guide to
YOUR 2026 BENEFITS AND SERVICES

SAMPLE

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

GROUP EVIDENCE OF COVERAGE

DISTRICT OF COLUMBIA

SELECT CARE DELIVERY SYSTEM

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

DCML-HDHP(01-26)

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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.

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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.

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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;

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- $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.

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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.

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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).

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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**).

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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**).

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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
District of Columbia Large Group Agreement and Evidence of Coverage

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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 Group 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, or physical or mental disability.

About This Group Agreement

Once you are enrolled under this Group Agreement, you become a Member. A Member may be a Subscriber and/or any eligible Dependents, once properly enrolled. 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."

Note: Under no circumstances should the terms "you" or "your" be interpreted to mean anyone other than the Member, including any nonmember reading or interpreting this contract on behalf of a Member.

Important Terms

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

Purpose of this Group Agreement and EOC

This EOC, including the Group Agreement and any attached applications, riders and amendments serves three important purposes. It:

1. Constitutes the entire contract between your Group and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2. Provides evidence of your health care coverage; and
3. Describes the Kaiser Permanente Select[SM] health care coverage provided under this contract.

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

Group Agreement and EOC Binding on All Members
By electing coverage or accepting benefits under this EOC, legally capable Subscribers accept this contract and all provisions contained within it on behalf of his or herself and any Dependent Members not legally permitted to accept this contract themselves.

Amendment of Group Agreement and EOC
Your Group's Agreement with us may change periodically. If any changes affect this contract, we will notify you of such changes and will issue an updated EOC to you.

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

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 Group Agreement replaces any earlier Group Agreement that may have been issued by us. The term of this EOC is based on your Group's contract year and your effective date of coverage. Your Group's benefits administrator can confirm that this EOC is still in effect.

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

1. Bind the Health Plan in any way, verbally or otherwise, by:
    a. Making any promise or representation; or
    b. Giving or receiving any information.

Any change to this contract may not be valid until the:

1. Approval is endorsed by an executive officer of the Health Plan; and
2. Endorsement appears on, or is attached to the contract.

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

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 the direct service nature in mind as you read this Group Agreement and EOC.

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

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Relations Among Parties Affected By This Group Agreement and EOC

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 the medical records of Members 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 Group Agreement and EOC;
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 Select[SM]

Getting the care you need is easy. Kaiser Permanente Select[SM] provides you with health care benefits administered by Plan Providers at our Plan Medical Centers, and through affiliated Plan Providers located throughout our Service Area.

Plan Medical Centers and medical offices are conveniently located throughout the Washington, D.C. and Baltimore metropolitan areas. We have placed an integrated team of Specialists, nurses and technicians alongside our physicians, all working together to support your health and wellbeing at our state-of-the-art Plan Medical Centers. Pharmacy, optical, laboratory and X-ray facilities are also available at many Plan Medical Centers.

Eligibility for This Plan

General

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

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

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Should Know section). However, you or your Spouse's eligible children who live outside our Service Area may be eligible to enroll if you are required to cover them pursuant to a Qualified Medical Child Support Order. Please note that coverage is only limited to Emergency Services, Visiting Member Services and Urgent Care Services provided outside of our Service Area, unless you elect to bring the Dependent within our Service Area to receive covered Services from Plan Providers.

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

Subscribers

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

Dependents

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

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

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

You or your Spouse's currently enrolled Dependents who meet the Dependent eligibility requirements except for the age limit, may be eligible as a disabled Dependent if they meet all the following requirements:

1. They are incapable of self-sustaining employment because of a mentally- or physically-disabling injury, illness, or condition that occurred prior to reaching the age limit for Dependents;
2. They receive 50 percent or more of their support and maintenance from you or your Spouse; and
3. You give us proof of their incapacity and dependency within sixty (60) days after we request it (see the ***Disabled Dependent Certification*** provision, immediately below, for additional eligibility requirements).

Disabled Dependent Certification

A Dependent who meets the Dependent eligibility requirements except for the age limit may be eligible as

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a disabled Dependent as described above. You must provide us documentation of your Dependent's incapacity and dependency as follows:

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

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

2. If we determine that your Dependent does not meet the eligibility requirements as a disabled Dependent, we will notify you that he or she is not eligible and let you know the membership termination date.

   If we determine that your Dependent is eligible as a disabled Dependent, there will be no lapse in coverage. Also, beginning two (2) years after the date that your Dependent reached the age limit, you must provide us documentation of his or her incapacity and dependency annually within sixty (60) days after we request it so that we can determine if he or she continues to be eligible as a disabled Dependent.

