents
Subscribers may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, within thirty-one (31) days after:

1. Marriage; or
2. Birth, adoption, or placement for adoption by submitting to your Group a Health Plan-approved enrollment application.

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

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

1. **For newborn children, the moment of birth.** If payment of additional Premium is required to provide coverage for the newborn child then, in order for coverage to continue beyond thirty-one (31) days from the date of birth, notification of birth and payment of additional Premium must be provided within thirty-one (31) days of the date of birth, otherwise coverage for the newborn will terminate thirty-one (31) days from the date of birth.

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

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

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

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

**Special Enrollment Due to Loss of Other Coverage**
You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, if all of the following are true:

1. The Subscriber or at least one of the Dependents had other coverage when he or she previously declined all coverage through your Group;
2. The loss of the other coverage is due to one of the following:
   a. Exhaustion of COBRA coverage;
   b. Termination of employer contributions for non-COBRA coverage;
   c. Loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (non-group) plan for nonpayment.
      i. 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.
YOUR GROUP EVIDENCE OF COVERAGE (EOC)
KAISER PERMANENTE

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

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

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

**Special Enrollment Due to Eligibility for Premium Assistance under Medicaid or CHIP**
You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, if the Subscriber or at least one of the enrolling Dependents becomes eligible to receive premium assistance under Medicaid or CHIP. To request enrollment, the Subscriber must submit a Health Plan-approved enrollment or change of enrollment application to your Group within sixty (60) days after the Subscriber or Dependent is determined eligible for premium assistance.

The effective date of an enrollment resulting from eligibility for the premium assistance under Medicaid or CHIP is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

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

**PREMIUM**
Members are entitled to health care coverage only for the period for which we have received the appropriate Premium from your Group. You are responsible for the Member contribution to the Premium. Your Group will tell you the amount and how you will pay it to your Group (i.e., through payroll deduction(s)).
SECTION 2: HOW TO OBTAIN SERVICES

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

As a Member, you are selecting our medical care delivery 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, Section 3: Benefits;
3. Getting a Referral, as described in this section; and
4. Receiving Care in Another Kaiser Foundation Health Plan Service Area, as described in this section.

YOUR PRIMARY CARE PLAN PHYSICIAN

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

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

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

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

GETTING A REFERRAL

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

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

When you need covered services, you will be referred to a Plan Hospital within the delivery system where the Plan Provider who is providing the Service has admitting privileges.

If your primary care Plan Physician decides that you require covered Services not available from us, he or
she will refer you to a non-Plan Provider inside or outside of our Service Area. You must have an approved written referral to the non-Plan Provider in order for us to cover the Services. Any additional radiology studies, laboratory Services or other Services from any other professional not named in the referral are not authorized and will not be reimbursed. If the non-Plan Provider recommends Services not indicated in the approved referral, your primary care Plan Physician will work with you to determine whether those Services can be provided by a Plan Provider. The Cost Shares for approved referral Services provided by a non-Plan Provider are the same as those required for Services provided by a Plan Provider.

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. Obstetrical or gynecological care, for females, from a Plan Provider who specializes in obstetrics or gynecology;
3. Optometry Services; and
4. Urgent Care Services provided within our Service Area.

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

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 Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

**STANDING REFERRALS TO SPECIALISTS**

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

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

**SECOND OPINIONS**

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

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

If you think you are experiencing an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital 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 24 hours a day, seven days a week.

GETTING ASSISTANCE FROM OUR ADVICE NURSES
If you are not sure whether you are experiencing an Emergency Medical Condition, or may require Urgent Care Services (for example, a sudden rash, high fever, severe vomiting, ear infection, or a sprain), you may call our advice nurses at:

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

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

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

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

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

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

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

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

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

The following visiting member care is covered when it is provided or arranged by a Plan Physician in the service area you are visiting. Certain Services, such as transplant Services or infertility Services, are not covered for visiting members. Visiting member benefits may not be the same as those you receive in your home Service Area.

**Hospital Inpatient Care:**
1. Physician Services;
2. Room and board;
3. Necessary Services and supplies;
4. Maternity Services; and
5. Prescription drugs.

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

**Laboratory and X-Ray:**
1. Covered in or out of the hospital.

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

**Mental Health Services other than for Emergency or Urgent Care Services:**
1. Outpatient visits and inpatient hospital days.

**Substance Abuse Treatment other than for Emergency or Urgent Care Services:**
1. Outpatient visits and inpatient hospital days.

**Skilled Nursing Facility Care:**
1. Up to one-hundred (100) days per calendar year.

**Home Health Care:**
1. Home health care Services inside the visited Service Area.

**Hospice Care:**
1. Home-based hospice care inside the visited Service Area.

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

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

**Visiting Member Service Exclusions**

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

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

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

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

**VALUE ADDED SERVICES**

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

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

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

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

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

**PAYMENT TOWARD YOUR COST SHARE AND WHEN YOU MAY BE BILLED**

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

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

1. **You receive non-preventive Services during a preventive visit.** For example, you go in for a
   routine physical exam, and at check-in you pay your Cost Share for the preventive exam (your
   Cost Share may be "no charge"). However, during your preventive exam your provider finds a
   problem with your health and orders non-preventive Services to diagnose your problem (such as
   laboratory tests). You may be asked to pay your Cost Share for these additional non-preventive
diagnostic Services.

2. **You receive diagnostic Services during a treatment visit.** For example, you go in for treatment
   of an existing health condition, and at check-in you pay your Cost Share for a treatment visit.
   However, during the visit your provider finds a new problem with your health and performs or
   orders diagnostic Services (such as laboratory tests). You may be asked to pay your Cost Share
for these additional diagnostic Services.

3. **You receive treatment Services during a diagnostic visit.** For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay your Cost Share for these additional treatment Services.

4. **You receive non-preventive Services during a no-charge courtesy visit.** For example, you go in for a blood pressure check or meet and greet visit and the provider finds a problem with your health and performs diagnostic or treatment Services. You may be asked to pay your Cost Share for these additional diagnostic or treatment Services.

5. **You receive Services from a second provider during your visit.** For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay your Cost Share for the consultation with the specialist.
SECTION 3: BENEFITS

The Services described in this section are covered only when:
1. You are a Member on the date the Services are rendered;
2. The Services are provided:
   a. By a Plan Provider; or
   b. By a non-Plan Provider, subject to an approved referral as described in Section 2; and
   c. In accordance with the terms and conditions within this EOC including but not limited to the
      requirements, if any, for prior approval (authorization);
3. The Services are Medically Necessary; and
4. You receive the Services from a Plan Provider except as described within this EOC.

You must receive all covered Services from Plan Providers inside our Service Area, except for:
1. Emergency Services;
2. Urgent Care outside our Service Area;
3. Authorized referrals to non-Plan Providers (as described in Section 2: How to Obtain Services); and
4. Receiving care in another Kaiser Foundation Health Plan Service Area 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 all benefits are described in Section 4: Exclusions,
Limitations and Reductions.

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

A. OUTPATIENT CARE

We cover the following outpatient care:
1. Primary care visits for internal medicine, family practice, pediatrics, and routine preventive
   obstetrics/gynecology (OB/GYN) Services (Refer to “Preventive Health Care Services” for coverage
   of preventive care Services);
2. Specialty care visits (Refer to “Referrals to Plan Providers” in 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. This includes, but is not limited to:
5. Diagnostic exams, including digital rectal exams and prostate antigen (PSA) tests provided:
   a. To persons age 40 and older who are at high risk for prostate cancer according to the most recent
      published guidelines of the American Cancer Society;
6. Colorectal cancer screening, specifically: screening with an annual fecal occult blood test; flexible
   sigmoidoscopy or colonoscopy; or, in appropriate circumstances, radiologic imaging, for persons who
   are at high risk of cancer. High risk is determined based on the most recently published guidelines of
   the American College of Gastroenterology, in consultation with the American Cancer Society;
7. Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified

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individual when a Plan Provider requires the bone mass measurement. A “qualified individual” means an individual:
   a. Who is estrogen deficient individual at clinical risk for osteoporosis;
   b. With a specific sign suggestive of spinal osteoporosis. This includes: roentgenographic osteopenia or roentgenographic evidence suggestive of collapse; wedging; or ballooning of one or more thoracic or lumbar vertebral bodies; and who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
   c. Receiving long-term glucocorticoid (steroid) therapy;
   d. With primary hyperparathyroidism; or
   e. Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;
8. Outpatient surgery;
9. Anesthesia, including Services of an anesthesiologist;
10. Chemotherapy and radiation therapy;
11. Respiratory therapy;
12. Medical social Services;
13. House calls when care can best be provided in your home as determined by a Plan Provider; and
14. After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to the Urgent Care provision for covered Services.

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

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

B. HOSPITAL INPATIENT CARE
We cover the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by an acute care general hospital in our Service Area:
   1. Room and board (includes bed, meals and special diets), including private room when deemed Medically Necessary;
   2. Specialized care and critical care units;
   3. General and special nursing care;
   4. Operating and recovery room;
   5. Plan Physicians’ and surgeons’ Services, including consultation and treatment by specialists;
   6. Anesthesia, including Services of an anesthesiologist;
   7. Medical supplies;
   8. Chemotherapy and radiation therapy;
   9. Respiratory therapy; and
   10. Medical social Services and discharge planning.

Additional inpatient Services are covered, but only as described in this section, 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 met:
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 be requested 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 the injury started.

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 the injury occurred.
- Services for teeth that have been avulsed (knocked out) or that have been so severely damaged that in the opinion of the Plan Provider, restoration is impossible.

**D. ALLERGY SERVICES**
We cover the following allergy Services:
- Evaluations, and treatment; and
- Injections and serum.

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

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

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

We cover licensed ambulance and ambulette (non-emergent transportation) Services ordered by a Plan Provider only inside our Service Area, except as covered under the “Emergency Services” provision 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.

- Ambulette (non-emergent transportation) Services that are not medically appropriate and that have not been ordered by a Plan Provider.

F. ANESTHESIA FOR DENTAL SERVICES
We cover general anesthesia and associated hospital or ambulatory facility Services for dental care provided to Members who are age:

1. 7 or younger or are developmentally disabled and for whom a:
   a. Superior result can be expected from dental care provided under general anesthesia; and
   b. Successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition.

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

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

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

Anesthesia for Dental Services Exclusions:

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

G. 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; cord blood procurement and storage for approved Medically Necessary care, when authorized by a Plan Provider; and the administration of prescribed whole blood and blood products.

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

Blood, Blood Products and their Administration Limitations:

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

Blood, Blood Products and their Administration Exclusions:

- Directed blood donations.

H. CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES
We cover the treatment of treatable mental illnesses, emotional disorders, drug abuse and alcohol abuse for conditions that in the opinion of a Plan Provider, would be responsive to therapeutic management.
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.

While you are in a hospital, we cover all medical Services of physicians and other health professionals as performed, prescribed or directed by a Plan Provider including, but not limited to:

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

Medical Services for detoxification are limited to the removal of the toxic substance or substances from the system. Detoxification will be covered for a minimum of twelve (12) days annually.

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

Partial hospitalization is defined as the provision of medically directed intensive or intermediate short term treatment for mental illness, emotional disorders, 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 as performed, prescribed, or directed by a physician including, but not limited to:

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

**Chemical Dependency and Mental Health Services Exclusions:**

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

**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 routine patient care costs you may incur as an eligible participant in an approved clinical trial undertaken for the purposes of: the prevention, early detection, treatment; or monitoring of cancer, chronic disease, or life-threatening illness.

