



guide to YOUR BENEFITS AND SERVICES



kaiserpermanente.org

YOUR 2009 GROUP EVIDENCE OF COVERAGE

Select Delivery Care System



This plan has Excellent Accreditation from the NCQA.
See 2008 NCQA Guide for more information on Accreditation.



KAISER PERMANENTE®

**Kaiser Foundation Health Plan
of the Mid-Atlantic States, Inc.**
2101 East Jefferson Street
Rockville, Maryland 20849

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SECTION 1 – Introduction

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

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

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

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

Kaiser Permanente SelectSM

Kaiser Permanente SelectSM provides health care Services to Members using Plan Providers located throughout our Service Area, which is described in the “Definitions” section of this EOC.

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

- Emergency Services
- Urgent Care Services outside our Service Area
- Authorized Referrals
- Covered Services received in Other Kaiser Permanente Regions

Through our medical care system, you have convenient access to all of the covered health care Services you may need, such as routine care with your own Plan Physician, hospital care, nurses,

laboratory and pharmacy Services, and other benefits described in the “Benefits” section.

Who is Eligible

General

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

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

However, 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 and Urgent Care Services provided outside of our Service Area, unless you elect to bring the Dependent within our Service Area to receive covered Services from Plan Providers.

- C. Neither you nor any member of your family may enroll under this EOC if you or any dependent have ever had entitlement to Services through Health Plan terminated for:
 - (1) If you or any Dependent have ever had entitlement to receive Services through us terminated for any of the reasons listed under “Termination for Cause” in the “Termination of Membership” section, neither you nor any member of your family is eligible to enroll under this EOC.
 - (2) You may not enroll under this EOC until you pay all amounts owed by you and your Dependents if you were ever a subscriber in this or any other plan who had entitlement to receive Services through us terminated for:
 - (a) failure of you or your Dependent to pay any amounts owed to us, Kaiser Foundation Hospitals, or Medical Group, or
 - (b) failure to pay your Cost Share to any Plan Provider, or
 - (c) failure to pay non-group dues.

Subscribers

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

Dependents

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

- A. Your Spouse;
- B. Your or your Spouse's unmarried child (including adopted children) who are under the age limit specified on the Summary of Services and Cost Shares section of the Appendix;
- C. Other unmarried Dependent persons who are under the age limit specified on the Summary of Services and Cost Shares section of the Appendix, who:
 - (1) you or your Spouse may claim an exemption on your federal income tax return and who permanently resides in your (the Subscriber) household; or
 - (2) is in the court-ordered custody of you or your Spouse; or
 - (3) you or your Spouse have received a court or administrative order; or
 - (4) is under testamentary or court-appointed guardianship.

You or your Spouse's currently enrolled Dependents may continue membership beyond the age limit for Dependents, discussed in this section, if all of the following requirements are met:

- A. he or she is incapable of self-sustaining employment because of mental retardation or physical handicap that occurred prior to reaching the age limit for Dependents; and
- B. he or she receives from you or your Spouse substantially all of their support and maintenance.
- C. you must provide us with proof of their incapacity and dependency within 31 days after we request it.

Note: We will not use, require or request a genetic test, the results of a genetic test, genetic information, or genetic Services for the purpose of rejecting, limiting, canceling or refusing to renew a health insurance policy or contract. In addition, genetic information or the request for such information shall

not be used to increase the rates of, affect the terms or conditions of, or otherwise affect a Member's coverage.

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

Enrollment and Effective Date of Coverage

Membership begins at 12:00 a.m. on the membership effective date. Eligible people may enroll as follows:

New Employees and Their Dependents

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

Special Enrollment Due to Newly Acquired Dependents

Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

The membership effective date for newly acquired Dependents will be:

- A. For newborn children, the moment of birth.

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

provided within 31 days of the date of adoption, otherwise coverage for the newly adopted child will terminate 31 days from the date of adoption.

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

- C. For a newly eligible grandchild, the date the grandchild is placed in your or your Spouse's custody.

If payment of additional Premium is required to provide coverage for the child then, in order for coverage to continue, notification of the court ordered custody and payment of additional Premium must be provided within 31 days of the date of the court ordered custody, otherwise coverage terminates 31 days from the date of the court ordered custody.

- D. For children who are newly eligible for coverage as the result of a court or administrative order received by you or your Spouse, the date of the court or administrative order.

If payment of additional Premium is required to provide coverage for the child, notification of the court or administrative order may be provided at any time but, payment of additional Premium must be provided within 31 days of enrollment of the child, otherwise, enrollment of the child will be void. Enrollment for such child will be allowed in accordance with Section 15-405(c) of the Insurance Article, if applicable. Other unmarried Dependents who attain eligibility for enrollment due to a court or administrative order may be enrolled within 31 days of such event.

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

Special Enrollment due to Loss of Other Coverage

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 within 31 days after the enrolling persons lose other coverage if:

- A. The enrolling persons had other coverage when you previously declined Health Plan coverage for them (some groups require you to have stated in writing when declining Health Plan coverage that other coverage was the reason), and
- B. The loss of the other coverage is due to (1) exhaustion of COBRA coverage, or (2) in the case of non-COBRA coverage, loss of eligibility or termination of employer contributions, but not because of individual nonpayment.

Exception: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you need lose other coverage, and only one of you must have had other coverage when you previously declined Health Plan coverage.

Your Group will let you know the membership effective date, which will be no later than the first day of the month following the date your Group receives the enrollment application.

Open Enrollment

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

Premium

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

SECTION 2 – How to Obtain Services

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

As a Member, you are selecting our medical care 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:

- Emergency Services, in the “Benefits” section
- Urgent Care Outside our Service Area, in the “Benefits” section
- Getting a Referral, in this section
- Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas, in this section
- Visiting Member Services, in the “Benefits” section

Your Primary Care Plan Physician

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

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

You may also access our Provider Directory online at the following website address:

www.kaiserpermanente.org

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

Inside the Washington, D.C., Metropolitan area
(301) 468-6000
TTY (301) 8796 380

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

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

Getting a Referral

Plan Physicians offer primary medical, pediatric, and obstetrics/gynecology care as well as specialty care in areas such as general surgery, orthopedic surgery, dermatology and other medical specialties. If your primary care Plan Physician decides, in consultation with you, that you require covered Services from a Specialist, you will be referred to a Plan Provider who is a specialist that can provide the care you need.

If your primary care Plan Physician decides that you require covered Services not available from us, he or she will refer you to a non-Plan Provider inside or outside our Service Area. You must have an approved written referral to the non-Plan Provider in order for us to cover the Services. Copayments, Coinsurance and Deductibles for approved referral Services 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. For continued treatment, you or your Plan Provider must contact the Behavioral Health Access Unit for assistance with arranging for and scheduling of Covered Services. The Behavioral Access Unit may be reached at 866-530-8778.
- (2) Gynecological Services for females age 13 and over (including preventive care and medically necessary care)
- (3) Optometry services
- (4) Urgent care services provided inside our Service Area

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.

Plan Facilities and Our Network of Plan Providers

Our facilities include Plan Medical Centers and Plan Hospitals located within our Service Area. You can receive most of the covered Services you routinely need, as well as specialized care, at Plan Medical Centers.

If you have selected a primary care Plan Physician located in one of our Plan Medical Centers, you will receive most of your health care Services at our Plan Medical Centers. When you require specialty care, your primary care Plan Physician will work with you to select the specialist from our listing of Plan Providers.

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

For the most up-to-date list of Plan Medical Centers and Plan Providers, visit our Web site at www.kaiserpermanente.org. To request a provider directory, please call our Member Services Department at the number listed on your Health Plan identification card.

Getting the Care You Need; Emergency Services, Urgent Care and Advice Nurses

Emergency Services are covered 24 hours a day, seven days a week anywhere in the world. If you think you have a medical emergency condition, call 911 or go to the nearest emergency room. For coverage information about emergency care, including emergency benefits away from home, refer to Emergency Services in the “Benefits” section.

Getting Assistance from our Advice Nurses

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

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

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

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

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

Making Appointments

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

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

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

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

Missed Appointment Fee

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

Using Your Identification Card

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

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

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

Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas

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

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

Inside the Washington, D.C. Metropolitan Area
(301) 468-6000
TTY (301) 816-6380

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

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

The following visiting member care is covered when it is provided or arranged by a Plan Physician in the visited service area. The benefits may not be the same as those you receive in your home service area.

Hospital Inpatient Care:

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

Outpatient Care:

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

Laboratory and X-Ray:

- Covered in or out of the hospital

Outpatient Prescription Drugs:

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

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

- Outpatient visits and inpatient hospital days

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

- Inpatient and outpatient medical detoxification and other outpatient visits

Skilled Nursing Facility Care:

- Up to 100 days per calendar year

Home Health Care:

- Home health care Services inside the visited service area

Hospice Care:

- Home-based hospice care inside the visited service area

Pre-Authorization Required for Certain Services

The following Services require preauthorization from your home Service Area while you are visiting another Health Plan or allied plan service area:

- Inpatient physical rehabilitation
- Mental health hospital services in excess of 10 days
- Residential facility admissions for chemical dependency
- Outpatient mental health or chemical dependency benefits beyond 20 visits

Visiting Member Service Exclusions

The following Services are not covered under your visiting member benefits. (“Services” include equipment and supplies.) However, some of these Services, such as Emergency Services, may be covered under your home Service Area benefits, and applicable Copayments, Coinsurance and/or Deductibles will apply. For coverage information, refer to the “Benefits” section of this EOC.