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

   If we determine that your Dependent is eligible as a disabled Dependent, you must provide us documentation of his or her incapacity and dependency annually within sixty (60) days after we request it so that we can determine if he or she continues to be eligible as a disabled Dependent.

Member Rights and Responsibilities: Our Commitment to Each Other

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

Rights of Members

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

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

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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. You or your 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 prudent 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

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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.

Responsibilities of Members

As a Member of Kaiser Permanente, you 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 contract 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.

If You Have a Health Savings Account-Qualified High-Deductible Health Plan

The health care coverage described in this Agreement has been designed to be a High-Deductible Health Plan (HDHP) qualified for use with a Health Savings Account. 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

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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, you 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 or greater and a family Deductible of $3,400 or greater; and
2. Individual Out-of-Pocket Maximum of no more than $8,500 and a family Out-of-Pocket Maximum of no more than $17,000 in the current contract 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 contract 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 another health plan (for example, through your Spouse's employer) that is not also an HSA-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 contract 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

Members are entitled to health care coverage only for the period for which we have received the appropriate Premium from your Group. You are responsible to pay any required contribution to the Premium, as determined and required by your Group. Your Group will tell you the amount you owe and how you will pay it to your Group. For example: A payroll deduction.

Payment of Copayments, Coinsurance and Deductibles

In addition to your monthly Premium payment, you may also be required to pay a Cost Share when you receive certain covered Services. A Cost Share may consist of a Copayment, Coinsurance, Deductible or a combination of these. Copayments are due at the time you receive a Service. You will be billed for any Deductible and/or Coinsurance you owe.

There are limits to the total amount of Copayments, Coinsurance and Deductibles you have to pay during the contract year. This limit is known as the Out-of-Pocket Maximum.

Any applicable Copayment, Coinsurance or Deductible you may be required to pay, along with the Out-of-Pocket Maximum, will be listed in the ***Summary of Services and Cost Shares***, which is attached to this EOC.

The Health Plan will keep accurate records of each Member's Cost Sharing and will notify the Member in writing within thirty (30) days of when he or she has reached the Out-of-Pocket Maximum. Once you have

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paid the Out-of-Pocket Maximum for Services received within the contract year, no additional Copayments, Coinsurance or Deductibles will be charged by the Health Plan for the remainder of the contract year. We will promptly refund a Member's Copayment, Coinsurance or Deductible if it was charged after the Out-of-Pocket Maximum was reached.

Open Enrollment

By submitting a Health Plan-approved enrollment application to your Group during the open enrollment period, you may enroll:

1. Yourself, as a new Subscriber, along with any of your eligible Dependents; or
2. Eligible Dependents, if you are already an existing Subscriber.

Enrollment and Effective Date of Coverage

When the Health Plan provides its annual open enrollment period, it will begin at least thirty (30) days prior to the 1st day of the contract year. During the annual open enrollment period an eligible employee may enroll or discontinue enrollment in this health benefit plan; or change their enrollment from this health benefit plan to a different health benefit plan offered by the large Employer.

Your Group will let you know when the open enrollment period begins and ends. Your membership will be effective at 12 a.m. Eastern Time (the time at the location of the administrative office of carrier at 4000 Garden City Drive, Hyattsville, Maryland 20785) on the 1st day of the contract year.

New Employees and Their Dependents

Employees who become eligible outside of the annual open enrollment period may enroll themselves and any eligible Dependents thirty-one (31) days from the date that the employee first becomes eligible.

The Group shall notify you and any enrolled Dependents of your effective date of membership if that date is different than the effective date of the Group Agreement, or if it is different than the dates specified under ***Special Enrollment Due to New Dependents***, below.

Special Enrollment

You can only enroll during the annual open enrollment described above, unless one of the following is true. You:

1. Become eligible for a special enrollment period, as described in this section; or
2. Did not enroll in any coverage through your Group when you were first eligible, and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling at a later time. The effective date of an enrollment resulting from this provision is no later than the 1st day of the month following the date your Group receives a Health Plan-approved enrollment or change of enrollment application from the Subscriber.

Special Enrollment Due to New Dependents

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

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

1. **For new Spouse**, no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber.