For the purposes of this benefit, an approved clinical trial means:

1. A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
   a. The National Institutes of Health (NIH);
   b. The Centers for Disease Control and Prevention (CDC);
   c. The Agency for Health Care Research and Quality;
   d. The Centers for Medicare and Medicaid Services;
   e. A bona fide clinical trial cooperative group, including: the National Cancer Institute Clinical Trials Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the AIDS Clinical Trials Group; and the Community Programs for Clinical Research in AIDS; or
   f. The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;

2. A study or investigation approved by the United States Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA; or

3. An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

“Routine patient care costs” mean:

1. Items, drugs, and Services that are typically provided absent a clinical trial;
2. Items, drugs, and Services required solely for the provision of the investigational item or service (such as the administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
3. Items, drugs, and Services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

Clinical Trials Exclusions:

Routine patient care costs shall not include:

- The cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or items, drugs, or Services provided solely to satisfy data collection and analysis needs; or
- Items, drugs, or Services customarily provided by the research sponsors free of charge for any qualified individual enrolled in the trial.

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 diabetes outpatient self-management training and educational Services, including medical nutrition therapy, when both prescribed by a Plan Provider and purchased from a Plan Provider, for the treatment of:

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

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

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

To obtain information about Plan preferred vendors, contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

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 Provider provides a written referral for care at the facility.

We cover the following renal dialysis Services:

1. Outpatient maintenance dialysis treatments in a Plan dialysis facility. Coverage includes the cost of lab 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

We cover home dialysis, which includes:

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

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

M. DRUGS, SUPPLIES, AND SUPPLEMENTS

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

1. Oral infused or injected drugs, and radioactive materials used for therapeutic purposes, including chemotherapy;
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: dressings; splints; casts; hypodermic needles; syringes; or any other Medically Necessary supplies provided at the time of treatment;
5. Vaccines and immunizations approved for use by the FDA that are not considered part of routine preventive care.

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

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

N. DURABLE MEDICAL EQUIPMENT

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

Durable Medical Equipment does not include coverage for Prosthetic Devices, such as implants, artificial eyes or legs, or Orthotic Devices, such as braces or therapeutic shoes. Refer to “Prosthetic and Orthotic Devices” for coverage of Prosthetic Devices and Orthotic Devices.
Basic Durable Medical Equipment
We cover Durable Medical Equipment as prescribed by a Plan Provider for use in your home (or an institution used as your home). We also cover Durable Medical Equipment used during a covered stay in a Plan Hospital or Skilled Nursing Facility, but only if the Skilled Nursing Facility ordinarily furnishes Durable Medical Equipment.

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

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

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

Oxygen and Equipment
We cover oxygen and equipment when prescribed by a Plan Provider and your medical condition meets the Health Plan’s criteria for being Medically Necessary. A Plan Provider must certify the continued medical need for oxygen and equipment.

Positive Airway Pressure Equipment
We cover continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BIPAP) equipment when prescribed by a Plan Provider and your medical condition meets the Health Plan’s criteria for 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
3. Nebulizers

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

International Normalized Ratio (INR) Home Testing Machines
INR home testing machines when deemed Medically Necessary by a Plan Physician.

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

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

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

We cover Emergency Services as follows:

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

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

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

**Continuing Treatment Following Emergency Services**

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

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

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

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

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

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

**Emergency Services HIV Screening Test**
We cover the cost of a voluntary HIV screening test performed on a Member while the Member is receiving emergency medical Services, other than HIV screening, at a hospital emergency room. The test is covered whether or not the HIV screening test is necessary for the treatment of the medical emergency which caused the member to seek Emergency Services.

Covered Services include:
1. The costs of administering such a test;
2. All lab costs to analyze the test; and
3. The costs of telling the Member the results of the test; and any applicable follow-up instructions for obtaining health care and supportive Services.

Other than the Cost Share shown in the Summary of Services and Cost Shares for Emergency Services, no additional Cost Share will be imposed for these Services.

**Emergency Services Limitations:**

- **Notification:** If you receive care at a hospital emergency room or are admitted to a non-Plan Hospital, you, or someone on your behalf, must notify us as soon as possible, but not later than 48 hours or the next business day, whichever is later, of the emergency room visit or 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 emergency room visit, or hospital care you receive after transfer would have been possible.

- **Continuing or Follow-up Treatment:** Except as provided for under “Continuing Treatment Following Emergency Surgery,” we do not cover continuing or follow-up treatment after Emergency Services unless authorized by Health Plan. We cover only the out-of-Plan emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Foundation Health Plan or allied plan service area.
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- **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. Family planning counseling, including pre-abortion and post-abortion counseling and information on birth control;
2. Insertion and removal, and any Medically Necessary exams associated with the use of contraceptive drugs and devices. Contraceptive devices (other than diaphragms) and implantable contraceptive drugs are supplied by the provider, and are covered under this benefit. Contraceptive drugs and diaphragms are covered only under an “Outpatient Prescription Drug Rider,” if applicable;
3. Tubal ligations;
4. Male sterilization (i.e., vasectomies); and
5. Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (a) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (b) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.

*Voluntary termination of pregnancy limitations:*
- We cover up to a maximum of two (2) voluntary terminations of pregnancy during a contract year.

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

Q. HABILITATIVE SERVICES

**Children under age 21**

We cover Medically Necessary Services, including speech therapy, occupational therapy and physical therapy, for children under the age of 21 years with a congenital or genetic birth defect, to enhance the child’s ability to function. Medically Necessary Habilitative Services are those Services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, and shall include Services that enhance functional ability without effecting a cure. Congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. The term congenital or genetic birth defect includes: (1) autism or an autism spectrum disorder and (2) cerebral palsy.

*Habilitative Services Exclusions:*
- Assistive technology Services and devices.
- Services provided through federal, state or local early intervention programs, including school programs.
- Services not preauthorized by Health Plan.
- Services for a Member that has plateaued and is able to demonstrate stability of skills and functioning even when Services are reduced.
- Services not provided by a licensed or certified therapist.
- Applied Behavioral Analysis (ABA).
R. HEARING SERVICES

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

Hearing Services Exclusions:
- Tests to determine an appropriate hearing aid.
- Hearing aids or tests to determine their efficacy; except as specifically provided in this section, or as provided under a “Hearing Services Rider,” if applicable.

S. HOME HEALTH CARE

Except as provided for under Visiting Member Services, we cover the following Home Health Care only within our Service Area, only if you are substantially confined to your home, and only if a Plan Provider 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 Care Services are Medically Necessary health Services that can be safely and effectively provided in your home by health care personnel and are directed by a Plan Provider. They include visits by registered nurses, practical nurses or home health aides who work under the supervision or direction of a registered nurse or medical doctor.

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

Home Health Visits Following Mastectomy or Removal of Testicle

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

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

Home Health Care Limitations:
- Home 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 (2) hours, then each two (2)-hour increment counts as a separate visit. For example, if a nurse comes to your home for three (3) hours and then leaves, that counts as two (2) visits. Also, each person providing Services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two (2) hours that counts as two (2) visits.

Additional limitations may be stated in the “Summary of Services and Cost Share.”

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

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

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

1. Nursing care;
2. Physical, occupational, speech, and respiratory therapy;
3. Medical social Services;
4. Home health aide Services;
5. Homemaker Services;
6. Medical supplies and appliances;
7. Palliative drugs in accord with our drug formulary guidelines;
8. Physician care;
9. General hospice inpatient Services for acute symptom management including pain management;
10. Respite Care that may be limited to five (5) consecutive days for any one inpatient stay up to 4 times in any contract year;
11. Counseling Services for the Member and his Family Members, including dietary counseling for the Member; and bereavement counseling for the Member’s Family for a period of one year after the Member’s death; and
12. Services of hospice volunteers.

Definitions:

1. **Family Member** means a relative by blood, marriage or adoption who lives with or regularly participates in the care of the terminally ill Member.
2. **Hospice Care** means a coordinated, inter-disciplinary program of hospice care Services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health Services through home or inpatient care during the illness and bereavement counseling following the death of the Member.
3. **Respite Care** means temporary care provided to the terminally ill Member to relieve the Member’s Caregiver from the daily care of the Member.
4. **Caregiver** means an individual primarily responsible for the day to day care of the Member during
the period in which the Member receives Hospice Services.

U. INFERTILITY SERVICES

We cover the following:

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

Notes:

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

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

Infertility Services Exclusions:

- Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member’s eggs and/or male Member’s sperm for future attempts.
- Assisted reproductive procedures and any related testing or service that includes the use of donor sperm, donor eggs or donor embryos.
- Any charges associated with obtaining donor eggs, donor sperm or donor embryos.
- Infertility Services when the member does not meet medical guidelines established by the American Society of Reproductive Medicine and the American Society for Reproductive Endocrinology.
- Services not preauthorized by the Health Plan.
- Services to reverse voluntary, surgically induced infertility.
- Infertility Services when the infertility is the result of an elective male or female surgical procedure.
- Assisted reproductive technologies and, procedures including but not limited to: in vitro fertilization; gamete intrafallopian transfers (GIFT); zygote intrafallopian transfers (ZIFT); assisted hatching; and prescription drugs related to such procedures.

V. MATERNITY SERVICES

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

Services for pre-existing conditions care related to the development of a high risk condition(s) during pregnancy, and non-routine obstetrical care are covered subject to applicable Cost Share for specialty, diagnostic, and/or treatment Services.

We cover inpatient hospitalization Services for you and your enrolled 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 you are required to remain hospitalized after childbirth for medical reasons.

Comprehensive lactation (breastfeeding) education and counseling, by trained clinicians during pregnancy and/or postpartum period in conjunction with each birth, Breastfeeding equipment is issued, per pregnancy. The breast feeding pump (including any equipment that is required for pump functionality) is covered for six (6) months at no cost sharing to the member.

**Maternity Services Exclusions**

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

**W. MEDICAL FOODS**

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

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

Low protein modified foods are food products that are (1) specially formulated to have less than one 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.

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

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

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

**Morbid Obesity Services Exclusions**
- Services not preauthorized by the Health Plan

**Y. ORAL SURGERY**
We cover treatment of tumors where a biopsy is needed for pathological reasons.

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

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

**Temporomandibular Joint Services**
Coverage is provided for:
1. Orthognathic surgery, including inpatient and outpatient surgery to correct temporomandibular joint (TMJ) pain dysfunction syndrome and craniomandibular joint services, that are required because of a
medical condition or injury that prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part;

2. Removable appliances for TMJ repositioning; and

3. Therapeutic injections for TMJ.

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

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

**Z. PREVENTIVE HEALTH CARE SERVICES**

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

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

1. Preventive care exams, including:
   a. Routine physical examinations and health screening tests appropriate to your age and sex;
   b. Well-woman examinations; and
   c. Well child care examinations;

2. Routine and necessary immunizations (travel immunizations are not preventive and are covered under Outpatient Services in this section) for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;

3. An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;

4. Low dose screening mammograms to determine the presence of breast disease is covered as follows:
   a. One mammogram for persons age 35 through 39;
   b. One mammogram biennially for persons age 40 through 49; and
   c. One mammogram annually for person 50 and over;

5. Bone mass measurement to determine risk for osteoporosis;

6. Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to men who are age 40 or older;

7. Colorectal cancer screening in accordance with screening guidelines issued by the American Cancer Society including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy;

8. Cholesterol test (lipid profile);

9. Diabetes screening (fasting blood glucose test);

10. Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis and HPS), subject to the following:
    a. Annual chlamydia screening is covered for (a) women under age of 20, if they are sexually active; and (b) women age 20 years of age or older, and men of any age, who have multiple risk
factors, which include: (i) a prior history of sexually transmitted diseases; (ii) new or multiple sex partners; (iii) inconsistent use of barrier contraceptives; or (iv) cervical ectopy;

b. Human Papillomavirus Screening (HPS) as recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;

11. HIV tests;
12. TB tests;
13. Newborn hearing screenings that include follow up audiological examinations, as recommended by a physician or audiologist, and performed by a licensed audiologist to confirm the existence or absence of hearing loss when ordered by a Plan Provider;
14. Associated preventive care radiological and lab tests not listed above; and
15. CT scan of the Thorax when ordered as a preventive for smokers age 55 to 80 years of age.

