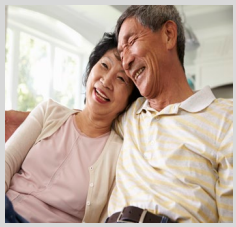

guide to

YOUR 2026 BENEFITS AND SERVICES

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

KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES MEMBERSHIP AGREEMENT AND EVIDENCE OF COVERAGE

DISTRICT OF COLUMBIA

ACCREDITED NCQA HEALTH PLAN ACCREDITED

See 2026 NCQA Guide
for more information on accreditation

KAISER PERMANENTE®

**Kaiser Foundation Health Plan
of the Mid-Atlantic States, Inc.
4000 Garden City Drive
Hyattsville, MD 20785
www.kp.org**

DC-DP-COVER(01-26)

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

Residents of the District of Columbia should know that licensed insurers or health maintenance organizations who sell health benefit plans, disability income insurance, long-term care insurance, life insurance, and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association").

The purpose of the Guaranty Association is to provide statutorily-determined benefits associated with covered policies and contracts in the unlikely event that a member insurer is unable to meet its financial obligations and is found by a court of law to be insolvent. When a member insurer is found by a court to be insolvent, the Guaranty Association will assess the other member insurers to satisfy the benefits associated with any outstanding covered claims of persons residing in the District of Columbia. However, the protection provided through the Guaranty Association is subject to certain statutory limits explained under the "Coverage Limitations" section below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep the coverage in-force, with no change in contractual rights or benefits.

Coverage

The Guaranty Association, established pursuant to the Life and Health Guaranty Association Act of 1992 ("Act"), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code §31-5401 *et seq*.), provides insolvency protection for certain types of insurance policies and contracts.

The insolvency protections provided by the Guaranty Association are generally conditioned on a person being 1) a resident of the District of Columbia and 2) either the individual insured or an owner under a health benefit plan, disability income insurance, long-term care insurance, life insurance, or annuity contract issued by a member insurer or the individual insured under a group policy insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of District insureds are also generally covered under the Act, even if they reside in another state.

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- With respect to any one life, regardless of the number of policies, contracts, or certificates:
    - $300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
    - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
    - $300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
    - $300,000 for long-term care insurance benefits;
    - $300,000 for disability income insurance benefits;
    - $500,000 for health benefit plans;

- $100,000 for coverage not defined as disability income insurance, health benefit plans, or long-term care insurance including any net cash surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than $300,000 in benefits with respect to any one life (except in the event of health benefit plans in which the Guaranty Association is liable for no more than $500,000).

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner regardless of the number of policies owned.

Exclusions Examples

Policy or contract holders are not protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insureds that live outside of that state);
- Their insurer was not authorized to do business in the District of Columbia at the time the policy or contract was issued; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a risk retention group.

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits, or fees for services in connection with policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contacts.

Consumer Protection

To learn more about the above referenced protections, please visit either:

District of Columbia
Life and Health Insurance
Guaranty Association
www.dclifega.org
410-248-0407

District of Columbia
Department of Insurance, Securities and Banking
disb.dc.gov
202-727-8000

Pursuant to the Act (D.C. Official Code §31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and the amounts of coverage provided under the Act. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on the insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association will cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any rights established in any policy or contract or under the Act.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network and/or your plan does not cover out-of-network services.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than your in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit. Your health plan coverage may not cover out-of-network services when you agree (consent) to receive services from the out-of-network providers.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service. Providers and facilities are not balance billing you when they seek to collect cost sharing or another amount that you agreed to pay or are required to pay under your plan for the services that they provided.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, or when an in-network provider is not available. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers and facilities.
    - Base what you owe the provider or facility (your cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or non-emergency services provided by certain out-of-network providers at an in-network facility toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed by a provider or facility, contact the federal government at: **1-800-985-3059** or the District of Columbia Department of Insurance, Securities & Banking at *https://disb.dc.gov/page/request-help-dealing-financial-institutions-form* or call **202-727-8000**.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

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

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

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

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at:

Kaiser Permanente
Appeals and Correspondence Department
Attn: Kaiser Civil Rights Coordinator
4000 Garden City Drive
Hyattsville, MD 20785
Telephone Number: 1-800-777-7902

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
Telephone Number: 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/language-assistance/nondiscrimination-notice.

HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ትኩረት፡ እንግሊዘኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች ለእርስዎ ይገኛሉ። በ **1-800-777-7902** ይደውሉ (TTY: **711**)።

العربية (Arabic) تنبيه: إذا كنت تتحدث الإنجليزية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك وسائل المساعدة والخدمات المناسبة. اتصل بالرقم **1-800-777-7902** (TTY: **711**).

Bǎsɔ́ɔ̀ Wùɖù (Bassa) Mbi sog: nia maa Engilì, njàl mbom a ka maa njàng ndol ni mbom mi tsoŋ ni soŋ, niŋ ma kénŋɛn yé, mbi èyɛm. Wɔ nàŋ **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) মনোযোগ দিন: আপনি যদি ইংরেজিতে কথা বলেন, আপনি বিনামূল্যে, উপযুক্ত সহায়ক পরিষেবা ও সাহায্য সমেত ভাষা সহায়তা পরিষেবা পেতে পারেন। **1-800-777-7902** (TTY: **711**)-এ ফোন করুন।

中文 (Chinese) 注意事項：如果您說英語，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان انگلیسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با **1-800-777-7902** تماس بگیرید (TTY (تلفن متنی): **711**).

Français (French) ATTENTION : si vous parlez anglais, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Englisch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-777-7902** an (TTY: **711**).

ગુજરાતી (Gujarati) ધ્યાન આપો: જો તમે અંગ્રેજી બોલો છો, તો યોગ્ય સહાયક સહાય અને સેવાઓ સહિતની ભાષા સહાય સેવાઓ, તમારા માટે મફત ઉપલબ્ધ છે. **1-800-777-7902** (TTY: **711**) પર કૉલ કરો.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale angle, w ap jwenn sèvis asistans lang tankou èd ak sèvis konplemantè adapte gratis. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: अगर आप अंग्रेज़ी बोलते हैं, तो आपके लिए उपयुक्त सहायक उपकरण और सेवाओं सहित भाषा सहायता सेवाएँ मुफ़्त उपलब्ध हैं। **1-800-777-7902** पर कॉल करें (TTY: **711**).

Igbo (Igbo) TINYE UCHE: Ọ bụrụ na ị na-asụ bekee, Ọrụ enyemaka nke asụsụ gụnyere udi enyemaka na ọrụ kwesịrị ekwesị, n'efu, dị nye gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE. Se parla inglese, può usufruire gratuitamente dei servizi di assistenza linguistica compresi gli opportuni aiuti e servizi ausiliari. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (Japanese) 注意：英語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-777-7902** までお電話ください（TTY: **711**）。

한국어 (Korean) 주의: 영어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-777-7902** 로 전화해 주세요(TTY: **711**).

Naabeehó (Navajo) BAA NAANISH 'AGHA: Daa nihi t'aa 'aanii 'adishni Bilagaana bizaad, saad 'ahilka 'ana'alwo' biniit'aa da beeso ndinish'aah t'aala'I bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, bineesh'a bil hadlee' goo nihi. Bika 'adishni **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala inglês, temos à sua disposição serviços gratuitos de assistência linguística, incluindo serviços e materiais de apoio adequados. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-английски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: Si habla inglés, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng English, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาอังกฤษ ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) توجہ: اگر آپ انگریزی بولتے ہیں تو آپ مفت زبان کی معاونت کی خدمات حاصل کر سکتے ہیں، جیسے مناسب معاون امداد اور خدمات۔ کال کریں **1-800-777-7902** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Anh, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) ÀKÍYÈSÍ: Tí o bá ń sọ èdè Gẹ̀ẹ́sì, àwọn iṣẹ́ ìrànlọ́wọ́ èdè àwọn ohun èlò ìrànlọ́wọ́ àti àwọn iṣẹ́ láìsí ìdíyelé wà fún ọ. Pe **1-800-777-7902** (TTY: **711**).

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Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

SECTION 1: Introduction to Your Kaiser Permanente Health Plan

Welcome to Kaiser Permanente

Thank you for choosing us as your partner in total health. Kaiser Permanente provides you with many resources to support your health and wellbeing. This Membership Agreement and Evidence of Coverage (EOC) is one of them. It provides you with an overview of your Health Plan, including the benefits you are entitled to, how to get care, what services are covered and what part of the costs of your care you will have to pay.

We ask that you review this Agreement in full and contact us with any questions you may have. Member Services representatives are ready and available to assist you Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

You may also visit our website, www.kp.org, to schedule an appointment, select a Plan Provider, choose or change your Primary Care Plan Physician, access valuable wellness tips and find answers to frequently asked questions.

Again, thank you for enrolling with Kaiser Permanente. We look forward to the opportunity to help you live a happier, healthier life!

Our Commitment to Diversity and Nondiscrimination

Diversity, inclusion and culturally competent medical care are defining characteristics of Kaiser Permanente. We champion the cause of inclusive care – care that is respectful of, and sensitive to the unique values, ideals and traditions of the cultures represented in our population. Our diverse workforce reflects the diversity of the people in the communities we serve.

We do not discriminate in our employment practices or the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, gender identity or expression, or physical or mental disability.

About This Agreement

Once you are enrolled in this Plan, you become a Member of Kaiser Permanente. A Member may be a Subscriber and/or any eligible Dependents who are enrolled in a Kaiser Permanente for Individuals and Families Plan, or an eligible child enrolled in a Kaiser Permanente Child Only Plan. Members are sometimes referred to by the terms "you" and "your." Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., is sometimes referred to as "Health Plan," "we," "us," "our" and "Kaiser Permanente."

Under no circumstances should the terms "you" or "your" be interpreted to mean a Financially Responsible Person, Parent/Guardian or any other nonmember reading or interpreting this Agreement on behalf of a Member.

Important Terms

Some terms in this Agreement are capitalized. They have special meanings. Please see the ***Important Terms You Should Know*** section to familiarize yourself with these terms.

Purpose of this Agreement

This Agreement serves two important purposes. It:

Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

1. Is a legally binding contract between a Member and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.; and
2. Provides evidence of your health care coverage under this Kaiser Permanente Individuals and Families Membership Agreement or Kaiser Permanente Child Only Membership Agreement, as applicable.

Acceptance of Agreement

Payment of due Premium indicates to the Health Plan that a Subscriber or Financially Responsible Person accepts this Agreement in full. Acceptance of this Agreement confirms that a Subscriber or Financially Responsible Person and the Health Plan agree to all of the provisions contained within it.

Agreement Binding on Members

By this Agreement, the Subscriber makes Health Plan coverage available to persons who are eligible. However, this Agreement is subject to amendment, modification or termination in accord with any provision hereof or by mutual agreement between the Health Plan and Subscriber without consent or concurrence of Members.

Right to Reject Agreement

You may return this Agreement to the Health Plan within ten (10) days of receiving it if you feel the Agreement is not satisfactory for any reason. If you return this Agreement and it is received by us within ten (10) days, you will receive a full refund of paid Premium and the Agreement will be void and canceled. This right may not be exercised if any Member covered under the Agreement receives Services under this Agreement within the aforementioned ten (10)-day period.

Administration of Agreement

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

Amendment of Agreement

The Health Plan may amend this Agreement with respect to any matter, if the modification is consistent with state law and is effective uniformly for all individuals with that product, only at the time of coverage renewal. The Agreement of Subscriber to such amendment shall be established by the making of Monthly Payments to Health Plan pursuant to this section, or the acceptance of benefits hereunder after the effective date of such amendment.

In the event that this Agreement must be altered to comply with a change in state or federal law, the Health Plan may modify the benefits and/or Monthly Payments for enrolled Members. Changes in benefits and/or Monthly Payments shall take effect on the latter of the effective date of the change in coverage, or the date the rate change is approved by the Department of Insurance in the state in which this Agreement is delivered, if such approval is required.

No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, nor impair our right thereafter to require your strict performance of any provision.

Entire Contract

This Agreement, including all appendices attached, constitutes the entire contract between you and us and replaces any earlier Agreement that may have been issued to you by us.

Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

This Agreement will only be modified as allowed or required by law. We may not amend this Agreement with respect to any matter, including rates.

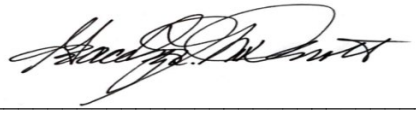
No agent or other person, except an officer of the Health Plan, has the authority to:

1. Change or waive any conditions or restrictions of this Agreement;
2. Extend the time for paying required Premium; or
3. Bind the Health Plan in any way, verbally or otherwise, by:
   a. Making any promise or representation; or
   b. Giving or receiving any information.

No change in this Agreement will be considered valid unless recorded in a written amendment signed and approved by an officer of the Health Plan and attached to this Agreement.

This Agreement is undersigned by us immediately below. Your signature is not required.

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



Gracelyn McDermott
Vice President, Marketing, Sales & Business Development

How Your Health Plan Works

The Health Plan provides health care Services to Members through an integrated medical care system, rather than reimbursement of expenses on a fee-for-service basis. Please keep this direct service nature in mind as you read this Agreement. Our integrated medical care system is made up of various entities. The relationship between them is explained immediately below.

Relations Among Parties Affected By This Agreement

Kaiser Permanente is comprised of three entities: the Health Plan, Medical Group and Plan Hospitals. Please note that:

1. The relationship between the Health Plan and Medical Group and between the Health Plan and Plan Hospitals are those of independent contractors;
2. Plan Providers and Plan Hospitals are not agents or employees of the Health Plan; and
3. Neither the Health Plan nor any employee of the Health Plan is an employee or agent of Plan Hospitals, the Medical Group or any other Plan Provider.

Additionally:

1. Plan Physicians maintain the physician-patient relationship with Members and are solely responsible to Members for all medical Services; and
2. Plan Hospitals maintain the Hospital-patient relationship with Members and are solely responsible to Members for all Hospital Services.

Patient Information Obtained By Affected Parties

Patient-identifying information from Member medical records, and that is received by Plan Physicians or Plan Hospitals incident to the physician-patient or Hospital-patient relationship, is kept confidential.

Patient-identifying information is not disclosed without the prior consent of a Member, except for use by the Health Plan, Plan Hospitals, Medical Group or Plan Physicians in relation to:

1. Administering this Agreement;
2. Complying with government requirements; and
3. Bona fide research or education.

Liability for Amounts Owed By the Health Plan

Members are not liable for any amounts owed to the Medical Group or Plan Hospitals by the Health Plan, as stipulated by contracts between these entities.

Kaiser Permanente for Individuals and Families Plan/Kaiser Permanente Child Only Plan Services Overview

Health care Services are provided to you through an integrated medical care system using Plan Providers located in our state-of-the-art Plan Medical Centers and through affiliated Plan Providers located throughout our Service Area.

Getting the care you need is easy. Health care Services are accessible at Plan Medical Centers, which are conveniently located throughout the Washington, D.C. and Baltimore Metropolitan Areas. At our Plan Medical Centers, we have integrated teams of specialists, nurses and technicians working alongside your Primary Care Plan Physician to support your health and wellbeing. Pharmacy, optical, laboratory and X-ray facilities are also available at many Plan Medical Centers.

Under this Agreement, you must receive Services from Plan Providers within our Service Area, except for:

1. Emergency Services, as described in ***Section 3: Benefits, Exclusions and Limitations***;
2. Urgent Care Services outside of our Service Area, as described in ***Section 3: Benefits, Exclusions and Limitations***;
3. Continuity of Care for New Members, as described in ***Section 2: How to Get the Care You Need***;
4. Approved referrals, as described in ***Section 2: How to Get the Care You Need*** under the ***Getting a Referral*** provision, including referrals for Clinical Trials, as described in ***Section 3: Benefits, Exclusions and Limitations***.

Enrollment Through the Exchange

The Health Plan will enroll all Qualified Individuals that apply for coverage with us through the Exchange only if the Exchange:

1. Notifies us that the individual is a Qualified Individual; and
2. Transmits all the information necessary for us to enroll the applicant.

Who is Eligible

The Exchange will determine if an individual may be accepted for enrollment and continuing coverage hereunder only if you meet all applicable requirements as set forth below. In order to be eligible, you and your covered Dependents must live in the Service Area. (The Service Area is defined in the ***Important Terms You Should Know*** section).

Subscriber and Dependents

To be a:

1. Subscriber, you must meet the requirements established from time to time by Health Plan. These requirements may include but are not limited to place of residence.

2. Dependent, you must be:
   a. The Subscriber's Spouse, Domestic Partner, or Legal Partner; or
   b. A Dependent child, under the limiting age of 26 of the Subscriber or of the Subscriber's Spouse, Domestic Partner, or Legal Partner.
      i. As used in this Agreement, a Dependent child under the limiting age will include:
         a) A natural or adopted child of the Subscriber or the Subscriber's Spouse, Domestic Partner, or Legal Partner;
         b) A child who is not a natural or adopted child, but for whom the Subscriber or the Subscriber's Spouse, Domestic Partner, or Legal Partner is eligible to claim an exemption on his or her Federal income tax return and who is permanently residing in the Subscriber's household; and
         c) A child for whom the Subscriber or the Subscriber's Spouse, Domestic Partner, or Legal Partner has received a qualified medical child support order.
   c. For the purpose of age appropriate health screening only, eligible children shall include all children, from birth to 21 years of age, in the District of Columbia, regardless of their insurance status, who:
      i. Reside in the District;
      ii. Are wards of the District; or
      iii. Are children with special needs who reside or are receiving services in another state.

Coverage is also provided for a minor grandchild, niece, or nephew if under the primary care of the Subscriber and, if other than the Subscriber, the legal guardian of the minor grandchild, niece, or nephew is not covered by an accident or sickness policy. For the purposes of this paragraph, "primary care" means the Subscriber provides food, clothing, and shelter on a regular and continuous basis for the minor grandchild, niece, or nephew during the time that the District of Columbia public schools are in regular session.

A child who is covered as a Dependent when he/she reaches the limiting age under #2. b., above, may continue coverage if incapable of self-support by reason of mental incapacity or physical handicap and chiefly dependent upon the Subscriber or the Subscriber's Spouse, Domestic Partner, or Legal Partner for support and maintenance, with proof of incapacity and dependency furnished annually if requested by Health Plan.

Coverage for a newborn child is automatically covered for the first thirty-one (31) days from their date of birth. If payment of additional Premium is required to provide coverage for a newborn child then, in order for coverage to continue beyond thirty-one (31) days from the date of birth, notification of birth and payment of additional Premium must be provided within thirty-one (31) days of the date of birth, otherwise coverage for the newborn will terminate thirty-one (31) days from the date of birth and the newborn child cannot be covered until the next annual open enrollment period.

When a newborn child is enrolled following the guidelines immediately described above, subrogation and coordination of benefits, as described in ***Section 4: Subrogation, Reductions and Coordination of Benefits***, will not apply. If a Member has not attempted to enroll a newborn child following the above guidelines, we will provide coverage for the newborn child thirty-one (31) days following the newborn child's date of birth but, after claims are paid, we may request subrogation from another insurer where applicable.

Subscribers must notify the Health Plan of any change in eligibility of a Dependent for any reason other than when a child reaches age 26.

Note: A Dependent child's coverage under this EOC will terminate at the end of the Calendar Year (December 31st) during which the Dependent child turns 26 years of age.

Genetic Information

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.

Eligibility for Catastrophic Coverage Plans

This provision applies only to Members with catastrophic coverage. Some Plans offer catastrophic coverage, depending on Member age and other factors. Review the Cost Sharing information provided in this Agreement to determine whether or not you are enrolled in catastrophic coverage.

Member Eligibility

In order to enroll and to continue enrollment in our catastrophic Plan, you and each Dependent must individually meet one of the following requirements:

1. You and your Dependent(s) must not have reached age 30 before January 1st of the Calendar Year. If you reach age 30 on or after January 1st, your catastrophic coverage will continue until the end of the current Calendar Year. However, you will no longer meet the age qualification for catastrophic coverage beginning January 1st of the next year; or
2. The Exchange has certified that for the 1st day of the current Calendar Year, you and/or your Dependent are exempt from the shared responsibility payment for the reasons identified in Internal Revenue Code Section 5000A(e)(1) (relating to individuals without affordable coverage) or 5000A(e)(5) (relating to individuals with hardships).

Member Rights and Responsibilities: Our Commitment to Each Other

Kaiser Permanente is committed to providing you with quality health care Services. In the 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 or your Authorized Representative, Parent/Guardian or a Financially Responsible Person, as applicable, have the right to:

1. **Receive information that empowers you to be involved in health care decision making. This includes the 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 Care, Living Will, or other health care treatment directive. You can rescind or modify these documents at any time;
g. Receive information about research projects that may affect your health care or treatment. You have the right to choose to participate in research projects; and
h. Receive access to your medical records and any information that pertains to you, except as prohibited by law. This includes the right to ask us to make additions or corrections to your medical record. We will review your request based on applicable federal and state law to determine if the requested additions are appropriate. If we approve your request, we will make the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. The Member or Member's Authorized Representative will be asked to provide written permission before a Member's records are released, unless otherwise permitted by law.

2. **Receive information about Kaiser Permanente and your Plan. This includes the right to:**
   a. Receive the information you need to choose or change your Primary Care Plan Physician, including the name, professional level and credentials of the doctors assisting or treating you;
   b. Receive information about Kaiser Permanente, our Services, our practitioners and Providers, and the rights and responsibilities you have as a Member. You also can make recommendations regarding Kaiser Permanente's Member rights and responsibility policies;
   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 layperson, acting reasonably, would have believed that an emergency medical condition existed, and receive information regarding cost sharing, payment obligations and balance billing protections for Emergency Services;
   e. Receive covered urgently needed Services when traveling outside Kaiser Permanente's Service Area;
   f. Receive information about what Services are covered and what you will have to pay and to examine an explanation of any bills for Services that are not covered; and
   g. File a complaint, grievance or appeal about Kaiser Permanente or the care you received without fear of retribution or discrimination, expect problems to be fairly examined, and receive an acknowledgement and a resolution in a timely manner.
3. **Receive professional care and Service. This includes the 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 (PHI) handled confidentially and in a way that respects your privacy;
   c. Be treated with respect and dignity;

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

Member Responsibilities

As a Member of Kaiser Permanente, you or your Parent/Guardian, as applicable, are responsible to:

1. **Promote your own good health:**
   a. Be active in your health care and engage in healthy habits;
   b. Select a Primary Care Plan Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics or Family Practice as your Primary Care Plan Physician. You may also choose a personal OB/GYN in addition to Primary Care Plan Physician;
   c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you;
   d. Work with us to help you understand your health problems and develop mutually agreed upon treatment goals;
   e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment;
   f. Do your best to improve your health by following the treatment plan and instructions your Primary Care Plan Physician or health care professional recommends;
   g. Schedule the health care appointments your Primary Care Plan Physician or health care professional recommends;
   h. Keep scheduled appointments or cancel appointments with as much notice as possible; and
   i. Inform us if you no longer live within the Plan Service Area.
2. **Know and understand your Plan and benefits:**
   a. Read about your health care benefits in this Agreement and become familiar with them. Call us when you have questions or concerns;
   b. Pay your Plan Premium, and bring payment with you when your Visit requires a Copayment, Coinsurance or Deductible;
   c. Let us know if you have any questions, concerns, problems or suggestions;
   d. Inform us if you have any other health insurance or prescription drug coverage; and
   e. Inform any network or nonparticipating provider from whom you receive care that you are enrolled in our Plan.
3. **Promote respect and safety for others:**
   a. Extend the same courtesy and respect to others that you expect when seeking health care Services; and
   b. Assure a safe environment for other Members, staff and physicians by not threatening or harming others.

Health Savings Account-Qualified Plans

This provision only applies if you are enrolled in a qualified High Deductible Health Plan. It does not

apply to Members with catastrophic Plan coverage. A Health Savings Account is a tax-exempt account established under Section 223(d) of the Internal Revenue Code for the exclusive purpose of paying current and future Qualified Medical Expenses. Contributions to such an account are tax deductible, but in order to qualify for and make contributions to a Health Savings Account, a Member must be enrolled in a qualified High Deductible Health Plan.

A qualified High Deductible Health Plan provides health care coverage that includes an:

1. Individual Deductible of $1,700.00 or greater and a family Deductible of $3,400.00 or greater; and
2. Individual Out-of-Pocket Maximum of no more than $8,500.00 and a family Out-of-Pocket Maximum of no more than $17,000.00 in the current Calendar Year.

In a qualified High Deductible Health Plan, all Deductible, Copayment and Coinsurance amounts must be counted toward the Out-of-Pocket Maximum. Review the Cost Sharing information contained within this Agreement to see whether or not this Plan meets the High Deductible Health Plan requirements described in this paragraph. A Plan is a qualified High Deductible Health Plan only if it meets those requirements. Enrollment in a qualified High Deductible Health Plan is only one of the eligibility requirements for establishing and contributing to a Health Savings Account. Other requirements include the following prohibitions: The Member must not be:

1. Covered by other health coverage that is not also a Health Savings Account-qualified plan, with certain exceptions;
2. Enrolled in Medicare; and/or
3. Able to be claimed as a Dependent on another person's tax return.

Please note that the tax references contained in this Agreement relate to federal income tax only. The tax treatment of Health Savings Account contributions and distributions under a state's income tax laws may differ from the federal tax treatment. Kaiser Permanente does not provide tax advice. Contact your financial or tax advisor for more information about your eligibility for a Health Savings Account or to obtain tax advice.

Payment of Premium

Premium may be paid in different ways depending on how you applied for coverage under this Plan. This may include payment directly to the Health Plan or through the Exchange. In consideration of the timely Premium paid to the Health Plan or Exchange, we agree to arrange health care Services in accordance with the terms, conditions, limitations and exclusions of this Agreement.

Members covered under a Kaiser Permanente Child Only Plan may require someone to contractually agree to pay due Premium on their behalf. That individual is known as the Financially Responsible Person.

This Plan is contributory in that the Subscriber, on behalf of his/herself and any applicable Dependents, or a Financially Responsible Person, on behalf of a child Member, is responsible for payment of all required Premium. Premium is due directly to Health Plan on or before the last day of the month preceding the month of membership.

The Financially Responsible person may be a Parent/Guardian, but sometimes they are different people. In the event that the Financially Responsible Person and Parent/Guardian:

1. Are not the same person, then this Agreement is a legally binding contract between the:
   a. Health Plan;

b. Financially Responsible Person; and
c. Parent/Guardian who holds the legal authority to make medical decisions for a Member under age 18 or who is age 18 or older, but incapable of making medical decisions by reason of mental incapacity.

2. Is the same person, they shall be recognized as having the rights and responsibilities of both the Financially Responsible Person and the Parent/Guardian under this Agreement.

When requested by the Parent/Guardian, more than one (1) eligible child, when properly enrolled and for whom Premium has been paid, may be covered under this Agreement.

Only Members for whom the Health Plan has received the appropriate Premium payments are entitled to coverage under this Agreement, except as provided in ***Section 6: Extension of Benefits***, and then only for the period for which such Premium is received, in accordance with ***Section 6: Termination Due to Nonpayment of Premium***. Returned checks or insufficient funds on electronic payments may be subject to a fee.

The Premium due under this Agreement is determined by the Health Plan upon application for coverage. The Subscriber or Financially Responsible Person, as applicable, will be given at least forty-five (45) days' notice of any Premium change.

For Members who enroll through the Exchange: If you use Advance Premium Tax Credit, your monthly Premium payment may change if you take fewer or more tax credits due to changes in your income or the addition of loss of members of your household enrolled under your coverage. Use of Advance Premium Tax Credit may have an impact on your income tax return. Kaiser Permanente does not provide tax advice. Contact your financial or tax advisor for more information about your eligibility for Advance Premium Tax Credit or to obtain tax advice.

Annual Enrollment Period and Effective Date of Coverage

There is an annual enrollment period during which Qualified Individuals may:

1. Enroll in this Plan;
2. Discontinue enrollment in this Plan; or
3. Change enrollment from this Plan to another Plan offered by us.

The annual enrollment period shall begin on November 01, 2025 and extend through December 15, 2025.

If a Qualified Individual enrolls in this Plan during the annual enrollment period for 2026, the effective date of coverage shall be January 01, 2026, for completed applications received on or before December 15, 2025.

Open Enrollment Periods for Child Only Members

A person eligible for the Kaiser Permanente Child Only Membership Agreement may submit an application for coverage during one of the two open enrollment periods that occur each year from:

1. January 1 through January 31; and
2. July 1 through July 31.

We will request from an applicant information to determine whether the applicant has substantially similar coverage available and will obtain an attestation that the applicant does not have substantially similar

coverage available. We will reject an application during the open enrollment period if the child has other substantially similar coverage available or if no attestation is submitted upon request.

Upon receipt of a completed application, including but not limited to any information that we may request, such applicant shall then be offered coverage on a guaranteed issue basis, without any limitations.

Special Enrollment Periods Due to Triggering Events

Health Plan will provide a special enrollment period for each individual who experiences a triggering event. To learn more, contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY) or visit kp.org/specialenrollment to obtain a copy of our Special Enrollment Guide.

The special enrollment period shall be for sixty (60) days beginning on the date of the triggering event. In the case of the events described in items #2 and #9, the special enrollment period begins sixty (60) days prior to the loss of coverage and ends sixty (60) days after the loss of coverage.

During the special enrollment period, the individual will be permitted to enroll in or change from one Health Benefit Plan to another Health Benefit Plan offered by Health Plan; or enroll through the Exchange.

A triggering event occurs when:

1. You or your Dependent loses Minimum Essential Coverage. Loss of Minimum Essential Coverage does not include loss of coverage due to:
    a. failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage;
    b. a rescission authorized under 45 C.F.R. §147.128; or
    c. voluntary termination by the individual.
2. Your or your Dependent loses pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A) (ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX). The date of the loss of coverage is the last day you or your Dependent would have pregnancy-related coverage.
3. You or your Dependent loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per Calendar year. The date of the loss of coverage is the last day you or your Dependent would have medically needy coverage.
4. You gain a Dependent or become a Dependent through marriage, birth, adoption, or placement for adoption or foster care; or through a child support order or other court order. If you gain a Dependent or become a Dependent through marriage, you or your Dependent must demonstrate they:
    a. had minimum essential coverage for one or more days during the sixty (60) days preceding the date of marriage;
    b. lived in a foreign country for one or more days during the sixty (60) days preceding the date of marriage; or
    c. is an American Indian or Alaska Native, as defined in §4 of the federal Indian Health Care Improvement Act.
5. Your or your Dependent's enrollment or non-enrollment in a Qualified Health Plan (QHP) is evaluated and determined by the Exchange to be:

a. Unintentional, inadvertent, or erroneous; and
b. The result of the error, misrepresentation, misconduct or inaction of an officer, employee, or agent of the Exchange or the U.S. Department of Health and Human Services (HHS), its instrumentalities; or a non-Exchange entity providing enrollment assistance or conducting enrollment activities.

Note: The Exchange may take action as may be necessary to correct or eliminate the effects of the errors, misrepresentation, misconduct or inaction.