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2. **For newborn children, the moment of birth.** If payment of additional Premium is required to provide coverage for the newborn child then, in order for coverage to continue beyond thirty-one (31) days from the date of birth, notification of birth and payment of additional Premium must be provided within thirty-one (31) days of the date of birth, otherwise coverage for the newborn will terminate thirty-one (31) days from the date of birth.
3. **For newly adopted children (including children newly placed for adoption),** the "date of adoption." The "date of adoption" means the earlier of: (1) a judicial decree of adoption, or (2) the assumption of custody, pending adoption of a prospective adoptive child by a prospective adoptive parent. If payment of additional Premium is required to provide coverage for the child then, in order for coverage to continue beyond thirty-one (31) days from the date of adoption, notification of adoption and payment of additional Premium must be provided within thirty-one (31) days of the date of adoption, otherwise coverage for the newly adopted child will terminate thirty-one (31) days from the date of adoption. Once coverage is in effect, it will continue according to the terms of this EOC, unless the placement is disrupted prior to a final decree of adoption and the child is removed from placement with the Subscriber. In such case, coverage will terminate on the date the child is removed from placement.
4. **For children who are newly eligible for coverage as the result of guardianship granted by court or testamentary appointment, the date of court or testamentary appointment.** If payment of additional Premium is required to provide coverage for the child, notification of the court or testamentary appointment may be provided at any time but, payment of Premium must be provided within thirty-one (31) days of the enrollment of the child, otherwise, enrollment of the child terminates thirty-one (31) days from the date of court or testamentary appointment.

Special Enrollment Due to Court or Administrative Order

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

If the Subscriber fails to enroll a child under a court or administrative order, the child's other parent or the Department of Social Services may apply for coverage. A Dependent child enrolled under this provision may not be disenrolled unless we receive satisfactory written proof that:

1. The court or administrative order is no longer in effect; and
2. The child is or will be enrolled in comparable health coverage that will take effect not later than the effective date of termination under this EOC; or
3. Family coverage has been eliminated under this EOC.

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

Special Enrollment Due to Loss of Other Coverage

By submitting a Health Plan-approved enrollment application to your Group within thirty (30) days after an enrolling person you are dependent upon for coverage loses that coverage, you may enroll:

1. Yourself, as a new Subscriber, along with any of your eligible Dependents; or
2. Eligible Dependents, if you are already an existing Subscriber, as long as the:

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a. Enrolling person or at least one (1) of the Dependents had other coverage when you previously declined all coverage through your Group, and
b. Loss of the other coverage is due to:
    i. Exhaustion of COBRA coverage;
    ii. Termination of employer contributions for non-COBRA coverage;
    iii. Loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (non-group) plan for nonpayment.
        a) For example, this loss of eligibility may be due to legal separation or divorce, reaching the age limit for dependent children, death, termination of employment or reduction in hours of employment;
    iv. Loss of eligibility for Medicaid coverage or Child Health Insurance Program (CHIP) coverage, but not termination for cause; or
    v. Reaching a lifetime maximum on all benefits.

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

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

Special Enrollment Due to Eligibility for Premium Assistance under Medicaid or CHIP

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

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

Special Enrollment Due to Reemployment after Military Service

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

Genetic Testing

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. Additionally, genetic information or the request for such information will not be used to increase the rates or affect the terms or conditions of, or otherwise affect the coverage of a Member.

We will not release identifiable genetic information or the results of a genetic test without prior written

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authorization from the Member from whom the test results or genetic information was obtained to:

1. Any person who is not an employee of the Health Plan; or
2. A Plan Provider who is active in the Member's health care.

As used in this provision, genetic information shall include genetic information of:

1. A fetus carried by a Member or family member of a Member who is pregnant; and
2. An embryo legally held by a Member or family member of a Member utilizing an assisted reproductive technology.

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SECTION 2: How to Get the Care You Need

Please read the following information so that you will know from whom and what group of providers you may obtain health care.

When you join the Health Plan, you are selecting our medical care system to provide your medical care. You must receive your care 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. Approved Referrals, as described in this section under the ***Getting a Referral***, including referrals for Clinical Trials as described in ***Section 3: Benefits, Exclusions and Limitations***; and
4. Covered Services received in other Kaiser Permanente regions and Group Health Cooperative service areas.

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 with a Primary Care Plan Physician in one of our Plan Medical Centers 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 in our Network of Plan Providers, but not located in a Plan Medical Center, please 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).

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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).

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).

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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 Providers offer primary medical, pediatric and obstetric/gynecological (OB/GYN) care as well as specialty care areas such as general surgery, orthopedic surgery, dermatology and other medical specialties. If your Primary Care Plan Physician decides, in consultation with you, that you require covered Services from a Specialist, you will be referred to a Plan Provider in your Select[SM] care delivery system who is a Specialist that can provide the care you need.

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

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

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

If your Plan Provider decides that you require covered Services not available from us, he or she will refer you to a non-Plan Provider inside or outside our Service Area. You must have an approved referral to the non-Plan Provider in order for us to cover the Services.