- Services that are not medically necessary
- Physical examinations and related Services for insurance, employment, or licensing
- Drugs for the treatment of sexual dysfunction disorders
- Dental care and dental X-rays
- Services to reverse voluntary infertility
- Infertility Services
- Services related to conception by artificial means, such as IVF and GIFT
- Experimental Services and all clinical trials
- Cosmetic surgery or other Services primarily to change appearance
- Custodial care and care provided in an intermediate care facility
- Services related to sexual reassignment
- Transplants and related care
- Complementary and alternative medicine Services, such as chiropractic services
- Services received as a result of a written referral from a Plan provider in your home service area
- Emergency Services, including emergency ambulance Services
- Services that are excluded or limited in your home Service Area

Moving to Another Health Plan or Allied Plan Service Area

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

Value Added Services

Health Plan makes available a variety of value added services to its Members in order to aid Members in their quest for better health by providing access to additional services, which may not be covered under this plan. Examples may include discounted eyewear, non-covered health education classes and

publications, discounted fitness club memberships, health promotion and wellness programs and rewards for participating in those programs. Some of these value added services are available to all Members and others may be available only to Members enrolled in certain groups and/or plans. To take advantage of these services, a Member need only identify himself/herself as a Health Plan Member by showing his/her ID card and paying the fee, if any, at the time of service. Because these value added services are not covered Services, any fees you pay will not accrue to any coverage calculations, such as deductibles and out-of-pocket maximum calculations.

For information concerning these services, including which ones are available to you, you may contact our Member Services Department at:

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

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

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

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

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

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

SECTION 3 – Benefits

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

- A Plan Physician determines that the Services are medically necessary to prevent, diagnose, or treat a medical condition. A Service is medically necessary only if a Plan Physician determines that it is medically appropriate for you and, based on medical guidelines, there is a reasonable possibility that its omission would adversely affect your health. Covered services may be subject to our utilization management review process.

- The Services are provided, prescribed, or directed by a Plan Physician, and authorized by Health Plan if required.

- You receive the Services at a Plan Facility or Skilled Nursing Facility, and inside our Service Area, except where specifically noted to the contrary in this EOC.

- You have met the Deductible requirement described in the "Deductible" section of the Summary of Cost Shares section of the Appendix.

We will not cover other Services provided by a non-Plan Provider, or outside our Service Area, except for:

- Emergency Services
- Urgent Care outside our Service Area
- Authorized referrals
- Care in other Health Plan Regions

Exclusions and limitations that apply only to a particular benefit are described in this section. Other exclusions, limitations, and reductions that generally affect benefits are described in the “Exclusions, Limitations, and Reductions” section of this EOC.

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

A. Outpatient Care

We cover the following outpatient care:

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

- Specialty care visits (refer to “Referrals to Plan Providers” in the “How to Obtain Services” section for information about referrals to Plan specialists);
- Consultations and immunizations for foreign travel;
- Diagnostic testing for care or treatment of an illness, or to screen for a disease for which you have been determined to be at high risk for contracting, including, but not limited to:
 - Diagnostic examinations, including digital rectal exams and prostate antigen (PSA) tests provided:
 - to persons age 40 and over who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society;
 - Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, for persons, who are at high risk of cancer, in accordance with the most recently published guidelines of the American College of Gastroenterology, in consultation with the American Cancer Society;
 - Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A “qualified individual” means
 - an estrogen deficient individual at clinical risk for osteoporosis;
 - an individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
 - an individual receiving long-term gluco-corticoid (steroid) therapy;
 - an individual with primary hyperparathyroidism; or
 - an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

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

- Outpatient surgery;

- Anesthesia;
- Chemotherapy and radiation therapy;
- Respiratory therapy;
- Medical social Services;
- House calls when care can best be provided in your home as determined by a Plan Provider;
- After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to the Urgent Care provision for covered Services.

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

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

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

C. Accidental Dental Injury Services

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

- The accident has been reported to your primary care Plan Physician within 72 hours of the accident.
- A Plan Provider provides the restorative dental Services.

- The injury occurred as the result of an external force that is defined as violent contact with an external object, not force incurred while chewing.
- The injury was sustained to Sound Natural Teeth.
- The covered Services must be requested within 60 days of the injury.
- The covered services are provided during the 12 consecutive month period commencing from the date that the injury occurred.

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

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

Accidental Dental Injury Services Exclusions:

- Services provided by non-Plan Providers.
- Services provided after 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
- 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 rendered as the result of a 911 call. Your Cost Share will apply to each encounter, whether or not transport was required.

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

Ambulance Services Exclusions:

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

F. Anesthesia for Dental Services

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

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

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

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

Anesthesia for Dental Services Exclusions:

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

G. Blood, Blood Products and Their Administration

We cover blood, blood products, both derivatives and components, including the collection and storage of autologous blood for elective surgery, as well as cord

blood procurement and storage for approved medically necessary care, when authorized by a Plan Provider. The administration of prescribed whole blood and blood products are also covered.

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

Blood, Blood Products and Their Administration Limitations:

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

Blood, Blood Products and Their Administration Exclusions:

- Directed blood donations.

H. Chemical Dependency and Mental Health Services

We cover the treatment of 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 hospitalized, we cover all medical Services of physicians and other health professionals as performed, prescribed or directed by a Physician including:

- Individual therapy
- Group therapy
- Shock therapy
- Drug therapy
- Education
- Psychiatric nursing care
- Appropriate hospital Services

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

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

Partial hospitalization is defined as the provision of medically directed intensive or intermediate short term treatment for mental illness, emotional disorders, drug and alcohol abuse for a period of less than 24 hours but more than 4 hours in a day in a licensed or certified facility or program. We cover up to 60 days of partial hospitalization each contract year.

In an outpatient setting, we cover all necessary Services of physicians and other health care professionals as performed, prescribed, or directed by a physician including, but not limited to:

- Evaluations
- Crisis intervention
- Individual therapy
- Group therapy
- Psychological testing
- Medical treatment for withdrawal symptoms
- Visits for the purpose of monitoring drug therapy

Chemical Dependency and Mental Health Exclusions:

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

I. Cleft Lip, Cleft Palate or Both

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

J. Clinical Trials

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

“Patient costs” mean the cost of a medically necessary Service that is incurred as a result of the treatment being provided to the member for purposes of the clinical trial. “Patient costs” do not include:

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

We cover the Patient Costs incurred for clinical trials if:

- (a) The treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer.
- (b) The treatment is being provided in a clinical trial approved by:
 - the National Cancer Institute (NCI);
 - an NCI cooperative group or an NCI center;
 - the FDA in the form of an investigational new drug application;
 - the federal Department of Veterans Affairs; or
 - an institutional review board of an institution in the state which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the National Cancer Institutes of Health;
- (c) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
- (d) There is no clearly superior, noninvestigational treatment alternative; and
- (e) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative.

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

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

K. Diabetic Equipment, Supplies, and Self-Management

We cover diabetes equipment, diabetes supplies, and in-person diabetes outpatient self-management training and educational Services, including medical nutrition therapy for:

- insulin-using diabetes;
- insulin-dependent diabetes;
- non-insulin using diabetes; or
- elevated blood glucose levels induced by pregnancy, including gestational diabetes.

We cover diabetic equipment and supplies, when prescribed by a Plan Provider and purchased from a Plan Pharmacy or Plan Provider, including:

- (a) Diabetic equipment including Insulin pump.
- (b) Blood/urine testing agents, including glucose test tablets, glucose test tape, and acetone test tablets. Blood glucose test strips are provided for preferred product only.
- (c) Disposable needles and syringes in quantities needed for injecting prescribed insulin.
- (d) Glucost test strips and test meters
- (e) Control Solutions
- (f) Lancets

Diabetic Equipment, Supplies and Self Management Exclusion

(a) Glucose meter (glucometer) batteries

(b) Insulin is not covered under this benefit. Refer to the “Outpatient Prescription Drug Rider”, if applicable.

L. Dialysis

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

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

We cover the following renal dialysis Services:

- Outpatient maintenance dialysis treatments in a plan dialysis facility. Coverage includes the cost of laboratory tests, equipment, supplies and other Services associated with your treatment.
- Inpatient maintenance dialysis if you are admitted to a Plan Hospital because your medical

condition requires specialized Hospital Services on an inpatient basis.

- Plan Provider Services related to inpatient and outpatient dialysis.

We cover the following self-dialysis Services:

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

We cover home dialysis, which includes:

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

M. Drugs, Supplies, and Supplements

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:

- Drugs, injectables, and radioactive materials used for therapeutic purposes;
- Vaccines and immunizations approved for use by the federal Food and Drug Administration (FDA), that are not considered part of routine preventive care

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

Drugs, Supplies and Supplements Exclusions:

- Drugs, supplies, and supplements which can be self-administered or do not require administration or observation by medical personnel;
- Drugs for which a prescription is not required by law;

- Drugs for the treatment of sexual dysfunction disorders;
- Drugs for the treatment of infertility; and
- Internally implanted and injected contraceptives.

N. Durable Medical Equipment

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

Durable Medical Equipment does not include coverage for prosthetic devices, such as artificial eyes or legs, or orthotic devices, such as braces or therapeutic shoes. Refer to “Prosthetic Devices” for coverage of internal prosthetic devices, ostomy and urological supplies and breast prosthesis. Additional coverage for external prosthesis and orthotic devices is only covered if a Prosthetic and Orthotic Devices Rider is attached to this EOC.