**Preventive Health Care Services Limitation:**
While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services. The applicable Cost Shares will apply.

- Monitoring a chronic disease;
- Follow-up Services after you have been diagnosed with a disease;
- Testing and diagnosis for specific diseases for which you have been determined to be at high risk for contracting based on factors determined by national standards;
- Services provided when you show signs or symptoms of a specific disease or disease process;
- Non-routine gynecological visits; and
- Treatment of a medical condition or problem identified during the course of a preventive screening exam.

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

**AA. PROSTHETIC AND ORTHOTIC DEVICES**
We cover the devices listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or injured. Coverage includes fitting and adjustment of these devices, repair or replacement (unless due to loss or misuse), and Services to determine whether you need the Prosthetic Device. If we do not cover the Prosthetic Device, we will try to help you find facilities where you may obtain what you need at a reasonable price. Coverage is limited to the standard device that adequately meets your medical needs.

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

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

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

**Artificial Arms, Legs or Eyes**
We cover the following when prescribed by a Plan Provider and your medical condition meets Health Plan’s criteria for being Medically Necessary:
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.

**Ostomy and Urological Supplies and Equipment**
We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets the Health Plan’s criteria for Medical Necessity. Covered equipment and supplies include, but is not limited to flanges, collection bags, clamps, irrigation devices, sanitizing products, ostomy rings, ostomy belts and catheters used for drainage of urostomies.

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

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

**Prosthetic and Orthotic Device Limitations:**
- Coverage for mastectomy bras is limited to a maximum of two (2) per contract year.
- Coverage for hair prosthesis is limited to one (1) prosthesis per course of chemotherapy and/or radiation therapy, not to exceed a maximum benefit of $350 per prosthesis.
- Standard Devices: Coverage is limited to standard devices that adequately meet your medical needs.
- Therapeutic shoes and inserts are covered when deemed medically necessary by a Plan Provider, and are limited to individuals who have diabetic foot disease with impaired sensation or altered peripheral circulation.

**Prosthetic and Orthotic Device Exclusions:**
- Services not preauthorized by Health Plan.
- Internally implanted breast prosthetics for cosmetic purposes.
- Repair or replacement of prosthetics devices due to loss or misuse.
- Microprocessor and robotic controlled external prosthetics and orthotics that does not meet the Health Plan criteria as Medical Necessary.
- Multifocal intraocular lens implants.
- More than one piece of equipment or device for the same part of the body, except for replacements, spare devices or alternate use devices.
- Dental prostheses, devices and appliances, except as specifically provided in this section, or as provided under an “Adult Dental Plan Rider” or a “Pediatric Dental Plan Rider,” if applicable.
• Hearing aids, except as specifically provided in this section, or as provided under a “Hearing Services Rider,” if applicable.
• Corrective lenses and eyeglasses, except as specifically provided in this section.
• Orthopedic shoes or other supportive devices, unless the shoe is an integral part of a leg brace; or unless indicated above.
• Non-rigid appliances and supplies, including but not limited to: jobst stockings; elastic garments and stockings; and garter belts.
• Comfort, convenience, or luxury equipment or features.

**BB. RECONSTRUCTIVE SURGERY**

We cover reconstructive surgery. This shall include plastic, cosmetic and related procedures required to: (1) correct significant disfigurement resulting from an injury or Medically Necessary surgery, (2) correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function, and (3) treat congenital hemangioma known as port wine stains on the face. Breast augmentation is covered only if determined to be Medical 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. Mastectomy is the surgical removal of all or part of a breast as a result of breast cancer. Reconstructive breast surgery is surgery performed as a result of a mastectomy to reestablish symmetry between both breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

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

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

**CC. ROUTINE FOOT CARE**

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

*Routine Foot Care Limitations:*

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

*Routine Foot Care Exclusions:*

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

**DD. SKILLED NURSING FACILITY CARE**

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

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

Note: The following Services are covered, but not under this provision:
1. Blood (see “Blood, Blood Products and Their Administration”);
2. Drugs (see “Drugs, Supplies and Supplements”);
3. Durable Medical Equipment ordinarily furnished by a Skilled Nursing Facility, including oxygen dispensing equipment and oxygen (see “Durable Medical Equipment”);
4. Physical, occupational, and speech therapy (see “Therapy and Rehabilitation Services”); and
5. X-ray, laboratory, and special procedures (see “X-ray, Laboratory and Special Procedures”).

**Skilled Nursing Facility Care Exclusions:**
- Custodial care (see definition in Section 4: Exclusions, Limitations, and Reductions).
- Domiciliary care.

**EE. TELEMEDICINE SERVICES**
We cover telemedicine Services that would otherwise be covered under this Benefits section when provided by 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. 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.

**Telemecine Services Exclusion:**
- Services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions.

**FF. THERAPY AND REHABILITATION SERVICES**

**Physical, Occupational, and Speech Therapy Services**
If, in the judgment of a Plan Provider, significant improvement is achievable within a two (2)-month period, we cover physical, occupational and speech therapy:
1. While you are confined in Plan Hospital; and
2. For up to thirty (30) visits of physical therapy, thirty (30) visits of occupational therapy, and thirty (30) visits of speech therapy per contract year per injury, incident or condition in a Plan Medical Center, a Plan Provider’s medical office, a Skilled Nursing Facility or as part of home health care. These limits do not apply to necessary treatment of cleft lip or cleft palate.

**Physical, Occupational, and Speech Therapy Services Limitations:**
- Physical therapy is limited to treatment to restore physical function that was lost due to injury or
illness. It is not covered to develop physical function, except as provided for under “Habilitative Services” in this section.

- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Speech therapy is limited to treatment for speech impairments due to injury or illness.

**Multidisciplinary Rehabilitation Services**

If, in the judgment of a Plan Provider, 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 consecutive months of treatment per injury, incident or condition.

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

**Multidisciplinary Rehabilitation Services Limitations:**

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

**Cardiac Rehabilitation Services**

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

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

**Therapy and Rehabilitation Services Exclusion:**

- Long-term rehabilitative therapy.

**GG. THERAPY: RADIATION, CHEMOTHERAPY AND INFUSION THERAPY**

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

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

**HH. TRANSPLANT SERVICES**

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

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

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

1. Unless otherwise authorized by Medical Group, transplants are covered only in our Service Area.
2. If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for transplant, we will pay only for covered Services you receive before that determination was made.

3. The Health Plan, Plan Hospitals, Medical Group and Plan Providers are not responsible for finding, furnishing, or ensuring the availability of a bone marrow or organ donor.

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

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

II. URGENT CARE

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

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

Inside our Service Area

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

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

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

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

Outside of our Service Area

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

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

Urgent Care Limitations:

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

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

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

Eye Exams
We cover routine and necessary eye exams, including:
1. Routine tests such as eye health and glaucoma tests; and
2. Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.

Pediatric Eye Exams
We cover the following for children until the end of the month in which the child turns age 19:
1. One routine eye exam per year, including:
   a. Routine tests such as eye health and glaucoma tests; and
   b. Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.

Pediatric Lenses and Frames
We cover the following for children until the end of the month in which the child turns age 19 at no charge:
1. One (1) pair of lenses per year;
2. One (1) pair of frames per year from a select group of frames;
3. Regular contact lenses (in lieu of lenses and frames) for the first regular supply for that contact lens per year; or
4. Medically Necessary contact lenses up to two (2) pair per eye per year.

In addition, we cover the following Services:

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

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

Contact Lenses
We provide a discount on the initial fitting for contact lenses, when purchased at a Kaiser Permanente Optical Shop. Initial fitting means the first time you have ever been examined for contact lens wear at a Plan Facility. The discount includes the following Services:
1. Fitting of contact lenses;
2. Initial pair of diagnostic lenses (to assure proper fit);
3. Insertion and removal of contact lens training; and
4. Three (3) months of follow-up visits.

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

**Vision Exclusions:**

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

**KK. X-RAY, LABORATORY, AND SPECIAL PROCEDURES**

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

1. Diagnostic imaging;
2. Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
3. Special procedures, such as electrocardiograms and electroencephalograms;
4. Sleep lab and sleep studies; and
5. Specialty imaging: including CT, MRI, PET Scans, and Nuclear Medicine studies; and interventional radiology.
SECTION 4: EXCLUSIONS, LIMITATIONS AND REDUCTIONS

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

It also provides information on how your benefits may be coordinated with other types of coverage.

IMPORTANT DEFINITIONS

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

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

EXCLUSIONS

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

Alternative Medical Services
Chiropractic and acupuncture Services and any 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 or licensing or disability determinations; or (3) on court-order or required for parole or probation.

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

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

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

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

The Health Plan consults the Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.
Prohibited Referrals
Payment of any claim, bill or other demand or request for payment for covered Services determined to be furnished as the result of a referral prohibited by law.

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

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

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

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

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

Workers’ Compensation or Employer’s Liability
Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to a “Financial Benefit”), is provided under any workers’ compensation or employer’s liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit; but we may recover the value of any covered Services from the following sources:
1. Any source providing a Financial Benefit or from whom a Financial Benefit is due; or
2. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers’ compensation or employers’ liability law.

LIMITATIONS
We will use our best efforts to provide or arrange for covered Services in the event of unusual circumstances that delay or render impractical the provision of Services such as major disaster, epidemic, war, terrorist activity, riot, civil insurrection, disability of a large share of personnel of a Plan Hospital or Plan Medical Center, complete or partial destruction of facilities, and labor disputes not involving the Health Plan, Kaiser Foundation Hospitals, or Medical Group. However, in these circumstances the Health Plan, Kaiser Foundation Hospitals, Medical Group, and Medical Group Physicians will not have any liability for any delay or failure in providing covered Services, except to the extent prescribed by the Commissioner of Insurance of the District of Columbia.

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

DCLG-ALL-SEC4(01-18) 4.3 ALL
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 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 settlement you obtain against a third party for covered medical expenses, in accordance with the first paragraph of this section. The Health Plan's recovery shall be made only to the extent that the Health Plan provided covered Services or made payments for covered Services as a result of the occurrence that gave rise to the cause of action. The proceeds of any judgment or settlement that the Member or Health Plan obtains shall first be applied to satisfy the Health Plan’s lien, regardless of whether the total amount of recovery is less than the actual losses and damages you incurred.

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

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

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

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

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

Medicare and TRICARE Benefits
Your benefits are reduced by any benefits for which you are enrolled and receiving under Medicare Part
A and/or Part B, except for Members whose Medicare benefits are secondary by law. TRICARE benefits
are secondary by law.