6. You or your Dependent who is enrolled in this Plan adequately demonstrate to the Exchange that we have substantially violated a material provision of this Agreement.
7. You or your Dependent who is enrolled in this Plan is determined newly eligible or newly ineligible for advance payments of federal premium tax credits or has a change in eligibility for federal cost-sharing reductions.
    a. If you or your Dependent are newly eligible for cost-sharing reductions and not enrolled in a silver-level Qualified Health Plan, you or your Dependent may enroll only in a silver-level Qualified Health Plan.
8. You or your Dependent gains access to a new health benefit plan as a result of a permanent move or is recently released from incarceration.
9. Either you or your Dependent, while enrolled in an eligible employer-sponsored plan, becomes newly-eligible for Advance Premium Tax Credit because you or your Dependent will be ineligible for qualifying coverage in an employer-sponsored. This includes loss of coverage as a result of the employer's discontinuation or change of available coverage within the next sixty (60) days, provided that you or your Dependent may terminate your existing coverage under the employer-sponsored plan.
10. You lose a Dependent or you are no longer considered to be a Dependent due to divorce or legal separation as defined by state law in the state where the divorce or legal separation occurs.
11. The Subscriber or a Dependent dies.
12. For a Plan offered through the Exchange, an individual:
    a. who was not previously a citizen, national, or lawfully present individual becomes a citizen, national, or lawfully present individual; or
    b. an individual or a dependent demonstrates to the Exchange, in accordance with guidelines issued by the U.S. Department of Health and Human Services (HHS), that the individual or Dependent meets other exceptional circumstances as the Exchange may provide.
13. If the triggering event described in item #9 above occurs, Health Plan shall permit an individual to access the special enrollment period before the end of the individual's coverage through the employer-sponsored plan.
14. You or your Dependent are confirmed by a provider to be pregnant.
15. You receive termination notice of your enrollment in a Qualified Health Plan due to a rejected credit card or debit card payment in an auto-payment arrangement established with Health Plan and the auto-payment rejection was not due to insufficient funds in your account or you terminating the

auto-payment arrangement with Health Plan. You will have sixty (60) days from the date you receive termination of notice of your enrollment in a Qualified Health Plan to re-enroll in the same Qualified Health Plan for the same enrollees.

16. Pursuant to DC Code §47-5102, you or your Dependent initially became aware of the District's Individual Health Insurance Responsibility Requirement (IRR) but no later than the application tax filing deadline applicable to you or your Dependent. You will have sixty (60) days form the date you or your Dependent initially became aware of the District's IRR to enroll in a Qualified Health Plan.

Note: This special enrollment period may only be granted once and is not available if you or your Dependent have received the time-limited exceptional circumstance special enrollment period associated with the District's IRR.

17. You or your Dependent newly meet the District's residency requirement to enroll in a Qualified Health Plan. You will have sixty (60) days from the date you or your Dependent meet the District's residency requirement to enroll in a Qualified Health Plan.

Note: You may enroll in any Qualified Health Plan if you are not currently enrolled in a Qualified Health Plan or if you are currently enrolled in a Qualified Health Plan, you may enroll in another Qualified Health Plan within the same level of coverage or one metal tier higher or lower, if no such Qualified Health Plan is available. If your Dependent is currently enrolled in a Qualified Health Plan, they may be enrolled into your currently Qualified Health Plan, may enroll with you into another Qualified Health Plan within the same level of coverage or one tier higher or lower, if no such Qualified Health Plan is available, or may enroll in any separate Qualified Health Plan.

Effective Date for Special Enrollment Periods

If an individual enrolls in or changes health plan coverage during a special enrollment period as the result of a triggering event, the effective date of such coverage shall be determined as described below. For more information on triggering events that create special enrollment periods, see ***Special Enrollment Periods Due To Triggering Events***.

1. In the case of loss of Minimum Essential Coverage, pregnancy-related or medically needy coverage, or non-calendar year group health plan or individual health insurance coverage; or upon gaining access to new plans due to a permanent move, recent release from incarceration or for becoming newly eligible for the Advance Premium Tax Credit due to a move from a non-Medicaid expansion state, the coverage effective date is based on date of your plan selection. If the plan selection:
   a. Is made on or before the date of the loss of coverage, then new coverage becomes effective the 1st day of the month following the loss of coverage; or
   b. Occurs after the date of loss of coverage, then new coverage becomes effective the 1st day of the following month when selection is made between the 1st and 15th day of any month; and the 1st day of the second following month when a selection is made between the 16th and last day of any month.
2. In the case of marriage or domestic partnership, the coverage effective date shall be the 1st day of the month following plan selection or, if you choose and the Exchange permits, according to the

plan selection rule in paragraph #10, below.

3. In the case of a newly-eligible Dependent child, as a result of the Dependent child's birth, the coverage effective date shall be the moment of the Dependent child's birth.
   a. Coverage is automatic and unconditional for the first thirty-one (31) days following the date of birth. When an additional Premium is required to add the new Dependent child to the Subscriber's Plan, the Subscriber must affirmatively enroll the new Dependent child and pay any required Premium within those thirty-one (31) days in order for the Dependent child's coverage to extend beyond that period. If proof of the eligibility of the new Dependent child is required, the Health Plan will pay the reasonable cost of the providing of such proof. When additional Premium is not required, coverage automatically continues beyond the thirty-one (31) day period. While notification and enrollment of the new Dependent is recommended to expedite the claims process in situations where no additional Premium is due, it is not required.
   b. Coverage for a newly-eligible Dependent child shall consist of coverage for injury or sickness, including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
   c. Any other individual(s) including the Subscriber or Subscriber's Spouse, Domestic Partner, or Legal Partner, who are added due to this triggering event, will have the same effective date of coverage as the newly-born child.
4. In the case of adoption, a newly-eligible Dependent child's coverage effective date shall be the date of adoption of the Dependent child. The "date of adoption" means the earlier of a judicial decree of adoption or the assumption of custody, pending adoption of a prospective adoptive child by a prospective adoptive parent.
   a. Coverage is automatic and unconditional for the first thirty-one (31) days following the date of adoption. When an additional Premium is required to add the newly-Dependent child to the Subscriber's Plan, the Subscriber must affirmatively enroll the newly-Dependent child and pay any required Premium within those thirty-one (31) days in order for the Dependent child's coverage to extend beyond that period. If proof of the eligibility of the new Dependent child is required, the Health Plan will pay the reasonable cost of the providing of such proof. When additional Premium is not required, coverage automatically continues beyond the thirty-one (31) day period. While notification and enrollment of the new Dependent is recommended to expedite the claims process, it is not required.
   b. Coverage for a newly-eligible Dependent child shall consist of coverage for injury or sickness, including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
   c. Any other individual(s), including the Subscriber or Subscriber's Spouse, Domestic Partner, or Legal Partner, who are added due to this triggering event, will have the same effective date of coverage as the newly-adopted child.
5. In the case of a newly-eligible Dependent child, resulting from a child support order or other court order, the effective date for all enrolled individuals is the date the court order is effective. For Subscribers who enrolled through the Exchange, it may be determined in accordance with paragraph #10, below.
6. In the case of either placement for adoption or into foster care, the effective date of coverage shall be either the date of placement for adoption or into foster care.

   a. Additionally, any other individual(s), including the Subscriber or Subscriber's Spouse, Domestic Partner, or Legal Partner, who are added due to this triggering event, will have the same effective date of coverage as the Dependent placed for adoption or into foster care.
7. In the case of loss of coverage, or new eligibility for Advance Premium Tax Credit due to an employer-sponsored coverage change ***Special Enrollment Periods Due To Triggering Events***, the effective date is based on date of plan selection. If plan selection is made:
   a. On or before the date of the triggering event, then the coverage effective date shall be the 1st day of the month following the loss of coverage; or
   b. After the date of the triggering event, then the coverage effective date shall be in accordance with the effective rule described in paragraph #10, below, or the 1st day of the month following the plan selection, at the option of the Exchange. This potential alternate effective date only applies to plans sold on the Exchange.
8. In the case of triggering event described in paragraphs #7, #8, #11 or #12, or in the section ***Special Enrollment Periods Due to Triggering Events*** or paragraphs #3 or #4 under the Exchange-only Member enrollment section in ***Special Enrollment Periods Due to Triggering Events***, coverage for policies that are sold through the Exchange will be effective on an appropriate date based on the specific circumstances as determined by the Exchange. If you did not enroll through the Exchange, the effective date will be determined as described in paragraph #10, below.
9. In the case of the death of you or your Dependent, the coverage effective date shall be the 1st day of the month following plan selection, or if you choose and the Exchange allows, according to the plan selection rule in paragraph #10, below. This potential alternate effective date only applies to plans sold on the Exchange.
10. In the case of the triggering event described in item #14, the coverage effective date shall be:
    a. The 1st of the month in which your or your Dependent are confirmed by a provider to be pregnant; or
    b. The 1st of the month following the date you or your Dependent makes a plan selection.
11. In the case of the triggering event described in item #15, the coverage effective date shall be the 1st day following the date of termination, provided that you will have continuous coverage in the same Qualified Health Plan for the same enrollees prior to termination.
12. For all other triggering events, for a plan selection received by the Exchange or us between the:
    a. 1st and the 15th day of any month, then the coverage effective date will be the 1st day of the following month; and
    b. 16th and the last day of any month, then the coverage effective date will be the 1st day of the second following month.

Premium Payment Requirements for Special Enrollment Periods

When No Additional Premium is Required

If you experience a triggering event then enroll during a special enrollment period, coverage will be effective as of the date described above in the event that no additional Premium is required.

When Additional Premium is Due

If additional Premium is required following enrollment after you experience a triggering event, the Premium is due no later than the last day of the special enrollment period described above in order for us to provide coverage. If the premium is not paid prior to the end of the special enrollment period, coverage never

becomes effective. The only exceptions are in the case of a triggering event involving:

1. Birth;
2. Adoption; and
3. Placement for adoption.

Under those circumstances, coverage will terminate as of the 31st day during the sixty (60) day period if additional due Premium is not paid before expiration of the sixty (60) day enrollment period mentioned above under ***Effective Date for Special Enrollment Periods*** in this section.

Special Enrollment Periods and Effective Date of Coverage for American Indians and Alaska Natives Who Enroll Through the Exchange

For American Indian and Alaska Native Members who enroll through the Exchange: This provision only applies to individuals who are American Indian or Alaska Native, as defined in §4 of the federal Indian Health Care Improvement Act and enroll in a Plan on the Exchange. If you meet those criteria, you may enroll in a Plan, or change from one Plan in the Exchange to another Plan in the Exchange once per month. The effective date of the new Plan will be the 1st day of the month following your enrollment or change.

Notice of Your Effective Date of Coverage

The Health Plan will notify you and any enrolled Dependents of your effective date of coverage under this Plan based on the rules described above.

SECTION 2: How to Get the Care You Need

Making and Cancelling Appointments and Who to Contact

At Kaiser Permanente, we are available to assist you in getting the care you need. Should you experience a medical condition or require assistance from us, please contact the appropriate number below.

Medical Emergencies

- **Call 911, where available, if you think you have a medical emergency.**

Medical Advice

- **Call us at 1-800-677-1112 if you are unsure of your condition and require immediate medical advice.** You should also call this number in the event that you have an emergency hospital admission. We require notice within forty-eight (48) hours, or as soon as reasonably possible thereafter, of any emergency hospital admission.

Making or Canceling Appointments

To make or cancel an appointment, please visit us online at **www.kp.org**.

You may also make or cancel an appointment by phone. To do so, please have your Kaiser Permanente identification card with you and contact us at 1-800-777-7904 or 711 (TTY). We are available to assist you 24/7.

If your Primary Care Plan Physician is not located at one of our Plan Medical Centers, you may need to contact his/her office directly for assistance making or canceling an appointment. The telephone number for their office is located on your Kaiser Permanente identification card.

Choosing or Changing Your Primary Care Plan Physician

We recommend that you choose a Primary Care Plan Physician if you have not done so already. For more information, see ***Choosing Your Primary Care Plan Physician*** in this section.

You may choose or change your Primary Care Plan Physician at any time, for any reason, by visiting **www.kp.org/doctor**. On the website, you can browse all doctor's profiles and select a doctor who matches your needs.

You may also choose or change your Primary Care Plan Physician by phone by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Customer Service

We want you to be satisfied with your health care. Member Services representatives are available to assist you with questions about your Plan Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Member Services representatives are also available at most of our Plan Medical Centers. You may also ask your Primary Care Plan Physician or other health care professionals about problems you may have.

Advance Directives to Direct Your Care While Incapacitated

Advance directives are legal forms that help you control the kind of health care you will receive if you become very ill or unconscious. We ask that you please consider the benefits of completing a:

1. Durable Power of Attorney for Health Care, which 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; and
2. Living Will and the Natural Death Act Declaration to Physicians, which 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, visit us online at **www.kp.org** or contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Receiving Health Care Services

To receive the Services covered under this Agreement, you must be a current Health Plan Member for whom Premium has been paid. Anyone who is not a Member will be billed the Allowable Charge(s) for any Services we provide and claims for Emergency or Urgent Care Services from non-Plan Providers will be denied.

As a current Member under this Plan, we agree to provide and/or arrange health care Services in accordance with the terms, conditions, limitations and exclusions of this Agreement. You may receive these Services and other benefits specified in this Agreement when provided, prescribed or directed by Plan Providers within our Service Area.

You have your choice of Plan Physicians and Facilities within our Service Area. Covered Services are available only from the Medical Group, Plan Facilities and in-Plan Skilled Nursing Facilities. Neither the Health Plan, Medical Group nor any Plan Physicians have any liability or obligation extending from any Service or benefit sought or received by a Member from any non-Plan:

1. Doctor;
2. Hospital;
3. Skilled Nursing Facility;
4. Person;
5. Institution; or
6. Organization, except when you:
    a. Have a Prior Authorized referral for the Services; or
    b. Are covered under the ***Emergency Services*** or ***Urgent Care Services*** provisions in ***Section 3: Benefits, Exclusions and Limitations***.

Emergency and Urgent Care Services, in addition to Services associated with Prior Authorized referrals are the only Services a Member may seek outside of the Service Area.

Your Kaiser Permanente Identification Card

Digital Kaiser Permanente Identification Card

Managing your health care is convenient with the Kaiser Permanente mobile app. The app gives you access to your digital Kaiser Permanente identification card, which allows you to check in for appointments, pick up prescriptions and provide your membership information, all from your smartphone. To access your digital Kaiser Permanente identification card:

1. Log into the Kaiser Permanente mobile app; and
2. Select “Member ID Card” from the menu options.

Note: Verify that the Kaiser Permanente mobile app is available on your smartphone and create your login before arriving at your appointment. Additionally, the availability of the digital Kaiser Permanente identification card is limited to certain types of Plans and does not replace the physical card. Each Member will also receive a physical Kaiser Permanente identification card.

Using Your Kaiser Permanente Identification Card

Your Kaiser Permanente identification card is for identification purposes only. It contains your name, Medical Record Number and our contact information. When you Visit a Plan Facility, please have both your Kaiser Permanente identification card and a valid photo ID with you. You will be asked to show both of them when checking in.

Your 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 Kaiser Permanente identification card, or if we ever issue you more than one (1) Medical Record Number, please let us know by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Note: Allowing another person to use your ID card will result in forfeiture of your Kaiser Permanente identification card and may result in termination of your membership.

Choosing Your Primary Care Plan Physician

We highly encourage you to choose a Primary Care Plan Physician when you enroll. He or she will play an important role in coordinating your health care Services, including Hospital stays and referrals to specialists. Additionally, your Primary Care Plan Physician and Plan Providers will work as a team, along with you, to ensure continuity of care and medically appropriate courses of treatment.

Each Member in your family should select a 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 or change your Primary Care Plan Physician at any time by visiting us online at **www.kp.org** or contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Our Provider Directory is available online at **www.kp.org** and updated daily. A listing of all Primary Care Plan Physicians is also provided to you on an annual basis.

You may select a Primary Care Plan Physician, who is available to accept new Members, from the following areas: Internal medicine, family practice and pediatrics. Within pediatrics, you may select an allopathic or osteopathic pediatrician as the Primary Care Plan Physician for your child. In addition to selecting a Primary Care Plan Physician, Members may choose a Plan Physician who practices in the specialty of obstetrics or gynecology (OB/GYN) as their personal OB/GYN.

Getting a Referral

Our Plan Physicians offer primary medical, pediatric and OB/GYN care as well as specialty care in areas such as general surgery, orthopedic surgery, dermatology and other medical specialties. We have Plan Medical Centers and specialty facilities such as imaging centers, located within our Service Area. You will receive most of the covered Services that you routinely need at these facilities unless you have an approved referral to another Plan Provider.

All referrals will be subject to review and approval, which is known as authorization, in accordance with the terms of this Agreement. We will notify you when our review is complete.

Receiving an Authorized Specialist or Hospital Referral

If your Plan Provider decides that you require covered Services from a Specialist, you will receive an authorized referral to a Plan Provider who specializes in the type of care you need.

In the event that the covered Services you need are not available from a Plan Provider, we may refer you to another provider. For more information, see ***Referrals to Non-Plan Specialists and Non-Physician Specialists*** below.

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

Post-Referral Services Not Covered

Any additional Services not specifically listed, and/or that are provided by a professional not named in the referral, are not authorized and will not be reimbursed.

If a non-Plan Provider for whom you have received an authorized referral recommends additional Services that are not indicated in that approved referral, advise your Plan Provider. He or she will work with you to determine whether those Services can be provided by a Plan Provider. Additional services not specifically listed in the referral are not authorized and will not be reimbursed unless you have received a Prior Authorization for those Services.

Standing Referrals to Specialists

If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires Specialty Services, your Primary Care Plan Physician may determine, in consultation with you and a Specialist, that you need continuing care from that Specialist. In such instances, your Primary Care Plan Physician will issue a standing referral to the Specialist.

A standing referral should be developed by the specialist, your Primary Care Plan Physician and you, and made in accordance with a written treatment plan consisting of covered Services. The treatment plan may limit the authorized number of Specialist Visits and/or the period of time in which those Specialist Visits are authorized. It may also require that the Specialist communicate regularly with your Primary Care Plan Physician regarding your treatment and health status.

Referrals to Non-Plan Specialists and Non-Physician Specialists

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

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

You must have an approved written referral to the non-Plan Specialist or Non-Physician Specialist in order for the Health Plan to cover the Services. The Cost Share amounts for approved referral Services are the

same as those required for Services provided by a Plan Provider.

Services that Do Not Require a Referral

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:

1. An initial consultation for treatment of mental illness, emotional disorders and drug or alcohol abuse, when provided by a Plan Provider. For continued treatment, you or your Plan Provider must contact the Behavioral Health Access Unit for assistance to arrange and schedule these covered Services. The Behavioral Access Unit can be reached at 1-866-530-8778;
2. OB/GYN Services provided by an OB/GYN, a certified nurse-midwife or other Plan Provider authorized to provide OB/GYN Services including the ordering of related, covered OB/GYN Services; and
3. Optometry Services.

Prior Authorization for Prescription Drugs

Requests for covered outpatient prescription drugs may be subject to certain utilization management protocols, such as Prior Authorization or step therapy.

If we deny a Service or prescription drug because Prior Authorization was not obtained, or if a step-therapy exception request is denied, you may submit an appeal. For information on how to submit an appeal, see ***Section 5: Filing Claims, Appeals and Grievances***.

To find out if a prescription drug is subject to Prior Authorization or step-therapy requirements, please see ***Drugs, Supplies and Supplements*** in ***Section 3 – Benefits, Exclusions and Limitations*** or the ***Benefits*** section of the ***Outpatient Prescription Drug Benefit***.

For the most up-to-date list of Plan Medical Centers and Plan Providers, visit us online at **www.kp.org**. To request a Provider Directory, please contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Continuity of Care for Members

A Continuing Care Patient receiving care from a Participating Provider may elect to continue to receive transitional care from such provider if the provider's Participating Provider contract is terminated or non-renewed for reasons other than for failure to meet applicable quality standards, for fraud, or if the group contract terminates resulting in a loss of benefits with respect to such provider or facility. Health plan will notify each Member who is a Continuing Care Patient at the time of termination or non-renewal on a timely basis of such termination and the Member's right to elect transitional care.

When elected, benefits will be provided under the same terms and conditions as would have applied with respect to items and Services that would have been covered had termination not occurred and with respect to the course of treatment provided by such provider or facility relating to the Member's status as a Continuing Care Patient. Benefits will be provided during the period beginning on the date Health Plan notifies the Continuing Care Patient of the termination and ending on the earlier of (i) ninety-(90) days beginning on such date or (ii) the date on which such Member is no longer a Continuing Care Patient with respect to such provider or facility.

The Member will not be liable for an amount that exceeds the cost-sharing that would have applied to the Member had the termination not occurred.

Continuity of Care for New Members

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

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

As described below, the Health Plan will accept the Prior Authorization and allow a new Member to continue to receive Services from a non-Plan Provider for:

1. The course of treatment or ninety (90) days, whichever is less; and
2. Up to three (3) trimesters of a pregnancy and the initial postpartum Visit.

Transitioning to our Services

At the end of the applicable time period immediately above under ***Continuity of Care for New Members*** in this section, we may elect to perform our own review to determine the need for continued treatment; and to authorize continued Services as described under ***Getting a Referral*** in this section.

Getting Emergency and Urgent Care Services

Emergency Services

Emergency Services are covered 24 hours per day, 7 days per week no matter when or where in the world they occur without Prior Authorization and without regard to whether the health care provider furnishing the services is a Plan Provider.

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department or Independent Freestanding Emergency Department. You do not need Prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services that you receive from Plan Providers or non-Plan Providers anywhere in the world, as long as the Services would be covered under ***Emergency Services*** in ***Section 3: Benefits, Exclusions and Limitations*** if You had received them from Plan Providers. Emergency Services are available from Plan Hospital emergency departments 24 hours a day, seven days a week.

You will incur the same cost sharing (deductible, coinsurance and/or copayment, as applicable) for Emergency Services furnished by non- Plan Providers as Plan Providers and such cost sharing will be calculated based on the Allowable Charge in accordance with applicable law if you Cost Sharing is not a fixed amount.

If Emergency Services are provided by a Non-Plan Provider, Health Plan will make payment for the covered Emergency Services directly to the Non-Plan Provider. The payment amount will be equal to the amount by which the Allowable Charge exceeds your cost-sharing amount for the Services. You will not be liable for an amount that exceeds the recognized Amount as further described in this Agreement.

Bills for Emergency Services

You should not receive a bill for Emergency Services directly from a Plan Provider or non-Plan Provider when the federal No Surprises Act applies. When you do receive a bill from a hospital, physician or ancillary provider for Emergency Services that were provided to you, you should either (1) contact the hospital, physician or other provider to inform them that the bill should be sent to us at the address listed

below, or (2) simply mail or submit online to us the bill with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. You do not have to pay the bill until we determine what amount you owe, if any, for the Emergency Services. A bill from either the provider or you can be mailed or submitted online to us at:

Kaiser Permanente National Claims Administration - Mid-Atlantic States
PO Box 371860
Denver, CO 80237-9998
Website: www.kp.org

If you have already paid the bill, then please send proof of payment and a copy of the bill to the address listed above. Please remember to include your medical record number on your proof. For more information on the payment or reimbursement of covered services and how to file a claim, see ***Filing for Payment or Reimbursement of a Covered Service or Post-Service Claim*** in ***Section 5: Filing Claims, Appeals and Grievances***.

Urgent Care Services

All Primary Care Plan Physicians are on-call 24/7. When a situation is not an emergency but requires prompt attention for symptoms such as a sudden rash, high fever, severe vomiting, ear infection or sprain, please call your Primary Care Plan Physician as instructed under ***Making and Cancelling Appointments and Who to Contact*** at the beginning of this section.

Hospital Admissions

If you are admitted to a non-Plan Hospital, you, your Parent/Guardian, Financially Responsible Person or someone else must notify us within the later of forty-eight (48) hours of a Member's hospital admission or on the first working day following the admission unless it was not reasonably possible to notify us within that time.

Getting Assistance from Our Advice Nurses

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

If you are not sure you are experiencing a medical emergency, or for Urgent Care Services for symptoms such as a sudden rash, high fever, severe vomiting, ear infection or sprain, you may call our advice nurses at 1-800-777-7904 or 711 (TTY). You may also call 1-800-677-1112 from anywhere in the United States, Canada, Puerto Rico or the Virgin Islands.

Getting a Second Opinion

You are welcome to receive a second medical opinion from a Plan Physician. We will assist you to arrange an appointment for a second opinion upon request.

Receiving Care in Another Kaiser Foundation Health Plan Service Area

You may receive covered Services from another Kaiser Foundation Health Plan, if the Services are provided, prescribed, or directed by that other plan, and if the Services would have been covered under this EOC. Covered Services are subject to the terms and conditions of this EOC, including Prior Authorization

requirements, the applicable Copayments, Coinsurance and/or Deductible shown in the "Summary of Cost Shares," and the exclusions, limitations and reductions described in this EOC.

For more information about receiving care in other Kaiser Foundation Health Plan service areas, including availability of Services, and provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

Extra Services

In addition to the Services that we describe in this EOC, we may make available a variety of extra services. Extra services are not covered by your Plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your Plan;
2. Certain health education publications; and
3. Discounts for fitness club memberships.

Some of these extra services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

1. Show your Health Plan ID card;
2. Pay the fee, if any; and/or
3. Participate in any required activity.

Because these services are not covered by your Plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

We do not endorse or make any representations regarding the quality or medical efficacy of any extra service or the financial integrity of the companies offering them. We expressly disclaim any liability for the administration of any extra services provided by these companies. If you have a dispute regarding extra services, you must resolve it with the company providing it. Although we have no obligation to assist with this resolution, you may call Member Services, Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY), and a representative may try to assist in getting the issue resolved.

Payment Toward Your Cost Share and When You May Be Billed

In most cases, you will be asked to make a payment toward your Cost Share at the time you receive Services. Cost Share payments may be made by you, or on your behalf, (including manufacturer coupons, when accepted), and will apply toward your Out-of-Pocket Maximum. If you receive more than one type of Services, such as Primary Care treatment and laboratory tests, you may be required to pay separate Cost Shares for each of those Services. In some cases, your provider may not ask you to make a payment at the time you receive Services, and you may be billed for your Cost Share.

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

1. **You receive non-preventive Services during a preventive Visit**. For example, you go in for a routine physical exam, and at check-in you pay your Cost Share for the preventive exam (your Cost Share may be "no charge"). However, during your preventive exam your provider finds a problem

with your health and orders non-preventive Services to diagnose your problem, such as laboratory tests. You may be asked to pay your Cost Share for these additional non-preventive diagnostic Services.

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

Note: If your plan is subject to a Deductible, any required Deductible amount must be met by the Member prior to our payment of non-preventive or diagnostic Services.

SECTION 3: Benefits, Exclusions and Limitations

Your Benefits

The benefits described in this section are covered only when:

1. A Plan Physician determines that the Services are Medically Necessary;
2. The Services are provided, prescribed, authorized or directed by a Plan Physician; and
   a. You receive the Services at a Plan Facility, Plan Provider or contracted Skilled Nursing Facility inside our Service Area (except when specifically noted otherwise within this Agreement); or
   b. You agree to have Services delivered through a patient centered medical homes program for individuals with chronic conditions, serious illnesses or complex health care needs. This includes associated costs for coordination of care, such as:
      i. Liaison Services between the individual and the Health Care Provider, nurse coordinator and the care coordination team;
      ii. Creation and supervision of a care plan;
      iii. Education of the Member and their family regarding the Member's disease, treatment compliance and self-care techniques; and
      iv. Assistance with coordination of care, including arranging consultations with Specialists and obtaining Medically Necessary supplies and Services, including community resources.

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

1. Emergency Services, as described in this section;
2. Urgent Care Services outside of our Service Area, as described in this section;
3. Continuity of Care for New Members, as described in ***Section 2: How to Get the Care You Need***;
4. Approved referrals, as described under ***Getting a Referral*** in ***Section 2: How to Get the Care You Need***, including referrals for clinical trials as described in this section.

Note: Some benefits may require payment of a Copayment, Coinsurance or Deductible. Refer to the ***Appendix – Summary of Cost Shares*** for the Cost Sharing requirements that apply to the covered Services contained within the ***List of Benefits*** in this section.

This Agreement does not require us to pay for all health care Services, even if they are Medically Necessary. Your right to covered Services is limited to those that are described in this contract in accordance with the terms and conditions set forth herein. To view your benefits, see the ***List of Benefits*** in this section.

Out-of-Pocket Maximums

The Out-of-Pocket Maximum is the limit to the total amount that you must pay for covered Services in a calendar year. The total amount includes what you have paid for your Coinsurance, Copayments, and Deductible, if applicable. Once you reach this limit, you do not pay any additional Coinsurance or Copayments for Services covered under this Agreement for the remainder of the calendar year.

See ***Appendix – Summary of Cost Shares*** for the exact dollar amount of your Out-of-Pocket Maximum.

The Health Plan will keep accurate records of your Copayment and Coinsurance expenses. We will notify you when you reach your Out-of-Pocket Maximum. Such notification will be given no later than thirty (30) days after the Out-of-Pocket Maximum is reached. The Health Plan will not charge additional Copayments or Coinsurance for Services for the remainder of the calendar year. The Health Plan will promptly refund any Copayment and Coinsurance you have paid for Services after the Out-of-Pocket Maximum is reached.

When you pay for Services, ask for and keep receipts. You will need them for your tax records and to verify against our records the payments credited toward the Out-of-Pocket Maximum. When you have questions about the status of your Out-of-Pocket Maximum, contact us at 1-800-777-7902.

List of Benefits

The following benefits are covered by the Health Plan. Benefits are listed alphabetically for your convenience. Some benefits are subject to benefit-specific limitations and/or exclusions, which are listed, when applicable, directly below each benefit. A broader list of exclusions that apply to all benefits, regardless of whether they are Medically Necessary, is provided under ***Exclusions*** in this section.

Accidental Dental Injury Services

Regardless of the date of injury, we cover Medically Necessary restorative Services necessary to promptly repair or replace, teeth that have been injured as the result of an external force. Coverage is provided when all of the following conditions have been satisfied:

1. A Plan Provider provides the restorative dental Services;
2. The injury occurred as the result of an external force that is defined as violent contact with an external object, not force incurred while chewing; and
3. The covered Services must be requested within six (6) months of the accident for injuries occurring on or after the effective date of coverage.

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

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):
Services provided by non-Plan Providers

Allergy Services

We cover the following allergy Services:

1. Evaluation;
2. Treatment;
3. Injections; and
4. Serum

Ambulance Services

We cover licensed ambulance Services only if your medical condition requires that either the:

1. Basic life support, advanced life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer; and

2. Ambulance transportation has been ordered by a Plan Provider. Coverage is also provided for Medically Necessary transportation or Services including Medically Necessary air ambulance transport to the nearest hospital able to provide needed Services, provided during an encounter with an ambulance Service, as a result of a 911 call.

Cost Shares for Air Ambulance Services provided by a non-Participating Provider will not exceed that of Cost Shares for Air Ambulance Services provided by a Participating Provider and will apply toward your Deductible, if any, and Out-of-Pocket Maximum, if any. Any Cost Sharing requirement will be calculated based on the lesser of the qualifying payment amount or the billed amount for the Services. We will make payment for the Air Ambulance Services directly to the non- Participating Provider of ambulance Services. The payment amount will be equal to the amount by which the Out-of-Network Rate exceeds the Cost Sharing amount for Air Ambulance Services. You will not be liable for any additional payment other than your Cost Share for Air Ambulance Services provided by a non-Participating Provider.

We cover medically appropriate non-emergent transportation Services when ordered by a Plan Provider. We will not cover ambulance or non-emergent transportation Services in any other circumstances, even if no other transportation is available. We cover ambulance and medically appropriate non-emergent transportation Services only inside our Service Area, except as related to out of area Services covered under the Emergency Services provision in this section. Your Cost Share will apply to each encounter whether or not transport was required.

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):

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

Anesthesia for Dental Services

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

1. Who are 7 years of age or younger or are developmentally disabled;
2. For whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition; and
3. For whom a superior result can be expected from dental care provided under general anesthesia; or
4. 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
5. 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
6. 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:

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

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):
The dentist's or Specialist's professional Services.

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 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.

See the benefit-specific limitation(s) and exclusion(s) immediately below for additional information.