Basic Durable Medical Equipment

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

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

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

Supplemental Durable Medical Equipment

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

1. Oxygen and Equipment

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

2. Positive Airway Pressure Equipment

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

3. Apnea Monitors

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

4. Asthma Equipment

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

- Spacers
- Peak-flow meters
- Nebulizers

5. Bilirubin Lights

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

Durable Medical Equipment Exclusions:

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

O. Emergency Services

As described below you are covered for medical emergencies anywhere in the world.

“**Emergency Services**” are health care Services that are provided by a Plan or non-Plan Provider after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- (a) Placing the patient’s health in serious jeopardy;
 - (b) Serious impairment to bodily functions;
 - (c) Serious dysfunction of any bodily organ or part;
- or

(d) In the case of a pregnant woman, serious jeopardy to the health of the mother and/or fetus.

If you experience a medical emergency you should contact 911 immediately. If you are not sure whether you are experiencing a medical emergency, please contact us at the number listed on the reverse side of your ID card for immediate medical advice. You or your representative must notify the Health Plan as soon as possible, not to exceed forty-eight (48) hours or the next business day, whichever is later, if you receive care at a hospital emergency room (ER) to ensure coverage. If the emergency room visit was not due to an emergency, as defined above, and was not authorized by 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 our Service Area:

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

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

Continuing Treatment Following Emergency Services

Inside our Service Area

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

Inside another Kaiser Permanente Region:

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

Outside our Service Area:

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

Transport to a Service Area

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

Continued Care in Non-Plan Facility Limitation

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

Filing Claims for Non-Plan Emergency Services

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

Emergency Services Limitations:

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

- Family planning counseling, including pre-abortion and post-abortion counseling, and information on birth control
- Insertion and removal, and any medically necessary examination associated with the use of contraceptive drugs and devices, are covered under this benefit only if the purchase of contraceptive drug or device is covered under an “Outpatient Prescription Drug Rider”, if applicable.
- Tubal ligations
- Vasectomies
- Voluntary termination of pregnancy

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

Q. Habilitative Services

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. 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.

R. Hearing Services

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

Hearing Services Exclusions:

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

S. Home Health Care

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

- Skilled nursing care
- Home health aide Services
- Medical social Services

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

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

Home Health Visits Following Mastectomy or Removal of Testicle

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

- One home visit scheduled to occur within 24 hours following his or her discharge; and

- One additional home visit, when prescribed by the patient's attending physician.

Home Health Care Limitations:

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

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

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

Home Health Care Exclusions:

- Custodial care (see definition under "Exclusions" in the "Exclusions, Limitations, and Reductions" section of this EOC).
- Routine administration of oral medications, eye drops, ointments.
- General maintenance care of colostomy, ileostomy, and ureterostomy.
- Medical supplies or dressings applied by a Member or family caregiver.
- Corrective appliances, artificial aids, and orthopedic devices.
- Homemaker Services.
- 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 Health Plan
- Transportation and delivery service costs of Durable Medical Equipment, medications, drugs, medical supplies and supplements to the home.

T. Hospice Care

We cover hospice care if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

Hospice care is for terminally ill Members. If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is 6 months or less, you can choose home-based hospice care instead of traditional Services otherwise provided for your illness. If you elect hospice care, you are not entitled to any other benefits for the terminal illness under this EOC.

We cover hospice care only when provided by licensed hospice agencies approved by Medical Group. We cover the following Services when approved by a Plan Provider and our hospice care team:

- Physician care;
- Nursing care;
- Physical, occupational, speech and respiratory therapy;
- Medical social Services;
- Home health aide Services;
- Short-term inpatient care including Respite Care, care for pain control, and acute and chronic pain management;
- Palliative drugs in accord with our drug formulary guidelines;
- Medical supplies and appliances;
- Homemaker Services; and
- Counseling and bereavement Services.

Definitions:

Family Caregiver means a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the terminally ill Member.

Hospice Care means a coordinated, inter-disciplinary program of hospice care Services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health Services through home or inpatient care during the illness and bereavement to individuals who have no reasonable prospect of cure as estimated by a physician and the immediate family or Family Caregiver.

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

Hospice Care Exclusions

- Services not preauthorized by Health Plan.

U. Infertility Services

We cover the following:

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

Notes:

- Involuntary infertility means the inability to conceive after 1 year of unprotected vaginal intercourse.

- Diagnostic procedures and any covered drugs administered by or under the direct supervision of a Plan Provider are covered under this provision. Refer to the Prescription Drug Rider, if applicable, for coverage of outpatient infertility drugs.

Infertility Services Exclusions:

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

V. Maternity Services

After confirmation of pregnancy, we cover all obstetrical Services for routine maternity Services, including routine prenatal visits, childbirth and delivery, including cesarean section, and the first postpartum visit with Plan Providers as a single Service. Non-routine obstetrical care is covered subject to the applicable cost share for the Service.

Non-routine maternity Services include Services for any diagnosis other than normal pregnancy that exceed the number of Services for a routine pregnancy, as defined by accepted medical standards of care, including emergency room care or hospital confinement for false labor. Non-routine prenatal visits also include outpatient obstetrical or gynecological Services provided during pregnancy that are not directly related to the pregnancy.

We cover inpatient hospitalization services for you and your enrolled newborn child for a minimum stay of at least 48 hours following an uncomplicated vaginal delivery; and at least 96 hours following an uncomplicated cesarean section. We also cover postpartum home 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 24 hours after discharge, and an additional home visit if prescribed by the attending provider.

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

W. Medical Foods

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

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

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

Medical Foods Exclusions:

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

X. Morbid Obesity

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

Morbid obesity is defined as:

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

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

Morbid Obesity Services Exclusions

- Services not preauthorized by Health Plan.

Y. Oral Surgery

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

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

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

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

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

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

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

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

Oral Surgery Exclusions:

- Oral surgery Services when the functional aspect is minimal and would not in itself warrant surgery.
- Lab fees associated with cysts that are considered dental under our standards.
- Medical and dental services for treatment of the condition commonly referred as TMJ (temporomandibular joint syndrome).
- Orthodontic Services.
- Dental appliances.

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:

- Preventive care exams, including:
 - routine physical examinations and health screening tests appropriate to your age and sex;
 - well-woman examinations; and
 - well child care examinations;
- Routine and medically necessary immunizations (excluding travel immunizations) 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.
- An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
- Low dose screening mammograms to determine the presence of breast are covered as follows: (i) one mammogram for persons age 35 through 39; (ii) one mammogram biennially for persons age 40 through 49; and (iii) one mammogram annually for person 50 and over;
- Bone mass measurement to determine risk for osteoporosis;
- Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and

- prostate antigen (PSA) tests provided to men who are age 40 or older;
- Colorectal cancer screening in accordance with screening guidelines issued by the American Cancer Society including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy;
- Cholesterol test (lipid profile);
- Diabetes screening (fasting blood glucose test);
- Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis and HPS), subject to the following:
 - Annual chlamydia screening is covered for (1) women under the age of 20, if they are sexually active; and (2) women 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;
 - Human Papillomavirus Screening (HPS) as recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;
- HIV tests;
- TB tests;
- 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; and
- Associated preventive care radiological and lab tests not listed above.

Preventive Health Services Limitation:

While treatment may be provided in the following situations, the following services are not considered Preventive Care Services. 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, such as removal of a polyp during a sigmoidoscopy.

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

AA. Prosthetic Devices

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

Internally Implanted Devices

We cover medically necessary internal devices implanted during surgery, such as pacemakers, ocular lens implants, artificial hips and joints, breast implants following mastectomy (see “Reconstructive Surgery” benefits below), and cochlear implants that are approved by the Federal Food and Drug Administration for general use.

Ostomy and Urological Supplies

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

Breast Prosthetics

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

Breast Prosthetics Limitation:

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

Prosthetic Devices Exclusions:

- Services not preauthorized by Health Plan.
- Internally implanted breast prosthetics for cosmetic purposes.
- External prosthetics, except as provided in this Section under “Cleft-Lip, Cleft Palate, or Both”,

“Hearing Services”, or as provided under a “Prosthetic and Orthotic Devices Rider”, if applicable.

- Repair or replacement of prosthetics due to loss or misuse.
- Hair Prostheses.

BB. Reconstructive Surgery

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

Following mastectomy, we also cover reconstructive breast surgery and all stages of reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. Mastectomy is the surgical removal of all or part of a breast as a result of breast cancer. Reconstructive breast surgery is surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

Reconstructive Surgery Exclusions:

- Cosmetic surgery, plastic surgery, or other Services, supplies, dermatological preparations and ointments, other than those listed above, that are intended primarily to improve your appearance, or are not likely to result in significant improvement in physical function.
- Services not preauthorized by Health Plan.

CC. Skilled Nursing Facility Care

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

We cover the following Services:

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

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

- Blood (see “Blood, Blood Products and Their Administration);

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

Skilled Nursing Facility Care Exclusions:

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

DD. Therapy and Rehabilitation Services

Physical, Occupational, and Speech Therapy Services

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

1. while you are confined in Plan Hospital; and
2. for up to 90 consecutive days of treatment per injury, incident or condition for each therapy in a Plan Medical Center, a Plan Provider’s medical office, or a Skilled Nursing Facility, or as part of home health care. This limit does not apply to necessary treatment of cleft lip or cleft palate.