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

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

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

Definition
"Plan": Any of the following that provides benefits or services for, or because of, medical care or
treatment: Individual or group insurance or group-type coverage, whether insured or uninsured. This
includes prepaid group practice or individual practice coverage. “Plan” does not include an individually
underwritten and issued, guaranteed renewable, specified disease policy or intensive care policy that does
not provide benefits on an expense-incurred basis.

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

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

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

1. If another Plan does not have a COB provision, that Plan is the Primary Plan.
2. If another Plan has a COB provision, the first of the following rules that apply will determine which Plan is the Primary Plan:
   a. **Subscriber/Dependent.** A Plan that covers a person as a Subscriber is Primary to a Plan that covers the person as a dependent.
   b. **Dependent Child/Parents Not Separated, Divorced.** Except as stated in subparagraph (b)(iii) below, when the Health Plan and another Plan cover the same child as a dependent of different persons, called "parents":
      i. The Plan of the parent whose birthday falls earlier in the year is Primary to the Plan of the parent whose birthday falls later in the year; but
      ii. If both parents have the same birthday, the Plan that covered a parent longer is Primary; or
      iii. If the rules in (i) or (ii) do not apply to the rules provided in the other Plan, then the rules in the other Plan will be used to determine the order of benefits.
   c. **Dependent Child/Separated or Divorced Parent.** If two (2) or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
      i. First, the Plan of the parent with custody of the child;
      ii. Then, the Plan of the spouse of the parent with custody of the child; and
      iii. Finally, the Plan of the parent not having custody of the child.
      iv. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the Plan obligated to pay or provide the benefits of that parent has actual knowledge of those terms, that Plan is primary. This paragraph (iv) does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payer has that actual knowledge.
   d. **Active/Inactive Employee.** A Plan that covers a person as an employee who is neither laid off nor retired (or as such an employee's dependent) is Primary to a Plan that covers that person as a laid off or retired employee (or as such an employee's dependent).
   e. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the Plan that has covered a Subscriber longer is Primary to the Plan which has covered the Subscriber for the shorter time.

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

1. **Coordination with This Plan's Benefits.** The Health Plan may coordinate benefits payable or may recover the reasonable cash value of services it has provided when the sum of:
   a. The benefits that would be payable for, or the reasonable cash value of, the services provided as Allowable Expenses by the Health Plan in the absence of this COB provision; and
   b. The benefits that would be payable for Allowable Expenses under one or more of the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or
not a claim thereon is made; exceeds Allowable Expenses in a Claim Determination Period. In that case, the Health Plan benefits will be coordinated, or the reasonable cash value of any services provided by the Health Plan may be recovered, from the Primary Plan, so that they and the benefits payable under the other Plans do not total more than the Allowable Expenses.

2. **Right to Reserve and Release Needed Information.** Certain information is needed to apply these COB rules. The Health Plan will decide the information it needs, and may get that information from, or give it to, any other organization or person. Health Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under Health Plan must give Health Plan any information it needs.

3. **Facility of Payment.** If a payment made or service provided under another Plan includes an amount that should have been paid or provided by or through the Health Plan, the Health Plan may pay that amount to the organization that made the 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.
SECTION 5: GETTING ASSISTANCE, FILING CLAIMS AND THE APPEALS PROCEDURE

GETTING ASSISTANCE

Member Services representatives are available at our Plan Medical Offices and through our Call Center to answer any questions you have about your benefits, available services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace your Kaiser Permanente identification card. These representatives can also help you file a claim for Emergency Services and Urgent Care Services outside of our Service Area (see Post-Service Claims) or to initiate an appeal for any unresolved problem.

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

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

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

    Kaiser Permanente
    2101 East Jefferson Street
    Rockville, MD 20852

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

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

By Facsimile
To fax us your correspondence, send it to:
(301) 816-6192

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. Authorized Representative;
3. Concurrent Care Claim;
4. Pre-Service Claim;
5. Post-Service Claim; and
6. Urgent Medical Condition.
PROCEDURE FOR FILING A CLAIM AND INITIAL CLAIM DECISIONS

The Health Plan will review claims that you make for Services or payment, and we may use medical experts to help us review claims and appeals. You may file a claim or an appeal on your own behalf or through an Authorized Representative. As used with respect to Pre-Service, Concurrent Care, or Post-Service Claims and appeals related thereto, the term “Member” “you” or “your” shall include an Authorized Representative, as defined in the Definitions Appendix.

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

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

A. PRE-SERVICE CLAIMS

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

Procedure for Making a Non-Urgent Pre-Service Claim

1. Tell Member Services that you want to make a claim for the Health Plan to provide or pay for a Service you have not yet received. Your written or oral request and any related documents you give us constitute your claim. You may write or call us at the address and number listed above.

2. We will review your claim, and if we have all the information we need we will send you a written decision within fifteen (15) days after we receive your claim.

   If we tell you we need more time because of circumstances beyond our control, we may take an additional fifteen (15) days to send you our written decision. If we cannot make a decision because we do not have all the information we need, we will ask you for more information within fifteen (15) days of receipt of your claim.

   You will have forty-five (45) days to send us the requested information. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. We will send you our written decision within fifteen (15) days after receipt of the requested information. If we do not receive any of the requested information (including documents) within forty-five (45) days after our request, we will make a decision based on the information we have and send you a written decision within fifteen (15) days after the end of the forty-five (45) days.

3. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can appeal.

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

DCLG-ALL-SEC5(01-17) 5.2
YOUR GROUP EVIDENCE OF COVERAGE (EOC)
KAISER PERMANENTE

Expedited Procedure for an Urgent Medical Condition

1. Tell Member Services you want to make an urgent claim for the Health Plan to provide or pay for a Service that you have not yet received. Your written or oral request and any related documents you give us constitute your claim.

2. If we determine your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Pre-Service Claim.

3. We will review your claim and if we have all the information we need we will notify you orally or in writing of our decision, as soon as possible taking into account your medical condition, but no later than twenty-four (24) hours after receiving your claim. If we notified you orally, we will send a written confirmation within three (3) days after that. If we do not have all the information we need, we may ask for more information within twenty-four (24) hours of receipt of your claim. If we do not receive the requested information (including documents) within forty-eight (48) hours after our request, we will make our decision based on the information we have.

4. We shall notify you by telephone within one (1) working day of making the decision, and shall provide written notice of our decision within three days after that.

5. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can appeal.

6. When you or your Authorized Representative sends an appeal, you or your Authorized Representative may also request simultaneous external review of our initial adverse decision. If you or your Authorized Representative wants simultaneous external review, your or your Authorized Representative’s appeal must tell us this. You will be eligible for the simultaneous external review only if your Pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, than you or your Authorized Representative may be able to request external review after we make our decision regarding the appeal. See the section entitled, External Appeal Procedures for additional information about filing an external appeal.

B. CONCURRENT CARE CLAIMS

Concurrent care claims are requests that the Health Plan continue to approve an ongoing course of covered treatment to be provided over a period of time or number of treatments, when either (1) the course of treatment prescribed will expire, or (2) the course of treatment prescribed will be shortened. We will decide if your claim involves an Urgent Medical Condition or not. If you have any questions about Concurrent Care Claims, please contact Member Services at the phone numbers listed above.

Procedure for Making a Non-Urgent Concurrent Care Claim When Your Course of Treatment Will Expire

1. We will review your claim, and if we have all the information we need we will send you a written decision within fifteen (15) days after we receive your claim.

If we tell you we need more time because of circumstances beyond our control, we may take an additional fifteen (15) days to send you our written decision. If we cannot make a decision because we do not have all the information we need, we will ask you for more information within fifteen (15) days of receipt of your claim.
You will have forty-five (45) days to send us the requested information. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. We will send you our written decision within fifteen (15) days after receipt of the requested information. If we do not receive any of the requested information (including documents) within forty-five (45) days after our request, we will make a decision based on the information we have and send you a written decision within fifteen (15) days after the end of the forty-five (45) days.

2. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can appeal.

3. If we deny your claim or if we do not agree to continue approval of all the Services you requested, we will tell you in writing why we denied your claim and how you can appeal.

Procedure for Making a Concurrent Care Claim When Your Course of Treatment for an Urgent Medical Condition Will Expire

1. At least twenty-four (24) hours before the expiration of the Services or before your shortened course of care ends, you should call or write Member Services to notify them that you have an Urgent Medical Condition or your course of treatment has been terminated early and that you want to continue your course of care. Your written or oral request and any related document you give us constitute your claim. Call or write Member Service at the address and telephone numbers listed above.

2. If you filed a request for additional services at least twenty-four (24) hours before the end of an approved course of treatment, you may continue to receive those services during the time your claim is under consideration. If your claim is 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 claim was received.

3. If we determine your claim does not involve an Urgent Medical Condition, we may treat your claim as non-urgent Concurrent Care Claim.

4. We will review your claim and notify you of our decision orally or in writing within twenty-four (24) hours after we receive your claim. If we notify you orally, we will send you a written decision within three (3) days (two (2) business days if an Adverse Decision could result) after that.

5. If we deny your claim or if we do not agree to continue approval of all the Services you requested, we will tell you in writing why we denied your claim and how you can appeal.

6. When you or your Authorized Representative sends the appeal, you or your Authorized Representative may also request simultaneous external review of our adverse decision. If you want simultaneous external review, your or your Authorized Representative’s appeal must tell us this. You or your Authorized Representative will be eligible for the simultaneous external review only if your Concurrent Care Claim qualifies as urgent. If you or your Authorized Representative
do not request simultaneous external review in the appeal, then you or your Authorized Representative may be able to request external review after we make our decision regarding the appeal. See the section entitled, “External Appeal Procedures” for additional information about filing an external appeal.

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

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

1. You must send the completed claim form to us at the address listed on the claim form within 180 days, or as soon as reasonably possible after the Services are rendered. You should attach itemized bills along with receipts if you have paid the bills. Incomplete claim forms will be returned to you. This will delay any payments which may be owed to you. Also, you must complete and submit to us any documents that we may reasonably need for processing your claim or obtaining payment from insurance companies or other payors.

2. We will review your claim, and if we have all the information we need we will send you a written decision within thirty (30) days after we receive your claim. If we tell you we need more time because of circumstances beyond our control, we may take an additional fifteen (15) days to send you our written decision. If we tell you we need more time and ask you for more information, you will have forty-five (45) days to provide the requested information. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within forty-five (45) days, we will make a decision based on the information we have. We will issue our decision within fifteen (15) days of the deadline for receiving the information.

3. If we deny your claim or if we do not pay for all the Services you requested, our written decision will tell you why we denied your claim and how you can appeal.

INTERNAL APPEAL PROCEDURES
The appeal procedures are designed by the Health Plan to assure that Member concerns are fairly and properly heard and resolved.

These procedures apply to a request for reconsideration of an Adverse Decision rendered by the Health Plan regarding any aspect of the Health Plan’s health care Service.

A Member or a Member’s Authorized Representative may request an informal or formal appeal by contacting the Member Services Department.
In addition, you or your Authorized Representative, as applicable, may review (without charge) the information on which Health Plan made its decision. You may also send additional information including comments, documents or additional medical records supporting your claim.

Additional information may be sent to:

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

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

In addition, prior to the Health Plan rendering its final decision, it will provide you, without charge, any new or additional evidence considered, relied upon, or generated by (or at the direction of) the Health Plan in connection with your appeal.

If during the Health Plan’s review of your appeal, it determines that an adverse decision can be made based on a new or additional rationale, the Health Plan will provide you with this new information prior to issuing its final adverse decision and will explain how you can respond to the information if you choose to do so. The additional information will be provided to you as soon as possible and sufficiently before the deadline to give you a reasonable opportunity to respond to the new information.