Benefit-Specific Limitation(s):
Member recipients must be designated at the time of procurement of cord blood.

Benefit-Specific Exclusion(s):
Directed blood donations.

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.

Clinical Trials

We cover routine patient costs you incur for clinical trials provided on an inpatient and an outpatient basis. "Patient costs" mean the cost of a Medically Necessary Service that is incurred as a result of the treatment being provided to the Member for purposes of the clinical trial. "Patient costs" do not include:

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

We cover Services received in connection with a clinical trial if all of the following conditions are met:

1. The Services would be covered if they were not related to a clinical trial.
2. The Member is eligible to participate in the clinical trial according to the trial protocol with respect to the prevention, early detection, treatment or monitoring of cancer, chronic disease, or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   a. A Plan Provider makes this determination.
   b. The Subscriber or Member provides us with medical and scientific information establishing this determination.
3. If any Plan Providers participate in the clinical trial and will accept the Member as a participant in the clinical trial, the Member must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where the Member lives.
4. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial for the prevention, detection, treatment, or monitoring of cancer, life-threatening disease or condition, or chronic disease and it meets one of the following requirements:
   a. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
   b. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
   c. The study or investigation is approved or funded by at least one of the following:
      i. The National Institutes of Health.
      ii. The Centers for Disease Control and Prevention.
      iii. The Agency for Health Care Research and Quality.
      iv. The Centers for Medicare & Medicaid Services.
      v. A bona fide clinical trial cooperative group or center of any of the above entities, 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
      vi. The Department of Defense, the Department of Veterans Affairs, the Department of Energy; or a qualified non-governmental research entity to which the National Cancer Institute has awarded a support grant;
      vii. 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
      viii. An investigation or study approved by an institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

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

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.

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):

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

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, and Medically Necessary routine foot care when prescribed by a Plan Provider and purchased from a Plan Provider, for the treatment of:

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

Covered medical supplies and equipment include the following:

1. Insulin pumps;
2. Supplies needed for the treatment of corns, calluses, and care of toenails;
3. Home blood glucose monitors, lancets, blood glucose test strips, control solutions, and hypodermic needles and syringes when purchased from a Plan Pharmacy or Plan Provider.

Member cost sharing for diabetes devices shall be limited to $100 for a 30-day supply of all Medically Necessary covered diabetes devices that are in accordance with the treatment plan. Member cost sharing for diabetic ketoacidosis devices shall be limited to $100 per Calendar Year of all Medically Necessary covered diabetic ketoacidosis devices that are in accordance with the treatment plan. Coverage for diabetes devices and diabetes ketoacidosis devices are not subject to the Deductible.

Diabetes devices mean a legend device or non-legend device used to cure, diagnose, mitigate, prevent, or treat diabetes or low blood sugar. Diabetes devices include blood glucose test strips, glucometers, continuous glucometers, lancets, lancing devices, ketone test strips, insulin pumps, and insulin needles and syringes.

Diabetic ketoacidosis device means a device that is a legend or non-legend device and used to screen for or prevent diabetic ketoacidosis and includes diabetic ketoacidosis devices prescribed and dispensed once during a Calendar Year.

Note: Insulin is not covered under this benefit. Refer to the ***Outpatient Prescription Drug Benefit*** appendix.

Pursuant to IRS Notice 2019-45, coverage for glucometers is not subject to the Deductible. Refer to

the ***Summary of Cost Shares*** appendix for Cost Sharing requirements.

See the benefit-specific limitation(s) immediately below for additional information.

Benefit-Specific Limitation(s):
Diabetic equipment and supplies are limited to the Health Plan's preferred equipment and supplies unless the equipment or supply:

1. Was prescribed by a Plan Provider; and
   a. There is no equivalent preferred equipment or supply available; or
   b. An equivalent preferred equipment or supply has:
      i. Been ineffective in treating the disease or condition of the Member; or
      ii. Caused or is likely to cause an adverse reaction or other harm to the Member. "Health Plan preferred equipment and supplies" are those purchased from a preferred vendor.

Dialysis Services

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

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

We cover the following renal dialysis Services:

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

We cover the following self-dialysis Services:

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

We cover home dialysis, which includes:

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

Members traveling outside the Service Area may receive pre-planned dialysis Services for up to sixty (60) days of travel per Calendar year. Prior Authorization is required.

Drugs, Supplies and Supplements

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

1. Oral, infused or injected drugs, and radioactive materials used for therapeutic purposes, including chemotherapy. This includes off-label use of a drug when the drug is recognized in Standard Reference Compendia or certain medical literature as appropriate in the treatment of the diagnosed condition;
2. Injectable devices;
3. The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
4. Medical and surgical supplies including dressings, casts, hypodermic needles and syringes, or any other Medically Necessary supplies provided at the time of treatment; and
5. Vaccines and immunizations approved for use by the 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. Refer to the ***Outpatient Prescription Drug Benefit*** appendix for coverage of self-administered outpatient prescription drugs, ***Preventive Health Care Services*** for coverage of vaccines and immunizations that are part of routine preventive care, ***Allergy Services*** for coverage of allergy test and treatment materials; and ***Family Planning Services*** for the insertion and removal of contraceptive drugs and devices.

Certain drugs may require prior authorization or step-therapy. For more information, see ***Getting a Referral*** in ***Section 2: How to Get the Care You Need***.

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):

1. Drugs for:
   a. Which a prescription is not required by law;
   b. The treatment of sexual dysfunction disorders; and
2. Drugs, supplies and supplements that can be self-administered or do not require administration or observation by medical personnel.

Durable Medical Equipment

Durable Medical Equipment is defined as equipment that:

1. Is intended for repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is generally not useful to a person in the absence of illness or injury; and
4. Meets the Health Plan's 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 prostheses.

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.

We cover the following types of equipment:

1. Hospital type beds;
2. Wheelchairs;
3. Traction equipment;
4. International Normalized Ratio (INR) home testing machines;
5. Walkers; and
6. Crutches.

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: See Diabetes Equipment, Supplies and Self-Management for coverage of diabetes equipment and supplies.

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.
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 the Health Plan's criteria for Medical Necessity. A Plan Provider must certify the continued medical need.
3. Apnea Monitors: We cover apnea monitors for a period not to exceed six (6) months.
4. Asthma Equipment: We cover the following asthma equipment for pediatric and adult asthmatics when purchased from a Plan Pharmacy or Plan Provider:
    a. Spacers;
    b. Peak-flow meters; and
    c. Nebulizers.
5. Bilirubin Lights: We cover bilirubin lights for a period not to exceed six (6) months.

Pursuant to IRS Notice 2019-45, coverage for peak flow meters is not subject to the Deductible. Refer to the ***Summary of Cost Shares*** appendix for Cost Sharing requirements.

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):

1. Comfort, convenience or luxury equipment or features.
2. Exercise or hygiene equipment.
3. Non-medical items such as sauna baths or elevators.
4. Modifications to your home or car.
5. Electronic monitors of the heart or lungs, except infant apnea monitors and oximetry monitors for patients on home ventilation.
6. Prosthetic and orthotic devices, except as covered under Prosthetic Devices.

Emergency Services (including Emergency Services HIV Screening Test)

As described below, you are covered for Emergency Services, without Prior Authorization, if you experience an Emergency Medical Condition, anywhere in the world.

If you think you are experiencing an Emergency Medical Condition, you should call 911 immediately.

If you are not sure whether you are experiencing an Emergency Medical Condition, please contact us at the number listed on the reverse side of your ID card for immediate medical advice. You or your representative must notify the Health Plan as soon as possible, not to exceed forty-eight (48) hours or the next business day, whichever is later, after you receive care in a hospital emergency room to ensure coverage.

Coverage depends on our determination of the situation in which care was provided, and not solely on the advice of the non-Plan Provider.

We cover Emergency Services as follows:

Inside our Service Area
We will cover reasonable charges for Emergency Services as defined in this section, received within the Service Area. After Emergency Services have been received inside the Service Area, continuing or follow-up treatment is available from your primary care Plan Physician. Coverage is limited to Emergency Services required before you can, without medically harmful consequences, be transported to a Plan Hospital or Primary Care Plan Physician's office.

Outside of our Service Area
If you are injured or become ill while temporarily outside the Service Area, we will cover reasonable charges for Emergency Services as defined in this section.

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

Covered Services include:

1. The costs of administering such a test;
2. All laboratory expenses to analyze the test; and

3. The costs of communicating to the patient the results of the test and any applicable follow-up instructions for obtaining health care and supportive Services.

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

Post-Stabilization Care
Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital, including the Emergency Department, after your treating physician determines that your Emergency Medical Condition is stabilized. Post-stabilization Care also includes durable medical equipment covered under this EOC, if it is Medically Necessary after your discharge from a hospital and related to the same Emergency Medical Condition. For more information about durable medical equipment covered under this EOC, see the ***Durable Medical Equipment*** provision of this ***Benefits, Exclusions and Limitations*** section and the ***Summary of Cost Shares*** appendix.

When you receive Emergency Services in the District of Columbia, and federal law does not require that we consider the Post-Stabilization Care as Emergency Services, we cover Post-Stabilization Care only if we provide Prior Authorization for the Post-Stabilization Care. Therefore, it is very important that you, your provider, including your non-Plan Provider, or someone else acting on your behalf, call us to notify us that you need Post-Stabilization Care and to get Prior Authorization from us before you receive the Post-Stabilization Care.

To request Prior Authorization, you, your provider, including your non-Plan Provider or someone else acting on your behalf, must call 1-800-225-8883 or the notification telephone number on the reverse side of your ID card before you receive the care. We will discuss your condition with the non-Plan Provider. If we determine that you require Post-Stabilization Care, we will authorize your care from the non-Plan Provider or arrange to have a Plan Provider, or other designated provider, provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated non-Plan Provider provide your care, we may authorize special transportation services that are non-Plan Providers. If you receive care from a non-Plan Provider that we have not authorized, you may have to pay the full cost of that care.

When you receive Emergency Services from non-Plan Providers, Post-Stabilization Care may qualify as Emergency Services pursuant to federal law. We will not require Prior Authorization for such Post-Stabilization Care at a non-Plan Hospital when your attending non-Plan Provider determines that, after you receive Emergency (screening and stabilization) Services, you are not able to travel using non-medical transportation or non-emergency medical transportation to an available Plan Provider located within a reasonable travel distance taking into account your medical condition.

Non-Plan Providers may provide notice and seek your consent to provide Post-Stabilization Care Services or other covered Services. Such Services will not be covered when you do not obtain Prior Authorization as described herein. If you, or your authorized representative, consent to the furnishing of Services by non-Plan Providers, then you will be responsible for paying for such Services in the absence of any Prior Authorization. The cost of such Services will not accumulate to your Deductible, if any, or your Out-of-Pocket Maximum costs.

See the benefit-specific limitation(s) immediately below for additional information.

Benefit-Specific Limitation(s):

1. Notification: If you receive care at a hospital emergency room and/or are admitted to a non-Plan hospital, you, or someone on your behalf, must notify us as soon as possible, not later than forty-eight (48) hours of any emergency room Visit or admission or on the first working day following the emergency room Visit or admission, whichever is later, unless it was not reasonably possible to notify us. If 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.
2. Continuing or follow-up treatment: We do not cover continuing or follow-up treatment after Emergency Services unless authorized by the Health Plan. We cover only the non-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.
3. 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, if applicable, will not be waived.

Family Planning Services

We cover the following:

1. Women's Preventive Services (WPS), including:
   a. Patient education and contraceptive method counseling for all women of reproductive capacity;
   b. Coverage for FDA-approved contraceptive drugs, devices, products and services, hormonal contraceptive methods, the insertion or removal of contraceptive devices, including any Medically Necessary examination associated with the use of contraceptive drugs and devices; and
   c. Female sterilization;

Note: Contraceptive devices, other than diaphragms, and implantable contraceptive drugs are supplied by the provider and are covered under this ***Family Planning Services*** benefit. Contraceptive drugs and diaphragms are covered under the ***Outpatient Prescription Drug Benefit Appendix***. WPS are preventive care and are covered at no charge.

2. Family planning counseling, including pre-abortion and post-abortion counseling;
3. Male sterilization;
4. Elective and therapeutic termination of pregnancy and abortion care Services, including follow-up Services, as permitted under state law.

Note: We cover therapeutic termination of pregnancy as permitted under state law:

1. If the fetus is believed to have an incapacitating chromosomal, metabolic or anatomic defect or deformity that has been certified by a Plan Provider; or
2. When the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy

itself; or
3. When the pregnancy is the result of an alleged act of rape or incest.

Habilitative Services

We cover Medically Necessary Habilitative Services.

Habilitative Services is defined as: Health care Services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age.

These Services may include physical and occupational therapy, speech-language pathology and other Services for people with disabilities in a variety of inpatient and/or outpatient settings, including, but not limited to applied behavioral analysis for the treatment of autism spectrum disorder.

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):

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

Hearing Services

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

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):

1. Tests to determine an appropriate hearing aid.
2. Hearing aids or tests to determine their efficacy.

Home Health Care Services

We cover the following home health Services only within our Service Area, only if you are substantially confined to your home, and only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home:

1. Skilled nursing Services
2. Home health aide Services
3. Medical social Services

Home health Services are Medically Necessary health Services that can be safely and effectively provided in your home by health care personnel, are directed by a Plan Provider, and are provided intermittently. 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.

The following types of Services are covered as part of home health Services only as described under the following headings in this section of this Agreement:

1. Blood, Blood Products and Their Administration
2. Dialysis Services
3. Drugs, Supplies and Supplements
4. Durable Medical Equipment
5. Ostomy and Urological Supplies
6. Therapy and Rehabilitation Services
7. Maternity Services

Home Health Visits Following Mastectomy or Removal of Testicle: Members undergoing a mastectomy or removal of a testicle on an outpatient basis, as well as those who receive less than forty-eight (48) hours of inpatient hospitalization following the surgery, are entitled to the following: one home visit scheduled to occur within twenty-four (24) hours following his or her discharge; and one additional home visit, when prescribed by the patient's attending physician.

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):

1. Custodial care (see definition in this section).
2. Routine administration of oral medications, eye drops or ointments.
3. General maintenance care of colostomy, ileostomy, and ureterostomy.
4. Medical supplies or dressings applied by a Member or family caregiver.
5. Corrective appliances, artificial aids and orthopedic devices.
6. Homemaker Services.
7. Services that a Plan Provider determines may be provided in a Plan Facility and we provide or offer to provide that care in one of these facilities.
8. Transportation and delivery Service costs of Durable Medical Equipment, medications and drugs, medical supplies and supplements to the home.

Hospice Care Services

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

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

1. Nursing care, including intermittent Skilled nursing care;
2. Physical, occupational, speech and respiratory therapy;
3. Medical social Services for the terminally ill patient and his or her immediate Family Members;
4. Home health aide Services;
5. Homemaker Services;

6. Medical/surgical supplies and appliances;
7. Palliative drugs in accord with our drug formulary guidelines;
8. Physician care;
9. General hospice inpatient Services for acute symptom management including pain management;
10. Respite Care;
11. Counseling Services for the Member, their Family Members, and Caregiver, including dietary counseling for the Member, before the Member's death; and bereavement counseling for the Member's family and Caregiver for a period of one (1) year after the Member's death; and
12. Services of hospice volunteers.

Definitions:

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

See the benefit-specific limitation(s) immediately below for additional information.

Benefit-Specific Limitation(s):

Hospice Care Services are limited to a maximum of 180 days per eligibility period. The hospice eligibility period begins on the first date hospice care Services are rendered and terminates 180 days later or upon the death of the terminally ill Member, if sooner. If the Member requires an extension of the eligibility period, we will extend the eligibility period on an individual case basis, if we determine that the Member's prognosis and continued need for Services are consistent with a program of hospice care Services.

Hospital Inpatient Care

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

1. Room and board (includes bed, meals, and special diets), including private room when deemed Medically Necessary;
2. Specialized care and critical care units;
3. General and special nursing Services;
4. Operating and recovery room;
5. Plan Physicians' and surgeons' Services, including consultation and treatment by Specialists;
6. Anesthesia, including Services of an anesthesiologist;

7. Medical supplies;
8. Chemotherapy and radiation therapy;
9. Respiratory therapy; and
10. Medical social Services and discharge planning.

Additional inpatient Services are covered only as specifically described under the appropriate heading in this section.

We cover a minimum hospital stay of at least forty-eight (48) hours following a radical or modified mastectomy. We cover a minimum hospital stay of at least twenty-four (24) hours following a total mastectomy or partial mastectomy with lymph node dissection for the treatment of breast cancer.

We cover a minimum hospital stay of not less than twenty-three (23) hours for a laparoscopy-assisted vaginal hysterectomy. We cover a minimum hospital stay of forty-eight (48) hours for a vaginal hysterectomy.

House Calls

We cover house calls when care can best be provided in your home as determined by a Plan Provider.

Human Immunodeficiency Virus (HIV)

We cover treatment for Members with HIV including primary care office Visits and certain Laboratory tests.

Note: Coverage for HIV applies only to Members enrolled in an HMO Essential or DHMO Essential plans.

Infertility & Standard Fertility Preservation Services

We cover Services for the diagnosis and treatment of infertility, including artificial insemination, and in vitro fertilization (IVF) Services as follows:

1. At least three-(3) complete oocyte retrievals with unlimited embryo transfers from those oocyte retrievals or from any oocyte retrieval procedure performed prior to January 01, 2025, in accordance with the American Society for Reproductive Medicine, using single embryo transfer when recommended and medically appropriate; and
2. Medical costs related to an embryo transfer to be made from a Member to a third-party except that the Member's coverage shall not extend to any medical costs of the surrogate or gestational carrier after the embryo transfer procedure.

We also cover standard fertility preservation Services. Standard fertility preservation Services means procedures that are consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology for a Member who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):

1. Ovum transplants and gamete intrafallopian tube transfer (GIFT), zygote intrafallopian transfer

(ZIFT), or cryogenic or other preservation techniques used in these or similar procedure.
2. Any Services or supplies provided, after an embryo transfer, to a person not covered under your Health Plan in connection with a surrogate/gestational carrier pregnancy (including, but not limited to, the bearing of a child by another person for an infertile couple).
3. Fallopian scar revision surgery.
4. Services to reverse voluntary and surgically induced infertility.

Infusion Therapy

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

Maternity Services

We cover pre-natal and post-natal Services, which includes routine and non-routine office Visits, telemedicine Visits, x-ray, laboratory and specialty tests. The Health Plan covers birthing classes and breastfeeding support, supplies, and counseling from trained providers during pregnancy and/or in the postpartum period. All pre-natal and post-natal Services are preventive and covered at no Cost Share.

We cover outpatient maternity care, which includes care provided for:

1. A condition not usually associated with pregnancy;
2. Conditions existing prior to pregnancy; and
3. High risk condition(s) that develop during pregnancy.

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

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

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

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

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):

1. Services for newborn deliveries performed at home.

Medical Foods

We cover Medically Necessary foods for the treatment of:

1. Inflammatory bowel disease, including Crohn 's disease, ulcerative colitis, and indeterminate colitis;
2. Gastroesophageal reflux disease that is nonresponsivc to standard medical therapies;
3. Immunoglobulin E-and non-lmmunoglobulin E-mediated allergies to food proteins;
4. Food protein-induced entcrocolitis syndrome;
5. Eosinophilic disorders, including eosinophilic esophagitis, eosinophilic gastroenteritis, eosinophilic colitis, and post-transplant eosinophilic disorders;
6. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract, including short bowel syndrome and chronic intestinal pseudo-obstruction;
7. Malabsorption due to liver or pancreatic disease;
8. Inherited metabolic disorders; and
9. Any other diseases or conditions as determined by the Mayor through rulemaking.

“Medically Necessary food" means food, including a low-protein modified food product or an amino acid preparation product, a modified fat preparation product, or a nutritional formula that is specially formulated and processed for the partial or exclusive feeding of an individual by means of oral intake or enteral feeding by tube, and intended for dietary management of an individual who, because of therapeutic or chronic medical needs, has limited or impaired capacity to ingest, digest, absorb, or metabolize ordinary foodstuffs or certain nutrients or who has other specially medically determined nutrient requirements, the dietary management of which cannot be achieved by modification of the normal diet alone.

Medical Nutrition Therapy & Counseling

Coverage is provided for unlimited Medically Necessary nutritional counseling and medical nutrition therapy provided by a licensed dietician-nutritionist, Plan Physician, physician assistant or nurse practitioner for an individual at risk due to:

1. Nutritional history;
2. Current dietary intake;
3. Medication use; or
4. Chronic illness or condition.

Coverage is also provided for unlimited Medically Necessary nutrition therapy provided by a licensed dietician-nutritionist, working in coordination with a Primary Care Plan Physician, to treat a chronic illness or condition.

Mental Health Services and Substance Use Disorder

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.

Substance use disorder means a problematic pattern of substance use leading to clinically significant impairment or distress as demonstrated by symptoms identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

While you are hospitalized, we cover all medical Services of physicians and other health professionals as performed, prescribed or directed by a Plan Provider including:

1. Individual therapy;
2. Group therapy;
3. Electroconvulsive therapy;
4. Drug therapy;
5. Education;
6. Psychiatric nursing care; and
7. Appropriate hospital Services.

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

We cover Medically Necessary treatment in a licensed or certified residential treatment center, including a psychiatric residential treatment facility. We cover residential crisis Services in a hospital, residential treatment facility, or psychiatric residential treatment facility. Residential crisis Services are Services provided for Medically Necessary intensive care or consultative Services on an urgent or emergency basis.

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 twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

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

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

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):

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

Morbid Obesity Services, including Bariatric Surgery

We cover diagnosis and treatment of morbid obesity including gastric bypass surgery or another 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:

1. A weight that is at least one-hundred (100) pounds over or twice the ideal weight for a patient's frame, age, height and gender, as specified in the 1983 Metropolitan Life Insurance tables; or
2. A body mass index that is equal to or greater than:
   a. Forty (40) kilograms per meter squared; or
   b. Thirty-five (35) kilograms per meter squared with a co-morbid or co-existing medical condition, such as hypertension, cardiopulmonary condition, sleep apnea or diabetes.

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

Oral Surgery

We cover the surgical treatment of tumors where a biopsy is needed for evaluation of pathology.

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

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

1. Fractures of the jaw or facial bones;
2. Removal of cysts or tumors of non-dental origin;
3. Surgical correction of malformation of the jaw when the malformation creates significant impairment in the Member's speech or nutrition, and when, in the judgment of a Plan Physician, significant improvement would be achieved by surgical revision;
4. Surgical treatment for temporomandibular joint syndrome (TMJ) if there is clearly demonstrable radiographic evidence of joint abnormality due to an illness; and
5. Medically Necessary oral restoration after major reconstructive surgery.

For the purposes of this benefit, coverage of treatment of significant congenital defects causing

functional impairment must be:

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

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

The Health Plan provides coverage for cleft lip and cleft palate under a separate benefit. Please see Cleft Lip, Cleft Palate, or Both in this ***List of Benefits*** for coverage.

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):

1. Oral surgery Services when the functional aspect is minimal and would not in itself warrant surgery.
2. Laboratory fees associated with cysts that are considered dental under our standards.
3. Orthodontic Services.
4. Dental appliances.

Outpatient Care

We cover the following outpatient care:

1. Primary care Visits for internal medicine, family practice, pediatrics, and obstetrics/gynecology Services (refer to ***Preventive Health Care Services*** for coverage of preventive care Services);
2. Specialty care Visits (refer to "Getting a Referral" in ***Section 2: How to Get the Care You Need*** for information about referrals to Plan specialists);
3. Consultations and immunizations for foreign travel;
4. Diagnostic testing for care or treatment of an illness, or to screen for a disease for which you have been determined to be at high risk for contracting, including, but not limited to:
    a. 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 screening guidelines issued by the National Comprehensive Cancer Network, to include no less than one (1) prostate-specific antigen test and digital rectal exam per year;
5. 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. Your initial screening colonoscopy will be preventive.;
6. 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
    a. An estrogen deficient individual at clinical risk for osteoporosis;
    b. An individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one (1) or more thoracic or lumbar vertebral bodies, who is a candidate for

therapeutic intervention or for an Extensive diagnostic evaluation for metabolic bone disease;

c. An individual receiving long-term gluco-corticoid (steroid) therapy;
d. An individual with primary hyper-parathyroidsm; or
e. An individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;

7. Outpatient surgery;
8. Anesthesia, including Services of an anesthesiologist;
9. Chemotherapy and radiation therapy;
10. Respiratory therapy;
11. Medical social Services;
12. House calls when care can best be provided in your home as determined by a Plan Provider; and
13. After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to the Urgent Care provision for covered Services.

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

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

Preventive Health Care Services

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

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

Resources and Services Administration (To see the current guidelines, visit HRSA at: https://www.hrsa.gov/womens-guidelines-2016); and

5. All state mandated preventive health care Services.

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

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

These Services include:

1. Routine physical examinations and health screening tests appropriate to your age and sex;
2. Well-woman examinations;
3. Well child care examinations including age appropriate health screening for all children, as determined by the Mayor, from birth to 21 years of age;
4. Routine and Medically Necessary immunizations (travel immunizations are not preventive and are covered under Outpatient Services in this section) for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;
5. Annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
6. High-risk human papillomavirus (HPV) DNA testing for women age 30 years and over whether or not they have normal Pap test results;
7. Screening for gestational (pregnancy-related) diabetes in asymptomatic pregnant women after twenty-four (24) weeks of gestation, without cost sharing and at the first prenatal Visit for pregnant women identified to be at high risk for diabetes;
8. Comprehensive lactation (breastfeeding) education and counseling, by trained clinicians during pregnancy and/or in the postpartum period in connection with each birth;
9. Breastfeeding equipment issued, per pregnancy and in accordance with Health Plan coverage guidelines;
10. Annual screening and counseling for sexually transmitted infections for all sexually active women;
11. Annual screening and counseling for human immune-deficiency virus (HIV) infection for all sexually active women;
12. Annual screening and counseling for interpersonal and domestic violence;
13. Patient education and contraceptive counseling for all women with reproductive capacity;
14. All prescribed FDA-approved contraceptive methods, including implanted contraceptive devices, hormonal contraceptive methods, barrier contraceptive methods, and female sterilization surgeries. Note that contraceptive methods that do not require clinician administration such as birth control pills will not be covered if you have outpatient drug coverage separate from your Health Plan coverage through another prescription drug provider;
15. Low dose screening mammograms, including 3-D mammograms, to determine the presence of

breast disease are covered as follows:
   a. A baseline mammogram for women; and
   b. An annual screening mammogram for women;
16. Adjuvant breast cancer screening, including magnetic resonance imaging (MRI), ultrasound screening, or molecular breast imaging of the breast, if:
   a. A mammogram demonstrates a Class C or Class D breast density classification; or
   b. A woman is believed to be at an increased risk for cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications of an increased risk for cancer as determined by a woman's physician or advanced practice registered nurse;
17. Risk assessment and genetic counseling and testing using the Breast Cancer Risk Assessment tool approved by the National Cancer Institute;
18. Bone mass measurement to determine risk for osteoporosis;
19. Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to persons who are age 40 or older, according to the most recent screening guidelines issued by the National Comprehensive Cancer Network, to include no less than one (1) prostate-specific antigen test and digital rectal exam per year;
20. Colorectal cancer screening in accordance with American Cancer Society guidelines including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy. Your initial screening colonocsopy will be preventive.
21. Cholesterol test (lipid profile);
22. Diabetes screening (fasting blood glucose test);
23. Sexually Transmitted Disease (STD) testing (including chlamydia, gonorrhea, and syphilis);
24. Annual chlamydia screening for:
   a. Women age 24 years and younger, if they are sexually active; and
   b. Women 25 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. A sex partner with concurrent partners;
      iv. A sex partner with an STI;
      v. Inconsistent use of barrier contraceptives; or
      vi. Cervical ectopy;
25. HIV testing;
26. Smoking and tobacco cessation counseling;
27. TB test;
28. Newborn screenings for congenital heart disease, hearing impairment, and metabolic disorders; and
29. Associated preventive care radiological and laboratory tests not listed above.

Pursuant to IRS Notice 2019-45, coverage is provided for expanded preventive care Services for laboratory tests and screenings without any cost sharing requirements such as Copayments, Coinsurance amounts and Deductibles:

1. Retinopathy screening for diabetics
2. HbA1C for diabetics
3. Low density Lipoprotein (LDL) laboratory test for people with heart disease
4. INR laboratory test for liver failure and bleeding disorders

For coverage of glucose monitoring equipment, see the ***Diabetes Equipment, Supplies and Self-Management*** benefit in this ***List of Benefits.***

For coverage of peak flow meters, see the ***Durable Medical Equipment*** benefit in this ***List of Benefits.***

See the benefit-specific limitation(s) immediately below for additional information.

Benefit-Specific Limitation(s):
While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services.

1. Monitoring a chronic disease;
2. Follow-up Services after you have been diagnosed with a disease;
3. Testing and diagnosis of a specific disease, not listed above under preventive health care Services, for which you have been determined to be at high risk for contracting based on factors determined by national standards.
4. Services when you show signs or symptoms of a specific disease or disease process;
5. Non-routine gynecological Visits.
6. Laboratory, imaging, and other ancillary Services not included in routine prenatal care.
7. Non-preventive Services performed in conjunction with a sterilization.
8. Laboratory, imaging, and other ancillary Services associated with male sterilizations. Laboratory, imaging, and other ancillary Services that are an integral part of a preventive Service, such as a preventive colonoscopy or female sterilization, will be covered without cost sharing.
9. Complications that arise after a sterilization procedure.
10. Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.
11. Replacement or upgrades for breastfeeding equipment that is not rented Durable Medical Equipment.
12. Prescription contraceptives that do not require clinical administration for certain group health plans that provide outpatient prescription drug coverage that includes FDA-approved contraception that is separate from Health Plan coverage and furnished through another prescription drug provider.

Note: Refer to Outpatient Care for coverage of non-preventive diagnostic tests. The applicable Copayment or Coinsurance will apply to any Services listed under these limitations.

Prosthetic and Orthotic Devices

We cover the devices listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or injured. Coverage includes fitting and adjustment of these devices, repair or replacement (unless due to loss or

misuse), and Services to determine whether you need the prosthetic. 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, including:

1. Internally Implanted Devices: We cover Medically Necessary internal devices implanted during surgery, such as pacemakers, monofocal intraocular lens implants, artificial hips and joints, breast implants (see "Reconstructive Surgery" below) and cochlear implants, that are approved by the federal Food and Drug Administration for general use.
2. External Prosthetic and Orthotic Devices: We cover the following external Prosthetic and Orthotic Devices when prescribed by a Plan Provider:
    a. External Prosthetic Devices (other than dental) that replace all or part of the function of a permanently inoperative or malfunctioning body part.
    b. 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.
    c. 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.
3. Artificial Arms, Legs, or Eyes: We cover the following when prescribed by a Plan Provider and your medical condition meets Health Plan's criteria for being Medically Necessary:
    a. Artificial devices to replace, in whole or in part, a leg, an arm or an eye;
    b. Components of an artificial device to replace, in whole or in part, a leg, an arm or an eye; and
    c. Repairs to an artificial device to replace, in whole or in part, a leg, an arm or an eye.
4. Ostomy and Urological Supplies: We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets the Health Plan's criteria for Medical Necessity. Covered equipment and supplies include, but is not limited to flanges, collection bags, clamps, irrigation devices, sanitizing products, ostomy rings, ostomy belts and catheters used for drainage of urostomies.
5. Breast Prosthesis: We cover breast prostheses and mastectomy bras, needed after a Medically Necessary mastectomy. Coverage includes custom-made internal and external breast prostheses, regardless of when the mastectomy was performed. Coverage for breast prostheses for the non-diseased breast is also provided to achieve symmetry.
6. Hair Prosthesis: We cover one (1) Medically Necessary hair prosthesis.