Limitations:

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

Multidisciplinary Rehabilitation

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

Multidisciplinary rehabilitation Service programs mean inpatient or outpatient day programs that

incorporate more than one therapy at a time in the rehabilitation treatment.

Limitations:

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

Cardiac Rehabilitation Services

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

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

Therapy and Rehabilitation Services Exclusions:

- Long-term rehabilitative therapy.

EE. Transplant Services

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

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

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

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

Transplant Services Exclusions:

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

FF. Urgent Care

As described below you are covered for Urgent Care Services anywhere in the world. “Urgent Care Services” are defined as Services required as the result of a sudden illness or injury, which requires prompt attention, but is not of an emergent nature.” Your Copayment or Coinsurance will be determined by the place of Service (i.e., at a Provider’s office or at an after hours urgent care center, as shown in the Summary of Services and Cost Shares section.

Inside our Service Area

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

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

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

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

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

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

Outside our Service Area

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

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

Urgent Care Limitations:

We do not cover Services outside our Service Area for conditions that, before leaving the Service Area, you should have known might require Services while outside our Service Area, such as dialysis for end-stage renal disease, post-operative care following surgery, and treatment for continuing infections, unless we determine that you were temporarily

outside our Service Area because of extreme personal emergency.

Urgent Care Exclusions:

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

GG. Vision Services

Medical Treatment

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

We cover the following Services:

Eye Exams

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

Eyeglass Lenses

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

Frames

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

Contact Lenses

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

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

You will also receive a discount on your initial purchase of contact lenses, if you choose to purchase

them at the same time. Note: Additional contact lens Services are available without the discount from any Kaiser Permanente Optical Shop.

Vision Exclusions:

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

HH. Visiting Member Services

We cover the same medically necessary Services that are covered under this plan in our Service Area, and your Cost Share will be the same, when you are temporarily (not more than 90 days) a visiting Member in a different Kaiser Foundation Health Plan or allied plan service area.

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

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

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

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

Visiting Member Services Limitations:

- Access to Services in the visited service area will be subject to availability at the time you request

the Service. Services may be unavailable due to temporary capacity constraints, inability to provide the Service generally, or other restrictions. If the Service is not available in the visited service area, you must call us for authorization to receive the Service.

- Except for Emergency Services, your right to receive covered Services in the visited service area ends after 90 days unless you receive prior written authorization from us to continue receiving covered Services in the visited service area. The 90-day limit on visiting member care does not apply to a dependent child who attends an accredited college or accredited vocational school.

Visiting Member Service Exclusions

- All the terms and conditions, exclusions and limitations that apply to covered Services in our Service Area, will apply to Services received as a visiting Member in a different Kaiser Foundation Health Plan or allied plan service area.

II. X-ray, Laboratory, and Special Procedures

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

- Diagnostic imaging and interventional diagnostic tests;
- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
- Special procedures, such as electrocardiograms and electroencephalograms;
- Sleep lab and sleep studies; and
- Specialty imaging: including CT, MRI, PET Scans, and Nuclear Medicine studies.

SECTION 4 – Exclusions, Limitations, and Reductions

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

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

Exclusions

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

Alternative Medical Services

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

Certain Exams and Services

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

Cosmetic Services

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

Custodial Care

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

Dental Care

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

Disposable Supplies

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

Durable Medical Equipment

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

Employer or Government Responsibility

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

Experimental or Investigational Services

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

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

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

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

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

External Prosthetic and Orthotic Devices

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

Prohibited Referrals

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

Routine Foot Care Services

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

Services for Members in the Custody of Law Enforcement Officers

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

Sexual Reassignment

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

Surrogacy Arrangements

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

Travel and Lodging Expenses

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

Vision Services

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

Workers' Compensation or Employer's Liability

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

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

Limitations

We will use our best efforts to provide or arrange for covered Services in the event of unusual circumstances that delay or render impractical the provision of Services such as major disaster, epidemic, war, 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 Health Plan, Kaiser Foundation Hospitals, or Medical Group. However, in these circumstances Health Plan, Kaiser Foundation Hospitals, Medical Group, and Medical Group Physicians will not have any liability for any delay or failure in providing covered Services, except to the extent prescribed by the Commissioner of Insurance of the District of Columbia.

Reductions

Injury or Illness Caused by Third Party

Except for any covered Services that would be (a) payable under Personal Injury Protection (PIP) coverage, and/or (b) payable under any capitation agreement 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, 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: (a) per Health Plan's fee schedule for Services provided or arranged by Medical Group, or (b) any actual expenses that were made for Services provided by Participating Providers.

Except for any covered Services that would be (a) payable under Personal Injury Protection (PIP) coverage, and/or (b) payable under any capitation agreement Health Plan has with a Participating Provider, when you recover for medical expenses in a cause of action, 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. 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: (a) per Health Plan's fee schedule for services provided by Medical Group at one of our Medical Offices, or (b) 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 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 Health Plan's lien, regardless of whether the total amount of recovery is less than the actual losses and damages you incurred.

Within 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 Health Plan to determine the existence of any rights we may have and to satisfy those rights, you must complete and send 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 Health Plan directly. You must not take any action prejudicial to 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 Health Plan's liens and other rights to the same extent as if you had asserted the claim against the third party. Health Plan may assign its rights to enforce its liens and other rights.

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

Medicare and TRICARE Benefits

Your benefits are reduced by any benefits to which you are entitled under Medicare except for Members whose Medicare benefits are secondary by law. TRICARE benefits are usually secondary 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 call our Member Services Call Center.

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

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

Order of Benefit Determination Rules

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

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

Definitions

"Plan": Any of the following that provides benefits or services for, or because of, medical care or treatment: 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.

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

"Allowable Expense" means a health care service or expense, including Deductibles, Coinsurance or Copayments that is covered in full or in part by any of the Plans covering the Member. This means that an expense or healthcare service or a portion of an expense or health care service that is not covered by any of the Plans is not an allowable expense. For example, if a Member is confined in a private hospital room, the difference between the cost of a

semi-private room in the hospital and the private room usually is not an Allowable Expense. "Allowable Expense does not include coverage for dental care except as provided under "Accidental Dental Injuries" in the "benefits" section.

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

Order of Benefit Determination Rules

1. If another Plan does not have a COB provision, that Plan is the Primary Plan.
2. If another Plan has a COB provision, the first of the following rules that apply will determine which Plan is the Primary Plan:
 - a. Subscriber/Dependent. A Plan that covers a person as a Subscriber is Primary to a Plan that covers the person as a dependent.
 - b. Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph (b)(iii) below, when Health Plan and another Plan cover the same child as a dependent of different persons, called "parents":
 - i. The Plan of the parent whose birthday falls earlier in the year is Primary to the Plan of the parent whose birthday falls later in the year; but
 - ii. If both parents have the same birthday, the Plan that covered a parent longer is Primary; or
 - iii. If the rules in (i) or (ii) do not apply to the rules provided in the other Plan, then the rules in the other Plan will be used to determine the order of benefits.
 - c. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - i. First, the Plan of the parent with custody of the child;
 - ii. Then, the Plan of the spouse or Domestic Partner of the parent with custody of the child; and
 - iii. Finally, the Plan of the parent not having custody of the child.
 - iv. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the Plan obligated to pay or provide the benefits of that parent has actual knowledge of those terms, that Plan is primary. This paragraph (iv) does not apply with

- respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payer has that actual knowledge.
- d. Active/Inactive Employee. A Plan that covers a person as an employee who is neither laid off nor retired (or as such an employee's dependent) is Primary to a Plan 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 Health Plan is the Primary Plan, COB has no effect on the benefits or services provided under this Agreement. When Health Plan is a Secondary Plan as to one or more other Plans, its benefits may be coordinated with the Primary Plan carrier using the guidelines below. COB shall in no way restrict or impede the rendering of services provided by Health Plan. At the Member's request, Health Plan will provider or arrange for covered services and then seek coordination with a Primary Plan.

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

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

Military Services

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

SECTION 5 – Getting Assistance, 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 an ID card. These representatives can also help you file a claim for Emergency Services and Urgent Care Services outside our Service Area (see Post-Service Claims) or to initiate an appeal for any unresolved problem.

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

Who to Contact

By Telephone

Member Services Department telephone numbers:

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

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

TDD **(301) 879-6380**

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:
301-816-6194

Definitions

Adverse Decision: Any determination by Health Plan that an admission, availability of care, continued stay, or other Service is or is not a covered benefit; and if it is a covered benefit, that it has been reviewed and does not meet the insurer's requirements for medical necessity, appropriateness, health care settings, level of care or effectiveness, and the requested Service is therefore denied, reduced, limited, delayed or terminated.

Authorized Representative: An individual authorized by the Member or 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.

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

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

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

Urgent Medical Condition: As used in this Section 5, a medical condition for which care has not been rendered, and which 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.

Procedure for Filing a Claim and Initial Claim Decisions

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

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

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

A. Pre-Service Claims

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

Procedure for Making a Non-Urgent Pre-Service Claim

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

2. We will review your claim, and if we have all the information we need we will send you a written decision within 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 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 15 days of receipt of your claim.

You will have 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 15 days after receipt of the requested information. If we do not receive any of the requested information (including documents) within 45 days after our request, we will make a decision based on the information we have and send you a written decision within 15 days after the end of the 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.