Wherever the term “Member” or “you” or “your” is used in this section, it shall include the Member’s Authorized Representative.

Member Service Representatives are available by telephone each day during business hours to describe to Members how appeals are processed and resolved and to assist the Member with filing an appeal. The Member Services can be contacted Monday through Friday from 7:30 AM to 5:30 PM ET at:

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

Informal Appeal

Step 1 - Telephone number: If you do not agree with an Adverse Decision, you may request the opportunity to discuss and review the decision with appropriate clinical staff. When requesting an informal appeal, the Member must include a telephone number where he/she may be contacted to discuss the case.

Step 2 – Sufficient Information: Before accepting a request for an informal review, the Health Plan will determine if it has sufficient information readily available to reach a decision within the required time.
frame. If additional information is needed, Health Plan will notify the Member to immediately proceed to initiate a formal appeal.

**Step 3 – Discussion:** All requests for informal appeals will be acted upon immediately. The Health Plan may have to contact the Member by telephone to discuss and review the Adverse Decision. When relevant, the Health Plan may arrange for the Member or the Member’s Representative to discuss the adverse decision with appropriate clinical staff.

**Step 4 – Decision:** The Health Plan must conclude the informal appeal as soon as possible, but no later than fourteen (14) business days after the request for an informal appeal was filed. The Health Plan will provide a written explanation of the appeal decision to the Member or Member’s Representative within five (5) business days from the date of the decision.

In the case of an adverse appeal decision, the written explanation shall inform the Member or Member’s Representative of the right to request a formal appeal of the informal appeal decision.

**Formal Appeal**
This procedure applies to decisions regarding non-urgent Pre-Service Claims and Concurrent Claims as well as for Post-Service Claims.

**Initiating a Formal Appeal**
You may initiate a formal appeal by submitting a written request, including all supporting documentation that relates to the appeal to:

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

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

Each request for a formal appeal will be acknowledged by the Health Plan, in writing, within ten (10) business days of receipt.

If the Health Plan does not have sufficient information to complete its internal appeal process, the acknowledgement letter will:
1. Notify the Member that it cannot proceed with reviewing the appeal unless additional information is provided;
2. Specify all additional information required to be filed; and
3. Assist in gathering the necessary information without further delay.

**Appeal Review**
Each formal appeal will be reviewed by a health care professional selected by the Health Plan based upon the specific issued presented in the appeal, and who was not involved in the initial Adverse Decision.
If the review requires medical expertise, the reviewer or panel will include at least one medical reviewer in the same specialty as the matter at issue.

Each medical reviewer shall be a physician or an advanced practice registered nurse or other health care provider possessing a non-restricted license to practice or provide care anywhere in the United States, and have no history of disciplinary action or sanctions pending or taken against them by any governmental or professional regulatory body.

**Formal Appeal Decisions**

Each formal appeal will be concluded as soon as possible after receipt of all necessary documentation by the Health Plan, but not later than thirty (30) calendar days after the date the appeal was received.

The Health Plan will notify you of its decision verbally or in writing. If the Service is approved, the Health Plan will provide assistance in arranging the authorized Service. If the Service is denied, written notice will be sent to you within three (3) days after a verbal decision has been communicated.

**Extension of Review Period**

The time frame for concluding our formal appeal decision may only be extended by written request to the Member. If the Member does not agree to an extension, the appeal will move forward to be completed by end of the original time frame. Any agreement to extend the appeal decision shall be documented in writing.

**Expeditied Appeals**

If you are appealing an Adverse Decision that involves an Urgent Medical Condition, you may request an expedited decision by contacting the Health Plan:

**During Regular Business Hours**

Monday through Friday from 7:30am – 5:30pm ET – The Member should 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

**During Non-Business Hours**

The Member should call the Advice/Appointment Line:

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

Once an expedited appeal is initiated, clinical review will determine if the appeal involves an Urgent Medical Condition. If the appeal does not meet the criteria for an expedited appeal, the request will be managed as a formal appeal, as described above. If such a decision is made, the Health Plan will call the Member within twenty-four (24) hours.

If the request for appeal meets the criteria for an expedited appeal, the appeal will be reviewed by a Plan Physician who is board certified or eligible in the same specialty as the treatment under review, and who is not the individual (or the individual’s subordinate) who made the initial adverse decision. If additional
information is needed to proceed with the review, the Member or the Authorized Representative will be contacted by telephone or facsimile.

**Expedited Appeal Decisions**
An expedited appeal will be concluded as soon as possible after receipt of all necessary documentation by the Health Plan, but not later than twenty-four (24) hours after receipt of the request for appeal. The Health Plan will notify you of its decision immediately by telephone. If the Service is approved, the Health Plan will provide assistance in arranging the authorized Service. If the Service is denied, written notice of its decision will be sent within one business day after that.

**Notification of Adverse Appeal Decisions**
If the review results in a denial, the Health Plan will notify the Member and the Authorized Representative in writing. The notification shall include:

1. The specific factual basis for the decision in clear understandable language;

2. References to any specific criteria or standards, including interpretive guidelines, on which the decision was based (including reference to the specific plan provisions on which determination was based);

3. A statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member’s medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request. 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. All pertinent instruction, including the telephone numbers and titles of persons to contact, any forms required to initiate an external review, and applicable time frames to request a formal external review of the decision; and

5. A statement of your rights under section 502(a) of ERISA, if applicable.

6. If we send you a notice of an adverse decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least 10% of the population is literate only in the same federally mandated non-English language. You or your Authorized Representative may request translation of the notice by contacting Member Services at:

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

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

DCLG-ALL-SEC5(01-17) 5.9
EXTERNAL APPEAL PROCEDURES
If you receive an adverse decision on your appeal, you have a right to seek a formal external review of the decision within thirty (30) business days after the decision.

If the appeal was denied because the Service was not considered medically necessary or appropriate, send your request for an external appeal to:

District of Columbia
Department of Health Care Finance
Office of the Health Care Ombudsman and
Bill of Rights
One Judiciary Square
441 4th St. N.W., 900 South
Washington, D.C. 20001
Phone number: (202) 724-7491
Toll Free: 1-877-685-6391
Fax number: (202) 442-6724

If the appeal was denied for any other reason, send your request for an external appeal to:

Commissioner of Insurance
District of Columbia
Department of Insurance, Securities and Banking
810 First Street, N.E., Suite 701
Washington, DC 20002
Phone number: (202) 727-8000
Fax number: (202) 535-1196

Note: A Member shall also have the option to contact the District of Columbia Department of Insurance, Securities and Banking to request an investigation or file a complaint with the Department at any time during the internal claims and appeal process.

External Appeals may be filed with Commissioner of Insurance, except in the following circumstances:
1. The Health Plan failed to comply with any deadline for completion of a formal internal review;

2. In the case of an Urgent Medical Condition, if the request demonstrates to the satisfaction of the Director a compelling reason to do so, including a showing that the potential delay in receipt of a Service until after the Member exhausts the internal grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the member remaining seriously mentally ill with symptoms that causes the Member to be a danger to self and others; or

3. The Health Plan failed to make a decision for an Expedited Appeal within 24 hours after the appeal was filed.
SECTION 6: TERMINATION OF MEMBERSHIP

We will inform you of the date your coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. ET (the time at the location of the administrative office of Health Plan at 2101 East Jefferson Street, Rockville, MD 20852) on the termination date. In addition, Dependents’ membership ends at the same time as the Subscriber’s membership ends.

You will be charged non-Member rates for any health care services and supplies 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.

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

Termination Due to Loss of Eligibility
If you meet the eligibility requirements, described under “Who is Eligible” in Section 1, on the 1st day of a month; but later in that month you no longer meet those eligibility requirements then your membership terminates on the last day of that month unless your Group has an agreement with us to terminate at a time other than on the last day of the month. Please check with your Group’s benefits administrator to confirm your termination date.

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

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

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

Termination for Nonpayment
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, subject to Premium payment, in the following instances:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
1. If:
   a. You become Totally Disabled while enrolled under this Agreement; and
   b. You remain so at the time your coverage ends, then we will continue to provide benefits for
      covered Services related to the condition causing the disability.

   Coverage will continue for:
   i. One-hundred eighty (180) days from the date of termination; or
   ii. Until you no longer qualify as being Totally Disabled; or
   iii. Until such time as a succeeding health plan elects to provide coverage to you without
      limitations, whichever comes first.

2. If you are a Health Plan approved inpatient in a Hospital or Skilled Nursing Facility at the time
   your coverage ends, we will continue to provide benefits for covered Services related to the
   condition for which you've been admitted.

   Coverage will continue for:
   i. One-hundred eighty (180) days from the date of termination; or
   ii. Until a determination is made by a Physician that care in the Hospital or Skilled Nursing
      Facility is no longer medically indicated; or
   iii. The admission terminates, whichever comes first.

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

Limitation(s)
The section listed above does not apply to the following:
1. Members’ whose coverage ends because of failure to pay Premium;
2. Members’ whose coverage ends because of fraud or material misrepresentation by the Member;
3. When coverage is provided by another health plan and that health plan’s coverage:
   a. Is provided at a cost less than or equal to the cost of the extended benefit available under this
      EOC; and
   b. Will not result in an interruption of benefits to the Member.

CONTINUATION OF GROUP COVERAGE UNDER FEDERAL LAW

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

CONTINUATION OF GROUP COVERAGE UNDER DISTRICT OF COLUMBIA LAW
Employers maintaining a health benefits plan for fewer than twenty (20) employees must offer you and
your Dependents who are eligible for state continuation coverage and who would otherwise lose
coverage, uninterrupted coverage for a period of fifteen (15) continuous months, in compliance with
applicable District of Columbia law, unless you:
1. Are terminated for gross misconduct;
2. Are eligible for an extension of coverage under federal COBRA law; or
3. Fail to complete the appropriate election forms and provide proper payment in a timely manner.

Affected employers are required by District of Columbia law to provide employees whose coverage has terminated with written notification of the right to continue this group coverage within fifteen (15) days following the date coverage would otherwise have terminated.

You and any Dependents who want to continue coverage must elect coverage by transmitting the amount required to continue coverage no later than forty-five (45) days after the date coverage would otherwise terminate.

Continuation coverage continues only upon payment of applicable monthly charges, which may include an allowable reasonable administrative fee, and terminates on the earliest of the following:
1. You establish residence outside Health Plan’s service area;
2. You fail to make timely payment of the required cost of coverage;
3. You violate a material condition of this contract;
4. You become covered under another group health benefits plan that does not contain any exclusion or limitation with respect to pre-existing conditions that affects the covered Member;
5. You become entitled to Medicare; or
6. Your employer no longer offers group health benefits coverage to any employee.

Your cost for continued coverage shall not exceed 102% of your group’s premium charge.

If you elect to continue coverage under this provision, you must pay to your employer the amount required to continue coverage no later than forty-five (45) days after the date that coverage would otherwise have terminated.

If your employer, without interruption, replaces coverage with similar coverage under another health benefits plan, you shall have the right to continue coverage under the replacement health benefits plan for the balance of your continuation of coverage benefit period, so long as you continue to meet the requirements for continuation of coverage.

**USERRA**

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

**COVERAGE AVAILABLE ON TERMINATION**

For information about non-group plans available through us with no waiting period or pre-existing condition limitations, visit our Website at: [www.kp.org](http://www.kp.org) or contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).
SECTION 7: MISCELLANEOUS PROVISIONS

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

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

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

2. **A Living Will** and the **Natural Death Act Declaration to Physicians** lets you write down your wishes about receiving life support and other treatment.