See the benefit-specific limitation(s) and exclusion(s) immediately below for additional information.

Benefit-Specific Limitation(s):

1. Coverage for mastectomy bras is limited to a maximum of four (4) per calendar year; and
2. Therapeutic shoes and inserts are covered when deemed Medically Necessary by a Plan Provider.

Benefit-Specific Exclusion(s):

1. Services not preauthorized by the Health Plan;

2. Internally implanted breast prosthesis for cosmetic purposes;
3. Repair or replacement of prosthetic devices due to loss or misuse;
4. Microprocessor and robotic controlled external prosthetics and orthotics not covered under the Medicare Coverage Database;
5. Multifocal intraocular lens implants;
6. More than one piece of equipment or device for the same part of the body, except for replacements, spare devices or alternate use devices;
7. Dental prostheses, devices and appliances, except as specifically provided in this section, or as provided under a Pediatric Dental Plan Appendix;
8. Hearing aids;
9. Corrective lenses and eyeglasses;
10. Orthopedic shoes or other supportive devices, unless the shoe is an integral part of a leg brace; or unless indicated above;
11. Non-rigid appliances and supplies, including but not limited to: jobst stockings; elastic garments and stockings; and garter belts; and
12. Comfort, convenience or luxury equipment or features.

Reconstructive Surgery

We cover reconstructive surgery. This shall include plastic, cosmetic and related procedures required to:

1. Correct significant disfigurement resulting from an injury or Medically Necessary surgery;
2. Correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function;
3. Treat congenital hemangioma known as port wine stains on the face.

Following mastectomy, we also cover reconstructive breast surgery and all stages of reconstruction of both breasts to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. Reconstructive breast surgery is surgery performed as a result of a mastectomy to reestablish symmetry between the two (2) breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):

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

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

Routine Foot Care

Coverage is provided for Medically Necessary routine foot care.

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):
Routine foot care Services that are not Medically Necessary.

Skilled Nursing Facility Care

We cover up to sixty (60) days of skilled inpatient Services in a licensed Skilled Nursing Facility per calendar year. The skilled inpatient Services must be those customarily provided by Skilled Nursing Facilities. A prior three (3) day stay in an acute care hospital is not required.

We cover the following Services:

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

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):

1. Custodial care (definition in this section).
2. Domiciliary care.

Telemedicine Services

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

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

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):
Services delivered through electronic mail messages or facsimile transmissions.

Therapy and Rehabilitation Services

Coverage is provided for:

1. Unlimited Medically Necessary inpatient rehabilitative Services and video and face-to-face Visits for each of the following outpatient Services:
    a. Physical therapy per condition, per year;
    b. Speech therapy per condition, per year; and
    c. Occupational therapy per condition per year.
2. Medically Necessary spinal manipulation, evaluation, and treatment of the musculoskeletal illness or injury of the spine when provided by a Plan Provider. Spinal manipulation Services other than for musculoskeletal conditions of the spine will not be covered.
3. Medically Necessary cardiac rehabilitation Services following coronary surgery, a myocardial infarction or for Members who have been diagnosed with significant cardiac disease for up to

ninety (90) consecutive days. Cardiac rehabilitation Services must be provided or coordinated by a facility approved by the Health Plan, and that offers the process of restoring, maintaining, teaching, or improving physiological, psychological, exercise stress testing, counseling, and social and vocational capabilities of patients with heart disease.

4. Medically Necessary pulmonary rehabilitation Services.

If, in the judgment of a Plan Provider, significant improvement is achievable within a ninety (90) day period, we also cover multidisciplinary rehabilitation Services in a Plan Hospital, Plan Medical Center, Plan Provider's medical office, or a Skilled Nursing Facility. Coverage is limited to a maximum of two (2) consecutive months of treatment per injury, incident, or condition. Multidisciplinary rehabilitation Service programs are inpatient or outpatient day programs that incorporate more than one therapy at a time in the rehabilitation treatment.

See the benefit-specific limitation(s) and exclusion(s) immediately below for additional information.

Benefit-Specific Limitation(s):

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

Benefit-Specific Exclusion(s):

1. Long-term rehabilitation therapy.
2. Except as provided for cardiac and pulmonary rehabilitation Services, no coverage is provided for any therapy that the Plan Physician determines cannot achieve measurable improvement in function within a ninety (90)-day period.

Transplant Services

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

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

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

1. Unless otherwise authorized by Medical Group, transplants are covered only in our Service Area.
2. If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for transplant, we will pay only for covered Services you receive before that determination was made.
3. Health Plan, Plan Hospitals, Medical Group and Plan Providers are not responsible for finding, furnishing, or ensuring the availability of a bone marrow or organ donor.

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

We also provide coverage for Medically Necessary routine dental Services recommended prior to transplant.

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):
Services related to non-human or artificial organs and their implantation.

Urgent Care Services

As described below you are covered for Urgent Care Services anywhere in the world. Your Copayment or Coinsurance will be determined by the place of Service (i.e., at a Provider's office or at an after hours Urgent Care center). Urgent Care Services are defined as Services required as the result of a sudden illness or injury that requires prompt attention, but is not of an emergent nature.

Inside the 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 Center please call: 1-800-777-7904 or 711 (TTY).
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 of the 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 the Health Plan, covered benefits include the cost of necessary ambulance or other special transportation Services medically required to transport you to a Plan Hospital or Medical Center in the Service Area, for continuing or follow-up treatment.

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):
Urgent Care Services within our Service Area that were not provided by a Plan Provider or Plan Facility.

Vision Services

Coverage is provided for:

1. 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.
2. Pediatric Vision Services: We provide Pediatric Vision Services for Members up to the end of

the month they turn age 19. Services include:

a. One (1) routine eye examination each calendar year, including dilation if professionally indicated; and
b. One (1) pair of prescription eyeglass lenses and one frame each year from an available selection of frames; or two (2) pairs of Medically Necessary contact lenses each year in lieu of eyeglasses from an available selection of lenses; and
c. Low vision Services, including one comprehensive low vision evaluation every five (5) years, four (4) follow-up Visits in any five (5) year period, and prescribed optical devices such as high-power spectacles, magnifiers and telescopes.

In addition, we cover the following Services:

1. Eye Exams: We cover routine and necessary eye exams, including:
   a. Routine tests such as eye health and glaucoma tests; and
   b. Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.
2. 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.
3. 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.

Note: You will receive a combined discount on the purchase of eyeglass lenses and frames.

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

a. Fitting of contact lenses;
b. Initial pair of diagnostic lenses (to assure proper fit);
c. Insertion and removal of contact lens training; and
d. 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.

See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):

1. Industrial and athletic safety frames;
2. Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures);
3. Eye exercises;
4. Orthoptic (eye training) therapy;
5. Plano lenses;

6. Non-prescription products such as eyeglass holders, eyeglass cases, and repair kits;
7. Eyeglass lenses and contact lenses with no refractive value;
8. Sunglasses without corrective lenses unless Medically Necessary;
9. Non-corrective contact lenses;
10. Replacement of lost or broken lenses or frames; and
11. Lens adornment such as engraving, faceting, and jewelling.

X-Ray, Laboratory and Special Procedures

We cover the following Services only when they are prescribed as part of a preventive, diagnostic or treatment Service covered under another heading in this section:

1. Diagnostic imaging Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
2. Special procedures, such as electrocardiograms and electroencephalograms;
3. Sleep laboratory tests and sleep studies;
4. Specialty imaging including CT, MRI, PET Scans, diagnostic Nuclear Medicine studies and interventional radiology.

Note: See Preventive Health Care Services for coverage of laboratory and radiology Services that are part of preventive care screenings.

Exclusions

This provision provides information on what Services the Health Plan will not pay for regardless of whether or not the Service is Medically Necessary.

These exclusions apply to all Services that would otherwise be covered under this Agreement. Benefit-specific exclusions that apply only to a particular Service are noted in the ***List of Benefits*** in this section. When a service is not covered, all services, drugs, or supplies related to the non-covered service are excluded from coverage, except services we would otherwise cover to treat serious complications of the non-covered service.

For example, if you have a non-covered cosmetic surgery, we will not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication, such as a serious infection, this exclusion will not apply and we would cover any Services that we would otherwise cover to treat that complication.

The following Services are excluded from coverage:

1. **Certain Alternative Medical Services**, except when used for anesthesia, Acupuncture Services and any other Services of an Acupuncturist, Naturopath, and Massage Therapist.
2. **Certain Exams and Services:** Physical examinations and other Services:
   a. Required for obtaining or maintaining employment or participation in employee programs;
   b. Required for insurance, licensing, or disability determinations; or
   c. On court-order or required for parole or probation.

3. **Cosmetic Services**, including surgery or related Services and other Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies. Examples of Cosmetic Services include but are not limited to cosmetic dermatology, cosmetic surgical Services and cosmetic dental Services.
4. **Custodial Care,** meaning 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.
5. **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 ***List of Benefits*** in this Section.
6. **Durable Medical Equipment**, except for Services covered under "Durable Medical Equipment" in the ***List of Benefits*** in this Section.
7. **Employer or Government Responsibility:** Financial responsibility for Services that an employer or government agency is required by law to provide.
8. **Experimental or Investigational Services:** Except as covered under Clinical Trials in this section, a Service is experimental or investigational for your condition if any of the following statements apply to it at the time the Service is or will be provided to you:
    a. It cannot be legally marketed in the United States without the approval of the federal Food and Drug Administration (FDA) and such approval has not been granted; or
    b. 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
    c. 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
    d. 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 determining whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:

a. your medical records;
b. the written protocols or other documents pursuant to which the Service has been or will be provided;
c. any consent documents you or your representative has executed or will be asked to execute, to receive the Service;
d. 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;

e. the published authoritative medical or scientific literature regarding the Service, as applied to your illness or injury; and
f. regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

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

9. **External Prosthetic and Orthotic Devices:** Services and supplies for external prosthetic and orthotic devices, except as specifically covered under this section of this Agreement.

10. **Infertility Services:**
    a. Except for artificial insemination or in vitro fertilization, Services for any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures.
    b. Any Services or supplies provided, after an embryo transfer, to a person not covered under your Health Plan in connection with a surrogate/gestational carrier pregnancy (including, but not limited to, the bearing of a child by another person for an infertile couple).

11. **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.

12. **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 Emergency Services.

13. **Travel and Lodging Expenses.**

14. **Worker's Compensation or Employer Liability:** Any illness or injury related to employment or self-employment including any illness or injury that arises out of, or in the course of, any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the Services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state, or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law, or a similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

Limitations

We will make our best efforts to provide or arrange for your health care Services in the event of unusual circumstances that delay or render impractical the provision of Services under this Agreement, for reasons such as:

1. A major disaster;
2. An epidemic;

3. War;
4. Riot;
5. Civil insurrection;
6. Disability of a large share of personnel of a Plan Hospital or Plan Medical Center; and/or
7. Complete or partial destruction of facilities.

A riot is a public disturbance involving an assemblage of five (5) or more persons which, by tumultuous and violent conduct or the threat thereof, creates grave danger of damage or injury to property or persons. An exclusion or limitation for riot shall apply only when a person willfully engages in a riot or willfully incites or urges other persons to engage in a riot.

In the event that we are unable to provide the Services covered under this Agreement, the Health Plan, Kaiser Foundation Hospitals, Medical Group and Kaiser Permanente's Medical Group Plan Physicians shall only be liable for reimbursement of the expenses necessarily incurred by a Member in procuring the Services through other providers, to the extent prescribed by the Commissioner of Insurance.

For personal reasons, some Members may refuse to accept Services recommended by their Plan Physician for a particular condition. If you refuse to accept Services recommended by your Plan Physician, he or she will advise you if there is no other professionally acceptable alternative. You may get a second opinion from another Plan Physician, as described under ***Getting a Second Opinion*** in ***Section 2: How to Get the Care You Need***. If you still refuse to accept the recommended Services, the Health Plan and Plan Providers have no further responsibility to provide or cover any alternative treatment you may request for that condition.

SECTION 4: Subrogation, Reductions and Coordination of Benefits

There may be occasions when we will seek reimbursement of the Health Plan's costs of providing care to you, or your benefits are reduced as the result of the existence other types of health benefit coverage. This section provides information on these types of situations, and what to do when you encounter them.

Subrogation

There may be occasions when we require reimbursement of the Health Plan's costs of providing care to you. This occurs when there is a responsible party for an illness you acquire or injury you receive. This process is called subrogation. For example, if you were involved in a slip-and-fall incident at a store because of a spill, and the store was found liable for associated injuries you receive, they may become responsible for payment of the costs of your care for those associated injuries. For more information, see ***When Illness or Injury is Caused by a Third Party*** in this section.

Reductions

In addition, there may be occasions when your benefits are reduced as the result of the existence of other types of health benefit coverage available to you. For example, if you have coverage under your Spouse's, Domestic Partner's, or Legal Partner's health plan in addition to this coverage, the costs of care may be divided between the available health benefit plans. For more information, see the ***Reductions Under Medicare and TRICARE Benefits*** and ***Coordination of Benefits*** provisions in this section.

The above scenarios are a couple of examples of when:

1. We would seek the right to recover the costs of the care we provided to you; or
2. We would reduce the payment of claims.

The remainder of this section will provide you with information on what to do when you encounter these situations.

When Illness or Injury is Caused by a Third Party

If the Health Plan provides coverage under this Agreement when another party is alleged to be responsible to pay for treatment you receive, we have the right to recover the costs of covered Services provided or arranged by Health Plan under this Agreement. To secure our rights, the Health Plan will have a lien on the proceeds of any judgment you obtain against, or settlement you receive from, a third party for medical expenses for covered Services provided or arranged by Health Plan under this Agreement.

The proceeds of any judgment or settlement that the Member or the 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. However, you will not have to pay Health Plan more than what you received from or on behalf of the third party for covered Services.

Notifying the Health Plan of Claims and/or Legal Action

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

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Patient Financial Services
4000 Garden City Drive
Hyattsville, MD 20785

When notifying us, please include the third party's liability insurance company name, policy and claim numbers, business address and telephone number and, if known, the name of the handler of the claim.

If you are represented by an attorney in relation to the loss for which you have brought legal action against a third party, please ensure that provide your attorney's name and contact information, including their business address and telephone number. If you change attorneys during the legal process, you are required to inform the Health Plan of your change in representation.

The Health Plan's Right to Recover Payments

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

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

The Health Plan's recovery shall be limited to the extent that the Health Plan provided benefits or made payments for benefits as a result of the occurrence that gave rise to the cause of action.

Except for any benefits that would be payable under either Personal Injury Protection coverage; and/or any capitation agreement the Health Plan has with a participating provider:

1. If you become ill or injured through the fault of a third party and you collect any money from the third party or their insurance company for medical expenses; or
2. When you recover for medical expenses in a cause of action, the Health Plan has the option of becoming subrogated to all claims, causes of action and other rights you may have against a third party or an insurer, government program, medical payments coverage under any premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage, or other source of coverage for monetary damages, compensation or indemnification on account of the injury or illness allegedly caused by the third party:
    a. The Health Plan will be subrogated for any Service provided by or arranged for as:
        i. A result of the occurrence that gave rise to the cause of action; or
        ii. At the time it mails or delivers a written notice of its intent to exercise this option to you or to your attorney, should you be represented by one, as follows:
            a) Per the Health Plan's fee schedule for Services provided or arranged by the Medical Group; or
            b) Any actual expenses that were made for Services provided by contracted providers.

When applicable, any amount returned to the Health Plan will be reduced by a pro rata share of the court costs and legal fees incurred by the Member that are applicable to the portion of the settlement returned to the Health Plan.

Medicare

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

Workers' Compensation or Employer's Liability

If benefits are paid by Health Plan and Health Plan determines you received workers' compensation benefits for the same incident, Health Plan has the right to recover as described under the section ***When Illness or Injury is Caused by a Third Party***. Health Plan will exercise its right to recover against you.

The recovery rights will be applied even though:

1. The workers' compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that bodily injury or illness was sustained in the course of or resulted from your employment;
3. The amount of workers' compensation due to medical or health care is not agreed upon or defined by you or the workers' compensation carrier;
4. The medical or health care benefits are specifically excluded from the workers' compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this policy, you will notify Health Plan of any workers' compensation claim you make, and that you agree to reimburse Health Plan as described above. If benefits are paid under this policy and you or your covered dependent recover from a responsible party by settlement, award or otherwise, Health Plan has a right to recover from you or your covered dependent an amount equal to the amount Health Plan paid.

If you have an active worker's compensation claim for injuries sustained while conducting the duties of your occupation, you must send written notice of the claim to us within thirty (30) days at the following address:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Patient Financial Services
4000 Garden City Drive
Hyattsville, MD 20785

When notifying us, please include the worker's compensation insurance company or third-party administrator (TPA) name, policy and claim numbers, business address and telephone number and, if known, the name of the handler of the claim.

If you are represented by an attorney in relation to the worker's compensation loss for which you have brought legal action against your employer, please ensure that provide your attorney's name and contact information, including their business address and telephone number. If you change attorneys during the legal process, you are required to inform the Health Plan of your change in representation.

Health Plan Not Liable for Illness or Injury to Others

Who is eligible for coverage under this Agreement is stated in ***Section 1: Introduction to Your Kaiser Permanente Health Plan***. Neither the Health Plan, Plan Hospitals nor the Medical Group provide benefits or health care Services to others due to your liabilities. If you are responsible for illness or injury caused to another person, coverage will not be provided under this Agreement unless they are a Member.

Failure to Notify the Health Plan of Responsible Parties

It is a requirement under this Agreement to notify the Health Plan of any third party who is responsible for an action that causes illness or injury to you.

Failure to notify the Health Plan of your pursuit of claims against a third party due to their negligence is a violation of this Agreement. If a member dually recovers compensation by obtaining benefits from the Health Plan and compensation for the same loss from a responsible third party, the Health Plan reserves the right to directly pursue reimbursement of its expenses from the Member who received the settlement as compensation.

No Member, nor the legal representative they appoint, may take any action that would prejudice or prevent the Health Plan's right to recover the costs associated with providing care to any Member covered under this Agreement.

Pursuit of Payment from Responsible Parties

The Health Plan may use the services of another company to handle the pursuit of subrogation against a responsible third party. When we use these services, the Health Plan may need to release information that does not require Member consent, including, but not limited to, your name, medical record number, the date of loss, policy and claim numbers (including those of the insurance carrier for a third party), attorney information and copies of bills.

In the event that medical records or other protected information that requires your consent to be released is requested from us, we will notify you to obtain your consent and you must provide such consent in a timely manner.

Reductions Under Medicare and TRICARE Benefits

If you are enrolled in Medicare Part A and/or Part B, your benefits are reduced by any benefits for which you are enrolled and receive under Medicare; except for Members whose Medicare benefits are secondary by law.

TRICARE benefits are secondary by law.

Coordination of Benefits

Coordination of Benefits Overview

Coordination of benefits applies when a Member has health care coverage under more than one (1) health benefit plan. If you or your eligible dependent has coverage under more than one (1) health benefit plan, then you are responsible to inform the Health Plan that the additional coverage exists. When you have other coverage with another health plan or insurance company, we will coordinate benefits with the other coverage.

The Health Plan may need information from you to coordinate your benefits. Any information that we request to help us coordinate your benefits must be provided to us upon request in a timely manner.

Right to Obtain and Release Needed Information

When information is needed to apply these coordination of benefits rules, the Health Plan will decide the information it needs, and may get that information from, or give it to, any other organization or person. The Health Plan does not need not tell nor obtain consent from any person to do this.

Primary and Secondary Plan Determination

The health benefit plan that pays first, which is known as the primary plan, is determined by using National Association of Insurance Commissioners Order of Benefits Guidelines. The primary plan provides benefits as it would in the absence of any other coverage.

The plan that pays benefits second, which is known as the secondary plan, coordinates its benefits with the primary plan, and pays the difference between what the primary plan paid, or the value of any benefit or Service provided, but not more than 100 percent of the total Allowable Expenses, and not to exceed the maximum liability of the secondary plan. The secondary plan is never liable for more expenses than it would cover if it had been primary.

Coordination of Benefits Rules

To coordinate your benefits, you will find the rules under ***Order of Benefit Determination Rules*** in this section.

The ***Order of Benefit Determination Rules*** will be used to determine which plan is the primary plan. Any other plans will be secondary plan(s). If the Health Plan is the:

1. Primary Plan, it will provide or pay its benefits without considering the other plan(s) benefits.
2. Secondary Plan, the benefits or Services provided under this Agreement will be coordinated with the primary plan so the total of benefits paid, or the reasonable cash value of the Services provided, between the primary plan and the secondary plan(s) do not exceed 100 percent of the total Allowable Expense.

Members with a High Deductible Health Plan with a Health Savings Account option: If you have other health care coverage in addition to a High Deductible Health Plan with a Health Savings Account option (as described in ***Section 1: Introduction to Your Kaiser Permanente Health Plan*** under the ***Health Savings Account-Qualified Plans*** provision), then you may not be eligible to establish or contribute to a Health Savings Account Kaiser Permanente does not provide tax advice. Ask your financial or tax advisor about your eligibility.

Assistance with Questions about the Coordination of Your Benefits

If you have any questions about coordination of your benefits, please contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Order of Benefit Determination Rules

The following rules determine the order in which benefits are paid by primary and secondary health benefit plans.

1. If another plan does not have a Coordination of Benefits provision, that plan is the primary plan.
2. If another plan has a Coordination of Benefits provision, the first of the following rules that apply will determine which plan is the primary plan:

Rules for a Non-Dependent and Dependents

1. Subject to #2 (immediately below), a plan that covers a person other than as a Dependent, such as an employee, Member, Subscriber, policyholder, or retiree, is the primary plan and the plan that covers the person as a Dependent is the secondary plan.
2. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:
   a. Secondary to the plan covering the person as a dependent; and
   b. Primary to the plan covering the person as other than a dependent:

i. Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

Rules for a Dependent Child/Parent

1. **Dependent child with parents who are not separated or divorced:** When the Health Plan and another plan cover the same child as a Dependent of different persons, called "parents," then 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. When both parents have the same birthday, the plan that covered a parent longer is primary – this is known as the "Birthday Rule". If the "Birthday Rules" does not apply by the terms of the other plan, then the applicable rule in the other plan will be used to determine the order of benefits.
2. **Dependent child with separated or divorced parents:** If two (2) or more plans cover a person as a dependent child, and that child's parents are divorced, separated or are not living together, whether or not they have ever been married the following rules apply. If a court decree states that:
   a. One (1) of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's Spouse, Domestic Partner, or Legal Partner does, that parent's Spouse's, Domestic Partner's, or Legal Partner's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision; or
   b. Both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph #1 of this provision: ***Dependent Child with Parents Who Are Not Separated or Divorced***, shall determine the order of benefits; or
   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph #1 of this provision: ***Dependent Child with Parents Who Are Not Separated or Divorced***, shall determine the order of benefits; or
      i. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         a) The plan covering the custodial parent;
         b) The plan covering the custodial parent's Spouse, Domestic Partner, or Legal Partner;
         c) The plan covering the non-custodial parent; and then
         d) The plan covering the non-custodial parent's Spouse, Domestic Partner, or Legal Partner.

Dependent Child Covered Under the Plans of Non-Parent(s)

1. For a dependent child covered under more than one (1) plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the dependent child provisions above, as if those individuals were parents of the child.

Dependent Child Who Has Their Own Coverage

1. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a Spouse's, Domestic Partner's, or Legal Partner's plan, the

rule in this provision for ***Longer or Shorter Length of Coverage*** applies.

2. In the event the dependent child's coverage under the Spouse's, Domestic Partner's, or Legal Partner's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the "Birthday Rule".

Active/Inactive Employee Coverage

1. A plan that covers a person as an employee who is neither laid off nor retired (or that employee's dependent) is primary to a plan that covers that person as a laid off or retired employee (or a laid off or retired employee's dependent).

COBRA or State Continuation Coverage

1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree, or that covers the person as a dependent of an employee, member, subscriber or retiree, is the primary plan and the Plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer/Shorter Length of Coverage

1. If none of the above rules determines the order of benefits, then the plan that has covered a Subscriber longer time is primary to the plan that has covered the Subscriber for a shorter time.

Effect of Coordination of Benefits on the Benefits of this Plan

When the Health Plan is the primary Plan, coordination of benefits has no effect on the benefits or Services provided under this Agreement. When the Health Plan is a secondary Plan to one or more other plans, its benefits may be coordinated with the primary plan carrier using the guidelines below. This ***Coordination of Benefits*** provision shall in no way restrict or impede the rendering of Services covered by the Health Plan. At the request of the Member or Parent/Guardian, when applicable, the Health Plan will provide or arrange for covered Services and then seek coordination with a primary plan.

Coordination with the Health Plan's Benefits

The Health Plan may coordinate benefits payable or recover the reasonable cash value of Services it has provided, when the sum of the benefits that would be payable for:

1. Or the reasonable cash value of, the Services provided as Allowable Expenses by the Health Plan in the absence of this ***Coordination of Benefits*** provision; and
2. Allowable Expenses under one (1) or more of the other primary plans covering the Member, in the absence of provisions with a purpose like that of this ***Coordination of Benefits*** provision, whether or not a claim is made thereunder; exceeds Allowable Expenses in a Claim Determination Period.

In that case, the Health Plan benefits will be coordinated, or the reasonable cash value of any Services provided by the Health Plan may be recovered from the primary plan, so that the Health Plan benefits and the benefits payable under the other Plans do not total more than the Allowable Expenses.

Facility of Payment

If a payment is made or Service provided under another Plan, and it includes an amount that should have been paid for or provided by us, then we may pay that amount to the organization that made that payment.

The amount paid will be treated as if it was a benefit paid by the Health Plan.

Right of Recovery of Payments Made Under Coordination of Benefits

If the amount of payment by the Health Plan is more than it should have been under this ***Coordination of Benefits*** provision, or if we provided Services that should have been paid for by the primary plan, then we may recover the excess or the reasonable cash value of such Services, as applicable, from the person who received payment or for whom payment was made, or from an insurance company or other organization.

Military Service

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. When we cover any such Services, we may recover the value of the Services from the Department of Veterans Affairs.

Members with a High Deductible Health Plan with a Health Savings Account option who receive health benefits from the Department of Veterans Affairs: If a Member has actually received health benefits from the Department of Veterans Affairs within the past three (3) months, they will not be eligible to establish or contribute to a Health Savings Account, even when they are enrolled in a High Deductible Health Plan. Kaiser Permanente does not provide tax advice. Ask your financial or tax advisor about your eligibility.

SECTION 5: Filing Claims, Appeals and Grievances

This section provides you with information on how to file claims, Appeals and Grievances with the Health Plan and receive support with these processes.

Important Definitions

Several terms used within this section have special meanings. Please see the section ***Important Terms You Should Know*** for an explanation of these terms. They include:

1. Adverse Decision;
2. Appeal;
3. Appeal Decision;
4. Authorized Representative;
5. Commissioner;
6. Complaint;
7. Coverage Decision;
8. Emergency Case;
9. Filing Date;
10. Grievance;
11. Grievance Decision;
12. Health Care Provider;
13. Notice of Appeal Decision;
14. Notice of Coverage Decision; and
15. Urgent Medical Condition.

Questions About Filing Claims, Appeals or Grievances

If you have questions about how to file a claim, Appeal or Grievance with the Health Plan, please contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Member Services representatives can also help you submit a request for payment and/or reimbursement for Emergency Services and Urgent Care Services outside of our Service Area.

Notice of Claim

We do not require a written notice of claim. Additionally, Members are not required to use a claim form to notify us of a claim.

Filing for Payment or Reimbursement of a Covered Service or Post-Service Claim

Claim Forms and Proof of Loss

When the Health Plan receives a notice of claim, we will provide you with the appropriate forms for filing proof of loss. If we do not provide you with claim forms within fifteen (15) days of your notice to us, then you will be considered to have complied with the proof of loss requirements of this Agreement after you have submitted written proof that details the occurrence and the character and extent of the loss for which you have made a claim.

We consider an itemized bill or a request for payment or reimbursement of the cost of covered Services received from physicians, hospitals or other health care providers not contracting with us to be sufficient proof of the covered Service you received or your post-service claim. Simply mail or submit online proof of payment and a copy of the bill to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. Please mail or submit online your proof to us within one (1) year at the following address:

Kaiser Permanente National Claims Administration - Mid-Atlantic States
PO Box 371860
Denver, CO 80237-9998
Website: www.kp.org

Failure to submit such proof within one (1) year will not invalidate or reduce the amount of your claim if it was not reasonably possible to submit the proof within that time frame. If it is not reasonably possible to submit the proof within one (1) year after the date of Service, we ask that you ensure that it is sent to us no later than two (2) years from the date of Service. A Member's legal incapacity shall suspend the time restrictions regarding the submission of proof; however, any suspension period will end when legal capacity is regained.

You may file a claim by visiting www.kp.org and completing an electronic form and uploading supporting documentation or by mailing a paper form that can be obtained by either visiting www.kp.org or by calling the Member Services Department at the number listed above.

If you are unable to access the electronic form or obtain a paper form, you may also file your claim by submitting the following information we need to process your claim:

1. Member Name;
2. Member Medical Record Number (MRN);
3. The date the Member received the Services;
4. Where the Member received the Services;
5. The Physician who provided the Services;
6. Reason you believe Health Plan should pay for the Services; and
7. A copy of the bill, the Member's medical record(s) for the Services, and the receipt, if the Service have already been paid for.

Paper forms, supporting documentation, and any other information can be mailed to the address listed above.

You should attach itemized bills along with receipts if you have paid the bills. Incomplete forms will be returned to you. This will delay any payments which may be owed to you.

Physicians, hospitals or other health care providers not contracting with us must submit to us within six (6) months any request for payment or reimbursement of the cost of covered Services. If they fail to submit such a request within six (6) months, your request will not be invalidated if it was not reasonably possible to submit your request within such time, provided your request is furnished as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required.

Each Member claiming reimbursement hereunder shall complete and submit to Health Plan such consents, releases, assignments and other documents that Health Plan may reasonably request for the purpose of acting upon the claim.

If you are admitted to a non-Plan hospital, you, or someone on your behalf, must notify us within the later of forty-eight (48) hours of any hospital admission or on the first working day following the admission unless it was not reasonably possible to notify us within that time.

Time Payment of Claims

The Health Plan will immediately pay claims upon receipt of due written proof of your loss. Claims that

include the essential data elements will be paid no later than thirty (30) days after receipt of the claim. Payment for covered Services will be made to the provider of the Services. If the Health Plan has paid the claim, reimbursement will be made to you or, in the case of a child, to the parent who incurred the expenses resulting from the claim.

If we deny payment of the claim, in whole or in part, you or your Authorized Representative may then file an Appeal, as defined in this Section.

Payment of Claims

The Health Plan shall act upon claims promptly and pay them no more than thirty (30) days following receipt of your claim. Your claim should include all of the required information listed above. Payment for covered Services will be made to the provider of the Services, or, if the claim has been paid, reimbursement will be made to either the:

1. Member, for child-only plans; or
2. Parent/Guardian or Financially Responsible Person who incurred the expenses resulting from the claim, for non-child only plans.

In the event of loss of life, payment for covered Services will be paid to you, if living, or to the beneficiary. If no beneficiary is living, payment for covered Services will be paid to your estate. If payment for covered Services are to be payable to your estate, we may pay up to $1,000.00 to any relative of yours who we find is entitled to it. Any payment made in good faith will fully discharge us to the extent of the payment.

Physical Examination and Autopsy

The Health Plan, at its own expense, shall have the right and opportunity to examine a Member when and as often as it may reasonably require during the pendency of a claim hereunder, and to make an autopsy in the case of death where it is not forbidden by law.