Expedited Procedure for an Urgent Medical Condition

1. Tell the Member Services Department you want to make an urgent claim for 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 72 hours after receiving your claim. If we notified you orally, we will send a written confirmation within three days after that. If we do not have all the information we need, we may ask for more information within 24 hours of receipt of your claim. If we do not receive the requested information (including documents) within 48 hours after our request, we will make our decision based on the information we have.

4. We shall notify you by telephone within 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.

B. Concurrent Care Claims

Concurrent care claims are requests that Health Plan continue to approve an ongoing course of covered

treatment to be provided over a period of time or number of treatments, when either (a) the course of treatment prescribed will expire, or (b) the course of treatment prescribed will be shortened. We will decide if your claim involves an Urgent Medical Condition or not. If you have any questions about Concurrent Care Claims, please contact the Member Service Department 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 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 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 15 days of receipt of your claim.

You will have 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 15 days after receipt of the requested information. If we do not receive any of the requested information (including documents) within 45 days after our request, we will make a decision based on the information we have and send you a written decision within 15 days after the end of the 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 24 hours before the expiration of the Services or before your shortened course of care ends, you should call or write the Member Services Department 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 the member Service Department at the address and telephone numbers listed above.

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

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

4. 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.

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 our Service Area. If you have any questions about post-service claims or appeals, please call the Member Services Department at the address and telephone numbers listed above.

Procedure for Making a Post-Service Claim

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

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

2. We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. If we tell you we need more time because of circumstances beyond our control, we may take an additional 15 days to send you our written decision. If we tell you we need more time and ask you for more information, you will have 45 days to provide the requested information. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our

decision. If we do not receive any of the requested information (including documents) within 45 days, we will make a decision based on the information we have. We will issue our decision within 15 days of the deadline for receiving the information.

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

Internal Appeal Procedures

The Appeal Procedures are designed by 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. 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 Service Representative can be contacted Monday through Friday from 7:30 AM to 5:30 PM at 301-468-6000, if calling within the local area, or 301-816-6344 TDD (Telephonic Device for the Deaf).

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, 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. Health Plan may have to contact the Member by telephone to discuss and review the Adverse Decision. When

relevant, Health Plan may arrange for the Member or the Member's Representative to discuss the adverse decision with appropriate clinical staff.

Step 4 – Decision: Health Plan must conclude the informal appeal as soon as possible, but no later than 14 business days after the request for an informal appeal was filed. 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:

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

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

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

If Health Plan does not have sufficient information to complete its internal appeal process, the acknowledgement letter will:

- a. notify the Member that it cannot proceed with reviewing the appeal unless additional information is provided;
- b. Specify all additional information required to be filed; and
- c. assist in gathering the necessary information without further delay.

Appeal Review

Each formal appeal will be reviewed by a health care professional selected by 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 Health Plan, but not later than 30 calendar days after the date the appeal was received.

Health Plan will notify you of its decision verbally or in writing. If the Service is approved, Health Plan will provide assistance in arranging the authorized Service. If the Service is denied, written notice will be sent to you within three 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.

Expedited Appeals

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

During Regular Business Hours

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

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

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

During Non-Business Hours

The Member should call the Advice/Appointment Line.

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

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

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, Health Plan will call the Member within 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 Health Plan, but not later than 24 hours after receipt of the request for appeal. Health plan will notify you of its decision immediately by telephone. If the Service is approved, 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, 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;

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.

3. Health Plan failed to make a decision for an Expedited Appeal within 24 hours after the appeal was filed.

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 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
Grievance and Appeals Coordinator
Office of the General Counsel
825 North Capital Street, N.E., Room 4119
Washington, DC 20002
Phone number: 202-442-5979
Fax number: 202-442-4797

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
e-mail: www.disb.dc.gov

Exhaustion of Internal Appeal Process

You must exhaust Health Plan's Internal Appeal Process *before* you may file an external appeal with, except in the following circumstances:

1. 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

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. on the termination date. In addition, Dependents' membership end 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 "Termination of Membership" section.

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

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who is Eligible" in the "Eligibility and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership terminates on the last day of that month unless your Group has an 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 31 days before the termination date if anyone in your Family Unit commits one of the following acts:

- You knowingly (1) misrepresent membership status; or (2) present an invalid prescription or physician order; or (3) misuse (or let someone else misuse) a Member ID card; or, (4) you commit other types of fraud in connection with your membership;
- You knowingly furnish incorrect or incomplete information to us or fail to notify us of changes in your family status that may affect your eligibility or benefits; or

- You no longer live or work within Health Plan's Service Area.

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:

- (1) If you become Totally Disabled while enrolled under this Agreement and remain so at the time your coverage ends, we will continue to provide benefits for covered services related to the condition causing the disability. Coverage will continue for 180 days from the date of termination or until you no longer qualify as being Totally Disabled, or until such time as a succeeding health plan elects to provide coverage to you without limitations, 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 180 days from the date of termination or until a determination is made by a Physician that care in the Hospital or Skilled Nursing Facility is no longer medically indicated, or the admission terminates, whichever comes first.

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

Limitation(s):

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

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

Federal Law

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 COBRA law. Please contact your Group if you want to know 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

District of Columbia Law

Employers maintaining a health benefits plan for less than 20 employees must offer you and your dependents, who would otherwise lose coverage, uninterrupted coverage for a period of 3 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 coverage under this act within 15 days following the date coverage would otherwise have terminated.

Coverage under this act 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 violate a material condition of this contract;
- (3) 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;
- (4) You become entitled to Medicare; or
- (5) Your employer no longer offers group health benefits coverage to any employee.

Your cost for continued coverage shall not exceed 102% of the group rate.

If you elect to continue coverage under this act you must pay to your employer the amount required to continue coverage no later than 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.

At the conclusion of the 3 month continuation of coverage period, you may be eligible to continue coverage under Health Plan's Conversion Plan, as described below.

USERRA

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

Conversion of Membership

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

You may not convert to this non-group plan if (1) you continue to be eligible through your Group; or (2) your membership ends because your Group ends its Agreement with us and elects to provide you with other health plan options; or, (3) if we terminated your membership under "Termination for Cause" or "Non-Payment" in this "Termination of Membership" section.

You must apply to convert your membership within 31 days after your Group coverage ends. During this period, no medical review is required, and your non-group coverage begins when your Group coverage ends. You will have to pay Premium, and the benefits and Copayments under the non-group coverage may differ from those under this EOC. If we fail to notify eligible Members of their conversion option within 31 days of the Group's termination, then such Members shall have 90 days from such termination date to exercise their conversion option.

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

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

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

SECTION 7 – Miscellaneous Provisions

Administration of Agreement

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

Advance Directives

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

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

For additional information about Advance Directives, including how to obtain forms and instructions, contact our Member Services Call Center.

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

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

Amendment of Agreement

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

Applications and Statements

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

Assignment

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

Attorney Fees and Expenses

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

Contracts with Plan Providers

Health Plan and Plan Providers are independent contractors. Your Plan Providers are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee for service, and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please refer to your *Provider Directory* or call our Member Services Call Center in the Washington, D.C., Metropolitan area at (301) 468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902. Our TTY is (301) 816-6344.

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

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

Governing Law

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

Groups and Members not Health Plan's Agents

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

Member Rights and Responsibilities

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

MEMBER RIGHTS

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

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

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

protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. You, or your authorized representative, will be asked to provide written permission before your records are released, unless otherwise permitted by law.

2. Receive information about Kaiser Permanente and your plan. This includes your right to:

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

3. Receive professional care and service. This includes your right to:

- a. See Plan Providers, get covered health care Services and get your prescriptions filled within a reasonable period of time and in an efficient, prompt, caring, and professional manner.
- b. Have your medical care, medical records and protected health information handled confidentially and in a way that respects your privacy.
- c. Be treated with respect and dignity.

- d. Request that a staff member be present as a chaperone during medical appointments or tests.
- e. Receive and exercise your rights and responsibilities without any discrimination based on age, gender, sexual orientation, race, ethnicity, religion, disability, medical condition, national origin, educational background, reading skills, ability to speak or read English, or economic or health status, including any mental or physical disability you may have.
- f. Request interpreter services in your primary language at no charge.
- g. Receive health care in facilities that are environmentally safe and accessible to all.

- b. Pay your plan premiums and bring payment with you when your visit requires a Copayment, Coinsurance or Deductible.

3. Promote respect and safety for others:

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

MEMBER RESPONSIBILITIES

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

1. Promote your own good health:

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

2. Know and understand your plan and benefits:

- a. Read about your health care benefits in this EOC and become familiar with them. Call us when you have questions or concerns.

Named Fiduciary

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

No Waiver

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

Nondiscrimination

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

Notices

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

Overpayment Recovery

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

the date we paid the claim submitted by the health care provider.

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, social security number, or other information that reveals who you are. 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, and health care operations purposes, including health research and measuring the quality of care and Services. In addition, we are sometimes required by law to give PHI to government agencies or in judicial actions. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* explains our privacy practices in detail. To request a copy, please call:

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

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

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

By: 

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

APPENDICES

Definitions

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

Allowable Charges (AC): means either:

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

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

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

Cost Share: The amount of the Allowable Charge that you must pay for covered Services through 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 Services: Health care Services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1. Placing the patient's health in serious jeopardy;

2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. In the case of a pregnant woman, serious jeopardy to the health of the mother and/or fetus.