For additional information about Advance Directives, including how to obtain forms and instructions, contact Member Services:

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

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

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

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

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

CONTRACTS WITH PLAN PROVIDERS
The Health Plan and Plan Providers are independent contractors. Your Plan Providers are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee for service, and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please contact Member Services:
YOUR GROUP EVIDENCE OF COVERAGE (EOC)
KAISER PERMANENTE

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

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

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

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

GROUPS AND MEMBERS ARE NOT HEALTH PLAN’S AGENTS
Neither your Group nor any Member is the agent or representative of the Health Plan.

MEMBER RIGHTS AND RESPONSIBILITIES: OUR COMMITMENT TO EACH OTHER
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 applicable state and federal law to determine if the requested additions are appropriate. If we approve your request, we will make the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. You, or your authorized representative, will be asked to provide written permission before your records are released, unless otherwise permitted by law.

2. **Receive information about Kaiser Permanente and your plan. This includes your right to:**
   a. Receive the information you need to choose or change your Primary Care Physician, including the name, professional level, and credentials of the doctors assisting or treating you;
   b. Receive information about Kaiser Permanente, our Services, our practitioners and providers, and the rights and responsibilities you have as a Member. You also can make recommendations regarding Kaiser Permanente’s member rights and responsibility policies;
   c. Receive information about financial arrangements with physicians that could affect the use of Services you might need;
   d. Receive Emergency Services when you, as a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed;
   e. Receive covered urgently needed Services when traveling outside Kaiser Permanente’s Service Area;
   f. Receive information about what Services are covered and what you will have to pay and to examine an explanation of any bills for services that are not covered; and
   g. File a complaint, grievance or appeal about Kaiser Permanente or the care you received without fear of retribution or discrimination, expect problems to be fairly examined, and receive an acknowledgement and a resolution in a timely manner.

3. **Receive professional care and service. This includes your right to:**
   a. See Plan Providers, get covered health care Services and get your prescriptions filled within a reasonable period of time and in an efficient, prompt, caring, and professional manner;
   b. Have your medical care, medical records and protected health information handled confidentially and in a way that respects your privacy;
   c. Be treated with respect and dignity;
   d. Request that a staff member be present as a chaperone during medical appointments or tests;
   e. Receive and exercise your rights and responsibilities without any discrimination based on age, gender, sexual orientation, race, ethnicity, religion, disability, medical condition, national origin, educational background, reading skills, ability to speak or read English, or economic or health status, including any mental or physical disability you may have;
   f. Request interpreter services in your primary language at no charge; and
   g. Receive health care in facilities that are environmentally safe and accessible to all.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Member Responsibilities
As a Member of Kaiser Permanente, you have the responsibility to:

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

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

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

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

NO WAIVER
Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

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

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
NOTICES
Our notices to you will be sent to the most recent address we have on file for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should contact Member Services as soon as possible to give us their new address:

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

NOTICE OF GRANDFATHERED GROUP PLAN
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. believes that your Plan is "a grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when PPACA was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the PPACA that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the PPACA.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause your Plan to change from grandfathered health plan status can be directed to your plan administrator. If your Plan is governed by ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov

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

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

We may use or disclose your PHI for treatment, payment, health research and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give PHI to others, such as government agencies or in judicial actions. In addition, Member-identifiable health information is shared with your Group only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative’s) written authorization, except as described in our Notice of Privacy Practices (see below). Giving us authorization is at your discretion.
This is only a brief summary of some of our key privacy practices. For a more detailed explanation of our privacy practices please refer to the Notice of Privacy Practices, which provides additional information about our privacy practices and your rights regarding your PHI. It is mailed with your enrollment materials or available on our website at www.kp.org.
The following terms, when capitalized and used in any part of this EOC, mean:

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

**Allowable Charges (AC):** means either:
1. For Services provided by Health Plan or Medical Group, the amount in the Health Plan’s schedule of Medical Group and Health Plan charges for Services provided to Members;
2. For items obtained at a Plan Pharmacy, the “Member Standard Value” which means the cost of the item calculated on a discounted wholesale price plus a dispensing fee;
3. For all other Services,
   a. The contracted amount;
   b. The negotiated amount;
   c. The amount stated in the fee schedule that providers have agreed to accept as payment for those Services; or,
   d. The amount that the Health Plan pays for those Services.

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

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

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

**Coinsurance:** The percentage of Allowable Charges that you must pay when you receive a covered Service as listed under "Copayments and Coinsurance" in the Summary of Services and Cost Shares section of the Appendix.
Concurrent Care Claim: A request that Health Plan continue to approve an ongoing course of covered treatment to be provided over a period of time or number of treatments, when either (1) the course of treatment prescribed will expire, or (2) the course of treatment prescribed will be shortened.

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

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

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements see “Who Is Eligible” in the “Eligibility and Enrollment” section.)

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:
1. Placing the person’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

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

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.

Habilitative Services: Services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, and shall include Services that enhance functional ability without affecting a cure.
**YOUR GROUP EVIDENCE OF COVERAGE (EOC)**

**KAISER PERMANENTE**

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

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

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

**Medically Necessary:** Medically Necessary means that the Service is all of the following: (1) medically required to prevent, diagnose or treat your condition or clinical symptoms; (2) in accordance with generally accepted standards of medical practice; (3) not solely for the convenience of you, your family and/or your provider; and (4) the most appropriate level of Service which can safely be provided to you. The fact that a physician may prescribe, authorize, or direct a Service does not of itself make it Medically Necessary or covered by the Group policy. For purposes of this definition, “generally accepted standards of medical practice” means (a) standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; (b) physician specialty society recommendations; (c) the view of physicians practicing in the Kaiser Permanente Medical Care Program; and/or (d) any other relevant factors reasonably determined by us. Unless otherwise required by law, we decide if a Service (described in Section 3: Benefits) is Medically Necessary and our decision is final and conclusive subject to your right to appeal as set forth in Section 5: Getting Assistance, Filing Claims and the Appeals Procedure.

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

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

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

**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 (a) is operated by us or contracts to provide Services and supplies to Members, and (b) is included in your Signature provider network.

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

**Plan Medical Center:** Medical office and specialty care facilities such as imaging centers operated by us in which Medical Group and other health care providers including non-physician specialists employed by us provide primary care, specialty care, and ancillary care Services to Members.

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

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

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

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

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

**Premium:** Periodic membership charges paid by Group.

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

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

**Services:** Health care Services or items.

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

**Spouse:** Your legal husband or wife. The term Spouse shall include your same-sex spouse if you were legally married in another jurisdiction, and the marriage is not expressly prohibited or deemed illegal under District of Columbia 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 the “Eligibility and Enrollment” section).
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 require prompt attention, but are not of an emergent nature.

**Urgent Medical Condition:** As used in Section 5: Getting Assistance, Filing Claims and the Appeals Procedure, a medical condition for which care has not been rendered, and which if not treated within 24 hours:

1. Could reasonably be expected to result in:
   a. Placing your life or health in serious jeopardy;
   b. Serious impairment to bodily function; or
   c. Serious dysfunction of any bodily organ or part; or
2. Would, in the opinion of a physician with knowledge of your medical condition, subject the Member to severe pain that cannot be adequately managed without the Services which are the subject of the claim.
Summary of Services and Cost Shares

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

DEPENDENT AGE LIMIT
Eligible Dependent children are covered from birth to age 26, 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 below in the schedule for each Service in this “Summary of Services and Cost Shares.” Allowable Charge is defined in the Definitions Appendix.

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

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
</tr>
<tr>
<td>Office visits (for other than preventive health care Services)</td>
<td></td>
</tr>
<tr>
<td>Primary care office visits</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>For adults</td>
<td></td>
</tr>
<tr>
<td>For children under 5 years of age</td>
<td>No charge</td>
</tr>
<tr>
<td>For children 5 years of age or older</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Specialty care office visits</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Consultations and immunizations for foreign travel</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td></td>
</tr>
<tr>
<td>• Outpatient surgery facility fee</td>
<td>$100 per visit</td>
</tr>
<tr>
<td>• Outpatient surgery physician Services</td>
<td>No charge</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>No charge</td>
</tr>
<tr>
<td>Respiratory therapy</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>House calls</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Hospital Inpatient Care</strong></td>
<td>$250 per admission</td>
</tr>
<tr>
<td>All charges incurred during a covered stay as an inpatient in a hospital</td>
<td></td>
</tr>
<tr>
<td><strong>Accidental Dental Injury Services</strong></td>
<td>Applicable Cost Shares will apply based on type and place of Service</td>
</tr>
</tbody>
</table>

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

Kaiser PERMANENTE

DCLG-HMO-COST(01-18) 1 HMO
<table>
<thead>
<tr>
<th>Covered Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allergy Services</strong></td>
<td></td>
</tr>
<tr>
<td>Allergy evaluation and treatment</td>
<td>Applicable Cost Shares will apply based on type and place of Service</td>
</tr>
<tr>
<td>Injection visit and serum</td>
<td>Applicable Cost Shares will apply based on type and place of Service, not to exceed the cost of the serum plus administration</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td></td>
</tr>
<tr>
<td>Ambulance (Emergency transport by a licensed ambulance Service, per encounter)</td>
<td>$100 per encounter</td>
</tr>
<tr>
<td>Ambulette(Non-emergent transportation Services ordered by a Plan Provider)</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Anesthesia for Dental Services</strong></td>
<td></td>
</tr>
<tr>
<td>Anesthesia and associated hospital or ambulatory Services for certain individuals only.</td>
<td>Applicable Cost Shares will apply, based on type and place of Service</td>
</tr>
<tr>
<td><strong>Blood, Blood Products and Their Administration</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Chemical Dependency and Mental Health Services</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient treatment in a hospital or residential treatment center</td>
<td>$250 per admission</td>
</tr>
<tr>
<td>Partial hospitalization</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Outpatient office visits</td>
<td></td>
</tr>
<tr>
<td>• Individual therapy</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>• Group therapy</td>
<td>$7 per visit</td>
</tr>
<tr>
<td>• Intensive Outpatient Treatment</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>• Medication management visits</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>All other outpatient Services</td>
<td></td>
</tr>
<tr>
<td>• Crisis intervention</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>• Electroconvulsive Therapy (ECT)</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>• Psychological and neuropsychological testing (for diagnostic purposes)</td>
<td>$15 per visit</td>
</tr>
<tr>
<td><strong>Cleft Lip, Cleft Palate, or Both</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Applicable Cost Shares will apply based on type and place of Service</td>
</tr>
<tr>
<td><strong>Clinical Trials</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Applicable Cost Shares will apply based on type and place of Service</td>
</tr>
<tr>
<td><strong>Diabetic Equipment, Supplies and Self-Management Training</strong></td>
<td></td>
</tr>
<tr>
<td>Diabetic equipment and supplies</td>
<td>20% of AC*</td>
</tr>
<tr>
<td>Self-management training</td>
<td>Applicable Cost Shares will apply based on type and place of Service</td>
</tr>
</tbody>
</table>
### Copayments and Coinsurance