Copayments, Coinsurance and Deductibles for approved referral Services provided by a non-Plan Provider are the same as those required for Services provided by a Plan Provider. When Prior Authorization is the

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responsibility of an in-network provider, any reduction or denial of benefits will not affect the enrollee.

Any additional radiology studies, laboratory services or services from any other professional not named in the referral are not authorized and will not be reimbursed. If the non-Plan Provider recommends Services not indicated in the approved referral, your Primary Care Plan Physician will work with you to determine whether those Services can be provided by a Plan Provider.

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 the following:

1. An initial consultation for treatment of mental illness, emotional disorders, and drug or alcohol misuse 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 Health Access Unit may be reached at 1-866-530-8778;
2. OB/GYN Services provided by an OB/GYN, a certified nurse-midwife or any other Plan Provider authorized to provide OB/GYN Services, including routine care and the ordering of related, covered obstetrical and gynecological Services; and
3. Optometry Services.

Although a referral or Prior Authorization is not required to receive care from these Providers, the Provider may have to get Prior Authorization for certain Services.

For the most up-to-date list of Plan Medical Centers and 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).

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.

If a Member has been diagnosed with cancer, the Health Plan will allow for the Member's primary care Plan Physician to issue a standing referral to any Health Plan-authorized oncologist or board-certified physician in pain management, as the Member chooses.

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-Physician Specialist with the professional training and expertise to treat or provide health care Services for the condition or disease; or

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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 referral to the non-Plan Specialist or Non-Physician Specialist in order for us to cover the Services. The Cost Share amounts for approved referral Services provided by non-Plan Providers are the same as those required for Services provided by a Plan Provider.

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.

Prior Authorization for Prescription Drugs
Requests for certain covered outpatient prescription drugs, supplies and supplements administered by medical personnel in an office setting may be subject to utilization management protocols, such as Prior Authorization or step therapy. A list of drugs subject to utilization management is available upon request.

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 Rider***, if applicable.

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

As described below, see ***Accepting Prior Authorization for Services*** in this section, 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.

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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.

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 think you have a medical emergency, 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 your Cost Sharing is not a fixed amount.

You will not be liable for an amount that exceeds the Allowable Charge as further described in this Agreement.

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.

Emergency Services, with respect to an Emergency Medical Condition, means:

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

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, Independent Freestanding Emergency Department, physician or ancillary provider for Emergency Services that were provided to you, simply 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. 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 to us at the following address:

Kaiser Permanente National Claims Administration - Mid-Atlantic States
PO Box 371860
Denver, CO 80237-9998

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

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

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.

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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.

Moving to Another Kaiser Permanente or Group Health Cooperative Service Area

If you move to another Kaiser Permanente or Group Health Cooperative service area, you may be able to transfer your Group membership if there is an arrangement with your Group in the new service area.

However, eligibility requirements, benefits, Premium, Copayments, Coinsurance and Deductibles may not be the same in the other service area. You should contact your Group's employee benefits coordinator before you move.

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 Deductibles shown in the ***Summary of Services and 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

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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

Wellness Programs

You may also participate in a wellness program to incentivize healthy activities ("Wellness Program"), which enables you to earn rewards for participating in health and wellness related activities that are designed to benefit you directly either by promoting physical, mental, or emotional wellness, healthy activity, or your general wellbeing.

The Wellness Program is free to participate in and does not require you to make any payment or exchange any item of value in order to participate and earn any available rewards. However, rewards are subject to a maximum cap on the number of rewards you can receive in a calendar year. Once you reach the maximum number of total rewards for the year, completing an activity will not earn a reward, however, to encourage you to continue to engage in healthy behaviors, you will continue to receive the same number of points as the activity would have earned as a reward. Points automatically are entered as entries in promotional contests of chance, also called drawings or promotions, for each additional activity you complete.

The Wellness Program may be available only to Members enrolled through certain groups or plans. Health Plan may engage a third party to act as the administrator of the drawings under applicable laws. This third party will ensure all details, such as drawing dates, are disclosed in official rules documents that are published on our website. This third party, and not the Health Plan, will be responsible for all aspects of these promotions. Additional conditions may apply to promotions, as explained by the administrator, including how to participate without internet access, including free alternate methods of entry, eligible activity periods, contact information, and winners lists. Participation in any promotion is always free and you are never required to make any purchase or provide any consideration, or exchange any item or thing of value, if you choose to voluntarily participate.

To learn about the Wellness Program, related rewards, and which ones are available to you, please check our website kp.org/rewards.

Neither the Wellness Programs nor any promotion accessible in connection with a Wellness Program is offered as an inducement to purchase a health care plan from us.

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) will apply toward your Out-of-Pocket Maximum.