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

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

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

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

Medical Group: Mid-Atlantic Permanente Medical Group.

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

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

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 Provider's medical office, a Plan Provider's facility, or a Plan Hospital.

Plan Hospital: Any hospital in our Service Area where you receive hospital care pursuant to our arrangements made by a Plan Physician.

Plan Medical Center: A building within our Service Area that is owned and operated by us in which Medical Group practices medicine and provides 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 who contracts with us to provide Services and supplies to Members.

Plan Provider: A Plan Hospital, Plan Physician, or other health care provider that contracts with us to provide Services to Members.

Premium: Periodic membership charges paid by Group.

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

Services: Health care Services or items.

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

Spouse: Your legal husband or wife.

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

Totally Disabled:

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

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

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

Summary of Services and Cost Shares

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

DEPENDENT AGE LIMIT

Eligible Dependents are covered from birth to age 26, 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. Allowable Charge means:

- For Services provided by Health Plan or Medical Group, the amount in the Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members;
- For items obtained at a Plan Pharmacy, the “Member Standard Value” which means the cost of the item calculated on a discounted wholesale price plus a dispensing fee;
- For all other Services,
 - the contracted amount;
 - the negotiated amount;
 - the amount stated in the fee schedule that providers have agreed to accept as payment for those Services; or,
 - the amount that the Health Plan pays for those Services.

Your Cost Share is due when you receive a Service. You must pay or arrange for payment of amounts you owe. If you are not able to pay your Cost Share at the time of your visit, we may agree to bill you. If we bill you, we will increase the Cost Share by \$10 and mail you a bill for the entire Cost Share amount, but the additional amount will not count toward your Copayment Maximum. If you do not pay your Cost Share when you receive the Service, Plan Providers may reschedule future non-urgent appointments until after you have paid in full or made other payment arrangements.

Missed Appointment Fee

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

Covered Service	You Pay
Outpatient Care	
Office visits (for other than preventive health care Services)	
Primary care office visits	
For adults	\$10 per visit
For children under age 5	No charge
For children age 5 or older	\$10 per visit
Specialty care office visits	\$10 per visit
Consultations and immunizations for foreign travel	\$10 per visit
Outpatient surgery (other than in a Provider’s office)	\$100 per visit

Covered Service	You Pay
Anesthesia	No charge
Chemotherapy and radiation therapy	\$10 per visit
Respiratory therapy	\$10 per visit
Medical social Services	\$10 per visit
House calls	No charge
Hospital Inpatient Care	
All charges incurred during a covered stay as an inpatient in a hospital	No charge
Accidental Dental Injury Services	
Limited to a maximum benefit of \$2,000 per contract year.	Applicable Cost Shares will apply, based on type and place of Service
Allergy Services	
Allergy evaluation and treatment	Applicable Cost Shares will apply, based on type and place of Service
Injection visit and serum	\$10 per visit
Ambulance Services	
By a licensed ambulance Service, per encounter	No charge
Anesthesia for Dental Services	
Anesthesia and associated hospital or ambulatory Services for certain individuals only.	Applicable Cost Shares will apply, based on type and place of Service
Blood, Blood Products and Their Administration	
	No charge
Chemical Dependency and Mental Health Services	
Inpatient psychiatric and substance abuse care, including detoxification (minimum of 12 days of detoxification per contract year)	Applicable inpatient Cost Shares will apply
Hospital alternative Services	
Intensive outpatient psychiatric treatment programs	\$10 per visit
Partial hospitalization (not to exceed 60 days per contract year)	\$10 per visit
Outpatient psychiatric and substance abuse care	\$20 per visit for individual therapy; \$10 per visit for group therapy
Medication management visits	\$10 per visit
Cleft Lip, Cleft Palate, or Both	
	Applicable Cost Shares will apply, based on type and place of Service
Clinical Trials	
	Applicable Cost Shares will apply, based on type and place of Service
Diabetic Equipment, Supplies and Self-Management Training	
Diabetic equipment and supplies	20% of AC*

Covered Service	You Pay
Self-management training	Applicable Cost Shares will apply, based on place of Service
Dialysis	
Inpatient care	Applicable inpatient care Cost Shares will apply
Outpatient Care	\$10 per visit
Drugs, Supplies, and Supplements	
Administered by or under the supervision of a Plan Provider	No charge
Outpatient Durable Medical Equipment (DME)	
Outpatient Basic Durable Medical Equipment	No charge
Outpatient Supplemental Durable Medical Equipment	
<ul style="list-style-type: none"> • Oxygen and Equipment (Must be certified every 30 days) 	No charge for 1st 3 months; 50% of AC each month thereafter.
<ul style="list-style-type: none"> • Positive Airway Pressure Equipment (Must be certified every 30 days) 	No charge for 1st 3 months; 50% of AC each month thereafter.
<ul style="list-style-type: none"> • Apnea Monitors (Infants under 3, not to exceed a period of 6 months) 	No charge
<ul style="list-style-type: none"> • Asthma Equipment 	No charge
<ul style="list-style-type: none"> • Bilirubin Lights (Infants under 3, not to exceed a period of 6 months) 	No charge
Emergency Services	
Emergency Room Visits	
<ul style="list-style-type: none"> • Inside the Service Area 	\$50 per visit; copay waived if immediately admitted as an inpatient.
<ul style="list-style-type: none"> • Outside the Service Area 	\$50 per visit; copay waived if immediately admitted as an inpatient.
	Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit copayment will not be waived.
Family Planning	
Office visits	\$10 per visit
Tubal ligation, Vasectomy, Voluntary termination of pregnancy	Applicable Cost Share will apply based on place of Service
Habilitative Services	
Limited to children up to age 21	\$10 per visit
Hearing Services	
Hearing tests (newborn hearing screening tests are covered under preventive health care Services)	Applicable office visit Cost Share will apply based on place of Service
Home Health Care	
See Section 3 for benefit limitations	No charge

Covered Service	You Pay
Hospice Care	No charge
Infertility Services	
Office visits	50% of AC*
Inpatient Hospital Care	50% of AC*
All other Services for treatment of infertility	50% of AC*
Maternity Services	
Outpatient prenatal care (after confirmation of pregnancy) and first postpartum visit	No charge
Outpatient obstetrical or gynecological Services provided during pregnancy that are not directly related to a routine pregnancy	\$10 per visit
Inpatient obstetrical care and delivery, including cesarean section	No charge
Medical Foods	25% of AC*
Morbid Obesity Services	Applicable Cost Shares will apply based on type and place of Service.
Oral Surgery	
Note: applicable inpatient Cost Shares will also apply for Services provided in a hospital or other inpatient facility.	\$10 per visit
Preventive Health Care Services	
Routine physical exams for adults	No charge
Routine preventive tests for adults	No charge
Well child care visits	No charge Copayment waived for children under age 5
Routine immunizations for children and adults conducted in a Lab or Radiology (No additional charge for immunization agent)	No charge Copayment waived for children under age 5
Prosthetic Devices	
Internally implanted devices	No charge
Ostomy and urological supplies	No charge
Breast prosthetics	No charge
Reconstructive Surgery	Applicable Cost Shares will apply based on place and type of Service.
Skilled Nursing Facility Care	
Limited to a maximum benefit of 100 days per contract year	No charge
Therapy and Rehabilitation Services (Refer to Section 3 for benefit maximums)	
Inpatient Services	Applicable inpatient Cost Shares will apply

Covered Service	You Pay
Outpatient Services	\$10 per visit
Note: All Services received in one day for multidisciplinary rehabilitation Services at a day treatment program will be considered one visit.	
Transplants	Applicable Cost Shares will apply based on place and type of Service
Urgent Care	
Office visit during regular office hours	Applicable office visit Cost Share will apply
After-Hours Urgent Care or Urgent Care Center	\$10 per visit
Vision Services	
Eye exams	
• by an Optometrist	\$10 per visit
• by an Ophthalmologist	\$10 per visit
Eyeglass lenses and frames	You receive a 25% discount for eyeglass lenses and frames once per contract year
Contact lenses	15% discount on initial pair of contact lenses
X-ray, Laboratory and Special Procedures	
Diagnostic and laboratory tests	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	No charge
Baseline mammograms, annual screening mammograms, and annual cervical cytologic screenings for women.	No charge.
Cervical cytologic screening for women upon certification by Plan Provider that Service is medically necessary.	No charge.
Specialty Imaging (including CT, MRI, PET Scans, Nuclear Medicine)	Applicable inpatient Cost Shares will apply
Inpatient Services	
Outpatient Services	\$50 per test

*AC means Allowable Charge

Copayment Maximum

The Copayment Maximum is the total amount of Copayments you must pay in a contract year for the basic health Services covered under this EOC as shown below. Once you have met the Copayment Maximum, you will not be required to pay any additional Copayments for these basic health Services.

Basic Health Services. Except as excluded below, the following Services are considered “basic health Services” that apply toward the Copayment 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

Copayment Maximum Exclusions. The following Services, if covered, are *not* considered “basic health Services” and *do not* apply toward your Copayment Maximum. Your Cost Share for these Services will continue to apply even after you have met your Copayment 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

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

Notice of Copayment Maximum. We will also keep accurate records of your Copayment 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 Copayment Maximum, we will promptly refund to you any Copayments charged after the maximum was reached.