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dialysis</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient care</td>
<td>Applicable inpatient care Cost Shares will apply</td>
</tr>
<tr>
<td>Outpatient Care</td>
<td>$15 per visit</td>
</tr>
<tr>
<td><strong>Drugs, Supplies, and Supplements</strong></td>
<td></td>
</tr>
<tr>
<td>Administered by or under the supervision of a Plan Provider</td>
<td>Applicable Cost Shares will apply based on type and place of Service</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME) – Outpatient</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Basic Durable Medical Equipment</strong></td>
<td></td>
</tr>
<tr>
<td>- Oxygen and Equipment</td>
<td>20% of AC*</td>
</tr>
<tr>
<td>- Positive Airway Pressure Equipment</td>
<td>20% of AC* for 1st 3 months; 50% of AC* each month thereafter.</td>
</tr>
<tr>
<td>- Apnea Monitors (Infants under 3, not to exceed a period of 6 months)</td>
<td>20% of AC*</td>
</tr>
<tr>
<td>- Asthma Equipment</td>
<td>20% of AC*</td>
</tr>
<tr>
<td>- Bilirubin Lights (Infants under 3, not to exceed a period of 6 months)</td>
<td>20% of AC*</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Visits</td>
<td></td>
</tr>
<tr>
<td>- Inside the Service Area</td>
<td>$100 per visit; Copayment waived if immediately admitted as an inpatient</td>
</tr>
<tr>
<td>- Outside the Service Area</td>
<td>$100 per visit; Copayment waived if immediately admitted as an inpatient</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Emergency Services HIV Screening Test</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td></td>
</tr>
<tr>
<td>Voluntary termination of pregnancy</td>
<td>Applicable Cost Share will apply based on type and place of Service</td>
</tr>
<tr>
<td>Male sterilization (i.e., vasectomies)</td>
<td>Applicable Cost Share will apply based on type and place of Service</td>
</tr>
<tr>
<td>Tubal ligations</td>
<td>Applicable Cost Share will apply based on type and place of Service</td>
</tr>
<tr>
<td><strong>Habilitative Services</strong></td>
<td></td>
</tr>
<tr>
<td>Limited to children up to age 21.</td>
<td>$15 per visit</td>
</tr>
</tbody>
</table>
## Copayments and Coinsurance

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hearing Services</strong></td>
<td></td>
</tr>
<tr>
<td>Hearing tests (newborn hearing screening tests are covered under preventive health care Services at no charge)</td>
<td>Applicable office visit Cost Share will apply based on type and place of Service</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td></td>
</tr>
<tr>
<td>See Section 3 for benefit limitations</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Infertility Services</strong></td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>50% of AC*</td>
</tr>
<tr>
<td>Inpatient Hospital Care</td>
<td>50% of AC*</td>
</tr>
<tr>
<td>All other Services for treatment of infertility</td>
<td>50% of AC*</td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td></td>
</tr>
<tr>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
</tr>
<tr>
<td>Inpatient obstetrical care and delivery, including cesarean section</td>
<td>$250 per admission</td>
</tr>
<tr>
<td><strong>Medical Foods</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>25% of AC*</td>
</tr>
<tr>
<td><strong>Medical Nutrition Therapy &amp; Counseling</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$15 per visit</td>
</tr>
<tr>
<td><strong>Morbid Obesity Services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Applicable Cost Shares will apply based on type and place of Service</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Applicable Cost Shares will apply based on type and place of Service</td>
</tr>
<tr>
<td><strong>Preventive Health Care Services</strong></td>
<td></td>
</tr>
<tr>
<td>Routine physical exams for adults</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Routine preventive tests for adults</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Well child care visits</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Routine immunizations for children and adults (No additional charge for immunization agent)</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Routine Preventive Care Screenings conducted in a Lab or Radiology</td>
<td>$15 per visit</td>
</tr>
<tr>
<td><strong>Prosthetic and Orthotic Devices</strong></td>
<td></td>
</tr>
<tr>
<td>External Prosthetics</td>
<td></td>
</tr>
<tr>
<td>• Artificial eyes, legs, and arms</td>
<td>20% of AC*</td>
</tr>
<tr>
<td>• Breast prosthesis following a Medically Necessary mastectomy (Limited to two prosthetic bras per year)</td>
<td>No charge</td>
</tr>
<tr>
<td>• Ostomy and urological supplies</td>
<td>20% of AC*</td>
</tr>
<tr>
<td>Internal Prosthetics</td>
<td>No charge</td>
</tr>
</tbody>
</table>
### Copayments and Coinsurance

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reconstructive Surgery</strong></td>
<td>Applicable Cost Shares will apply based on place and type of Service.</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Care</strong></td>
<td>No charge</td>
</tr>
<tr>
<td>Limited to a maximum benefit of 100 days per contract year</td>
<td></td>
</tr>
<tr>
<td><strong>Telemedicine Services</strong></td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Therapy and Rehabilitation Services</strong></td>
<td></td>
</tr>
<tr>
<td>(Refer to Section 3 for benefit maximums)</td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>Applicable inpatient Cost Shares will apply</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>$15 per visit</td>
</tr>
<tr>
<td><strong>Note:</strong> All Services received in one day for multidisciplinary rehabilitation Services at a day treatment program will be considered one visit.</td>
<td></td>
</tr>
<tr>
<td><strong>Therapy: Radiation/Chemotherapy/Infusion Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy and Radiation Therapy</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>Applicable Cost Shares will apply based on type and place of Service</td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td>Applicable Cost Shares will apply based on place and type of Service</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td></td>
</tr>
<tr>
<td>Office visit during regular office hours</td>
<td>Applicable office visit Cost Share will apply</td>
</tr>
<tr>
<td>After-Hours Urgent Care or Urgent Care Center</td>
<td>$15 per visit</td>
</tr>
<tr>
<td><strong>Vision Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Adult Vision</strong> (for adults age 19 or older)</td>
<td></td>
</tr>
<tr>
<td>Routine eye exams/refractions - Optometry Services</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Eye Care (Medical Treatment) - Ophthalmology Services</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Eyeglass lenses and frames</td>
<td>You receive a 25% discount off retail price** for eyeglass lenses and for eyeglass frames</td>
</tr>
<tr>
<td>Contact lenses</td>
<td>You receive a 15% discount off retail price** on initial pair of contact lenses</td>
</tr>
<tr>
<td><strong>Note:</strong> 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.</td>
<td></td>
</tr>
<tr>
<td><strong>Pediatric Vision (for children under age 19)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> A child is covered until the end of the month in which the child attains age 19.</td>
<td></td>
</tr>
<tr>
<td>Routine eye exams/refractions - Optometry Services</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Eye Care (Medical Treatment) - Ophthalmology Services</td>
<td>$15 per visit</td>
</tr>
</tbody>
</table>
# YOUR GROUP EVIDENCE OF COVERAGE (EOC)
## KAISER PERMANENTE

### Copayments and Coinsurance

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eyeglass lenses and frames</strong> <em>(Limited to one pair of lenses and frames per year from a select group. Lenses limited to single vision or bifocal lenses (ST28) in polycarbonate or plastic. Glasses not available if contacts are substituted for glasses.)</em></td>
<td>No charge for one pair per contract year</td>
</tr>
<tr>
<td><strong>Contact lenses</strong> <em>(Includes fitting fee and initial supply (based on standard packaging for type purchased) from a select group. Regular contacts may be substituted for pediatric lenses/frames once per calendar year.)</em></td>
<td>No charge for initial fit and first purchase per contract year</td>
</tr>
<tr>
<td><strong>Medically necessary contact lenses</strong> <em>(Limited to a select group)</em></td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Low Vision Aids</strong> <em>(Unlimited from available supply)</em></td>
<td>No charge</td>
</tr>
</tbody>
</table>

### X-ray, Laboratory and Special Procedures

<table>
<thead>
<tr>
<th>Inpatient diagnostic imaging, interventional diagnostic tests, laboratory tests, specialty imaging and special procedures</th>
<th>Applicable inpatient Cost Shares will apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient diagnostic imaging, interventional diagnostic tests, and laboratory tests</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient specialty imaging (including CT, MRI, PET Scans, Nuclear Medicine and Interventional Radiology) and special procedures</td>
<td>No charge</td>
</tr>
<tr>
<td>Sleep lab</td>
<td>No charge</td>
</tr>
<tr>
<td>Sleep studies</td>
<td>$15 per visit</td>
</tr>
</tbody>
</table>

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

*AC means Allowable Charge

** "Retail price" means the price that would otherwise be charged for the lenses, frames or contacts at the KP Vision Care Center on the day purchased.
YOUR GROUP EVIDENCE OF COVERAGE (EOC)
KAISER PERMANENTE

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 for the Basic Health Services covered under this EOC as shown below. Once you or your Family Unit have met the Out-of-Pocket Maximum, you will not be required to pay any additional Cost Shares for these Basic Health Services for the rest of the contract year.

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

Family Out-of-Pocket Maximum. If you have one or more Dependents covered under this EOC, the covered medical expenses incurred by all Members of the Family Unit together apply toward the Family Out-of-Pocket Maximum shown below; however, no one family Member’s medical expenses may contribute more than the Individual Out-of-Pocket Maximum shown below. After one member of a Family Unit has met the Individual Out-of-Pocket Maximum, 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.

Except as excluded below, the following Services are considered “Basic Health Services” that apply toward the Out-of-Pocket Maximum:
- Inpatient and outpatient physician Services
- Inpatient hospital Services
- Outpatient medical Services
- Preventive health care Services
- Emergency Services
- X-ray, laboratory and special procedures
- Inpatient and outpatient chemical dependency and mental health Services

Out-of-Pocket Maximum Exclusions:
The following Services, if covered, are not considered “Basic Health Services” and do not apply toward your Out-of-Pocket Maximum:
- Outpatient drugs, supplies and supplements, including blood, blood products, and medical foods
- Outpatient durable medical equipment and prosthetic and orthotic devices
- Inpatient and outpatient infertility Services
- Eyeglass lenses and frames, contact lenses available at a discount
- Adult vision 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 can 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 Copayment maximum is reached. If you have exceeded your Out-of-Pocket Maximum, we will promptly refund to you any Copayments or Coinsurance charged after the maximum was reached.

### Annual Out-of-Pocket Maximum

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined total of allowable Copayments and Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Self-Only Out-of-Pocket Maximum</td>
<td>$2,000 per individual per contract year</td>
</tr>
<tr>
<td>Family Out-of-Pocket Maximum</td>
<td>$4,000 per Family Unit per contract year</td>
</tr>
</tbody>
</table>
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) This Rider shall end as of the date your Group Agreement and EOC terminate.

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

A. DEFINITIONS

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

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

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

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

FDA: The United States Food and Drug Administration.

Formulary: A list of prescription drugs and compounded drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members. This Committee, which is made up of Plan Physicians and other Plan Providers, selects prescription drugs for inclusion in the Formulary 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.

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 that may be needed for six (6) months or more to treat a chronic condition.

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

Non-Formulary Drug: A drug that is not listed in the Formulary.
Oral Chemotherapy Drugs: An orally administered anticancer medication used to kill or slow the growth of cancerous cells.

Participating Network Pharmacy: Any pharmacy that has entered into an agreement with the 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.

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.

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 from time to time 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 Formulary guidelines, when prescribed by a Plan Physician or by a dentist. Each prescription refill is subject to the same conditions as the original prescription. Plan Providers prescribe drugs in accordance with Health Plan’s Formulary. If the price of the drug is less than the Rx Copayment, the Member will pay the lesser amount. You must obtain these drugs from a Plan Pharmacy or a Participating Network Pharmacy. It may be possible for you to receive refills using our Mail Service Delivery Program. You can ask for details at a Plan Pharmacy.