If you receive more than one type of Service, 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

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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.

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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. 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 ***Summary of Services and 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.

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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
We cover Medically necessary dental services to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. Dental appliances required to diagnose or treat an accidental injury to the teeth, and the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face, are also covered. Coverage is provided when all of the following conditions have been met:

1. The accident has been reported to your primary care Plan Physician within seventy-two (72) hours of the accident.
2. A Plan Provider provides the restorative dental Services;
3. The injury occurred as the result of an external force that is defined as violent contact with an external object;
4. The injury was sustained to sound natural teeth;

Note: An injury that results from chewing or biting is not considered an Accidental Injury under this Plan.

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

For the purposes of this benefit, sound natural teeth are defined as a tooth or teeth that have not been:

1. Weakened by existing dental pathology such as decay or periodontal disease, or
2. Previously restored by a crown, inlay, onlay, porcelain restoration, or treatment by endodontics.

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. Services provided by non-Plan Providers.
2. Services for teeth that have been avulsed (knocked out) or that have been so severely damaged that, in the opinion of the Plan Provider, restoration is impossible.

Allergy Services

We cover the following allergy Services:

1. Evaluations and treatment; and
2. Injections and serum.

Ambulance Services

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

1. The basic life support, advanced life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer; or
2. The ambulance transportation has been ordered by a Plan Provider.

Coverage is also provided for Medically Necessary transportation or Services including Medically Necessary air ambulance transport to the nearest Hospital able to provide needed Services, rendered as the result of a 911 call. Your Cost Share will apply to each encounter, whether or not transport was required.

Cost Shares for Air Ambulance Services provided by a non-Plan Provider will not exceed that of the Cost Shares for Air Ambulance Services provided by a Plan Provider, and will apply toward your Deductible, if any, and Out-of-Pocket Maximum.

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

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

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

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. Except for select non-emergent transportation ordered by a Plan Provider, we do not cover transportation by car, taxi, bus, minivan and/or any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider.
2. Ambulette (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 who are age:

1. 7 or younger or are developmentally disabled and for whom a:
   a. Superior result can be expected from dental care provided under general anesthesia; and
   b. Successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition.
2. 17 or younger who are extremely uncooperative, fearful or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred, and for whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.
3. 17 and older when the Member's medical condition requires that dental Service be performed in a Hospital or ambulatory surgical center for the safety of the Member (e.g., heart disease and hemophilia).

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

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. The dentist or Specialist's dental Services.

Blood, Blood Products and their Administration

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

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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 and exclusion immediately below for additional information.

Benefit-Specific Limitation:

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

Benefit-Specific Exclusion:

1. Directed blood donations.

Chemical Dependency and Mental Health Services

We cover the treatment of treatable mental illnesses, emotional disorders, drug abuse and alcohol misuse 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 misuse" means a disease that is characterized by a pattern of pathological use of a drug and/or alcohol with repeated attempts to control its use and with significant negative consequences in at least one the following areas of life: medical; legal; financial; or psycho-social.

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

1. Individual therapy;
2. Group therapy;
3. Electroconvulsive Therapy (ECT);
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. Detoxification will be covered for a minimum of twelve (12) days annually.

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

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

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

1. Evaluations;
2. Crisis intervention;
3. Individual therapy;
4. Group therapy;

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5. Psychological testing;
6. Medical treatment for withdrawal symptoms; and
7. Visits for the purpose of monitoring drug therapy.

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

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

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

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

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

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the FDA; or

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

"Routine patient care costs" mean items, drugs and Services:

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

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

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

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:
Routine patient care costs shall not include:

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

Diabetic Equipment, Supplies, and Self-Management Training

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

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

Note: Insulin is covered under the ***Outpatient Prescription Drug Rider*** attached to this EOC, if applicable. If the Outpatient Prescription Drug Rider does not apply, insulin is covered under this benefit.

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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: Pursuant to IRS Notice 2019-45, coverage for glucose monitoring equipment is not subject to the Deductible. Refer to the Summary of Services and Cost Shares for applicable Cost Sharing requirements.

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

Benefit-Specific Limitations:
Diabetic equipment and supplies are limited to Health Plan preferred equipment and supplies unless the equipment or supply:

1. Was prescribed by a Plan Provider; and
2. There is no equivalent preferred equipment or supply available, or an equivalent preferred equipment or supply has been ineffective in treating the disease or condition of the Member or has caused or is likely to cause an adverse reaction or other harm to the Member.

Note: "Health Plan preferred equipment and supplies" are those purchased from a Plan preferred vendor. To obtain information about Plan preferred vendors, contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Dialysis

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

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

We cover the following renal dialysis Services:

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

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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 twenty-six (26) days of travel per calendar year. Prior Authorization is required.