Annual Copayment Maximum

Combined total of allowable Copayments and Coinsurance for basic health Services

Individual Copayment Maximum

\$3,500.00 per individual per contract year

Family Copayment Maximum

\$9,400.00 per Family Unit per contract year

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

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

OUTPATIENT PRESCRIPTION DRUG RIDER

GROUP EVIDENCE OF COVERAGE

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

The following benefit, limitations, and exclusions are hereby added to the “Benefits” Section of the Group Evidence of Coverage in consideration of the application and payment of the additional Dues for such services.

Outpatient Prescription Drugs

A. Definitions:

Allowable Charge: Has the same meaning as defined in the Evidence of Coverage (EOC), see “Appendices – Definitions.

Annual Maximum Prescription Drug (“Rx”) Benefit: The maximum amount Health Plan will pay for covered outpatient prescription drugs under this Rider in a contract year.

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

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

Mail Service Delivery Program: A program operated by Health Plan that distributes prescription drugs to Members via mail. Certain drugs that require special handling are not provided through the Mail-Delivery Service Program. This includes, but is not limited to, drugs that are time or temperature sensitive, drugs that cannot legally be sent by U.S. mail, and drugs that require professional administration or observation.

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

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

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

Participating Network Pharmacy: Any pharmacy located within Health Plan’s Service Area that has entered into an agreement with Health Plan or the Health Plan’s agent to provide pharmacy services to its Members.

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

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

Preferred Drug List: A list of prescription drugs and compounded drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members. Our Pharmacy and Therapeutics Committee, which is comprised of Plan Physicians and other Plan Providers, selects prescription drugs for inclusion in the Preferred Drug List based on

a number of factors, including but not limited to safety and effectiveness as determined from a review of Medical Literature, Standard Reference Compendia, and research.

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

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

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

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

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

Standard Reference Compendia: The (a) United States Pharmacopoeia Drug Information; (b) American Medical Association Drug Evaluations; or (c) American Hospital Formulary Service Drug Information.

B. Benefit:

Except as provided in the Limitations and Exclusions sections of this Rider, we cover drugs as described in this section, in accordance with our Preferred Drug List guidelines, when prescribed by a Plan physician or by a dentist. Each prescription refill is subject to the same conditions as the original prescription. A Plan Provider prescribes drugs in accordance with Health Plan’s Preferred Drug List. If the price of the drug is less than the Rx Copayment, the Member will pay the lesser amount. You must obtain these drugs from a Plan Pharmacy or a Participating Network Pharmacy. It may be possible for you to receive refills using our Mail Service Delivery Program; ask for details at a Plan Pharmacy.

- Drugs for which a prescription is required by law.
- Compounded preparations with at least one ingredient requiring a prescription.
- Insulin
- Contraceptive drugs and devices that are approved by the United States Food and Drug Administration (FDA) for use as a contraceptive.
- Smoking-cessation drugs
- Off label use of drugs a drug is recognized in Standard Reference Compendia or certain Medical Literature as appropriate in the treatment of the diagnosed condition.

The Pharmacy and Therapeutics Committee sets dispensing limitations in accordance with therapeutic guidelines based on the Medical Literature and research. The Committee also meets periodically to consider adding and removing prescribed drugs and accessories on the Preferred Drug List. If you would like information about whether a particular drug or accessory is included in our Preferred Drug List, please visit us on line at www.kaiserpermanente.org, or call the Member Services Call Center at:

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

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

Where to Purchase Covered Drugs

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

Generic and Preferred Drug Requirements

Generic vs. Brand Name

- (1) Plan Pharmacies and Participating Network Pharmacies will substitute a generic equivalent for a Brand Name Drug unless prohibited by the prescribing provider.
- (2) 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 in our Formulary, or (b) an equivalent Generic Drug in our Formulary (i) has been ineffective in treating the disease or condition of the Member or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member.
- (3) If a Member requests a Brand Name Drug, for any reason other than those listed in the preceding paragraph, the Member will be responsible for the full charge for that drug.

Preferred vs. Non-Preferred

- (1) Plan Pharmacies and Participating Network Pharmacies will use Preferred Drugs unless prohibited by the prescribing provider.
- (2) Non-Preferred Drugs will be covered only when: (1) prescribed by a Plan physician or by a dentist or a referral physician; and (2) (a) there is no equivalent drug in our Preferred Drug List, or (b) an equivalent drug in our Preferred Drug List (i) has been ineffective in treating the disease or condition of the Member or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member.
- (3) If a Member requests a Non-Preferred Drug, for any reason other than those listed in the preceding paragraph, the Member will be responsible for the full charge for that drug.

Dispensing Limitations

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

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 Plan physician or by a dentist or a referral physician. This does not apply to the first prescription or change in a prescription. Members will be charged 3 Rx Copayment(s). The day supply and the Rx Copayment or Rx Coinsurance are based on (a) the place of purchase, (b) the prescribed dosage, (c) Standard Manufacturer's Package Size, and (d) specified dispensing limits.

C. Prescriptions Covered Outside the Service Area; Obtaining Reimbursement:

The Health Plan covers drugs prescribed by non-Plan Providers and purchased at non-Plan Pharmacies when the drug was prescribed during the course of an emergency care visit or an urgent care visit (see "Emergency Services" and "Urgent Care Services" sections of the Group Evidence of Coverage), or associated with a covered, authorized referral outside Health Plan's Service Area. To obtain reimbursement, the Member must submit a copy of the itemized receipts for their prescriptions to Health Plan. We may require proof of urgent or emergency care.

Reimbursement will be made at the Allowable Charge less the applicable Rx Copayment or Rx Coinsurance. Claims should be submitted to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Claims Department
P. O. Box 6233
Rockville, Maryland 20849-6233

D. Limitations:

Benefits are subject to the following limitations:

- (1) For drugs prescribed by a dentist, coverage is limited to antibiotics and pain relief drugs that are included on our Preferred Drug List and purchased at a Plan Pharmacy or a Participating Network Pharmacy.
- (2) In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with the Health Plan's emergency management department.

E. Exclusions:

The following are not covered by Health Plan:

- (1) Drugs for which a prescription is not required by law, except if the drug is approved by Preferred Drug List guidelines.
- (2) Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes.
- (3) Replacement prescriptions necessitated by theft or loss.
- (4) Prescribed drugs and accessories that are necessary for services that are excluded under the Group Evidence of Coverage.
- (5) Drugs to shorten the duration of the common cold.
- (6) Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from the Health Plan's standard packaging for prescription medications.
- (7) Alternative formulations or delivery methods that are (1) different from the Health Plan's standard formulation or delivery method for prescription drugs and (2) deemed not medically necessary.
- (8) Diabetic equipment and supplies, which are covered under Section 3 – Benefits of the Group Evidence of Coverage.
- (9) Drugs for the treatment of sexual dysfunction disorders.

F. Copayments/Coinsurance:

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

\$8 for Generic Drugs, \$18 for Preferred Brand Drugs and \$33 for Non-Preferred Brand Drugs through Mail Delivery; \$10 for Generic Drugs, \$20 for Preferred Brand Drugs and \$35 for Non-Preferred Brand Drugs at a

Plan Pharmacy; and \$20 for Generic Drugs, \$40 for Preferred Brand Drugs and \$55 for Non-Preferred Brand Drugs at a Participating Network Pharmacy.

Smoking cessation drugs for 50% of the Allowable Charge.

Weight management drugs for 50% of the Allowable Charge.

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

If the cost share for the prescription drug is greater than the price for the prescription drug, the Member will only be responsible for paying the price of the prescription drug.

G. Deductible:

No Rx Deductible

H. Annual Maximum Rx Benefit:

No Annual Maximum Rx Benefit

I. Out of Pocket Maximum:

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

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

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

By: 

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

**KAISER FOUNDATION HEALTH PLAN
OF THE MID-ATLANTIC STATES, INC.
2101 East Jefferson St., Rockville, MD 20849
301-816-2424**

EXTERNAL PROSTHETIC AND ORTHOTIC DEVICES RIDER

GROUP EVIDENCE OF COVERAGE

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

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

External Prosthetic and Orthotic Devices

A. Definitions

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

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

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

B. Benefits

External Prosthetic and Orthotic Devices are covered when prescribed by a Plan Provider as follows, subject to the Cost Share and Annual Benefit Maximum shown below.

We select the provider or vendor that will furnish the covered device. Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and Services to determine whether you need a Prosthetic or Orthotic Device. If we do not cover the device, we will try to help you find facilities where you may obtain what you need at a reasonable price.

External Prosthetic Devices

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

Orthotic Devices

We cover rigid and semi-rigid external Orthotic Devices that are used for the purpose of supporting a weak or deformed body member, or for restricting or eliminating motion in a diseased or injured part of the body. Examples of covered Orthotic Devices include, but are not limited to, leg, arm, back and neck braces. This benefit includes coverage of therapeutic shoes and inserts for individuals with severe diabetic foot disease only.

C. Limitations

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

D. Exclusions

- More than one piece of equipment or device for the same part of the body, except for replacements; spare devices or alternate use devices.
- Dental prostheses, devices and appliances, except as specifically covered under the Group EOC.

- Hearing aids, except as specifically covered under the Group EOC.
- Corrective lenses and eyeglasses, except as specifically covered under the Group EOC.
- Repair or replacement due to misuse or loss.
- Orthopedic shoes or other supportive devices, unless the shoe is an integral part of a leg brace, unless indicated above.
- 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.