Claim Denial

If we deny payment of your claim, in whole or in part, you or your Authorized Representative may file an Appeal or Grievance, as described in this section.

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 the course of treatment prescribed will either:

1. Expire; or
2. Be shortened.

Determinations regarding a Concurrent Care Claim request will be made, and notice provided to the Member's provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision, but no later than fifteen (15) calendar days of receipt of the request.

If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date of onset of services and the date of the next scheduled concurrent review of the case.

If we reduce or terminate coverage for an ongoing course of treatment that we already approved, we will notify the Member sufficiently in advance of the reduction or termination to allow the member to Appeal the decision as described below.

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

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

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

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

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.

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

At least twenty-four (24) hours before the expiration of the Services or before your shortened course of care ends, you should call or write to Member Services and advise 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.

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

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

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

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.

When you or your Authorized Representative sends the Appeal, you or your Authorized Representative may also request simultaneous external review of our adverse decision. If you want simultaneous external

review, your or your Authorized Representative's Appeal must tell us this. You or your Authorized Representative will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you or your Authorized Representative do not request simultaneous external review in the Appeal, then you or your Authorized Representative may be able to request external review after we make our decision regarding the Appeal. See the ***External Appeal Procedures*** section for additional information about filing an external appeal.

Our Internal Grievance Process

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

Initiating a Grievance

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

Kaiser Permanente
Attention: Member Relations
Nine Piedmont
3495 Piedmont Rd NE
Atlanta, GA 30305
Fax: 1-404-949-5001

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

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

Grievance Acknowledgment

We will acknowledge receipt of your Grievance within five (5) working days of the Filing Date of the written Grievance notice or five (5) calendar days after the date your written Grievance was received by us. The Filing Date is the earliest of five (5) calendar days after the date of the mailing postmark or the date your written Grievance was received by us.

Pre-service Grievance

If you have a Grievance about a Health Care Service that has not yet been rendered, an acknowledgment letter will be sent requesting any additional information that may be necessary within five (5) working days after the Filing Date. We will also inform you or your Authorized Representative that a decision regarding the Grievance will be made and provided in writing. Such written notice will be sent within thirty (30) working days of the Filing Date of the Grievance.

Post-service Grievance

If the Grievance requests payment for Services already rendered to you, an acknowledgment letter will be sent requesting additional information that may be necessary within five (5) working days after the Filing Date. We will also inform you or your Authorized Representative that a decision regarding the Grievance will be made and provided in writing. Such written notice will be sent within the earlier of forty-five (45) working days or sixty (60) calendar days of the Filing Date of the Grievance.

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

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

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

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

Grievance Decision Time Periods and Complaints to the Commissioner

For pre-service Grievances, if you or your Authorized Representative does not receive a Grievance Decision from us on or before the later of the:

1. 30th working day from the date the Grievance was filed; or
2. End of an extension period to which was agreed, then:
    a. You or your Authorized Representative may file a Complaint with the Commissioner without waiting to hear from us.

For post-service Grievances, if you or your Authorized Representative does not receive a post-service Grievance Decision from us on or before the later of the:

1. 45th working day from the date the Grievance was filed; or
2. End of an extension period that to which was agreed, then:
    a. You or your Authorized Representative may file a Complaint with the Commissioner without waiting to hear from us.

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

Expedited Grievances for Emergency Cases

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

Once an expedited review is initiated, a clinical review will determine whether you have a medical condition that meets the definition of an Emergency Case. A request for expedited review must contain a telephone number where we may reach you or your Authorized Representative to communicate information regarding our review. In the event that additional information is necessary for us to make a determination regarding the expedited review, we will notify you or your Authorized Representative by telephone to inform him/her that consideration of the expedited review may not proceed unless certain additional information is provided to us. Upon request, we will assist in gathering such information so that a determination may be made within twenty-four (24) hours from our date of receipt.

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

If we determine that an Emergency Case does exist, then the expedited review request will be reviewed by a physician who is board certified or eligible in the same specialty as the treatment under review and who is neither the individual nor a subordinate of the individual who made the initial decision. If additional information is needed to proceed with the review, we will contact you or your Authorized Representative by telephone.

Within twenty-four (24) hours of the Filing Date of the expedited review request, we will verbally notify you or your Authorized Representative of our decision. We will send written notification within one (1) calendar day following verbal communication of the decision. If approval is granted, then we will assist the Member in arranging the authorized treatment or benefit. If the expedited review results in a denial, we will notify you or your Authorized Representative in writing within one (1) calendar day following verbal communication of the decision.

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

Notice of Adverse Grievance Decision

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

1. The specific factual basis for the decision in clear and understandable language;
2. References to any specific criteria or standards on which the decision was based, including but not limited to interpretive guidelines used by us. Additionally, you or your Authorized Representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of the associated claim;
3. A statement that you or your Parent/Guardian, as applicable, 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 any specific criteria were relied upon, either a copy of such 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, we will provide either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or a statement that such explanation will be supplied free of charge, upon request;

4. The name, business address and business telephone number of the medical director who made the Grievance Decision:

   Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
   Attention: Office of the Medical Director
   4000 Garden City Drive
   Hyattsville, MD 20785
   Phone: 301-816-6482

5. A description of your or your Authorized Representative's right to file a complaint with the Commissioner within four (4) months following receipt of our Grievance Decision;
6. The Commissioner's address and telephone and facsimile numbers.

Note: The Health Plan must provide notice of an Adverse Decision in a non-English language if certain thresholds are met for the number of people who are literate in the same non-English language. A threshold language applies to a county if at least 10 percent of the population is literate only in the same foreign language that is identified as a federally mandated non-English language. If we send you a notice of an Appeal decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. You or your Authorized Representative may request translation of the notice by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Our Internal Appeal Process

This process applies to our Coverage Decisions. The Health Plan's internal Appeal process must be exhausted prior to filing a Complaint with the Commissioner, except if our Coverage Decision involves an Urgent Medical Condition. For Urgent Medical Conditions, a complaint may be filed with the Commissioner without first exhausting our internal Appeal process for pre-service decisions only, meaning that services have not yet been rendered.

Initiating an Appeal

These internal Appeal procedures are designed by the Health Plan to assure that concerns are fairly and properly heard and resolved. These procedures apply to a request for reconsideration of a Coverage Decision rendered by the Health Plan, in regard to any aspect of coverage for a Health Care Service. You or your Authorized Representative must file an Appeal within one-hundred eighty (180) calendar days from the date of receipt of the Coverage Decision. The Appeal should be sent to us at the following address:

Kaiser Foundation Health Plan of Georgia, Inc.
Attention: Member Relations
Nine Piedmont
3495 Piedmont Road, NE
Atlanta, GA 30305-1736

Fax: 1-404-949-5001

You or your Authorized Representative may also initiate an Appeal by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY). Member Services Representatives are also available to describe to you or your Authorized Representative how Appeals are processed and resolved.

You or your Authorized Representative, as applicable, may review the Health Plan's Appeal file and provide evidence and testimony to support the Appeal request.

Along with an Appeal, you or your Authorized Representative may also send additional information including comments, documents or additional medical records that are believed to support the claim. If the Health Plan requested additional information before and you or your Authorized Representative did not provide it, the additional information may still be submitted with the Appeal. Additionally, testimony may be given in writing or by telephone. Written testimony may be sent with the Appeal to the address listed above. To arrange to provide testimony by telephone, contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY). The Health Plan will add all additional information to the claim file and will review all new information regardless of whether this information was submitted and/or considered while making the initial decision.

Prior to rendering its final decision, the Health Plan will provide you or your Authorized Representative with any new or additional evidence considered, relied upon or generated by (or at the direction of) the Health Plan in connection with the Appeal, at no charge. If during the Health Plan's review of the Appeal, we determine that an adverse Coverage Decision can be made based on a new or additional rationale, then we will provide you or your Authorized Representative with this new information prior to issuing our final coverage decision and will explain how you or your Authorized Representative can respond to the information, if desired. The additional information will be provided to you or your Authorized Representative as soon as possible, and sufficiently before the deadline to provide a reasonable opportunity to respond to the new information.

After the Health Plan receives the Appeal, we will respond to you or your Authorized Representative in writing within:

1. Thirty (30) working days for a pre-service claim; or
2. Sixty (60) working days for a post-service claim.

If the Health Plan's review results in a denial, it will notify you or your Authorized Representative in writing within five (5) working days after the Appeal Decision has been verbally communicated. This notification will include:

1. The specific factual basis for the decision in clear and understandable language;
2. Reference to the specific plan provision on which determination was based. Additionally, you or your Authorized Representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of the associated claim;
3. A description of your or your Authorized Representative's right to file a complaint with the Commissioner within four (4) months following receipt of our Appeal Decision;
4. The Commissioner's address and telephone and facsimile numbers.

Note: The Health Plan must provide notice of an Adverse Decision in a non-English language if certain thresholds are met for the number of people who are literate in the same non-English language. A threshold

language applies to a county if at least 10 percent of the population is literate only in the same foreign language that is identified as a federally mandated non-English language. If we send you a notice of an Appeal Decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. You or your Authorized Representative may request translation of the notice by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Expedited Appeals

If you are Appealing an Adverse Decision that involves an Urgent Medical Condition, you may request an expedited decision by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY). During non-business hours, contact the Advice/Appointment Line at 1-800-777-7904.

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, the Health Plan will call the Member within twenty-four (24) hours.

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

Expedited Appeal Decisions

An expedited Appeal will be concluded as soon as possible after receipt of all necessary documentation by the Health Plan, but not later than twenty-four (24) hours after receipt of the request for Appeal. The Health Plan will notify you of its decision immediately by telephone. If the Service is approved, the Health Plan will assist in arranging the authorized Service. If the Service is denied, the Health Plan will provide written notice of the decision within one (1) business day after the decision is made.

Expedited Appeals for Exigent Circumstances for Use of a Drug

If the Health Plan has denied a request for a drug not on our Preferred Drug List, you or your Authorized Representative, or the prescribing physician (or other prescriber) may request an expedited review based on exigent circumstances. If the Health Plan grants an external exception request, they must pay for the drug for the duration of the prescription or exigency, as applicable.

Exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health or ability to regain maximum function or when the Member is undergoing a current course of treatment using a non-formulary drug.

Notification of Adverse Appeal Decisions

If the review results in a denial, the Health Plan will notify you and your Authorized Representative in writing. The notification shall include:

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

2. Reference to the specific plan provision on which determination was based. Additionally, you or your Authorized Representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of the associated claim;
3. A description of your or your Authorized Representative's right to file a complaint with the Commissioner within four (4) months following receipt of our Appeal Decision;
4. The Commissioner's address and telephone and facsimile numbers.

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 sixty (60) days after the decision.

If the Health Plan denies the Appeal because the Service was not considered medically necessary or appropriate, you may send your request for an external Appeal to:

District of Columbia Department of Health Care Finance
Office of the Health Care Ombudsman and Bill of Rights
One Judiciary Square
441 4th St. N.W., Suite 250 North
Washington, D.C. 20001
Phone: 202-724-7491
Toll Free: 1-877-685-6391
FAX: 202-442-6724

If Health Plan denies your Appeal for any other reason, send your request for an external Appeal to:

Commissioner of Insurance
District of Columbia Department of Insurance, Securities and Banking
1050 First Street, NE Suite 801
Washington, D.C. 20002
Phone: 1-202-727-8000
FAX: 1-202-535-1196

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

You may file an external Appeal with the Commissioner, except in the following circumstances:

1. The Health Plan failed to comply with any deadline for completion of a formal internal review;
2. In the case of an Urgent Medical Condition, if the request demonstrates to the satisfaction of the Director a compelling reason to do so, including a showing that the potential delay in receipt of a Service until after the Member exhausts the internal grievance process could result in loss of life, placing the Member's life or health in serious jeopardy, the inability of the Member to regain maximum function, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the member remaining seriously mentally ill with symptoms that causes the Member to be a danger to self and others; or
3. The Health Plan failed to make a decision for an expedited Appeal within twenty-four (24) hours after the Appeal was filed.

Filing Complaints About the Health Plan

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

Consumer and Professional Services Division
District of Columbia Department of Insurance, Securities and Banking
1050 First Street NE, Suite 801
Washington, D.C. 20002
Phone number: 1-202-727-8000
Fax: 1-202-671-0650
Email: disbcomplaints@dc.gov

SECTION 6: Change of Residence, Plan Renewal and Termination, and Transfer of Plan Membership

This section explains what to do when your location of residence changes and provides you with information on Plan renewal and termination, and transfer of Plan membership.

Change of Residence

If you move outside of the Health Plan's Service Area, you are no longer eligible for Health Plan coverage through the Exchange and your membership will be terminated as described above.

If you move to another Kaiser Foundation Health Plan region, you must promptly apply to a Health Plan Office or Exchange in that region to transfer your Membership. However, identical coverage may not be available in the new region.

This provision applies only to Members enrolled in an HMO or DHMO plan. You may obtain benefits as described in ***Section 2: How to Get the Care You Need***, while temporarily visiting in another Health Plan region. However, you have no right to benefits, except for Emergency Services or out-of-area urgent care as defined in ***Section 3: Benefits, Exclusions and Limitations***, in the new region after residing there for more than ninety (90) days, unless you:

1. Have enrolled as a Member in the new region; or
2. Demonstrate, by prior application to the Health Plan, that your stay in the new region for a period longer than ninety (90) days is "temporary," and the Health Plan approves continuation of this "temporary" status in writing.

Plan Renewal

This Plan is guaranteed renewable on an annual basis, subject to the redetermination of each Member's eligibility by the Exchange, depending on how you enrolled for coverage. Each Member that remains eligible for coverage following redetermination of eligibility shall remain enrolled under this Plan, unless the Member's coverage is terminated as described below.

Termination of Membership

Except as expressly provided in this section, all rights to Services and other benefits hereunder terminate as of the effective date of termination.

If your membership terminates, all rights to benefits end at 11:59 p.m. Eastern Time on the termination date. The membership of any Dependents will end at the same time that the Subscriber's membership ends. Members will be billed at Allowable Charges for any Services received following membership termination. The Health Plan and Plan Providers have no further responsibility under this Agreement after your membership terminates, except as provided under applicable law.

Termination of Agreement

This Agreement continues in effect from the effective date hereof and from month to month thereafter, subject to provisions in this section.

Termination by Member

The Subscriber may terminate membership under this Agreement for any reason, including as a result of

obtaining other Minimum Essential Coverage, by providing reasonable notice of the termination to the Exchange. The request will be reasonable if it is received at least 14 days prior to the requested effective date of termination.

The effective date of the termination will be:

1. The date requested by the Member if reasonable notice was given to the Exchange.
   a. If less than 14 days' notice was given, 14 days after the termination was requested by the Member; or
   b. If the Health Plan is able to effectuate termination in less than 14 days, and the Member requested an earlier termination date, the date determined by the Health Plan.
2. The day before coverage under Medicaid or CHIP begins, if the Member is newly eligible Medicaid or CHIP.

In the event of termination, the Health Plan shall promptly return any unearned portion of Premium. The earned Premium payment shall be computed pro rata. Termination shall be without prejudice to any claim originating prior to the effective date of termination.

Termination by Exchange and Health Plan

The Exchange may initiate, and the Health Plan may terminate your coverage:

1. When you are longer eligible for coverage through the Exchange;
2. For non-payment of Premiums, and
   a. The three (3)-month grace period required for Members receiving advance payments of the premium tax credit (APTC) has been exhausted as described in 45 CFR 156.270(g); or
   b. The thirty-one (31)-day grace period described below under Termination Due to Nonpayment of Premium has been exhausted;
3. When coverage is rescinded in accordance with 45 CFR §147.128;
4. When the Qualified Health Plan terminates or is decertified; or
5. When the Member changes from one Qualified Health Plan to another during an annual open enrollment period or a special enrollment period as described in ***Section 1: Introduction to Your Kaiser Permanente Plan***.

The Health Plan will provide the Member notice of termination of coverage, including the reason for the termination, at least thirty (30) days prior to the last day of coverage.

Termination Due to Loss of Eligibility

If you are no longer eligible for coverage through the Exchange, you will be terminated in accordance with 45 CFR §155.430.

Termination Due to Nonpayment of Premium – Members who Receive APTC

If you are receiving advance payments of the premium tax credit (APTC), and we do not receive your full Premium on time, we will provide a three-month grace period if we have previously received your full Premium for at least one (1) month in the calendar year.

We will send written notice stating when the grace period begins. We will pay claims for benefits you receive during the first month of the grace period. For the second and third months of the grace period, we are not required to pay any claims for Services rendered in the second and third months of the grace

period unless we receive all outstanding Premium (including Premium due during the grace period) by the end of the three (3)-month grace period. If we do not receive all outstanding Premium by the end of the three (3)-month grace period, your membership will end at 11:59 p.m. on the last day of the first month of the grace period.

Termination Due to Nonpayment of Premium and Grace Period – Other Members

Except for the first Premium payment, if a Subscriber fails to pay any required Premium payment when due according to ***Section 1: Introduction to Your Kaiser Permanente Health Plan***, the Health Plan may terminate this Agreement. We will send written notice of the termination to the Subscriber at least thirty-one (31) days before the termination date (grace period). Coverage shall continue in force during the thirty-one (31) day grace period, prior to the termination date, unless written notice of discontinuance in accordance with the terms of this Agreement is received from the subscriber in advance of the date of discontinuance. If payment in full is received within the thirty-one (31) day period set forth in the written notice, then the Subscriber and Dependents shall continue to receive all benefits and Services covered under this Agreement. If payment is not received within the thirty-one (31) day period set forth in the notice, then this Agreement will be terminated at the end of the 31st day. In the event of termination under this provision, the Subscriber is liable for the pro-rata Premium for the time the contract was in force during the grace period.

Termination for Cause

We may terminate your membership for cause if you:

1. Knowingly perform an act, practice or omission that constitutes fraud; or
2. Make an intentional misrepresentation of material fact.

If the fraud or intentional misrepresentation was made by the Subscriber, we may terminate the memberships of the Subscriber and all Dependents in your Family Unit. If the fraud or intentional misrepresentation was made by a Dependent, we may terminate the membership of the Dependent.

We will send written notice to the Subscriber or the Dependent at least thirty-one (31) days before the termination date.

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

Discontinuation of a Product or All Products

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

Extension of Benefits

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

If you are Totally Disabled at the time your coverage ends, we will continue to provide benefits for covered Services related to the condition causing the disability. Coverage will stop at the point you no longer qualify as being Totally Disabled, or up to twelve (12) months from the date your coverage ends, whichever comes first.

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

Limitation(s):
The Extension of Benefits section listed above does not apply to the following:

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

Return of Pro Rata Portion of Premium in Certain Cases

If your rights hereunder are terminated under this section, prepayments received on your account applicable to a period after the effective date of termination are refunded to the Subscriber or Financially Responsible Person, as applicable. Amounts due on claims, if any, less any amounts due to the Health Plan, Plan Hospitals or Medical Group, shall be refunded to the Subscriber within thirty-one (31) days. In such cases, neither the Health Plan, Plan Hospitals, Medical Group nor any Physician has any further liability or responsibility under this Agreement.

Age Limit/Misstatement of Age

This Agreement will continue in effect until the end of the period for which the Health Plan has accepted the payment if:

1. An individual Agreement establishes, as an age limit or otherwise, a date after which the coverage provided by the Agreement will not be effective and the:
   a. Date falls within a period for which the Health Plan accepts a payment for the Agreement; or
   b. Health Plan accepts a payment for the Agreement after the date specified in this section.

An equitable adjustment of payments will be made in the event the age of the Member has been misstated. The Health Plan's liability is limited to the refund, upon request, of the payment made for the period not covered by the Agreement if the age of the Member is misstated and according to the correct age of the Member the coverage provided by the Agreement would:

1. Not have become effective; or
2. Have ceased before the acceptance of the payment for the Agreement.

Transfer of Membership: Changing from Dependent to Subscriber Under a Kaiser Permanente for Individuals and Families Membership Agreement

A Member who enrolled as a Dependent under this Kaiser Permanente for Individuals and Families Membership Agreement, but ceases to qualify as a Dependent for any reason except those described in the either ***Termination for Cause*** or ***Termination for Nonpayment of Premium*** provisions in this section, may enroll as a Subscriber under this Agreement within sixty (60) days after ceasing to qualify as a Dependent. The Member will not be required to satisfy new evidence of insurability when changing from Dependent to Subscriber under this Agreement.

Reinstatement of Membership

If any renewal Premium is not paid in full within the time granted for payment, a later acceptance of Premium in full by us or by any agent authorized by us to accept the Premium, without requiring a reinstatement application in connection with the acceptance of the Premium in full, shall reinstate the Agreement.

However, if we or the agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Agreement will be reinstated upon approval of the application by us or, lacking approval, upon the 45th day following the date of the conditional receipt, unless we have previously notified the Member or Guardian or Financially Responsible Person, as applicable in writing of its disapproval of the reinstatement application.

In all other respects the Subscriber and Health Plan shall have the same rights under the reinstated Agreement as they had under the contract immediately before the due date of the defaulted premium, subject to any provisions endorsed on the Agreement or attached to the Agreement in connection with the reinstatement.

Any premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

SECTION 7: Other Important Provisions of Your Plan

This section contains additional special provisions that apply to this EOC.

Applications and Statements

Any applications, forms or statements specified in this Agreement, or that we request in our normal course of business, must be completed by you or your Authorized Representative or Financially Responsible Person, if applicable.

Assignment

A Member or Parent/Guardian, if applicable, may assign benefits in writing to a non-Plan Provider from whom the Member receives covered Services. A copy of this written assignment must accompany a claim for payment submitted to us by the non-Plan Provider or you.

The claim for payment is considered proof of having received the service. We request that the claim be submitted to us within six (6) months from the date of service.

If a Member receives a payment from us for covered Services rendered by a non-Plan provider that remains unpaid, then the Member or Financially Responsible Person is responsible to pay the non-Plan provider.

Attorney Fees and Expenses

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

Conformity with State Statutes

Any provision of this Agreement which, on its effective date, is in conflict with the statutes of the jurisdiction in which a Member resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Contestability

The Health Plan may void this Agreement and/or deny any claim made hereunder on the basis of any statement or representation made by a Subscriber for a period of three (3) years from the effective date of this Agreement. After this three (3)-year period, Health Plan may void this Agreement and/or deny any claim made hereunder only on the basis of a statement that was material to the risk and contained in a written application or in the existence of fraud.

Contracts with Plan Providers

Plan Provider Relationship and Compensation

The relationship between the Health Plan and Plan Providers are those of independent contractors. Plan Providers are paid in various ways, including salary, capitation, per diem rates, case rates, fee for service and incentive payments. If you would like additional information about the way Plan Providers are paid to provide or arrange medical and Hospital Services for Members, please refer to your Provider Directory or contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Plan Provider Termination

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 Cost Sharing for a period not to exceed ninety (90) days from the date we have notified you or your Parent/Guardian or Financially Responsible Person of the Plan Provider's termination.

Primary Care Plan Physician Termination

If our contract with your Primary Care Plan Physician terminates for reasons unrelated to fraud, patient abuse, incompetence, or loss of licensure status while you are under the care of that Primary Care Plan Physician, you may continue to see that provider and we will retain financial responsibility for covered Services you receive in excess of any applicable Cost Sharing, for a period not to exceed ninety (90) days from the date we have notified you of the Plan Physician's termination, or until you have chosen a new Primary Care Plan Physician, whichever occurs first.

Provider Directory Information Requirements

If a Member is furnished, by a non-Participating Provider, an item or Service that would otherwise be covered if provided by a Participating Provider, and the Member relied on a database, provider directory, or information regarding the provider's network status provided by Health Plan through a telephone call or electronic, web-based, or Internet-based means which incorrectly indicated that the provider was a Participating Provider for the furnishing of such item or Service, then the following apply:

1. The Copayment, Coinsurance, and/or other Cost Sharing requirement for such item or Service furnished by a non-Participating Provider is the same as the Copayment, Coinsurance, and/or other Cost Sharing requirement listed in the EOC for the item or Service when provided by a Participating Provider; and
2. Any Cost Sharing payments made with respect to the item or Service will be counted toward any applicable Deductible and Out-of-Pocket Maximum.
3. The Member will not be liable for an amount that exceeds the Cost Sharing that would have applied to the Member if the provider was a Participating Provider.

If you believe you are entitled to in-network benefits due to material error in a database, provider directory, or information regarding a provider's network status provided by us through a telephone call or electronic, web-based, or Internet-based means which incorrectly indicated that a provider was a Participating Provider for the furnishing of an item or Service, you may appeal a denial of such benefits through our internal and external appeals processes as described in ***Section 5: Filing Claims, Appeals and Grievances***.

Governing Law

Any provision in this policy that conflicts with the requirements of any state or federal law relevant to this policy are automatically changed to satisfy the minimum requirements of such laws.

Legal Actions

No legal action at law or in equity shall be brought to recover on this Agreement:

1. Before the expiration of sixty (60) days after you have provided us with proof of loss in accordance with the terms of this Agreement; or
2. After the expiration of three (3) years from the date that proof of loss was required to be provided.

Mailed Notices

Our notices to you will be sent to the most recent address we have on file for the Subscriber. You are responsible for notifying us of any change in address. Subscribers who move should promptly contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

You may mail a change of address notice to the Health Plan by postage prepaid U.S. Mail to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
P.O. Box 6831
4000 Garden City Drive
Hyattsville, MD 20785

Named Fiduciary

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

Overpayment Recovery

We may recover any overpayment we make for Services from:

1. Anyone who receives an overpayment; or
2. Any person or organization obligated to pay for the Services.

In the event of an overpayment to a Health Care Provider, we may only retroactively deny reimbursement to that Health Care Provider during the six (6)-month period after the date we paid a claim submitted by that Health Care Provider.

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. Your PHI is individually identifiable information about your health, the Health Care Services you receive, and payment for your health care. You may generally:

1. See and receive copies of your PHI;
2. Correct or update your PHI; and
3. Ask us for an account of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, health research and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give PHI to others, such as government agencies or in judicial actions. We will not use or disclose your PHI for any other purpose without written authorization from you or your Authorized Representative, except as described in our *Notice of Privacy Practices*. Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices*, which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request. To request a copy, contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

You can also find the notice at your local Plan Facility or online at **www.kp.org**.

Refusal to Accept Treatment

While the Health Plan may not cancel or fail to renew a Member's enrollment in the plan due to the Member's refusal to follow a prescribed course of treatment, it may refuse to furnish certain further benefits or Services for a particular condition.

If a Member disagrees with a prescribed course of treatment, the Member shall be permitted to receive a second opinion from another participating provider. If the second participating provider disagrees with the prescribed course of treatment, the Health Plan may refuse to provide some of the Services for that particular condition, subject to the terms, conditions, limitations and exclusions of this Agreement and Health Plan's utilization review protocols and policies.

Surrogacy Arrangements

A surrogacy arrangement is an arrangement between a Member who becomes a surrogate mother/gestational carrier and another person or persons. In a surrogacy arrangement, you agree to become pregnant, then surrender the baby (or babies) to another person or persons who intend to raise the child (or children).

You must pay us charges for Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with a surrogacy arrangement (Surrogacy Health Services). Your obligation to pay us for Surrogacy Health Services is limited to the compensation you are entitled to receive under the surrogacy arrangement. Note: This "Surrogacy Arrangements/Gestational Carrier" section does not affect your obligation to pay your Deductible, copayment, Coinsurance, or other amounts you are required to pay for these Services. After you surrender a baby (or babies) to the legal parents, you are not obligated to pay Charges for any Services that the baby (or babies) receive(s) (the legal parents are financially responsible for any Services that the baby receives).

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

Within thirty (30) days of entering into a surrogacy arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee

- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Kaiser Permanente
Attn: Patient Financial Services Surrogacy Coordinator
4000 Garden City Drive
Hyattsville, MD 20785

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

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

Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

Important Terms You Should Know

This section is alphabetized for your convenience. The terms defined in this section have special meanings. The following terms, when capitalized and used in this Agreement, mean:

A

Advance Premium Tax Credit (APTC): A tax credit based on estimated income that certain individuals who qualify can take to lower monthly payments for health insurance Premium. This definition only applies to plans offered on the Exchange.

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

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

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

Agreement: The entirety of this EOC document, including all attached appendices, which constitutes the entire contract between a Member and Kaiser Foundation Health Plan of the Mid-Atlantic State, Inc., and which replaces any earlier Agreement that may have been issued to you by us.

Air Ambulance Service: Medical transport of a patient by rotary wing air ambulance (as defined in 42 CFR 414.605) or fixed wing air ambulance (as defined in 42 CFR 414.605).

Allowable Charges: means either for:

1. Services provided by the Health Plan or Medical Group: The amount in the Health Plan's schedule of Medical Group and the Health Plan charges for Services provided to Members;
2. Items obtained at a Plan Pharmacy. For items covered under the ***Outpatient Prescription Drug Benefit*** appendix and:
    a. Obtained at a pharmacy owned and operated by Health Plan, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item. This amount is an estimate of the cost of acquiring, storing and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan.
    b. Obtained at a Plan Pharmacy other than a pharmacy owned and operated by Health Plan, the cost of the item calculated on a discounted wholesale price plus a dispensing fee;
3. Emergency Services from a Non-Plan Provider, including Post-Stabilization Care that constitutes Emergency Services under federal law, the Out-of-Network Rate.
4. For Services received from Plan Providers, the amount the Plan Provider has agreed to accept as payment;
5. All other Services: The amount:
    a. The provider has contracted or otherwise agreed to accept;
    b. The provider has negotiated with the Health Plan;
    c. Health Plan must pay the non-Plan Provider pursuant to state law, when it is applicable, or federal law, including the Out-of-Network Rate, or in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the provider and us;

d. The fee schedule, that providers have agreed to accept as determining payment for Services, states; or
e. Health Plan pays for those Services.

Allowable Expense: (For use in relation to Coordination of Benefits provisions only, which are located in ***Section 4: Subrogation, Reductions and Coordination of Benefits***): A Health Care Service or expense, including Deductibles, Copayments or Coinsurance, that is covered in full or in part by any of the Plans covering the Member. This means that an expense or Health Care 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.

American Indian/Alaska Native: Any individual as defined in §4 of the federal Indian Health Care Improvement Act.

Ancillary Service: Services that are:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner
2. Items and services provided by assistant surgeons, hospitalists, and intensivists
3. Diagnostic services, including radiology and laboratory services
4. Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility

Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-Plan Provider satisfies the notice and consent requirements under federal law.

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

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

Authorized Representative: An individual authorized in writing by the Member or Parent/Guardian, as applicable to act on the Member's behalf to file claims and to submit Appeals or Grievances to the Health Plan. A Health Care Provider may act on behalf of a Member with the Member's express consent, or without such consent.

C

Calendar Year: The calendar year during which the Health Maintenance Organization provides coverage for benefits.

Civil Union: A same-sex relationship similar to marriage that is recognized as a Civil Union by the District of Columbia.

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 Coordination of Benefits provision or a similar provision takes effect.

Coinsurance: After you have met your Deductible, a percentage of Allowable Charges that you must pay when you receive a covered Service.

Commissioner: The Commissioner of the Department of Insurance, Securities and Banking.

Complaint: A protest filed with the Commissioner involving a Coverage Decision or Adverse Decision.

Copayment: A defined dollar amount that you must pay when you receive certain covered Services.

Continuing Care Patient is a Member who, with respect to a provider or facility:

1. Is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;
2. Is undergoing a course of institutional or inpatient care from the provider or facility;
3. Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
4. Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. Is or was determined to be terminally ill, as determined under section 1861(dd)(3)(A) of the Social Security Act, and is receiving treatment for such illness from such provider or facility.

Cost Share: The Deductible, Copayment or Coinsurance for covered Services, as shown in the Summary of Copayments and Coinsurance.