Note: If you have ESRD, you may be eligible to enroll, at your option, in Original Medicare Part B. which can reduce costs for dialysis Services related to ESRD. Original Medicare Part B has a ninety (90)-day waiting period after dialysis begins and will not cover any costs until after the waiting period has been satisfied. Upon enrollment in Original Medicare Part B, we will directly reimburse you for your Original Medicare Part B premiums, should you opt-in to this benefit. We will continue to reimburse you for these premiums as long as you are covered under this Plan and eligible for and enrolled in Original Medicare Part B due to ESRD.

If you do not choose to enroll in Original Medicare Part B, the applicable Cost Share under this Plan will apply.

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 visits:

1. Oral, infused or injected drugs and radioactive materials used for therapeutic purposes including chemotherapy.
2. Injectable devices;
3. The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
4. Medical and surgical supplies including dressing, splints, casts, hypodermic needles, syringes or any other Medically Necessary supplies provided at the time of treatment; and
5. Vaccines and immunizations approved for use by the FDA that are not considered part of routine preventive care.

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

SAMPLE

and devices, if applicable.

Prior authorization or step-therapy may be required for covered prescription drugs or supplies, and supplements administered by medical personnel in an office Visit. A list of drugs subject to utilization management is available to you upon request. You may 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).

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. Drugs, supplies, and supplements which can be self-administered or do not require administration or observation by medical personnel.
2. Drugs for which a prescription is not required by law.
3. Drugs for the treatment of sexual dysfunction disorders.

Durable Medical Equipment

Durable Medical Equipment is defined as equipment that:

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

Durable Medical Equipment does not include coverage for Prosthetic Devices, such as implants, artificial eyes or legs, or Orthotic Devices, such as braces or therapeutic shoes. Refer to ***Prosthetic and Orthotic Devices*** for coverage of Prosthetic Devices and Orthotic Devices.

Basic Durable Medical Equipment

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

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

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

Supplemental Durable Medical Equipment

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

Oxygen and Equipment

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

SAMPLE

for oxygen and equipment.

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

Apnea Monitors
We cover apnea monitors for a period not to exceed six (6) months.

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

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

Note: Pursuant to IRS Notice 2019-45, coverage for peak-flow meters equipment is not subject to the Deductible. Refer to the ***Summary of Services and Cost Shares*** for applicable Cost Sharing requirements.

Bilirubin Lights
We cover bilirubin lights for infants for a period not to exceed six (6) months.

International Normalized Ratio (INR) Home Testing Machines
INR home testing machines when deemed Medically Necessary by a Plan Physician.
See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

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. Devices for testing blood or other body substances, except as covered under the ***Diabetes Equipment, Supplies and Self-Management Training*** benefit.
6. Electronic monitors of the heart or lungs, except infant apnea monitors, and oximetry monitors for patients on home ventilation.
7. Services not preauthorized by the Health Plan.

Emergency Services

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

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number listed on the reverse side of your ID card for immediate medical advice.

We cover Emergency Services as follows:

Inside our Service Area

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

Outside of our Service Area

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

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

Continuing Treatment Following Emergency Services

Inside our Service Area

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

Inside another Kaiser Permanente Region

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

Outside of our Service Area

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

Transport to a Service Area

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

Note: All ambulance transportation is covered under ***Ambulance Services***.

Continued Care in Non-Plan Facility Limitation

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

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after transfer would have been possible.

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 Services (screening and Stabilization), 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.

Filing Claims for Non-Plan Emergency Services
Keep all your receipts for Emergency Services provided by non-Plan Providers and verify that the non-

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Plan Provider has submitted the claims. All claims must be filed with us within six (6) months of the date of the Service, or as soon as reasonably possible in order to assure payment.

Bills for Emergency Services

If you are balance billed by a Hospital, Independent Freestanding Emergency Department, physician or ancillary provider for Emergency Services that were provided to you, simply mail 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 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

For more information on the payment or reimbursement of covered Services and how to file a claim, see ***Section 5: Filing Claims, Appeals and Grievances***.

Emergency Services HIV Screening Test

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

Covered Services include:

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

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

See the benefit-specific limitations immediately below for additional information.