We cover the following:

1. FDA-approved drugs for which a prescription is required by law, when the drug is listed in our Formulary.
2. Compounded preparations that contain at least one ingredient requiring a prescription and are listed in our Formulary, if (1) there is no medically appropriate alternative in our Formulary; and (2) the compound is prescribed for an appropriate FDA-approved indication.
3. Insulin.
4. Drugs that are FDA-approved for use as contraceptives 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. 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.
6. Growth hormone therapy (GHT) for treatment of children under age 18 with a growth hormone deficiency.
7. Non-prescription drugs when they are prescribed by a Plan Provider and are listed on the Formulary.
The Pharmacy and Therapeutics Committee sets dispensing limits 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 Formulary. If you would like information about whether a particular drug or accessory is included in our Formulary, please visit us online at www.kp.org, or call the Member Services Call Center Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

**Where to Purchase Covered Drugs**

We cover prescribed drugs only when purchased at a Plan Pharmacy, a Participating Network Pharmacy or through Health Plan’s Mail Service Delivery Program. Most non-refrigerated prescription medications ordered through the Health Plan’s Mail Service Delivery Program can be delivered to addresses in MD, VA, DC and certain locations outside the service area.

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

**Generic and Formulary Drug Requirements**

**Generic vs. Brand Name Drugs**

Plan Pharmacies and Participating Network Pharmacies will substitute a generic equivalent for a Brand Name Drug unless the prescribing provider indicated “dispense as written” (DAW) on the prescription.

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

If a Member requests a Brand Name Drug, for which the prescribing provider has not indicated “dispense as written” (DAW), the Member will be responsible for the full Allowable Charge for that Brand Name drug.

**Formulary vs. Non-Formulary Drugs**

Plan Pharmacies and Participating Network Pharmacies will dispense Formulary drugs unless the prescribing provider indicated “dispense as written” (DAW) on the prescription.

Non-Formulary Drugs will be covered only when: (1) prescribed by a Plan Physician or by a dentist or a referral physician; and (2) (a) there is no equivalent drug in our Formulary, or (b) an equivalent Formulary drug (i) has not been effective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member. The applicable Non-Formulary Drug Cost Share will apply.

If a Member requests a Non-Formulary Drug, for which the provider has not indicated “dispense as written” (DAW), the Member will be responsible for the full cost of that drug.

**Dispensing Limitations**

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

Drugs that have a short shelf life may require dispensing in smaller quantities to assure the quality is maintained. These 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 (1) the prescribed dosage, (2) Standard Manufacturer’s Package Size, and (3) specified dispensing limits.

**C. PRESCRIPTIONS COVERED OUTSIDE THE SERVICE AREA; OBTAINING REIMBURSEMENT**

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

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

**D. LIMITATIONS**

Benefits are subject to the following limitations:

1. For drugs prescribed by a dentist, coverage is limited to antibiotics and pain relief drugs that are included on our Formulary and purchased at a Plan Pharmacy or Participating Network Pharmacy.

2. In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with the Health Plan’s emergency management department and/or our Pharmacy and Therapeutics Committee. If limited, the applicable Cost Share per prescription will apply.

**E. EXCLUSIONS**

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

1. Drugs for which a prescription is not required by law, except when the drug is listed in our Formulary.
2. Compounded preparations that do not contain at least one ingredient requiring a prescription and are not listed in our Formulary; or for which: (1) there is a medically appropriate alternative in our Formulary; or (2) the compound was not prescribed for an appropriate FDA-approved indication.

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 Formulary, except as described in this Rider.

6. Drugs that are considered to be experimental or investigational. Refer to “Clinical Trials” in Section 3: Benefits.

7. Except as covered under this Outpatient Prescription Drug Rider, a drug (a) which can be obtained without a prescription, or (b) for which there is a non-prescription drug that is the identical chemical equivalent to a prescription drug (i.e., same active ingredient and dosage).

8. Drugs for which the Member is not legally obligated to pay, or for which no charge is made.


10. Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes, including but not limited to drugs used to slow or reverse the effects of skin aging or to treat nail fungus or hair loss.


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 as a result of damage, theft or loss.

14. Prescribed drugs and accessories that are needed for Services that are excluded under the EOC.

15. Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from the Health Plan’s standard packaging for prescription drugs.

16. Alternative formulations or delivery methods that are (a) different from the Health Plan’s standard formulation or delivery method for prescription drugs and (b) 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 and Orthotic Devices” in Section 3: Benefits.

18. Drugs and devices provided during a covered stay in a hospital or Skilled Nursing Facility; or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits. This includes equipment and supplies associated with the administration of a drug. Refer to “Drugs, Supplies, and Supplements” and “Home Health Services” 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 equal to an over-the-counter drug, upon a review and determination by the Pharmacy and Therapeutics Committee.

F. COPAYMENTS AND COINSURANCE

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

<table>
<thead>
<tr>
<th>30 Day Supply Medication</th>
<th>Plan Pharmacy</th>
<th>Participating Network Pharmacy</th>
<th>Mail Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs</td>
<td>$15</td>
<td>$30</td>
<td>$15</td>
</tr>
<tr>
<td>Brand Drugs</td>
<td>$30</td>
<td>$50</td>
<td>$30</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>Refer to the applicable Generic and Brand Drugs Cost Share above</td>
<td>Refer to the applicable Generic and Brand Drugs Cost Share above</td>
<td>Refer to the applicable Generic and Brand Drugs Cost Share above</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>90-day Supply of Maintenance Medication</th>
<th>Mail Delivery</th>
<th>Plan Pharmacy and Participating Network Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs</td>
<td>2 Rx Copayment(s) shown above</td>
<td>2 Rx Copayment(s) shown above</td>
</tr>
<tr>
<td>Brand Drugs</td>
<td>2 Rx Copayment(s) shown above</td>
<td>2 Rx Copayment(s) shown above</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>2 Rx Copayment(s) shown above</td>
<td>2 Rx Copayment(s) shown above</td>
</tr>
</tbody>
</table>

Weight management drugs for 50% of the Allowable Charge

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

Drugs for the treatment of sexual dysfunction, limited to 8 doses per month, for 50% of the Allowable Charge.

Tobacco Cessation drugs for 50% of the Allowable Charge.

Oral Chemotherapy Drugs for no charge.

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

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

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

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

By: 

Mark Ruszczyk
Vice President, Marketing, Sales & Business Development
The Group Agreement and Evidence of Coverage (hereinafter severally and collectively referred to as the “Agreement”) to which this amendment rider is attached is amended as described below.

**Definitions**

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

"Essential Health Benefits" has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) 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.

**Notice of Grandfathered Coverage**

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. believes that your Plan is "a grandfathered health plan" under the PPACA. As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when PPACA was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the PPACA that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the PPACA.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause your Plan to change from grandfathered health plan status can be directed to your plan administrator. If your Plan is governed by ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

**Children’s Coverage to Age 26**

The provisions of your Agreement that define a “child” or that describe the eligibility requirements or causes of termination of a child’s coverage are revised as follows to comply with 45 CFR Parts 144, 146, and 147.

**Eligibility**

Any provision of the Agreement that indicates that a child’s eligibility for coverage is based on any factor other than the relationship between the child and an individual covered under the Agreement is deleted. Any requirement that: the child be financially dependent on an individual covered under the Agreement; that a child share a residence with the individual covered under the Agreement; that the child meet certain student status requirements; that the child be unmarried; or that the child not be employed, is deleted.

For contract years beginning before January 1, 2014, any requirement that the adult child not be eligible for other coverage is amended to apply only if the adult child is eligible to enroll in an eligible employer-sponsored health plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than a group health plan of a parent.
Termination

Any provision of the Agreement that indicates that a child’s coverage will terminate when: the child marries; ceases to be financial dependent on an individual covered under the Agreement; ceases to share a residence with an individual covered under the Agreement; ceases to be a full-time or part-time student; becomes employed full-time or part-time; or reaches any limiting age which is less than 26, is deleted.

For contract years beginning before January 1, 2014, any provision of the Agreement that indicates that coverage of the adult child will cease due to eligibility of the adult child for other coverage is revised to provide that termination of coverage will occur only if the adult child is eligible to enroll in an eligible employer-sponsored health plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than a group health plan of a parent. For contract years beginning on or after January 1, 2014, any provision of the Agreement that indicates that coverage of the adult child will cease due to eligibility of the adult child for other coverage is deleted.

The Agreement is revised to provide that a child shall remain eligible for coverage through the last day of the month in which the child turns 26 years of age. The limiting age will not apply to a child, who at the time of reaching the limiting age, is incapable of self-support because of mental or physical incapacity that started before the child attained the limiting age, provided the incapacitated child is unmarried and dependent on an individual covered under the Agreement. Coverage of the incapacitated child will continue for as long as the child remains: incapable of self-support because of a mental or physical incapacity; unmarried; and dependent on an individual covered under the Agreement.

Definition of Child

Any provision of the Agreement that defines or describes which children can be covered under the Agreement is revised to include a child who has not attained the child’s 26th birthday irrespective of the child’s:

1. Financial dependency on an individual covered under the Agreement;
2. Marital status;
3. Residency with an individual covered under the Agreement;
4. Student status;
5. Employment; or,
6. Satisfaction of any combination of the above factors.

If the provision of the Agreement prohibits the adult child from being covered if the child is eligible for other coverage, the eligibility requirement prohibiting coverage for children eligible for other coverage is amended to apply only for contract years beginning before January 1, 2014; and only if the adult child is eligible to enroll in an eligible employer-sponsored health plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than a group health plan of a parent.

Transition for Children Previously Denied Enrollment or Who Terminated Coverage Due to Attaining Limiting Age

The Agreement is amended to provide coverage from the first day of the first contract year occurring on or after September 23, 2010, if the child meets both of the following:

1. The child was terminated from coverage previously due to failure to satisfy the child definition of the Agreement; or the child was prohibited from enrolling under the Agreement due to failure to meet the child definition in the Agreement; and
2. The child enrolls during the first 30 days of the first contract year occurring on or after September 23, 2010.

Annual Dollar Limits

Any annual dollar limit on any Essential Health Benefits in the Agreement is amended to be the greater of: (1) the annual dollar limit permitted under 45 CFR 147.126; and (2) the annual dollar limit described in the Agreement.
**Rescissions**

Any provision of the Agreement that describes the right of Health Plan to rescind or void the Agreement, or to rescind the coverage of a Member, is amended to permit Health Plan to rescind or void the entire Agreement or the coverage of a Member only if: (1) the Member (or a person seeking coverage on behalf of the Member) performs an act, practice, or omission that constitutes fraud; or (2) the Member (or a person seeking coverage on behalf of the Member) makes an intentional misrepresentation of material fact.

Any provision of the Agreement that describes notice of rescission of coverage and that provides less than 30-days advance written notice of rescission is amended to provide 30-days advance written notice of any rescission of coverage.

**Prohibition on Pre-Existing Conditions for Children**

The following provisions of the Agreement shall not apply to any child who is under the age of 19:

1. Any provision that describes a pre-existing condition exclusion or limitation;
2. Any provision that indicates that a pre-existing condition exclusion or limitation is applicable;
3. Any provision that indicates that benefits are contingent on an injury occurring or a sickness first manifesting itself while the child is covered under the Agreement; and
4. Any provision of the Agreement that describes possible denial or rejection of coverage due to underwriting.

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

Mark Ruszczyk  
Vice President, Marketing, Sales & Business Development