Coverage Decision: An initial determination by the Health Plan or a representative of the Health Plan that results in non-coverage of a Health Care Service. Coverage Decision includes:

1. A determination by the Health Plan that an individual is not eligible for coverage under the Health Plan's health benefit plan;
2. Any determination by the Health Plan that results in the rescission of an individual's coverage under a health benefit plan; and
3. A determination including non-payment of all or any part of a claim that a Health Care Service is not covered under this Agreement .

A Coverage Decision does not include an Adverse Decision or pharmacy inquiry.

D

Deductible: The amount you must pay in a Calendar Year for certain Services before we will start paying benefits for those Services in that calendar year. See ***Appendix - Summary of Cost Shares*** to find out which Services are subject to the Deductible**.**

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements see the ***Who is Eligible*** provision in ***Section 1: Introduction to your Kaiser Permanente Health Plan***).

Domestic Partner: An unmarried adult person of the same or opposite sex with whom you:

1. Reside with and have registered with in a state or local Domestic Partner registry; or

2. Have a relationship (other than marriage) established in accordance with the laws of another jurisdiction that are substantially similar to domestic partnerships established under laws of the District of Columbia, as recognized and set forth in a certified list by the Mayor; and
    a. Are at least age 18;
    b. Are not married or in a civil union or domestic partnership with another individual;
    c. Have been financially interdependent for at least six (6) consecutive months prior to application in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely; and
    d. Share a common primary residence.

E

Emergency Case: A case in which an Adverse Decision was rendered pertaining to Health Care Services which have yet to be delivered and such Health Care Services are necessary to treat a condition or illness that, without immediate medical attention would:

1. Seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function; or
2. Cause the Member to be in danger to self or others.

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

1. Placing the health of the Member or, with respect to a pregnant person, the health of the pregnant person or their unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services, with respect to an Emergency Medical Condition, means:

1. An appropriate medical screening examination, as required federal under the Emergency Medical Treatment and Active Labor Act (EMTALA), section 1867 of the Social Security Act, that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department, to evaluate such Emergency Medical Condition;
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment required under EMTALA, or would be required under EMTALA if EMTALA applied to an Independent Freestanding Emergency Department, to Stabilize the patient, regardless of the department of the hospital in which such further examination or treatment is furnished; and
3. Except as further described in this paragraph 3, covered Services, also referred to as Post-Stabilization Care, that are furnished by a Non-Plan Provider after you are Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Visit in which the Emergency Services are furnished:

a. When, under applicable federal law, the covered Services described in item #3 are not included as Emergency Services if all of the following conditions are met:
    i. The attending emergency physician or Treating Provider determines that the Member is able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Hospital or Plan Facility located within a reasonable travel distance, taking into account the Member's medical condition;
    ii. The provider or facility furnishing such additional covered Services satisfies the notice and consent requirements set forth in federal regulation 45 C.F.R § 149.420(c) through (g) with respect to such covered Services, provided that the written notice additionally (1) identifies Plan Providers to whom you can be referred when a non-Plan Provider proposes to furnish covered Services at a Plan Hospital or Plan Facility when a non-Plan Provider proposes to provide such covered Services and (2) includes a good faith estimate of the charges for covered Services to be furnished at a non-Plan Hospital or non-Plan Facility by non-Plan Providers during the Visit; and
    iii. The Member, or an Authorized Representative of such Member, is in a condition to receive the information in the consent as described in item #3, as determined by the attending emergency physician or Treating Provider using appropriate medical judgment, and to provide informed consent in accordance with applicable State law.

F

Family Coverage: Any coverage other than Self-Only Coverage.

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

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

Filing Date: The earlier of five (5) days after the date of mailing or the date of receipt by the Health Plan when you mail information to us.

Financially Responsible Person or **Guarantor:** The person who contractually agrees to pay the Premium due. This definition only applies to Child Only Plans.

G

Grievance: A protest filed by a Member or Parent/Guardian, as applicable, or by a provider or other Authorized Representative on behalf of the Member, with the Health Plan, through our internal grievance process regarding an Adverse Decision concerning the Member. A Grievance does not include a verbal request for reconsideration of a Utilization Review determination.

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

H

Habilitative Services: Health Care Services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age.

These services may include physical and occupational therapy, speech-language pathology and other Services for people with disabilities in a variety of inpatient and/or outpatient settings, including, but not limited to applied behavioral analysis for the treatment of autism spectrum disorder.

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

Health Savings Account: A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, the Member must be covered under a qualified High Deductible Health Plan and meet other tax law requirements. Kaiser Permanente does not provide tax advice. Consult with a financial or tax advisor for more information about your eligibility for a Health Savings Account. This definition only applies to High Deductible Health Plan Plans.

High Deductible Health Plan: A health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. This definition only applies to High Deductible Health Plans.

Hospital: Any hospital:

1. In the Service Area to which a Member is admitted to receive Hospital Services pursuant to arrangements made by a physician; or
2. Outside of the Service Area for clinical trials, Emergency or Urgent Care Services or upon receiving an approved referral.

I

Independent Freestanding Emergency Department: A Health Care Facility that is geographically separate and distinct and licensed separately from a Hospital under applicable State law and provides any Emergency Services.

K

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

L

Limiting Age: The age at which an eligible dependent child loses eligibility for coverage. Under this Plan, the limiting age is 26, except for dependents with conditions of incapacity as provided under the ***Who is Eligible*** provision in ***Section 1: Introduction to Your Kaiser Permanente Health Plan***.

Legal Partner/Legal Partnership: Any same-sex relationship, other than marriage, that is recognized as valid by any other jurisdiction, such as a civil union.

M

Medical Group: Mid-Atlantic Permanente Medical Group, Inc.

Medically Necessary/Medical Necessity: Medically Necessary means that the Service is all of the following:

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

   Note: The fact that a Plan Physician may prescribe, authorize or direct a Service does not of itself make it Medically Necessary or covered by this Plan.

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

Member: A person who is eligible and enrolled under this Agreement as a Subscriber or a Dependent, and for whom we have received applicable Premium. Members are sometimes referred to as "you" within this Agreement. Under no circumstances should the term "you" be interpreted to mean a Financially Responsible Person, Parent/Guardian or any other nonmember reading or interpreting this Agreement on behalf of a Member.

Minimum Essential Coverage: The type of coverage an individual needs to have to meet the individual responsibility requirement under the Patient Protection and Affordable Care Act.

Monthly Payments: Periodic membership charges paid by a Subscriber; or for Child Only Plans, a Parent/Guardian or Financially Responsible Person.

N

Network: Plan Providers who have entered into a provider service contract with Kaiser Permanente to provide Services on a preferential basis.

Non-Physician Specialist: A Health Care Provider who is:

1. Not a physician; and
2. Certified or trained to treat or provide Health Care Services for a specified condition or disease in a manner that is within the scope of the license or certification of the Health Care Provider.

O

Out-of-Pocket Maximum: The maximum amount of Deductibles, Copayments and Coinsurance that an individual or family is obligated to pay for covered Services per Calendar Year.

P

Parent/Guardian: The person who has legal authority to make medical decisions for a Member under age 19 or a Member age 19 or older who is incapable of making such decisions by reason of mental incapacity. This definition applies only to Child Only plans.

Plan: The health benefit Plan described in this Agreement.

Plan: (For use in relation to Coordination of Benefits provisions only, which are located in ***Section 4: Subrogation, Reductions and Coordination of Benefits***): 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. "Plan" also does not include the medical benefits under an automobile policy, including benefits for personal injury protection. "Plan" also does not include:

1. Accident only coverage;
2. Hospital indemnity coverage benefits or other fixed indemnity coverage;
3. Specified disease or specified accident coverage;
4. Limited benefit health coverage;
5. School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four (24)-hour basis or on a "to and from school" basis;
6. Benefits provided in long-term insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
7. Medicare supplement policies;
8. A state plan under Medicaid; or
9. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

Plan Facility: A Plan Medical Center, Plan Hospital or another freestanding facility that is:

1. Operated by us or contracts, directly or indirectly, to provide Services to Members; and
2. Included in the Signature provider network.

Plan Hospital: A Hospital that:

1. Contracts, directly or indirectly, to provide inpatient and/or outpatient Services to Members; and
2. Is included in the provider network.

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

Plan Pharmacy: Any pharmacy that:

1. Is located at a Plan Medical Office; or
2. Contracts, directly or indirectly, to provide Services to Members, and is included in the Signature provider network.

Plan Physician: Any licensed physician who is an employee of Medical Group, or any licensed physician (except for those physicians who contract only to provide Services upon referral) who:

1. Contracts to provide Services and supplies to Members; and
2. Is included in the Signature provider network.

Plan Provider: A Plan Physician or other Health Care Provider including but not limited to a Non-Physician Specialist, and Plan Facility that:

1. Is employed by or operated by an entity that participates in the Kaiser Permanente Medical Care Program; or
2. Contracts, directly or indirectly, with an entity that participates in the Kaiser Permanente Medical Care Program.

Post Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive after your attending emergency physician or treating provider determines that your Emergency Medical Condition is Stabilized. We cover Post-Stabilization Care only when (1) it is considered to be Emergency Services under federal law, without Prior Authorization, or, (2) we determine that such Services are Medically Necessary pursuant to a request for Prior Authorization for the Service(s).

Premium: The amount a Subscriber owes for coverage under this Agreement for his/her self and any covered Dependents; or for Child Only Plans, a Parent/Guardian or Financially Responsible Person.

Primary Care: Services rendered by a Health Care Practitioner in the following disciplines:

1. General internal medicine;
2. Family practice medicine;
3. Pediatrics; or
4. Obstetrics/gynecology (OB/GYN).

Prior Authorization: Our determination that a proposed Service is covered and Medically Necessary pursuant to our quality resource management program in advance of your receipt of the Service.

Q

Qualified Health Plan: Any health plan that has an effective certification that it meets the standards recognized by the Exchange through which such plan is offered. This definition applies only to plans offered on the Exchange.

Qualified Medical Expenses: Amounts paid by an account beneficiary for medical care that qualifies under §213(d) of the Internal Revenue Code, for the individual, or his or her Spouse, Domestic Partner, Legal Partner, or Dependent for purposes of an HSA account.

Qualifying Payment Amount: The amount calculated using the methodology described in federal regulation (45 C.F.R. § 149.140(c)), which is based on the median contracted rate for all individual plans

issued by Health Plan for the same or similar Service that is:

1. Provided by a provider in the same or similar specialty or facility of the same or similar facility type; and
2. Provided in the geographic region in which the item or Service is furnished.

The median contracted rate is subject to additional adjustments specified in the applicable federal regulation.

S

Self-Only Coverage: Coverage for a Subscriber only, with no Dependents covered under this Agreement.

Serious or Complex Condition: In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm or, in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time.

Service: A health care item or service that is covered under this Agreement and Medically Necessary to prevent, diagnose, or treat a medical condition.

Service Area: The areas of the District of Columbia; the following Virginia counties – Arlington, Fairfax, King George, Prince William, Loudoun, Spotsylvania, Stafford; the following Virginia cities – Falls Church, Fairfax, Fredericksburg, Alexandria, Manassas and Manassas Park; the following Maryland areas: the City of Baltimore; the following Maryland counties: Baltimore, Carroll, Harford, Anne Arundel, 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.

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.

Specialist: A licensed health care professional that includes physicians and non-physicians who is trained to treat or provide health care Services for a specified condition or disease in a manner that is within the scope of their license or certification. Specialist physicians shall be either board-eligible or board-certified.

Spouse: A person of the same or opposite sex who is legally married to the Subscriber under the laws of the state or jurisdiction in which the marriage occurred.

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

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber. For Subscriber eligibility requirements, see the ***Who is Eligible*** provision in ***Section 1: Introduction to your Kaiser Permanente Health Plan***.

T

Totally Disabled:

1. **For Subscribers and Adult Dependents:** In the judgment of a Medical Group Physician, a Member is totally disabled by reason of injury or sickness if the Member is unable to perform each and every duty pertaining to his or her occupation during the first fifty-two (52) weeks of the disability. After the first fifty-two (52) weeks, a Member is totally disabled if he or she 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.
2. **For Dependent Children and Members covered under a Child Only Plan:** In the judgment of a Plan 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.

Treating Provider: A physician or other health care provider who has evaluated the Member's Emergency Medical Condition.

U

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

Urgent Medical Condition: As used in ***Section 5: Filing Claims, Appeals and Grievances***, a condition that satisfies either of the following:

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

V

Visit: The instance of going to or staying at a health care facility, and, with respect to Services furnished to a Member at a Health Care Facility, includes, in addition to Services furnished by a provider at the health care facility, equipment and devices, telemedicine Services, imaging Services, laboratory Services, and preoperative and postoperative Services, regardless of whether the provider furnishing such Services is at the health care facility.

Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

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

Kaiser Permanente Smile Kids KPIF Embedded Dental EPO Plan Appendix

Under this Appendix, Members up to age 19 are eligible for Pediatric Dental Benefits as of the effective date of your Kaiser Permanente Membership Agreement (Agreement). This coverage will end on the earlier of the date your Agreement terminates, or the end of the month in which the Member turns 19.

Definitions

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

Covered Dental Services: A set of dental services that can include a range of diagnostic, preventive, restorative, endodontic, periodontic, prosthetic, orthodontic and oral surgery services that are benefits of your Pediatric Dental Plan.

Dental Administrator: The entity that provides or arranges for the provision of Covered Dental Services on behalf of the Health Plan. The name and information about the Dental Administrator can be found under "General Provisions" below.

Dental Specialist: A dentist that has received advanced training in one of the dental specialties approved by the American Dental Association, and practices as a specialist. Dental specialties include Endodontists, Oral Surgeon, Periodontists and Pediatric Dentists.

General Dentist: A dentist who provides your basic care and coordinates the care you need from other dental specialty providers.

Member Copayments: The amount listed on the Schedule of Benefits that is charged to a member at the time of service for covered dental plan benefits. Member Copayments are directly paid to the Participating Dental Provider at the time services are rendered. The Participating Dental Provider has agreed to accept that Member Copayment as payment in full of the Member's responsibility for that procedure. Neither the Health Plan nor Dental Administrator are responsible for payment of these Copayments or for any fees incurred as the result of receipt of non-Covered Dental Services or any other non-covered dental service. Participating Dental Providers have agreed to accept Member Copayments as payment in full of the Member's responsibility for that procedure.

Non-Participating Dental Provider or Out-of-Network Dentist: A licensed dentist who has not entered into an agreement with the Dental Administrator for the purposes of providing dental services to Members. Your plan does not include Out-of-Network benefits. When an Out-of-Network Dentist is selected for care, Covered Dental Services for Out-of-Network benefits will not be covered and you will be responsible for the entire cost.

Participating Dental Provider or In-Network Dentist: A licensed dentist who has signed a contract with the Dental Administrator to provide services to our members in accordance with the Dental Administrator's guidelines and criteria. When a Participating Dental Provider is selected for care, Covered Dental Services for "In-Network" benefits will apply.

Pediatric Dental Benefits or Pediatric Dental Plan: Refers to a dental plan provided to children only.

General Provisions

As a current Kaiser Permanente Member under this Plan, the Dental Administrator agrees to provide and arrange Pediatric Dental Benefits in accordance with the terms, conditions, limitations, and exclusions specified in this Agreement and Appendix.

This Appendix includes a Schedule of Dental Benefits, which lists what you will be charged for each Covered Dental Service you receive.

You have the freedom to select any General Dentist from our network. Your covered family members may select the same or a different General Dentist. Your General Dentist will refer you to a Dental Specialist in our network.

To find a dentist in your area, you can go to our website at www.kp.org, or call us toll-free at 1-888-798-9868/TTY: 1-877-855-8039, Monday through Friday from 8 a.m. to 8 p.m. Eastern Standard Time (EST). Once you have located a Participating Provider, you can call the office to schedule an appointment. The dental office will contact us to verify your eligibility. Be sure to identify yourself as a Kaiser member when you call the dentist for an appointment. We also suggest that you take this information with you when you go to your appointment. You can then reference benefits and applicable charges which are the out-of-pocket costs associated with your plan.

Alternate Treatment

If a condition can be corrected or treated by a professionally acceptable service at a lower cost, your plan will cover the lower-cost service. If you decide to choose a more costly service or treatment, you will be responsible for the difference in cost. Alternate benefits may include, but are not limited to, the use of porcelain or gold, crowns, inlays, fixed partial dentures, and removable complete and partial dentures.

Dental Administrator

The Health Plan has entered into an agreement with LIBERTY Dental Plan Corporation (LIBERTY), to provide Covered Dental Services as described in this Pediatric Dental Appendix. For assistance concerning dental coverage questions or for help finding a Participating Dental Provider, you can go to our website at www.kp.org, or call us toll-free 1-888-798-9868 or TTY: 1-877-855-8039, Monday through Friday from 8 a.m. to 8 p.m. Eastern Standard Time (EST).

Specialist Referrals

Participating Specialist Referrals

Your General Dentist may recommend a Specialist if the services are medically necessary and out of the scope of general dentistry. If your General Dentist requires you to get covered services from a Specialist, you may directly refer to a Specialist in our network. This Appendix includes a Schedule of Dental Benefits, which lists what you will be charged for each Covered Dental Service you receive.

Non-Participating Specialist Referrals

Benefits may be provided for referrals to Non-Participating Dental Provider specialists when you have been diagnosed by a Participating Dental Provider with a condition or disease that requires care from a dental specialist, and:

1. The Dental Administrator does not have a Participating Dental Provider who possesses the professional training and expertise to treat the condition or disease; or

2. The Dental Administrator is not able to provide reasonable access to a Participating Dental Provider with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

The Member's Cost Share will be calculated as if the Non-Participating Dental Provider specialist rendering the Covered Dental Services were a Participating Dental Provider.

Extension of Benefits

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

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

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

Extension of Benefits Limitations

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

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

Dental Emergencies

Out of Service Area

When a dental emergency occurs when you are more than fifty (50) miles from your General Dentist, the Dental Administrator will reimburse you for the reasonable charges for Covered Dental Services that may be provided, less any discounted fee, upon proof of payment, not to exceed $100 per incident. Proof of loss must be submitted to the Dental Administrator within ninety (90) days of treatment. Proof of loss should be mailed to:

LIBERTY Dental Plan
Claims Department
P.O. Box 15149

Tampa, FL 33684-5149

Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. Coverage is limited to those procedures not excluded under Plan limitations and exclusions. You must receive all post-emergency care from your Participating Dental Provider.

Failure to provide proof of loss for a dental emergency, or as may be required under "Non-Participating Specialist Referrals," within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than one (1) year from the time proof is otherwise required.

Within Service Area

When you have a dental emergency within the Service Area but are unable to make arrangements to receive care through your General Dentist, contact the Dental Administrator at 1-888-798-9868 or TTY: 1-877-855-8039, Monday through Friday from 8 a.m. to 8 p.m. Eastern Standard Time (EST) for assistance in locating another Participating Dental Provider.

Submission of Claims

When you receive Covered Dental Services from a Non-Participating Dental Provider, the Dental Administrator will reimburse the Non-Participating Provider directly. If the Member has already paid the charges, the Dental Administrator will reimburse the Member (upon proof of payment) instead of paying the provider directly for Covered Dental Services that may have been provided.

The Dental Administrator will accept a recognized ADA claim form from the dental provider's office. Claims can be submitted to:

LIBERTY Dental Plan
Claims Department
P.O. Box 15149
Tampa, FL 33684-5149

A claim form is available to download at www.kp.org. Once you have completed the claim form, you must include any copies of all itemized bills and proof of payment.

If you do not receive the claim form within fifteen (15) days after you notified the Dental Administrator, you may submit written proof of the occurrence, character, and extent of the loss for which the claim is made, including any copies of itemized bills and proof of payment.

All itemized bills and/or proof of payment must be submitted within ninety (90) days of treatment. Failure to submit the itemized bill and/or proof of payment within the time required does not invalidate or reduce Benefits payable if it was not reasonably possible for you to submit the itemized bills and/or proof of payment within the one-year period. If you submit the itemized bill and/or proof of payment as soon as reasonably possible and, except in the absence of legal capacity, no later than one (1) year from the time proof is otherwise required, Benefits will be payable.

Benefits payable under the Evidence of Coverage for any loss will be paid within the time required by state regulations after receipt of written proof of loss. If the Dental Administrator fails to pay a claim within the time required by state regulations, it will pay interest from the date on which payment is required to the

date the claim is paid. If a claim is denied in whole or in part, the written notice of the denial will contain the reasons for denial and reference to the pertinent provisions of the Evidence of Coverage and this Rider.

Appeals

If a claim is denied, you or your Authorized Representative may file an appeal with the Dental Administrator in accordance with the ***Section 5 – Filing Claims, Appeals and Grievances*** of this Evidence of Coverage.

Submit your Appeal to:

LIBERTY Dental Plan
Attn: Grievances and Appeals
Quality Management Department
PO BOX 26110
Santa Ana, CA 92799-6110

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

By: _____

Gracelyn McDermott
Vice President, Marketing, Sales & Business Development

Kaiser Permanente for Individuals and Families
Kaiser Permanente Membership Agreement and Evidence of Coverage

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Kaiser Permanente Smile Kids KPIF Embedded Dental EPO
2026 Schedule of Dental Benefits (up to 19)

This Schedule of Dental Benefits lists procedures covered under your Dental Plan and only apply when performed by a participating General Dentist or Dental Specialist.

You must visit a contracted dental office to utilize covered benefits. For services performed by a Dental Specialist, your dental office will initiate a treatment plan or recommend you see a participating Dental Specialist if the services are medically necessary and outside the scope of general dentistry. You may directly refer to a participating Dental Specialist in the network. For information on locating a Participating Dental Provider, please contact us Toll Free at 1-888-798-9868 or TTY: 1-877-855-8039, Monday through Friday, 8 a.m. to 8 p.m. Eastern Standard Time (EST).

This Schedule does not guarantee benefits. All services are subject to eligibility and dental necessity at the time of service. Dental procedures not listed are available at the dental office's usual and customary fee.

Annual Out-of-Pocket Maximum

Any Member Copayment you pay for covered dental services will accrue towards your medical plan's Out-of-Pocket Maximum. You will not be charged more than the amount of your Out-of-Pocket Maximum for any covered dental services. Please refer to your medical plan for specific details.

Refer to the ***Kaiser Permanente Smile Kids KPIF Embedded Dental EPO Plan Appendix*** for a complete description of the terms and conditions of your covered dental benefit.

CDT Code	Description	Member Copayment	Limitations
TYPE I - DIAGNOSTIC & PREVENTIVE SERVICES			
D0120	Periodic oral evaluation	$5	2 of (D0120, D0145, D0150) every calendar year, per provider or location, coverage begins with the eruption of the first tooth
D0140	Limited oral evaluation	$5	1 of (D0140) per date of service
D0145	Oral evaluation under age 3	$5	2 of (D0120, D0145, D0150) every calendar year, per provider or location
D0150	Comprehensive oral evaluation	$5	2 of (D0120, D0145, D0150) every calendar year, per provider or location
D0160	Oral evaluation, problem focused	$10	
D0170	Re-evaluation, limited, problem focused	$5	
D0171	Re-evaluation, post operative office visit	$0	
D0180	Comprehensive periodontal evaluation	$5	
D0210	Intraoral, comprehensive series of radiographic images	$10	1 of (D0210, D0330, D0701, D0709) every 36 months, per provider or location
D0220	Intraoral, periapical, first radiographic image	$0	
D0230	Intraoral, periapical, each add 'l radiographic image	$0	

CDT Code	Description	Member Copayment	Limitations
D0240	Intraoral, occlusal radiographic image	$0	
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	$0	
D0270	Bitewing, single radiographic image	$0	
D0272	Bitewings, two radiographic images	$0	2 of (D0272-D0274, D0277) every calendar year, per provider or location
D0273	Bitewings, three radiographic images	$5	2 of (D0272-D0274, D0277) every calendar year, per provider or location
D0274	Bitewings, four radiographic images	$5	2 of (D0272-D0274, D0277) every calendar year, per provider or location
D0277	Vertical bitewings, 7 to 8 radiographic images	$10	2 of (D0272-D0274, D0277) every calendar year, per provider or location
D0310	Sialography	$37	
D0320	TMJ arthrogram, including injection	$45	
D0321	Other TMJ radiographic images, by report	$0	
D0330	Panoramic radiographic image	$10	1 of (D0210, D0330, D0701, D0709) every 36 months, per provider or location
D0340	2D cephalometric radiographic image, measurement and analysis	$10	
D0350	2D oral/facial photographic image, intra-orally/extra-orally	$5	
D0391	Interpretation, diagnostic image by a practitioner, not associated with image, including report	$0	
D0460	Pulp vitality tests	$0	
D0470	Diagnostic casts	$10	
D0486	Accession of transepithelial cytologic sample, prep, written report	$10	
D0601	Caries risk assessment and documentation, low risk	$0	2 of (D0601-D0603) every calendar year
D0602	Caries risk assessment and documentation, moderate risk	$0	2 of (D0601-D0603) every calendar year
D0603	Caries risk assessment and documentation, high risk	$0	2 of (D0601-D0603) every calendar year
D0701	Panoramic radiographic image, image capture only	$0	1 of (D0701, D0709, D0210, D0330) every 36 months, per provider or location
D0702	2-D cephalometric radiographic image, image capture only	$0	
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally, image capture only	$0	
D0705	Extra-oral posterior dental radiographic image, image capture only	$0	
D0706	Intraoral, occlusal radiographic image, image capture only	$0	

CDT Code	Description	Member Copayment	Limitations
D0707	Intraoral, periapical radiographic image, image capture only	$0	
D0708	Intraoral, bitewing radiographic image, image capture only	$0	
D0709	Intraoral, comprehensive series of radiographic images, image capture only	$0	1 of (D0701, D0709, D0210, D0330) every 36 months, per provider or location
D1110	Prophylaxis, adult	$10	2 of (D1110, D1120, D4346) every calendar year
D1120	Prophylaxis, child	$5	2 of (D1110, D1120, D4346) every calendar year
D1206	Topical application of fluoride varnish	$0	2 of (D1206, D1208) every calendar year
D1208	Topical application of fluoride, excluding varnish	$0	2 of (D1206, D1208) every calendar year
D1310	Nutritional counseling for control of dental disease	$0	
D1320	Tobacco counseling, control/prevention oral disease	$0	
D1321	Counseling for the control and prevention of adverse oral, behavioral, health effects associated with high-risk substance use	$0	
D1330	Oral hygiene instruction	$0	
D1351	Sealant, per tooth	$5	1 of (D1351) per tooth every 36 months, limited to unrestored permanent molars
D1352	Preventive resin restoration, permanent tooth	$5	
D1354	Application of caries arresting medicament, per tooth	$0	1 of (D1354) per tooth every 6 months, no more than twice per tooth in a lifetime
D1355	Caries preventive medicament application, per tooth	$0	
D1510	Space maintainer, fixed, unilateral, per quadrant	$25	1 of (D1510, D1520, D1575) per quadrant when medically necessary due to the premature loss of a posterior primary tooth
D1516	Space maintainer, fixed, bilateral, maxillary	$36	1 of (D1516, D1517, D1526, D1527) per arch when medically necessary due to the premature loss of a posterior primary tooth
D1517	Space maintainer, fixed, bilateral, mandibular	$36	1 of (D1516, D1517, D1526, D1527) per arch when medically necessary due to the premature loss of a posterior primary tooth

CDT Code	Description	Member Copayment	Limitations
D1520	Space maintainer, removable, unilateral, per quadrant	$26	1 of (D1510, D1520, D1575) per quadrant when medically necessary due to the premature loss of a posterior primary tooth
D1526	Space maintainer, removable, bilateral, maxillary	$40	1 of (D1516, D1517, D1526, D1527) per arch when medically necessary due to the premature loss of a posterior primary tooth
D1527	Space maintainer, removable, bilateral, mandibular	$40	1 of (D1516, D1517, D1526, D1527) per arch when medically necessary due to the premature loss of a posterior primary tooth
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	$5	
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	$5	
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	$0	
D1556	Removal of fixed unilateral space maintainer, per quadrant	$0	1 of (D1556) per quadrant when medically necessary due to the premature loss of a posterior primary tooth
D1557	Removal of fixed bilateral space maintainer, maxillary	$0	1 of (D1557, D1558) per arch when medically necessary due to the premature loss of a posterior primary tooth
D1558	Removal of fixed bilateral space maintainer, mandibular	$0	1 of (D1557, D1558) per arch when medically necessary due to the premature loss of a posterior primary tooth
D1575	Distal shoe space maintainer, fixed, per quadrant	$26	1 of (D1510, D1520, D1575) per quadrant when medically necessary due to the premature loss of a posterior primary tooth
D9995	Teledentistry, synchronous; real-time encounter	$0	Must be accompanied by a covered procedure
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review	$0	Must be accompanied by a covered procedure
TYPE II - ROUTINE (Basic) SERVICES			
D2140	Amalgam, one surface, primary or permanent	$28	
D2150	Amalgam, two surfaces, primary or permanent	$36	
D2160	Amalgam, three surfaces, primary or permanent	$44	
D2161	Amalgam, four or more surfaces, primary or permanent	$51	

CDT Code	Description	Member Copayment	Limitations
D2330	Resin-based composite, one surface, anterior	$36	
D2331	Resin-based composite, two surfaces, anterior	$46	
D2332	Resin-based composite, three surfaces, anterior	$52	
D2335	Resin-based composite, four or more surfaces	$56	
D2390	Resin-based composite crown, anterior	$63	
D2391	Resin-based composite, one surface, posterior	$40	
D2392	Resin-based composite, two surfaces, posterior	$51	
D2393	Resin-based composite, three surfaces, posterior	$62	
D2394	Resin-based composite, four or more surfaces, posterior	$71	
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	$134	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 36 months
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	$59	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 36 months
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	$48	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 36 months
D4240	Gingival flap procedure, four or more teeth per quadrant	$169	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 36 months
D4241	Gingival flap procedure, one to three teeth per quadrant	$106	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 36 months
D4249	Clinical crown lengthening, hard tissue	$187	Prior Authorization Required
D4260	Osseous surgery, four or more teeth per quadrant	$282	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 36 months
D4261	Osseous surgery, one to three teeth per quadrant	$190	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 36 months
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	$101	
D4264	Bone replacement graft, retained natural tooth, each additional site	$86	
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	$101	
D4268	Surgical revision procedure, per tooth	$0	
D4270	Pedicle soft tissue graft procedure	$201	

CDT Code	Description	Member Copayment	Limitations
D4273	Autogenous connective tissue graft procedure, first tooth	$245	
D4274	Mesial/distal wedge procedure, single tooth	$139	
D4275	Non-autogenous connective tissue graft, first tooth	$234	
D4276	Combined connective tissue and pedicle graft	$275	
D4277	Free soft tissue graft, first tooth	$208	
D4278	Free soft tissue graft, each additional tooth	$124	
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	$209	
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	$157	
D4322	Splint, intra-coronal; natural teeth or prosthetic crowns	$23	
D4323	Splint, extra-coronal; natural teeth or prosthetic crowns	$23	
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	$58	1 of (D4341, D4342) per site/ quadrant, every 24 months
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$39	1 of (D4341, D4342) per site/ quadrant, every 24 months
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	$25	2 of (D1110, D1120, D4346) every calendar year
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit	$35	1 of (D4355) per lifetime
D4910	Periodontal maintenance	$32	4 of (D4910) per 12 months
D4921	Gingival irrigation with a medicinal agent, per quadrant	$19	1 of (D4921) per quadrant every 36 months, not payable within 4 weeks of periodontal scaling and root planing
D7111	Extraction, coronal remnants, primary tooth	$26	
D7140	Extraction, erupted tooth or exposed root	$34	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	$60	
D7220	Removal of impacted tooth, soft tissue	$72	
D7230	Removal of impacted tooth, partially bony	$95	
D7240	Removal of impacted tooth, completely bony	$115	
D7241	Removal impacted tooth, complete bony, complication	$137	
D7250	Removal of residual tooth roots (cutting procedure)	$60	
D9110	Palliative treatment of dental pain, per visit	$23	1 of (D9110) per date of service
D9420	Hospital or ambulatory surgical center call	$44	Prior Authorization Required
D9440	Office visit, after regularly scheduled hours	$28	