Benefit-Specific Limitations:

1. **Notification:** If you receive care at a hospital emergency room or are admitted to a non-Plan Hospital, you, or someone on your behalf, must notify us as soon as possible, but not later than 48 hours or the next business day, whichever is later, of the emergency room Visit or Hospital admission, unless it was not reasonably possible to notify us. If you are admitted to a Hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. Once your emergency condition has been Stabilized, all continuing, and follow-up treatment must be authorized by us. If you do not notify us and obtain authorization for a continued Hospital stay once your condition has Stabilized, we will not cover Hospital charges you incur after transfer would have been possible.
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 out-of-Plan

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Emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside of 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. 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 devices, products and services, hormonal contraceptive methods, and the insertion or removal of contraceptive devices, including any Medically Necessary examination associated with the use of contraceptive drugs and devices, products and services; and
   c. Female sterilization;
   Note: WPS are preventive care and are covered at no charge.
2. Family planning counseling, including pre-abortion and post-abortion counseling;
3. Male sterilization (i.e., vasectomies); and
4. Voluntary termination of pregnancy, 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.

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

Habilitative Services

We cover Medically Necessary Habilitative Services, including speech therapy, occupational therapy and physical therapy, for Member's with a congenital or genetic birth defect, to enhance their ability to function. Medically Necessary Habilitative Services are those Services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment and shall include Services that enhance functional ability without effecting a cure. Congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. The term congenital or genetic birth defect includes:

1. Autism or an autism spectrum disorder; and
2. Cerebral palsy.

Medical Necessary Habilitative Services to treat autism and autism spectrum disorders shall include

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Applied Behavioral Analysis (ABA).

Note: Speech therapy includes Services necessary to improve or teach speech, language, or swallowing skills, which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment and will treat communication or swallowing difficulties to correct a speech impairment.

See the benefit-specific limitation and exclusions immediately below for additional information.

Benefit-Specific Limitation:
ABA Services are covered Services only if they are provided by an individual professionally certified by a national board of behavior analysts or performed under the supervision of an individual professionally certified by a national board of behavior analysts.

Benefit-Specific Exclusions:

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 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.
5. Services not provided by a licensed or certified therapist.

Hearing Services

Hearing Exams

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

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. Tests to determine an appropriate hearing aid.
2. Hearing aids or tests to determine their efficacy; except as specifically provided in this section, or as provided under a ***Hearing Services Rider***, if applicable.

Home Health Care

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

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

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

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of a registered nurse or medical doctor.

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

Home Health Visits Following Mastectomy or Removal of Testicle

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

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

See the benefit-specific limitation and exclusions immediately below for additional information.

Benefit-Specific Limitation:

1. Home Health Care Visits shall be limited to two (2) hours per Visit. Intermittent care shall not exceed three (3) Visits in one day. The Visit maximum does not apply to home Visits following mastectomy or testicle removal, or postpartum home Visits

Note: If a Visit lasts longer than two (2) hours, then each two (2)-hour increment counts as a separate Visit. For example, if a nurse comes to your home for three (3) hours and then leaves, that counts as two (2) Visits. Also, each person providing Services counts toward these Visit limits. For example, if a home health aide and a nurse are both at your home during the same two (2) hours that counts as two (2) Visits.

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

Benefit-Specific Exclusions:

1. Custodial care (see the definition under ***Exclusions*** in this section).
2. Routine administration of oral medications, eye drops and/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 not preauthorized by the Health Plan.
8. Care that a Plan Provider determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, and we provide or offer to provide that care in one of these facilities.
9. Transportation and delivery Service costs of Durable Medical Equipment, medications, 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 through home or inpatient care instead of traditional Services otherwise provided for your illness. We cover Hospice Care Services in the home if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

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

Hospice Care Services include the following:

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

Definitions:

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

Hospital Inpatient Care

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

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

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

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

Infertility and 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.

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, after an embryo transfer, provided 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.

Maternity Services

We cover pre-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.

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

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

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

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

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

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

Benefit-Specific Exclusions:

1. Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.
2. 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 nonresponsive to standard medical therapies;
3. Immunoglobulin E-and non-immunoglobulin E-mediated allergies to food proteins;
4. Food protein-induced enterocolitis 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

SAMPLE

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 and 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.

Morbid Obesity Services

We cover diagnosis and treatment of morbid obesity, including gastric bypass surgery or other surgical method, that is:

1. Recognized by the NIH as effective for long-term reversal of morbid obesity; and
2. Consistent with criteria approved by the NIH.

Morbid obesity is defined as:

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

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

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

Benefit-Specific Exclusion:

1. Services not preauthorized by the Health Plan.

Oral Surgery

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

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

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

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

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

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

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

Temporomandibular Joint Services

Coverage is provided for:

1. Orthognathic surgery, including inpatient and outpatient surgery to correct temporomandibular joint (TMJ) pain dysfunction syndrome and craniomandibular joint services, that are required because of a medical condition or injury that prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part;
2. Removable appliances for TMJ repositioning and
3. Therapeutic injections for TMJ.