E. Your Cost Share

You pay the following copayment or coinsurance for each Service:

- No charge

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

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

By: 

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

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OF THE MID-ATLANTIC STATES, INC.
2101 East Jefferson Street, Rockville, Maryland 20849**

EXTENDED INFERTILITY SERVICES RIDER

GROUP EVIDENCE OF COVERAGE

This Extended Infertility Services Rider (herein called "Rider") is effective as of the date of your Group Agreement and Group Evidence of Coverage and shall terminate as of the date your Group Agreement and Group Evidence of Coverage terminates.

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

Extended Infertility Services

A. Benefits

We cover in vitro fertilization, if:

- the Member's oocytes are fertilized with the Member's spouse's sperm; and
- the Member and the Member's spouse have a history of infertility of at least 2 years duration; or the infertility is associated with any of the following:
 - endometriosis;
 - exposure in utero to diethylstilbestrol, commonly known as DES;
 - blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy);or
- abnormal male factors, including oligospermia, contributing to the infertility; and
- the Member has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this Group EOC; and,
- the in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or the American Fertility Society minimal standards for programs of in vitro fertilization.

Note: Diagnostic procedures and drugs administered by or under the direct supervision of a Plan Provider are covered under this Rider. Refer to the Prescription Drug Rider, if applicable, for coverage of outpatient infertility drugs.

B. Limitations

Coverage for in-vitro fertilization is limited to three (3) attempts per lifetime, not to exceed a maximum lifetime benefit of \$100,000.

C. Exclusions

- Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member's eggs and/or male Member's sperm for future attempts.
- Assisted reproductive procedures and any related testing or service that includes the use of donor sperm, donor eggs or donor embryos.
- Any charges associated with donor eggs, donor sperm or donor embryos.
- Infertility Services when the member does not meet medical guidelines established by the American Society of Reproductive Medicine and the American Society for Reproductive Endocrinology.
- Services 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 other than those described above, including but not limited to: gamete intrafallopian transfers (GIFT); zygote interfallopian transfers (ZIFT); intracytoplasmic sperm injection (ICSI); assisted hatching; preimplantation genetic diagnosis (PGD); and prescription drugs related to such procedures.

D. Your Cost Share

Refer to the Summary of Benefits and Cost Shares in the Group EOC for cost share information. The cost shares for “Infertility Services” in the Summary of Benefits and Cost Shares in the Group EOC also apply to the Services covered under this Rider.

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

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

By:  _____

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

**KAISER FOUNDATION HEALTH PLAN
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2101 East Jefferson St., Rockville, MD 20849
301-816-2424**

COMPLEMENTARY ALTERNATIVE MEDICINE SERVICES RIDER

GROUP EVIDENCE OF COVERAGE

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

The following benefits, limitations, and exclusions are hereby added to the "Benefits" Section of the Group Evidence of Coverage (herein referred to as the Group EOC), in consideration of the Group application and payment of the additional Dues for the Services pursuant to this Rider.

Complementary Alternative Medicine Services

A. Definitions

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

B. Benefits:

We cover the following complementary alternative medicine Services when deemed medically necessary and prescribed by a primary care Plan Physician in consultation with Kaiser Permanente's Complementary Alternative Medicine Department, for chronic pain management or chronic illness management:

- **Acupuncture Services**
- **Chiropractic Services**

C. Limitations:

The number of visits needed for the Member to reach of maximum level of recovery will be determined by the Plan Provider and shall not exceed a total of 20 visits per contract year.

D. Exclusions:

- Services requested by the Member that are deemed not medically necessary by the primary care Plan Physician in consultation with the Kaiser Permanente Complementary Alternative Medicine Department; and
- Services requested when the Member's medical condition does not satisfy Health Plan's clinical guidelines established for alternative care.

E. Your Cost Share:

You pay the following copayment or coinsurance for each visit:

- You pay \$15 per visit.

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

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

By: 

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



DOMESTIC PARTNER RIDER

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

I. Definitions

Domestic Partner means either:

- A. You are registered with the DC Department of Health, Vital Records Division;
- OR
- B. You are one of two people, one of whom is an employee of the Group policyholder, who has submitted an affidavit to the Group or Health Plan, as applicable, certifying that:
 - i. Each person is 18 years of age
 - ii. Neither person has had another Domestic Partner (or another spouse) within (6) months prior to the date you enrolled for insurance for the Domestic Partner under the Group policy, unless the previous partnership or marriage terminated due to the death of the former domestic partner or spouse.
 - iii. You have shared the same residence for at least (6) months prior to the date you enrolled for insurance for the Domestic Partner under the policy
 - iv. You have valid documentation demonstrating that you have joint financial commitments, such as a joint mortgage, a joint lease, financial statements, etc.

II. Eligibility

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

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

III. Enrollment and Effective Date of Coverage

In addition to submitting a Health Plan-approved enrollment application, as required under “Enrollment and Effective Date of Coverage” of Section 1 of the attached Group Evidence of Coverage, you and your Domestic Partner may either submit to Group or Health Plan, as applicable, a copy of a DC Domestic Partnership registration or a completed and signed “Affidavit of Domestic Partnership” form which can be obtained from the Group or Health Plan, as applicable, within the same time frame as the enrollment application.

IV. Termination of Domestic Partner Coverage

You must notify Group or Health Plan, as applicable, within 30 days if the Domestic Partnership terminates by either providing us with a copy of a DC Domestic Partnership Termination statement that has been filed with the Mayor's office of the DC Government, or by completing a "Statement of Termination of Domestic Partnership" form, which can be obtained from Group or Health Plan, as applicable.

Coverage will terminate as follows:

A. Terminating Domestic Partnerships Registered with the DC Department of Health

When terminating a Domestic Partnership relationship recognized by the DC Department of Health, your domestic partner's coverage under this contract will terminate 6 months from the date the termination is filed with the mayor's office. Please provide us with a copy of the termination statement filed with the DC mayor's office.

B. Terminating all other Domestic Partnerships

i. If the Domestic Partnership ends for any reason other than death, the date of your Domestic Partner's termination will align with your group's general guidelines regarding the termination of dependents. Coverage of your Domestic Partner's Dependents will terminate on the date the Domestic Partner's coverage terminates.

ii. If coverage ends due to the death of your Domestic Partner, coverage will terminate as of the date of death. Your Domestic Partner's Dependents termination will align with your group's general guidelines regarding the termination of dependents.

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

V. Addition of a Different Partner

Unless the new partnership has been registered with the Department of Health, Vital Resources Division, you will be required to wait six months from the date of notification of termination of a Domestic Partnership before enrolling a new partner, unless the Domestic Partnership ended because of the death of your Domestic Partner.

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

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

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

By: 

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



KAISER PERMANENTE®
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(301) 816-2424

2008 MANDATES AMENDMENT
(Clinical Trials)

This Amendment shall be effective on or after July 1, 2008 or on the effective date of the Group Agreement and Evidence of Coverage, whichever is later, and shall terminate as of the date the Group Agreement and Evidence of Coverage terminates.

Section 3 – BENEFITS J. “Clinical Trials” is hereby deleted and replaced with the following:

J. Clinical Trials

We cover the Routine Patient Costs you incur for participation in Phase I – Phase IV Approved Clinical Trials provided on an inpatient and/or outpatient basis as described herein. In order to receive coverage under this benefit (a) the member must be approved by the Health Plan for participation in an Approved Clinical Trial; and (b) the member’s participation in the Approved Clinical Trial must be undertaken for the proposes of prevention, early detection, treatment, or monitoring of cancer, chronic disease or a life threatening illness.

“Routine Patient Costs” mean the costs of medically necessary Services incurred as a result of treatment provided to a Member who is receiving treatment in an Approved Clinical Trial. “Patient costs” include:

- (i) Items, drugs, and services typically provided absent a clinical trial;
- (ii) 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
- (iii) 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.

Routine patient costs do not include:

- (i) The cost of tests or measurements conducted primarily for the purpose of the clinical trial or items, drugs or services provided solely to satisfy data collection and analysis needs;
- (ii) Items, drugs or services provided by the research sponsors free of charge for any qualified individual enrolled in the trial;
- (iii) Costs associated with managing the research for the clinical trial.

“Approved Clinical Trial” means the following:

(a) A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:

- The National Institute of Health (“NIH”)
- The Centers for Disease Control and Prevention

- The Agency for Health Care Research and Quality
 - The Centers for Medicare and Medicaid Services (“CMS”)
 - 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
 - The Department of Defense, the Department of Veterans Affairs, the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute (NCI) has awarded a support grant.
- (b) A study or investigation approved by the Food and Drug Administration (“FDA”) including those conducted under an investigational new drug or device application reviewed by the FDA; or
- (c) An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services (“DHHS”) that is associated with an institution that has a federal-wide assurance approved by the DHHS specifying compliance with 45 C.F.R. Part 46.

Filing of Grievances

A Qualified Member may file a grievance as the result of an Adverse Decision as described in Section 5 (“Getting Assistance, Filing Claims, and the Appeals Procedure”), including the right to file a formal external review as described in External Appeal Procedure.

Note: A member may be authorized to receive Clinical Trial services as described herein, outside the Service Area. Services may be provided by a non-Plan provider as arranged by Health Plan.

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

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

By:  _____

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


KAISER PERMANENTE
Kaiser Foundation Health Plan of
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2101 East Jefferson Street
Rockville, Maryland 20849

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