CDT Code	Description	Member Copayment	Limitations
TYPE III - MAJOR SERVICES			
Guideline: Single Crowns - Copayment includes all costs for lab bills and materials			
D2510	Inlay, metallic, one surface	$271	1 of (D2510-D2794) per tooth every 60 months
D2520	Inlay, metallic, two surfaces	$322	1 of (D2510-D2794) per tooth every 60 months
D2530	Inlay, metallic, three or more surfaces	$350	1 of (D2510-D2794) per tooth every 60 months
D2542	Onlay, metallic, two surfaces	$343	1 of (D2510-D2794) per tooth every 60 months
D2543	Onlay, metallic, three surfaces	$386	1 of (D2510-D2794) per tooth every 60 months
D2544	Onlay, metallic, four or more surfaces	$405	1 of (D2510-D2794) per tooth every 60 months
D2610	Inlay, porcelain/ceramic, one surface	$315	1 of (D2510-D2794) per tooth every 60 months
D2620	Inlay, porcelain/ceramic, two surfaces	$339	1 of (D2510-D2794) per tooth every 60 months
D2630	Inlay, porcelain/ceramic, three or more surfaces	$366	1 of (D2510-D2794) per tooth every 60 months
D2642	Onlay, porcelain/ceramic, two surfaces	$356	1 of (D2510-D2794) per tooth every 60 months
D2643	Onlay, porcelain/ceramic, three surfaces	$404	1 of (D2510-D2794) per tooth every 60 months
D2644	Onlay, porcelain/ceramic, four or more surfaces	$421	1 of (D2510-D2794) per tooth every 60 months
D2650	Inlay, resin-based composite, one surface	$252	1 of (D2510-D2794) per tooth every 60 months
D2651	Inlay, resin-based composite, two surfaces	$282	1 of (D2510-D2794) per tooth every 60 months
D2652	Inlay, resin-based composite, three or more surfaces	$305	1 of (D2510-D2794) per tooth every 60 months
D2662	Onlay, resin-based composite, two surfaces	$288	1 of (D2510-D2794) per tooth every 60 months
D2663	Onlay, resin-based composite, three surfaces	$338	1 of (D2510-D2794) per tooth every 60 months
D2664	Onlay, resin-based composite, four or more surfaces	$355	1 of (D2510-D2794) per tooth every 60 months
D2710	Crown, resin-based composite (indirect)	$168	1 of (D2510-D2794) per tooth every 60 months
D2712	Crown, ¾ resin-based composite (indirect)	$165	1 of (D2510-D2794) per tooth every 60 months
D2720	Crown, resin with high noble metal	$400	1 of (D2510-D2794) per tooth every 60 months
D2721	Crown, resin with predominantly base metal	$375	1 of (D2510-D2794) per tooth every 60 months
D2722	Crown, resin with noble metal	$383	1 of (D2510-D2794) per tooth every 60 months

CDT Code	Description	Member Copayment	Limitations
D2740	Crown, porcelain/ceramic	$474	1 of (D2510-D2794) per tooth every 60 months
D2750	Crown, porcelain fused to high noble metal	$468	1 of (D2510-D2794) per tooth every 60 months
D2751	Crown, porcelain fused to predominantly base metal	$403	1 of (D2510-D2794) per tooth every 60 months
D2752	Crown, porcelain fused to noble metal	$427	1 of (D2510-D2794) per tooth every 60 months
D2753	Crown, porcelain fused to titanium and titanium alloys	$477	1 of (D2510-D2794) per tooth every 60 months
D2780	Crown, ¾ cast high noble metal	$426	1 of (D2510-D2794) per tooth every 60 months
D2781	Crown, ¾ cast predominantly base metal	$372	1 of (D2510-D2794) per tooth every 60 months
D2782	Crown, ¾ cast noble metal	$401	1 of (D2510-D2794) per tooth every 60 months
D2783	Crown, ¾ porcelain/ceramic	$444	1 of (D2510-D2794) per tooth every 60 months
D2790	Crown, full cast high noble metal	$454	1 of (D2510-D2794) per tooth every 60 months
D2791	Crown, full cast predominantly base metal	$389	1 of (D2510-D2794) per tooth every 60 months
D2792	Crown, full cast noble metal	$425	1 of (D2510-D2794) per tooth every 60 months
D2794	Crown, titanium and titanium alloys	$400	1 of (D2510-D2794) per tooth every 60 months
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	$36	
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	$21	
D2920	Re-cement or re-bond crown	$36	
D2928	Prefabricated porcelain/ceramic crown, permanent tooth	$123	
D2929	Prefabricated porcelain/ceramic crown, primary tooth	$144	
D2930	Prefabricated stainless steel crown, primary tooth	$103	
D2931	Prefabricated stainless steel crown, permanent tooth	$112	
D2932	Prefabricated resin crown	$119	
D2933	Prefabricated stainless steel crown with resin window	$137	
D2934	Prefabricated esthetic coated stainless steel crown, primary tooth	$137	
D2940	Placement of interim direct restoration	$38	
D2950	Core buildup, including any pins when required	$96	

CDT Code	Description	Member Copayment	Limitations
D2951	Pin retention, per tooth, in addition to restoration	$21	
D2952	Post and core in addition to crown, indirectly fabricated	$161	
D2954	Prefabricated post and core in addition to crown	$119	
D2955	Post removal	$92	
D2962	Labial veneer (porcelain laminate), indirect	$355	1 of (D2962) per tooth every 60 months
D2980	Crown repair necessitated by restorative material failure	$84	
D2981	Inlay repair necessitated by restorative material failure	$70	
D2982	Onlay repair necessitated by restorative material failure	$72	
D2983	Veneer repair necessitated by restorative material failure	$70	
D2990	Resin infiltration of incipient smooth surface lesions	$25	
D3110	Pulp cap, direct (excluding final restoration)	$30	
D3120	Pulp cap, indirect (excluding final restoration)	$24	
D3220	Therapeutic pulpotomy (excluding final restoration)	$76	1 (D3220) in a lifetime, per tooth
D3221	Pulpal debridement, primary and permanent teeth	$68	
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	$72	
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	$79	1 (D3230) in a lifetime, per tooth
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	$87	1 (D3240) in a lifetime, per tooth
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$318	1 of (D3310-D3330) in a lifetime, per tooth
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$374	1 of (D3310-D3330) in a lifetime, per tooth
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$472	1 of (D3310-D3330) in a lifetime, per tooth
D3333	Internal root repair of perforation defects	$95	
D3346	Retreatment of previous root canal therapy, anterior	$395	1 of (D3346-D3348) in a lifetime, per tooth
D3347	Retreatment of previous root canal therapy, premolar	$454	1 of (D3346-D3348) in a lifetime, per tooth
D3348	Retreatment of previous root canal therapy, molar	$542	1 of (D3346-D3348) in a lifetime, per tooth
D3351	Apexification/recalcification, initial visit	$149	

CDT Code	Description	Member Copayment	Limitations
D3352	Apexification/recalcification, interim medication replacement	$67	
D3353	Apexification/recalcification, final visit	$205	
D3355	Pulpal regeneration, initial visit	$149	
D3356	Pulpal regeneration, interim medication replacement	$67	
D3357	Pulpal regeneration, completion of treatment	$149	
D3410	Apicoectomy, anterior	$295	
D3421	Apicoectomy, premolar (first root)	$328	
D3425	Apicoectomy, molar (first root)	$371	
D3426	Apicoectomy (each additional root)	$126	
D3430	Retrograde filling, per root	$93	
D3450	Root amputation, per root	$192	
D3471	Surgical repair of root resorption, anterior	$295	
D3472	Surgical repair of root resorption, premolar	$295	
D3473	Surgical repair of root resorption, molar	$295	
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption, anterior	$295	
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption, premolar	$295	
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption, molar	$295	
D3920	Hemisection, not including root canal therapy	$150	
D3921	Decoronation or submergence of an erupted tooth	$50	
D3950	Canal preparation and fitting of preformed dowel or post	$67	
Guideline: Removable Prosthodontics (Complete/Partial Dentures) - Copayment includes all costs for lab bills and materials			
D5110	Complete denture, maxillary	$593	1 of (D5110-D5120, D5863, D5865) per arch every 60 months
D5120	Complete denture, mandibular	$593	1 of (D5110-D5120, D5863, D5865) per arch every 60 months
D5130	Immediate denture, maxillary	$602	
D5140	Immediate denture, mandibular	$602	
D5211	Maxillary partial denture, resin base	$423	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months
D5212	Mandibular partial denture, resin base	$482	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months

CDT Code	Description	Member Copayment	Limitations
D5213	Maxillary partial denture, cast metal, resin base	$630	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months
D5214	Mandibular partial denture, cast metal, resin base	$627	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months
D5221	Immediate maxillary partial denture, resin base	$454	
D5222	Immediate mandibular partial denture, resin base	$525	
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	$669	
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	$669	
D5225	Maxillary partial denture, flexible base	$592	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months
D5226	Mandibular partial denture, flexible base	$590	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	$316	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	$316	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	$244	1 of (D5284, D5286) per quad every 60 months
D5286	Removable unilateral partial denture, one piece resin, per quadrant	$182	1 of (D5284, D5286) per quad every 60 months
D5410	Adjust complete denture, maxillary	$29	Not payable within first 6 months of initial placement by same provider
D5411	Adjust complete denture, mandibular	$30	Not payable within first 6 months of initial placement by same provider
D5421	Adjust partial denture, maxillary	$30	Not payable within first 6 months of initial placement by same provider
D5422	Adjust partial denture, mandibular	$29	Not payable within first 6 months of initial placement by same provider
D5511	Repair broken complete denture base, mandibular	$85	Not payable within first 6 months of initial placement by same provider
D5512	Repair broken complete denture base, maxillary	$85	Not payable within first 6 months of initial placement by same provider
D5520	Replace missing or broken teeth, complete denture, per tooth	$67	Not payable within first 6 months of initial placement by same provider
D5611	Repair resin partial denture base, mandibular	$63	Not payable within first 6 months of initial placement by same provider
D5612	Repair resin partial denture base, maxillary	$63	Not payable within first 6 months of initial placement by same provider

CDT Code	Description	Member Copayment	Limitations
D5621	Repair cast partial framework, mandibular	$70	Not payable within first 6 months of initial placement by same provider
D5622	Repair cast partial framework, maxillary	$70	Not payable within first 6 months of initial placement by same provider
D5630	Repair or replace broken retentive clasping materials, per tooth	$77	Not payable within first 6 months of initial placement by same provider
D5640	Replace missing or broken teeth, partial denture, per tooth	$54	Not payable within first 6 months of initial placement by same provider
D5650	Add tooth to existing partial denture, per tooth	$70	Not payable within first 6 months of initial placement by same provider
D5660	Add clasp to existing partial denture, per tooth	$87	Not payable within first 6 months of initial placement by same provider
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	$219	Not payable within first 6 months of initial placement by same provider
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	$223	Not payable within first 6 months of initial placement by same provider
D5710	Rebase complete maxillary denture	$200	Not payable within first 6 months of initial placement by same provider
D5711	Rebase complete mandibular denture	$190	Not payable within first 6 months of initial placement by same provider
D5720	Rebase maxillary partial denture	$188	Not payable within first 6 months of initial placement by same provider
D5721	Rebase mandibular partial denture	$188	Not payable within first 6 months of initial placement by same provider
D5730	Reline complete maxillary denture, direct	$112	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5731	Reline complete mandibular denture, direct	$112	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5740	Reline maxillary partial denture, direct	$103	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5741	Reline mandibular partial denture, direct	$103	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5750	Reline complete maxillary denture, indirect	$163	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5751	Reline complete mandibular denture, indirect	$162	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider

CDT Code	Description	Member Copayment	Limitations
D5760	Reline maxillary partial denture, indirect	$148	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5761	Reline mandibular partial denture, indirect	$148	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5810	Interim complete denture, maxillary	$427	
D5811	Interim complete denture, mandibular	$428	
D5820	Interim partial denture, maxillary	$205	
D5821	Interim partial denture, mandibular	$201	
D5850	Tissue conditioning, maxillary	$54	
D5851	Tissue conditioning, mandibular	$53	
D5863	Overdenture, complete, maxillary	$796	1 of (D5110, D5120, D5863, D5865) per arch every 60 months
D5864	Overdenture, partial, maxillary	$788	1 of (D5211-D5214, D5225-D5283, D5864, D5866) per arch every 60 months
D5865	Overdenture, complete, mandibular	$1,271	1 of (D5110, D5120, D5863, D5865) per arch every 60 months
D5866	Overdenture, partial, mandibular	$788	1 of (D5211-D5214, D5225-D5283, D5864, D5866) per arch every 60 months
D5951	Feeding aid	$125	Prior Authorization Required
D5992	Adjust maxillofacial prosthetic appliance, by report	$37	1 (D5992) per arch every 6 months
D5993	Maintenance & cleaning, maxillofacial prosthesis, other than required adjustments, by report	$0	1 (D5993) per arch every 6 months
Guideline: Implants and Implant Related Services - Copayment includes all costs for lab bills and materials			
D6010	Surgical placement of implant body, endosteal	$872	Prior Authorization Required
D6012	Surgical placement of interim implant body, transitional prosthesis: endosteal implant	$855	Prior Authorization Required
D6040	Surgical placement: eposteal implant	$2,819	Prior Authorization Required
D6050	Surgical placement: transosteal implant	$2,104	Prior Authorization Required
D6055	Connecting bar, implant supported or abutment supported	$270	Prior Authorization Required
D6056	Prefabricated abutment, includes modification and placement	$250	Prior Authorization Required
D6057	Custom fabricated abutment, includes placement	$358	Prior Authorization Required
D6058	Abutment supported porcelain/ceramic crown	$655	Prior Authorization Required

CDT Code	Description	Member Copayment	Limitations
D6059	Abutment supported porcelain fused to high noble crown	$648	Prior Authorization Required
D6060	Abutment supported porcelain fused to base metal crown	$578	Prior Authorization Required
D6061	Abutment supported porcelain fused to noble metal crown	$606	Prior Authorization Required
D6062	Abutment supported cast metal crown, high noble	$635	Prior Authorization Required
D6063	Abutment supported cast metal crown, base metal	$546	Prior Authorization Required
D6064	Abutment supported cast metal crown, noble metal	$595	Prior Authorization Required
D6065	Implant supported porcelain/ceramic crown	$673	Prior Authorization Required
D6066	Implant supported crown, porcelain fused to high noble alloys	$649	Prior Authorization Required
D6067	Implant supported crown, high noble alloys	$626	Prior Authorization Required
D6068	Abutment supported retainer, porcelain/ceramic FPD	$659	Prior Authorization Required
D6069	Abutment supported retainer, metal FPD, high noble	$641	Prior Authorization Required
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	$572	Prior Authorization Required
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	$603	Prior Authorization Required
D6072	Abutment supported retainer, cast metal FPD, high noble	$633	Prior Authorization Required
D6073	Abutment supported retainer, cast metal FPD, base metal	$541	Prior Authorization Required
D6074	Abutment supported retainer, cast metal FPD, noble	$587	Prior Authorization Required
D6075	Implant supported retainer for ceramic FPD	$656	Prior Authorization Required
D6076	Implant supported retainer for FPD, porcelain fused to high noble alloys	$642	Prior Authorization Required
D6077	Implant supported retainer for metal FPD, high noble alloys	$619	Prior Authorization Required
D6080	Implant maintenance procedures, prosthesis removed/reinserted, including cleansing	$50	Prior Authorization Required
D6081	Scaling and debridement of a single implant in the presence of inflammation or mucositis	$39	Prior Authorization Required
D6087	Implant supported crown, noble alloys	$617	Prior Authorization Required
D6090	Repair of implant/abutment supported prosthesis, by report	$0	

CDT Code	Description	Member Copayment	Limitations
D6091	Replacement of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	$186	Prior Authorization Required
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	$591	Prior Authorization Required
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	$623	Prior Authorization Required
D6100	Surgical removal of implant body	$51	
D6110	Implant/abutment supported removable denture, maxillary	$822	Prior Authorization Required
D6111	Implant/abutment supported removable denture, mandibular	$822	Prior Authorization Required
D6112	Implant/abutment supported removable denture, partial, maxillary	$884	Prior Authorization Required
D6113	Implant/abutment supported removable denture, partial, mandibular	$884	Prior Authorization Required
D6114	Implant/abutment supported fixed denture, maxillary	$1,000	Prior Authorization Required
D6115	Implant/abutment supported fixed denture, mandibular	$1,000	Prior Authorization Required
D6116	Implant/abutment supported fixed denture for partial, maxillary	$400	Prior Authorization Required
D6117	Implant/abutment supported fixed denture for partial, mandibular	$400	Prior Authorization Required
D6121	Implant supported retainer for metal FPD, predominantly base alloys	$562	Prior Authorization Required
D6122	Implant supported retainer for metal FPD, noble alloys	$611	Prior Authorization Required
Guideline: Bridge Services - Copayment includes all costs for lab bills and materials			
D6205	Pontic, indirect resin based composite	$400	Prior Authorization Required
D6210	Pontic, cast high noble metal	$457	Prior Authorization Required
D6211	Pontic, cast predominantly base metal	$391	Prior Authorization Required
D6212	Pontic, cast noble metal	$425	Prior Authorization Required
D6214	Pontic, titanium, and titanium alloys	$400	Prior Authorization Required
D6240	Pontic, porcelain fused to high noble metal	$469	Prior Authorization Required
D6241	Pontic, porcelain fused to predominantly base metal	$398	Prior Authorization Required
D6242	Pontic, porcelain fused to noble metal	$435	Prior Authorization Required
D6243	Pontic, porcelain fused to titanium and titanium alloys	$480	Prior Authorization Required
D6245	Pontic, porcelain/ceramic	$471	Prior Authorization Required
D6250	Pontic, resin with high noble metal	$439	Prior Authorization Required
D6251	Pontic, resin with predominantly base metal	$382	Prior Authorization Required
D6252	Pontic, resin with noble metal	$409	Prior Authorization Required
D6545	Retainer, cast metal for resin bonded fixed prosthesis	$178	Prior Authorization Required

CDT Code	Description	Member Copayment	Limitations
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis	$179	Prior Authorization Required
D6549	Resin retainer, for resin bonded fixed prosthesis	$106	Prior Authorization Required
D6600	Retainer inlay, porcelain/ceramic, two surfaces	$326	Prior Authorization Required
D6601	Retainer inlay, porcelain/ceramic, three or more surfaces	$349	Prior Authorization Required
D6602	Retainer inlay, cast high noble metal, two surfaces	$325	Prior Authorization Required
D6603	Retainer inlay, cast high noble metal, three or more surfaces	$343	Prior Authorization Required
D6604	Retainer inlay, cast base metal, two surfaces	$316	Prior Authorization Required
D6605	Retainer inlay, cast base metal, three or more surfaces	$340	Prior Authorization Required
D6606	Retainer inlay, cast noble metal, two surfaces	$318	Prior Authorization Required
D6607	Retainer inlay, cast noble metal, three or more surfaces	$344	Prior Authorization Required
D6608	Retainer onlay, porcelain/ceramic, two surfaces	$338	Prior Authorization Required
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	$400	Prior Authorization Required
D6610	Retainer onlay, cast high noble metal, two surfaces	$337	Prior Authorization Required
D6611	Retainer onlay, cast high noble metal, three or more surfaces	$397	Prior Authorization Required
D6612	Retainer onlay, cast base metal, two surfaces	$335	Prior Authorization Required
D6613	Retainer onlay, cast base metal, three or more surfaces	$382	Prior Authorization Required
D6614	Retainer onlay, cast noble metal, two surfaces	$328	Prior Authorization Required
D6615	Retainer onlay, cast noble metal three or more surfaces	$382	Prior Authorization Required
D6634	Retainer onlay, titanium	$250	Prior Authorization Required
D6710	Retainer crown, indirect resin based composite	$400	Prior Authorization Required
D6720	Retainer crown, resin with high noble metal	$390	Prior Authorization Required
D6721	Retainer crown, resin with predominantly base metal	$370	Prior Authorization Required
D6722	Retainer crown, resin with noble metal	$377	Prior Authorization Required
D6740	Retainer crown, porcelain/ceramic	$477	Prior Authorization Required
D6750	Retainer crown, porcelain fused to high noble metal	$470	Prior Authorization Required

CDT Code	Description	Member Copayment	Limitations
D6751	Retainer crown, porcelain fused to predominantly base metal	$402	Prior Authorization Required
D6752	Retainer crown, porcelain fused to noble metal	$437	Prior Authorization Required
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	$483	Prior Authorization Required
D6780	Retainer crown, ¾ cast high noble metal	$411	Prior Authorization Required
D6781	Retainer crown, ¾ cast predominantly base metal	$377	Prior Authorization Required
D6782	Retainer crown, ¾ cast noble metal	$395	Prior Authorization Required
D6783	Retainer crown, ¾ porcelain/ceramic	$436	Prior Authorization Required
D6784	Retainer crown ¾, titanium and titanium alloys	$422	Prior Authorization Required
D6790	Retainer crown, full cast high noble metal	$458	Prior Authorization Required
D6791	Retainer crown, full cast predominantly base metal	$389	Prior Authorization Required
D6792	Retainer crown, full cast noble metal	$426	Prior Authorization Required
D6794	Retainer crown, titanium and titanium alloys	$400	Prior Authorization Required
D6930	Re-cement or re-bond fixed partial denture	$52	
D6980	Fixed partial denture repair, restorative material failure	$88	
D6999	Unspecified fixed prosthodontic procedure, by report	$0	Prior Authorization Required
D7251	Coronectomy, intentional partial tooth removal	$192	1 of (D7251) in a lifetime, per tooth
D7260	Oroantral fistula closure	$609	
D7261	Primary closure of a sinus perforation	$254	
D7270	Tooth reimplantation and/or stabilization, accident	$190	
D7272	Tooth transplantation	$254	1 of (D7272) in a lifetime, per tooth
D7280	Exposure of an unerupted tooth	$178	
D7282	Mobilization of erupted/malpositioned tooth	$198	
D7283	Placement, device to facilitate eruption, impaction	$39	
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	$356	
D7286	Incisional biopsy of oral tissue, soft	$152	
D7288	Brush biopsy, transepithelial sample collection	$61	
D7290	Surgical repositioning of teeth	$152	1 of (D7290) in a lifetime, per tooth
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$24	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	$91	1 of (D7310-D7321) in a lifetime, per quadrant
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	$80	1 of (D7310-D7321) in a lifetime, per quadrant

CDT Code	Description	Member Copayment	Limitations
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	$149	1 of (D7310-D7321) in a lifetime, per quadrant
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	$126	1 of (D7310-D7321) in a lifetime, per quadrant
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	$629	
D7350	Vestibuloplasty, ridge extension	$1,829	
D7410	Excision of benign lesion, up to 1.25 cm	$274	
D7411	Excision of benign lesion, greater than 1.25 cm	$120	
D7413	Excision of malignant lesion, up to 1.25 cm	$121	
D7414	Excision of malignant lesion, greater than 1.25 cm	$158	
D7440	Excision of malignant tumor, up to 1.25 cm	$150	
D7441	Excision of malignant tumor, greater than 1.25 cm	$164	
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	$274	
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	$375	
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	$125	
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	$151	
D7471	Removal of lateral exostosis, maxilla or mandible	$340	
D7472	Removal of torus palatinus	$404	
D7473	Removal of torus mandibularis	$381	
D7485	Reduction of osseous tuberosity	$340	
D7510	Incision & drainage of abscess, intraoral soft tissue	$98	
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	$149	
D7520	Incision & drainage of abscess, extraoral soft tissue	$468	
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	$125	
D7880	Occlusal orthotic device, by report	$253	
D7910	Suture of recent small wounds up to 5 cm	$25	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot, stabilization, per site	$13	
D7961	Buccal/labial frenectomy (frenulectomy)	$148	1 of (D7961) in a lifetime, per arch
D7962	Lingual frenectomy (frenulectomy)	$148	1 of (D7962) in a lifetime
D7963	Frenuloplasty	$124	1 of (D7963) In a lifetime, per arch
D7970	Excision of hyperplastic tissue, per arch	$183	

CDT Code	Description	Member Copayment	Limitations
D7971	Excision of pericoronal gingiva	$70	1 of (D7971) in a lifetime, per tooth
D7972	Surgical reduction of fibrous tuberosity	$256	
D7979	Nonsurgical sialolithotomy	$75	
D7999	Unspecified oral surgery procedure, by report	$0	
D9210	Local anesthesia not in conjunction, operative or surgical procedures	$15	
D9211	Regional block anesthesia	$17	
D9212	Trigeminal division block anesthesia	$26	
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0	Not payable as separate service
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$0	
D9222	Deep sedation/general anesthesia, first 15 minute increment	$72	Prior Authorization Required
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	$72	Prior Authorization Required
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$25	Not allowed on same date of service asD9248
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	$68	Prior Authorization Required
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	$68	Prior Authorization Required
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	$125	Not allowed on same date of service as D9222, D9223, D9230
D9310	Consultation, other than requesting dentist	$45	
D9311	Consultation with a medical health care professional	$40	
D9610	Therapeutic parenteral drug, single administration	$39	Prior Authorization Required
D9612	Therapeutic parenteral drugs, two or more administrations, different meds.	$39	Prior Authorization Required
D9630	Drugs or medicaments dispensed in the office for home use	$39	Prior Authorization Required
D9910	Application of desensitizing medicament	$0	
D9920	Behavior management, by report	$5	
D9930	Treatment of complications, post surgical, unusual, by report	$0	
D9941	Fabrication of athletic mouthguard	$125	1 of (D9941) every 12 months
D9944	Occlusal guard, hard appliance, full arch	$223	1 of (D9944-D9946) every 12 months
D9945	Occlusal guard, soft appliance, full arch	$223	1 of (D9944-D9946) every 12 months
D9946	Occlusal guard, hard appliance, partial arch	$170	1 of (D9944-D9946) every 12 months
D9950	Occlusion analysis, mounted case	$111	
D9951	Occlusal adjustment, limited	$50	2 of (D9951) every 12 months

CDT Code	Description	Member Copayment	Limitations
D9952	Occlusal adjustment, complete	$234	1 of (D9952) every 12 months
D9986	Missed appointment	$0	
TYPE IV - MEDICALLY NECESSARY ORTHODONTIC SERVICES - Prior Authorization required for Orthodontic Services			
Guideline: Medically Necessary Orthodontic Services Orthodontic needs are limited to 1 course of treatment and must meet medically necessary requirements as determined by a verified score of 26 or higher (or other qualify conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.			
D8010	Limited orthodontic treatment of the primary dentition	$765	Prior Authorization Required for medically necessary benefits
D8020	Limited orthodontic treatment of the transitional dentition	$815	Prior Authorization Required for medically necessary benefits
D8030	Limited orthodontic treatment of the adolescent dentition	$965	Prior Authorization Required for medically necessary benefits
D8040	Limited orthodontic treatment of the adult dentition	$965	Prior Authorization Required for medically necessary benefits
D8070	Comprehensive orthodontic treatment of the transitional dentition	$2,169	Prior Authorization Required for medically necessary benefits
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2,169	Prior Authorization Required for medically necessary benefits
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,169	Prior Authorization Required for medically necessary benefits
D8210	Removable appliance therapy	$299	Prior Authorization Required for medically necessary benefits, for thumb sucking and tongue thrusting
D8220	Fixed appliance therapy	$300	Prior Authorization Required for medically necessary benefits, for thumb sucking and tongue thrusting
D8660	Pre-orthodontic treatment examination to monitor growth and development	$47	Prior Authorization Required for medically necessary benefits
D8670	Periodic orthodontic treatment visit	$54	Prior Authorization Required for medically necessary benefits
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$204	Prior Authorization Required for medically necessary benefits
D8681	Removable orthodontic retainer adjustment	$246	Prior Authorization Required for medically necessary benefits
D8698	Re-cement or re-bond fixed retainer, maxillary	$32	Prior Authorization Required for medically necessary benefits
D8699	Re-cement or re-bond fixed retainer, mandibular	$32	Prior Authorization Required for medically necessary benefits
D8701	Repair of fixed retainer, includes reattachment, maxillary	$94	Prior Authorization Required for medically necessary benefits
D8702	Repair of fixed retainer, includes reattachment, mandibular	$94	Prior Authorization Required for medically necessary benefits
D8703	Replacement of lost or broken retainer, maxillary	$94	Prior Authorization Required for medically necessary benefits

CDT Code	Description	Member Copayment	Limitations
D8704	Replacement of lost or broken retainer, mandibular	$94	Prior Authorization Required for medically necessary benefits
D8999	Unspecified orthodontic procedure, by report	$0	Prior Authorization Required for medically necessary benefits

General Exclusions:
The following services are not covered under this Dental Plan

- Any procedures not listed on this Plan
- Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.
- Dental procedures or services performed solely for Cosmetic purposes or that is not Dentally Necessary and/or medically necessary; unless the member has the additional Cosmetic Ortho Plus Plan and services are within the benefit guidelines listed in the Cosmetic Ortho Plus Plan.
- Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving You or Your Dependent's dental health, as determined by the Plan based on generally accepted dental standards of care.
- For elective procedures, including prophylactic extraction of third molars.
- Replacement of Dentures, Crowns, appliances or Bridgework that have been lost, stolen or damaged.
- Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
- Treatment required due to an accident from an external force or are intentionally self-inflicted, unless otherwise listed as Covered Service.
- Services that restore tooth structure due to attrition, erosion or abrasion are not covered.
- Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed.
- Procedures, appliances, or restoration to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
- Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.
- Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonable should have known that an Emergency Care situation did not exist.
- Composite or ceramic brackets, lingual adaptation of Orthodontic bands and other specialized or Cosmetic alternatives to standard fixed and removable Orthodontic appliances. Invisalign services are excluded from Orthodontic benefits.
- Broken appointments unless specifically covered.

Appendix – Summary of Cost Shares

Cost Share is the general term used to refer to your out-of-pocket costs (e.g. Deductible, Coinsurance and Copayments) for the covered Services you receive. The Cost Shares listed here apply to Services provided to Members enrolled in this Bronze Metal plan. In addition to the monthly Premium, you may be required to pay a Cost Share for some Services.

The Cost Share is the Copayment and Coinsurance, if any, and Deductible, if applicable, listed in this Appendix for each Service.†

You are responsible for payment of all Cost Shares. Copayments are due at the time you receive a Service. You will be billed for any Deductible, if applicable, and Coinsurance you owe.

This Summary does not describe benefits. For the description of benefits, including exclusions and limitations, please refer to:

1. ***Section 3: Benefits, Exclusions and Limitations***
2. ***Appendix: Kaiser Permanente Smile Kids KPIF Embedded Dental EPO Plan***
3. ***Appendix: Outpatient Prescription Drug Benefit***

†When a non-Plan Provider provides Ancillary Services at a Plan Hospital or Plan Facility, your Cost Share will be the same Cost Sharing amount for the same Service(s) from a Plan Provider. Such Cost Share shall count toward your Deductible and Out-of-Pocket Maximum. You will not be liable for any additional payment other than your Cost Share for Ancillary Services.

Deductible

The Deductible is the amount of Allowable Charges you must incur during a Calendar Year for certain covered Services before Health Plan will provide benefits for those Services.

For covered Services that are subject to a Deductible, you must pay the full charge for the Services when you receive them, until you meet your Deductible. The only amounts that count toward your Deductible are the Allowable Charges you incur for Services that are subject to the Deductible, but only if the Service would otherwise be covered. After you meet the Deductible, you pay the applicable Copayment or Coinsurance for these Services.

Self-Only Coverage Deductible

If you are covered as a Subscriber, and you do not have any Dependents covered under this Agreement, you must meet the Self-Only Coverage Deductible indicated below.

Family Coverage Deductible

If you have one or more Dependents covered under this Agreement, all members of your Family Unit together must meet the Family Coverage Deductible indicated below. No one family member's medical expenses may contribute more than the Self-Only Coverage Deductible shown below. After one (1) member of a Family Unit has met the Self-Only Coverage Deductible, this family member will start paying Copayments or Coinsurance for the remainder of the Calendar Year. Other family members will continue to pay full charges for Services that are subject to the Deductible until the Family Coverage Deductible is met. After two (2) or more members of your Family Unit, combined, have met the Family Coverage Deductible, the Deductible will be met for all members of your Family Unit for the rest of the Calendar Year.

Keep Your Receipts

When you pay an amount toward your Deductible, we will give you a receipt. Keep your receipts. Also, if you have

met your Deductible, and we have not received and processed all of your claims, you can use your receipts to prove that you have met your Deductible. You can also obtain a statement of the amounts that have been applied toward your Deductible from our Member Services Department.

Deductible	You Pay
Self-Only Coverage	$6,500 per individual per Calendar Year
Family Coverage	$13,000 per Family Unit per Calendar Year

Covered Service	You Pay
Outpatient Care	
Primary Care office Visits (Internal medicine, family practice, or pediatrics)	$65 per Visit (Copayment waived for children under age 5)
Specialty care office Visits (All other covered practitioner office Visits unless listed separately below)	$85 per Visit after Deductible
Outpatient Surgery	
Outpatient surgery facility fee (freestanding ambulatory surgical center or outpatient Hospital)	50% of AC* after Deductible
Outpatient surgery physician Services	50% of AC* after Deductible
Hospital Inpatient Care	
All charges incurred during a covered stay as an inpatient in a Hospital	50% of AC* after Deductible
Physician and surgical Services	50% of AC* after Deductible
Accidental Dental Injury Services	
Office Visit	$85 per Visit after Deductible
All other related Services	The applicable Cost Share will apply based on type and place of Service
Allergy Services	
Evaluation and treatment	$85 per Visit after Deductible

Injection Visit and serum	$65 per Visit
Ambulance Services	
By a licensed ambulance Service, per encounter	No charge after Deductible
Non-emergent transportation Services (ordered by a Plan Provider)	No charge
Anesthesia for Dental Services	
Anesthesia for Dental Services	The applicable Cost Share will apply based on type and place of Service
Blood, Blood Products and Their Administration	
Blood, Blood Products and Their Administration	50% of AC* after Deductible
Cleft Lip, Cleft Palate or Both	
Cleft Lip, Cleft Palate or Both	The applicable Cost Share will apply based on type and place of Service
Clinical Trials	
Clinical Trials	The applicable Cost Share will apply based on type and place of Service
Diabetic Equipment, Supplies and Self-Management	
Diabetic equipment and supplies	20% of AC*
Self-management training	The applicable Cost Share will apply based on type and place of Service
Dialysis Services	
Outpatient Care	$85 per Visit after Deductible
Drugs, Supplies and Supplements	
Administered by or under the supervision of a Plan Provider	
Drugs, Supplies and Supplements	The applicable Cost Share will apply based on type and place of Service

Durable Medical Equipment	
Durable Medical Equipment	50% of AC* after Deductible
Peak flow meters	50% of AC*
Home UV Light Box	No charge

Emergency Services (including Emergency Services HIV Screening Test)	
Emergency Services **Note:** Your Cost Share will be the same Deductible, Copayment, or Coinsurance, as applicable, for Emergency Services provided by Plan Providers and non-Plan Providers. Calculation of the Cost Share will be in accordance with the requirements of state law or, in the event that state law is inapplicable, then federal law.	50% of AC* after Deductible

Family Planning Services	
Women's Preventive Services, including all Food & Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity are covered under Preventive Health Care Services at no charge. Women's Preventive Services refers to Services considered to be Women's Preventive Care Services under the Patient Protection and Affordable Care Act of 2010, as amended, and are provided in accordance with the published guidelines supported by the Health Resources and Services Administration (HRSA). These guidelines are subject to change and can be found on the HRSA website: https://www.hrsa.gov/womens-guidelines-2016.	
Male Sterilization	No charge
Elective and therapeutic termination of pregnancy, as permitted under state law	No charge

Habilitative Services - Outpatient	
Physical, Occupational or Speech Therapy	50% of AC* after Deductible
Applied Behavioral Analysis (ABA)	$65 per Visit
All other Services	The applicable Cost Share will apply based on type and place of Service

Hearing Services
Newborn hearing screening tests are covered under Preventive Health Care Services at no charge

Hearing Services	The applicable Cost Share will apply based on type and place of Service
Home Health Care Services	
Home Health Care Services	No charge after Deductible
Hospice Care Services	
Limited to a maximum of one-hundred eighty (180) days per hospice eligibility period	
Hospice Care Services	No charge after Deductible
House Calls	
House Calls	No charge
Infertility & Standard Fertility Preservation Services	
Infertility Treatment	The applicable Cost Share will apply based on type and place of Service
Fertility Preservation for Iatrogenic Infertility	The applicable Cost Share will apply based on type and place of Service
Storage of Cryopreserved Semen, Oocytes or Embryos	50% of AC* after Deductible
Maternity Services	
Maternity Services that are required by the Affordable Care Act are covered under Preventive Care Services at no charge.	
Pre-natal and post-natal Services (includes routine and non-routine office Visits, telemedicine Visits, x-ray, laboratory and specialty tests), including: • Birthing Classes (offered once per pregnancy) • Breastfeeding support and equipment	No charge
Inpatient and Birthing Center Delivery	50% of AC* after Deductible
Postpartum home health visits	No charge
Medical Foods	
Medical Foods	50% of AC* after Deductible
Medical Nutrition Therapy and Counseling	
Medical Nutrition Therapy & Counseling	$65 per Visit

Mental Health Services and Substance Use Disorder	
Inpatient psychiatric and substance abuse Services, including detoxification	50% of AC* after Deductible
Residential Treatment Center Services	50% of AC* after Deductible
Residential crisis Services	50% of AC* after Deductible
Outpatient psychiatric and substance abuse care • Individual therapy • Group therapy • Intensive therapy • Medication management Visits • All other Outpatient Services (Office Visits)	 • $65 per Visit • $32 per Visit • $65 per Visit • $65 per Visit • $65 per Visit
All other Outpatient Services (Non-Office Visits) • Partial Hospitalization Treatment • Psychological and Neuropsychological Testing • Electroconvulsive Therapy (ECT) • Crisis Intervention and Stabilization	• No charge • No charge • No charge • No charge • No charge
Morbid Obesity Services, including Bariatric Surgery	
Morbid Obesity Services, including Bariatric Surgery	The applicable Cost Share will apply based on type and place of Service
Oral Surgery	
Oral surgery, including treatment of the temporomandibular joint (TMJ)	The applicable Cost Share will apply based on type and place of Service
TMJ appliances	50% of AC* after Deductible
Preventive Health Care Services	
Preventive Health Care Services	No charge
Prosthetic and Orthotic Devices	
Prosthetic and Orthotic Devices	50% of AC* after Deductible
Radiation Therapy/Chemotherapy/Infusion Therapy - Outpatient	
Radiation Therapy	$85 per Visit after Deductible
Chemotherapy	$85 per Visit after Deductible

Infusion Therapy	The applicable Cost Share will apply based on type and place of Service
Reconstructive Surgery	
Reconstructive Surgery	The applicable Cost Share will apply based on type and place of Service
Routine Foot Care	
Routine Foot Care	$85 per Visit after Deductible
Skilled Nursing Facility Care	
Limited to a maximum benefit of sixty (60) days per Calendar Year	
Skilled Nursing Facility Care	50% of AC* after Deductible
Telemedicine Services	
Telemedicine Services	No charge
Therapy and Rehabilitation Services - Outpatient	
Therapy and Rehabilitation Services – Outpatient	50% of AC* after Deductible
Transplant Services	
Transplant Services	The applicable Cost Share will apply based on type and place of Service
Pre-transplant dental Services • Dental Services Office Visit • All other related Services	• $85 per Visit after Deductible • The applicable Cost Share will apply based on type and place of Service
Urgent Care Services	
Office Visit during regular office hours	The applicable Cost Share will apply based on type and place of Service
After-hours Urgent Care or Urgent Care Center	$85 per Visit after Deductible
Vision Services (for adults age 19 or older)	
Eye exam by an Optometrist	$65 per Visit
Eye exam by an Ophthalmologist	$85 per Visit after Deductible

Eyeglass lenses and frames	You receive a $90 combined discount off retail price** for eyeglass lenses and for eyeglass frames (Discount is available once per year)
Contact lenses	You receive a $25 discount off retail price** on initial fit and first purchase of contact lenses (Discount is available once per year)
Vision Services **(for children until the end of the month in which the Member turns age 19)**	
Eye exam by an Optometrist	$65 per Visit
Eye exam by an Ophthalmologist	$85 per Visit after Deductible
Vision Hardware **(for children until the end of the month in which the Member turns age 19)**	
A child may select any pair of glasses in lieu of, or in addition to, the eyeglasses or contact lenses available at no charge under Vision Hardware and receive the discount under Vision Services (for adults age 19 or older) at any Plan vision center	
Eyeglass lenses and frames (Limited to a select group)	No charge for one (1) pair per year
Contact lenses, in lieu of eyeglass lenses and frames (Limited to a select group)	No charge for initial fit and first purchase per year
Medically Necessary contact lenses (in lieu of eyeglass lenses and frames. Limited to select group)	No charge for up to two (2) pair per eye per year
Low vision aids (Limited to available supply at Plan Provider only)	No charge
X-Ray, Laboratory and Special Procedures	
X-rays and Diagnostic Imaging	50% of AC* after Deductible
Laboratory Outpatient and Professional Services	50% of AC* after Deductible
Sleep laboratory	50% of AC* after Deductible
Sleep studies	$85 per Visit after Deductible
Specialty Imaging (including CT, MRI, PET Scans and Diagnostic Nuclear Medicine)	50% of AC* after Deductible
Interventional Radiology	50% of AC* after Deductible

*"AC" means Allowable Charge as defined in the section ***Important Terms You Should Know*** of this Agreement.

**"Retail price" means the price that would otherwise be charged for the lenses, frames or contacts at the Plan vision care center on the day purchased.

"The applicable Cost Share will apply based on type and place of Service" means that the Cost Share to be paid for the covered Service may vary depending on where and how a Member receives the respective Service. For example, the Cost Share for outpatient care will apply if the Member receives the Service in an outpatient care setting or the Cost Share for inpatient care will apply if the Member receives the Service in a Hospital.

Out-of-Pocket Maximum

Self-Only Out-of-Pocket Maximum	$9,200 per individual per Calendar Year
Family Out-of-Pocket Maximum	$18,400 per Family Unit per Calendar Year

The Out-of-Pocket Maximum is the maximum amount of Copayments, Deductibles and Coinsurance that an individual or family is obligated to pay for covered Services, except as excluded below, per Calendar Year. Once you or your Family Unit together have met your Out-of-Pocket Maximum, you will not be required to pay any additional Cost Shares for covered Services that apply toward the Out-of-Pocket Maximum for the rest of the Calendar Year.

Self-Only Out-of-Pocket Maximum

If you are covered as a Subscriber, and you do not have any Dependents covered under this Agreement, your medical expenses for covered Services apply toward the Self-Only Out-of-Pocket Maximum indicated above.

Family Out-of-Pocket Maximum

If you have one (1) or more Dependents covered under this Agreement, the covered medical expenses incurred by all family members together apply toward the Family Out-of-Pocket Maximum indicated above. No one family member's medical expenses may contribute more than the Self-Only Out-of-Pocket Maximum shown above. After one (1) member of a Family Unit has met the Self-Only Out-of-Pocket Maximum, this family member will not be required to pay any additional Cost Shares for covered Services for the rest of the Calendar Year. Other family members will continue to pay Cost Shares until the Family Out-of-Pocket Maximum is met. After two (2) or more Members of your Family Unit, combined, have met the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be met for all members of the Family Unit for the rest of the Calendar Year.

Out-of-Pocket Maximum Exclusions

The following Service(s) *do not* apply toward your Out-of-Pocket Maximum:

- Adult eyeglass lenses and frames and contact lenses that are available with a discount only.

Appendix: Outpatient Prescription Drug Benefit

The Health Plan will provide coverage for prescription drugs as follows:

Definitions

Allowable Charge: Has the same meaning as defined in the section ***Important Terms You Should Know*** in your Membership Agreement and Evidence of Coverage.

Biosimilar: FDA-approved biologics that are highly similar to a brand biologic product.

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

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

Complex or Chronic Medical Condition: A physical, behavioral, or developmental condition that:

1. May have no known cure;
2. Is progressive; or
3. Can be debilitating or fatal if left untreated or undertreated.

Complex or Chronic Medical Conditions include, but are not limited to: Multiple Sclerosis, Hepatitis C, and Rheumatoid Arthritis.

Contraceptive Drug: A drug or device that is approved by the Food & Drug Administration for use as a contraceptive and requires a prescription.

Copayment: The specific dollar amount that you must pay for each prescription or prescription refill.

Deductible: The amount of Allowable Charges you must incur during a Calendar Year for certain Benefits before Health Plan will provide benefits for those Services.

Food & Drug Administration/FDA: The United States Food & Drug Administration.

Formulary: A list of prescription drugs covered by this Plan.

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.

Limited Distribution Drug (LDD): A prescription drug that is limited in distribution by the manufacturer or the Food & Drug Administration.

Mail Service Delivery Program: A program operated or arranged by Health Plan that distributes prescription drugs to Members via mail. Some medications are not eligible for the Mail Service Delivery Program. These may include, but are not limited to, drugs that are time or temperature sensitive, drugs that cannot legally be sent by U.S. Mail, and drugs that require professional administration or observation. The Mail Service Delivery Program can mail to addresses in Maryland, Virginia, Washington, D.C., and certain locations outside the Service Area.

Maintenance Medication: 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 Drug: Includes all other Generic and Brand Name Drugs on Tier 3.

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

Preferred Drug: Generic or Brand Name Drug that is on the Formulary on Tier 1 or Tier 2.

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

Smoking Cessation Drugs: Over-the-counter and prescription drugs approved by the Food & Drug Administration to treat tobacco dependence.

Specialty Drug: A prescription drug that:

1. Is prescribed for an individual with a Complex or Chronic Medical Condition, or a Rare Medical Condition;
2. Costs $600 or more for up to a 30-day supply; and
3. Requires a difficult or unusual process of delivery to the Member in the:
    a. Preparation;
    b. Handling;
    c. Storage;
    d. Inventory; or
    e. Distribution of the drug; or
        i. Requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug.

A list of the drugs in our Formulary may be viewed on our website at www.kp.org. This list changes periodically. Please contact the Member Services Call Center to find out if a drug is covered under this Rider as a Specialty Drug.

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

Standard Reference Compendia: Any authoritative compendia as recognized periodically by the federal Secretary of Health and Human Services or the Commissioner.

Benefits

Except as provided in the Limitations and Exclusions sections of this Outpatient Prescription Drug Benefit, we cover drugs described below when prescribed by a Plan Physician, a non-Plan Physician to whom you have an approved referral, or a dentist. Each prescription refill is subject to the same conditions as the original prescription. A Plan Provider prescribes drugs in accordance with the Health Plan's Formulary. If the price of the drug is less than the Copayment, you will pay the price of the drug. You must obtain covered drugs from a Plan Pharmacy. You may also obtain prescription drugs using our Mail Service Delivery Program; ask for details at a Plan Pharmacy.

We cover the following prescription drugs:

1. Food & Drug Administration-approved drugs for which a prescription is required by law.
2. Compounded preparations that contain at least one ingredient requiring a prescription.
3. Insulin.
4. Oral chemotherapy drugs, including oral anticancer medications.
5. Drugs that are Food & Drug Administration-approved for use as contraceptives and diaphragms. For coverage of other types of contraception, including contraceptive injections, implants and devices, refer to ***"Family Planning Services"*** in ***Section 3 - Benefits, Exclusions and Limitations***.
6. Any prescription drug or over-the-counter drug approved by the Food & Drug Administration as an aid for the cessation of the use of tobacco products. Tobacco products include cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco, and candy-like products that contain tobacco.
7. Off label use of drugs when a drug is recognized in Standard Reference Compendia or certain Medical Literature as appropriate in the treatment of the diagnosed condition.
8. Non-prescription drugs when they are prescribed by a Plan Provider and are listed on the Formulary.
9. Growth hormone therapy for treatment of children under age 18 with a growth hormone deficiency; or when prescribed by a Plan Physician, pursuant to clinical guidelines for adults.
10. Hormone replacement therapy that is prescribed or ordered for treating symptoms and conditions of menopause.
11. Hormone replacement therapy and hormone blockers prescribed or ordered for treating symptoms and conditions of gender dysphoria.
12. Limited Distribution Drugs, regardless of where they are purchased, will be covered on the same basis as if they were purchased at a Plan Pharmacy.
13. Prescription eye drops and refills in accordance with guidance for early refills of topical ophthalmic products provided by the Centers for Medicare and Medicaid Services if the:
    a. Original prescription indicates additional quantities are needed; and
    b. The refill requested does not exceed the number of refills indicated on the original prescription.

The Health Plan 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 on the Formulary.

Certain covered outpatient prescription drugs may be subject to utilization management such as prior authorization, step therapy and other requirements. A list of drugs subject to utilization management is available to you upon request.

If you would like information about whether a particular drug is included in our Formulary, please visit us online at:

https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/mas/marketplace-formulary-mas-en.pdf

You may also contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Exclusions

Except as specifically covered under this Outpatient Prescription Drug Benefit, the Health Plan does not cover a drug:

1. That can be obtained without a prescription; or
2. For which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to the prescription drug, unless otherwise prohibited by federal or state laws governing essential health benefits.

Where to Purchase Covered Drugs

Except for Emergency Services and Urgent Care Services, you must obtain prescribed drugs from a Plan Pharmacy or through the Health Plan's Mail Service Delivery Program. Prescribed drugs are subject to the Cost Shares listed under "Copayment/Coinsurance." Most non-refrigerated prescription medications ordered through the Health Plan's Mail Service Delivery Program can be delivered to addresses in Maryland, Virginia, Washington, D.C., and certain locations outside the Service Area.

Generic and Preferred Drug Requirements

Generic vs. Brand Name Drugs

We cover Generic and Brand Name Drugs, including those for Specialty Drugs and biological drugs. Plan Pharmacies and mail order pharmacies will substitute a generic equivalent for a Brand Name Drug when a generic equivalent is listed as a Preferred Drug unless one of the following is met:

1. The Provider has prescribed a Brand Name Drug and has indicated "dispense as written," also sometimes referred to as "(DAW)" on the prescription;
2. The Brand Name Drug is listed on our Formulary as a Preferred Drug;
3. The Brand Name Drug is prescribed by a:
    a. Plan Physician;
    b. Non-Plan Physician to whom you have an approved referral;
    c. Non-Plan Physician consulted due to an emergency or for out-of-area urgent care; or
    d. Dentist; and
        i. There is no equivalent Generic Drug; or
        ii. An equivalent Generic Drug has:
            a. Been ineffective in treating the disease or condition of the Member; or
            b. Caused or is likely to cause an adverse reaction or other harm to the Member.

If a Member requests a Brand Name Drug, not on the Formulary, for which there is a generic equivalent and items #3(d)(ii)(a) and #3(d)(ii)(b) have not been met, the Member will be responsible for the full Allowable Charge for the Brand Name Drug.

Preferred Drugs vs. Non-Preferred Drugs

We cover Preferred Drugs and Non-Preferred Drugs, including those for Specialty Drugs and biological drugs. Plan Pharmacies and mail order pharmacies will dispense a Preferred Drug unless the following criteria are met:

The Non-Preferred Drug is prescribed by a:

1. Plan Physician;

2. Non-Plan Physician to whom you have a referral;
3. Non-Plan Physician consulted due to an emergency or for out-of-area urgent care; or
4. Dentist; and
   a. There is no equivalent drug in our Formulary; or
   b. An equivalent Formulary drug has:
      i. Been ineffective in treating the disease or condition of the Member; or
      ii. Caused or is likely to cause an adverse reaction or other harm to the Member.

If the above criteria are met, the applicable Tier Cost Share will apply based on the Formulary. If the Member requests a drug, not on the Formulary, and the criteria are not met, the Member will be responsible for the full Allowable Charge.

The Health Plan will treat the drug(s) obtained as prescribed above, under ***Generic vs. Brand Name Drugs*** and ***Preferred Drugs*** *vs.* ***Non-Preferred Drugs***, as an Essential Health Benefit, including by counting any Cost Sharing towards the health benefit plan's Out-of-Pocket Maximum described in the ***Summary of Cost Shares*** Appendix of this Agreement.

Dispensing Limitations

Except for Maintenance Medications as described below, Members are limited to a thirty (30)-day supply for drugs other than contraceptive drugs and will be charged the applicable Copayment or Coinsurance based on:

1. The prescribed dosage;
2. Standard Manufacturers Package Size; and
3. Specified dispensing limits.

For contraceptive drugs, Members may obtain up to a twelve (12)-month supply at one time at no charge.

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

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

Maintenance Medication Dispensing Limitations

Members may obtain up to a ninety (90)-day supply of Maintenance Medications in a single prescription, when authorized by the prescribing Plan Provider or by a dentist or a referral physician. This does not apply to the first prescription or change in a prescription. The day supply is based on:

1. The prescribed dosage;
2. Standard Manufacturer's Package Size; and
3. Specified dispensing limits.

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"*** in ***Section 3 - Benefits, Exclusions and***

Limitations), or associated with a covered, authorized referral inside or outside the Health Plan's Service Area. To obtain reimbursement, the Member must submit a copy of the itemized receipts for their prescriptions to the Health Plan. We may require proof that Emergency Services or Urgent Care Services were provided. Reimbursement will be made at the Allowable Charge less the applicable Copayment, subject to the Prescription Drug Deductible as shown below. Claims should be submitted to:

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

Limitations and Exclusions

Limitations

Benefits are subject to the following limitations:

1. For drugs prescribed by dentists, coverage is limited to antibiotics and pain relief drugs that are included on our Formulary and purchased at a Plan Pharmacy, unless the criteria for coverage of Non-Preferred Drugs has been met. The Non-Preferred Drugs coverage criteria is detailed in this Outpatient Prescription Drug Benefit in the subsection titled, "Preferred Drugs vs. Non-Preferred Drugs."
2. In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with the Health Plan's emergency management department and/or our Pharmacy and Therapeutics Committee. If limited, the applicable Cost Share per prescription will apply. However, a Member may file a claim for the difference between the Cost Share for a full prescription and the pro-rata Cost Share for the actual amount received. Instructions for filing a claim can be found in ***Section 5 – Filing Claims, Appeals and Grievances***. Claims should be submitted to:

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

Exclusions

The following are not covered under the Outpatient Prescription Drug Benefit. Please note that certain Services excluded below may be covered under other benefits in ***Section 3 - Benefits, Exclusions and Limitations***. Please refer to the applicable benefit to determine if drugs are covered:

1. Drugs for which a prescription is not required by law, except for non-prescription drugs that are prescribed by a Plan Provider and are listed in our Formulary.
2. Compounded preparations that do not contain at least one ingredient requiring a prescription and are not listed in our Formulary.
3. Drugs obtained from a non-Plan Pharmacy, except when the drug is prescribed during an emergency or urgent care Visit in which covered Services are rendered or associated with a covered authorized referral outside the Service Area.
4. Take home drugs received from a hospital, Skilled Nursing Facility, or other similar facility. Refer to ***"Hospital Inpatient Care"*** and ***"Skilled Nursing Facility Care"*** in ***Section 3 – Benefits, Exclusions and Limitations***.
5. Drugs that are not listed in our Formulary, except as described in this Prescription Drug Benefit.

6. Drugs that are considered to be experimental or investigational. Refer to ***"Clinical Trials"*** in ***Section 3 – Benefits, Exclusions and Limitations***.
7. Except as specifically covered under this Outpatient Prescription Drug Benefit, a drug which:
   a. Can be obtained without a prescription; or
   b. For which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug.
8. Drugs for which the Member is not legally obligated to pay, or for which no charge is made.
9. Blood or blood products. Refer to ***"Blood, Blood Products and their Administration"*** in ***Section 3 – Benefits, Exclusions and Limitations***.
10. Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes including but not limited to drugs used to retard or reverse the effects of skin aging or to treat nail fungus or hair loss.
11. Medical foods. Refer to ***"Medical Foods"*** in ***Section 3 – Benefits, Exclusions and Limitations***.
12. Drugs for the palliation and management of terminal illness if they are provided by a licensed hospice agency to a Member participating in our hospice care program. Refer to ***"Hospice Care"*** in ***Section 3 – Benefits, Exclusions and Limitations***.
13. Replacement prescriptions necessitated by theft or loss.
14. Prescribed drugs and accessories that are necessary for Services that are excluded under this Agreement.
15. Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from the Health Plan's standard packaging for prescription drugs.
16. Alternative formulations or delivery methods that are:
   a. Different from the Health Plan's standard formulation or delivery method for prescription drugs; and
   b. Deemed not Medically Necessary.
17. Durable medical equipment, prosthetic or orthotic devices, and their supplies, including: peak flow meters, nebulizers, and spacers; and ostomy and urological supplies. Refer to ***"Durable Medical Equipment"*** and ***"Prosthetic Devices"*** in ***Section 3 – Benefits, Exclusions and Limitations***.
18. Drugs and devices that are provided during a covered stay in a hospital or Skilled Nursing Facility, or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits. This includes the equipment and supplies associated with the administration of a drug. Refer to ***"Drugs, Supplies, and Supplements"*** and ***"Home Health Services"*** in ***Section 3 – Benefits, Exclusions and Limitations***.
19. Bandages or dressings. Refer to ***"Drugs, Supplies, and Supplements"*** and ***"Home Health Services"*** in ***Section 3 – Benefits, Exclusions and Limitations***.
20. Diabetic equipment and supplies. Refer to ***"Diabetic Equipment Supplies, and Self-Management"*** in ***Section 3 – Benefits, Exclusions and Limitations***.
21. Growth hormone therapy for treatment of adults age 18 or older, except when prescribed by a Plan Physician, pursuant to clinical guidelines for adults.
22. Immunizations and vaccinations solely for the purpose of travel. Refer to ***"Outpatient Care"*** in ***Section 3 – Benefits, Exclusions and Limitations***.

23. Any prescription drug product that is therapeutically equivalent to an over-the-counter drug, upon a review and determination by the Pharmacy and Therapeutics Committee.
24. Drugs for weight management.
25. Drugs for treatment of sexual dysfunction disorder, such as erectile dysfunction.

Copayment/Coinsurance

You pay the Copayment or Coinsurance amounts set forth below when purchasing covered outpatient prescription drugs from the Kaiser Permanente Plan Pharmacy. If the price of the drug is less than the Copayment, you will pay the price of the drug.

The following Copayments and Coinsurance apply to all covered prescription drugs purchased at a Kaiser Permanente Plan Pharmacy or through the Kaiser Permanente Mail Service Delivery Program. These Copayments and Coinsurance amounts also apply to covered prescription drugs offered at non-Plan Pharmacies in connection with Emergency Services and Urgent Care Services.

For outpatient prescription drugs and/or items that are covered under this ***Outpatient Prescription Drug Benefit*** appendix and obtained at a pharmacy owned and operated by Health Plan, you may be able to use manufacturer coupons as payment for the Cost Sharing that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of your Cost Sharing for your prescription. When you use a coupon for payment of your Cost Sharing, the coupon amount, and any additional payment that you make, will accumulate to your Out-of-Pocket Maximum. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at https://healthy.kaiserpermanente.org/learn/pharmacy/drug-manufacturer-coupons.

Tier 1 Drugs: Includes commonly prescribed Generic Drugs.

Tier 2 Drugs: Includes commonly prescribed Brand Name Drugs and commonly prescribed higher-cost Generic Drugs.

Tier 3 Drugs: Includes all other Brand Name Drugs that are on the Formulary list and not included in Tier 1 or Tier 2. A limited number of Generic Drugs may also be included in Tier 3. Drugs on this tier also include Biosimilar Drugs.

Tier 4 Drugs: Includes Specialty Drugs as defined in the ***Definitions*** section of this ***Outpatient Prescription Drug Benefit***.

Thirty (30)-Day Supply	**Plan Pharmacy and Mail Delivery**
Tier 1 Drugs	$40; not subject to Deductible
Tier 2 Drugs	50% of AC* after Deductible
Tier 3 Drugs	50% of AC* after Deductible
Tier 4 Drugs	50% of AC* but not to exceed $150 after Deductible
Oral Chemotherapy Drugs/Anticancer Medication	No charge after Deductible
Contraceptive Drugs**	No charge; not subject to Deductible
Preventive Care Drugs**	No charge; not subject to Deductible
Smoking Cessation Drugs	No charge; not subject to Deductible
All Insulin	No charge; not subject to Deductible

Infertility Drugs	Refer to the applicable Cost Share above

Ninety (90)-Day Supply	**Plan Pharmacy**	**Mail Delivery**
Tier 1 Drugs	$80; not subject to Deductible	$60; not subject to Deductible
Tier 2 Drugs	50% of AC* after Deductible	50% of AC* after Deductible
Tier 3 Drugs	50% of AC* after Deductible	50% of AC* after Deductible
Tier 4 Drugs	50% of AC* but not to exceed $300 after Deductible	50% of AC* but not to exceed $300 after Deductible
Oral Chemotherapy Drugs/Anticancer Medication	No charge after Deductible	No charge after Deductible
Contraceptive Drugs**	No charge; not subject to Deductible	No charge; not subject to Deductible
Preventive Care Drugs**	No charge; not subject to Deductible	No charge; not subject to Deductible
Smoking Cessation Drugs	No charge; not subject to Deductible	No charge; not subject to Deductible
All Insulin	No charge; not subject to Deductible	No charge; not subject to Deductible
Infertility Drugs	Refer to the applicable Cost Share above	Refer to the applicable Cost Share above

Twelve (12)-Month Supply	**Plan Pharmacy and Mail Delivery**
Contraceptive Drugs**	No charge; not subject to Deductible

*Allowable Charge (AC) is defined in the section ***Important Terms You Should Know*** in your Membership Agreement and Evidence of Coverage to which this Appendix is attached.

**Contraceptive Drugs and Preventive Drugs required to be covered by the Affordable Care Act (ACA) without Cost Sharing, including over-the-counter medications when prescribed by a Plan Provider, and obtained at a Plan Pharmacy or through the Mail Service Delivery Program, are covered at no charge. You can find a list of these drugs by referring to the "PRV" indicator under "Restrictions/Limits" at:

https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/mas/marketplace-formulary-mas-en-2023.pdf

Additional information on ACA covered Preventive Care Drugs and Contraceptive Drugs can be found at:

Summary of preventive services (kaiserpermanente.org)

About the Affordable Care Act | HHS.gov

Deductible

Covered outpatient prescription drugs are subject to the Deductible set forth in the ***Summary of Cost Shares*** Appendix of this of the Agreement, except for Tier 1 Drugs, Contraceptive Drugs, Preventive Care Drugs, Smoking Cessation Drugs, and All Insulin.

Out-of-Pocket Maximum

The Deductible and all Cost Shares for outpatient prescription drugs apply toward the Out-of-Pocket Maximum set forth in the ***Summary of Cost Shares*** Appendix of this Agreement.