The Health Plan provides coverage for cleft lip, cleft palate and ectodermal dysplasia under a separate benefit. Please see ***Cleft Lip, Cleft Palate or Both***.

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

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 routine preventive obstetrics/gynecology (OB/GYN) Services. (Refer to ***Preventive Health Care Services*** for coverage of preventive care Services);
2. Specialty care visits (Refer to ***Section 2: How to Get the Care You Need*** for information about referrals to Plan Specialists);

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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 in accordance with the most recent screening guidelines issued by the National Comprehensive Cancer Network:
        i. Persons age 50 or older and
        ii. Persons age 40 or older 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;

Note: Coverage for prostate cancer antigen (PSA) tests are not subject to any Cost Sharing requirements such as Deductibles, Copayment amounts or Coinsurance amounts.

    b. Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations. Your initial screening colonoscopy will be preventive;
    c. Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A "qualified individual" means an individual:
        i. Who is estrogen deficient individual at clinical risk for osteoporosis;
        ii. With a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
        iii. Receiving long-term glucocorticoid (steroid) therapy;
        iv. With primary hyperparathyroidism; or
        v. Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;
5. Outpatient surgery;
6. Anesthesia, including Services of an anesthesiologist;
7. Chemotherapy and radiation therapy;
8. Respiratory therapy;
9. Medical social Services;
10. House calls when care can best be provided in your home as determined by a Plan Provider;
11. After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to ***Urgent Care*** for covered Services; and
12. Equipment, supplies, complex decongestive therapy and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care professional

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legally authorized to prescribe or provide such items under law.

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

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

Preventive Health Care Services

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

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

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

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

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

1. Preventive care exams, including:
   a. Routine physical examinations and health screening tests appropriate to your age and sex;
   b. Well-woman examinations, including Visits to obtain necessary preventive care, and preconception care and prenatal care;
   c. Well childcare examinations;
2. Routine and necessary immunizations (travel immunizations are not preventive and are covered under ***Outpatient Care***) for children and adults in accordance with Plan guidelines. Childhood

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immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;

3. An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
4. Low dose screening mammograms, including 3-D mammograms to determine the presence of breast disease is covered as follows:
   a. One mammogram for persons age 35 through 39;
   b. One mammogram biennially for persons age 40 through 49; and
   c. One mammogram annually for person 50 or older;
5. 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.
6. Bone mass measurement to determine risk for osteoporosis;
7. Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to men 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.
8. Colorectal cancer screening in accordance with screening guidelines issued by the American Cancer Society including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy;
9. Cholesterol test (lipid profile);
10. Diabetes screening (fasting blood glucose test);
11. Sexually Transmitted Disease (STD) screening and counseling (including chlamydia, gonorrhea, syphilis and Human Papillomavirus (HPV), subject to the following:
    a. Annual chlamydia screening is covered for:
       i. Women under age 20 if they are sexually active; and
       ii. Women age 20 or older, and men of any age, who have multiple risk factors, which include:
          a) Prior history of sexually transmitted diseases;
          b) New or multiple sex partners;
          c) Inconsistent use of barrier contraceptives; or
          d) Cervical ectopy;
    b. Human Papillomavirus (HPV) testing as recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;
12. HIV screening and counseling;
13. TB tests;
14. Newborn hearing screenings that include follow up audiological examinations, as recommended by a physician or audiologist, and performed by a licensed audiologist to confirm the existence or absence of hearing loss when ordered by a Plan Provider;

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15. Associated preventive care radiological and laboratory tests not listed above;
16. BRCA counseling and genetic testing is covered at no Cost Share. Any follow up Medically Necessary treatment is covered at the applicable Cost Share based upon type and place of Service.; and
17. CT scan of the Thorax when ordered as a preventive for smokers age 55 to 80 years of age.

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 laboratory test for people with heart disease
4. INR laboratory test for liver failure and bleeding disorders

Note: Refer to ***Diabetes Treatment, Equipment and Supplies*** for coverage of glucose monitoring equipment.

Note: Refer to ***Durable Medical Equipment*** for coverage of peak flow meters.

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

See the benefit-specific limitations immediately below for additional information.

Benefit-Specific Limitations:
While treatment may be provided in the following situations, the following services are not considered Preventive Health Care Services. The applicable Cost Share will apply:

1. Monitoring chronic disease.
2. Follow-up Services after you have been diagnosed with a disease.
3. Testing and diagnosis for specific diseases for which you have been determined to be at high risk for contracting, based on factors determined by national standards.
4. Services provided when you show signs or symptoms of a specific disease or disease process.
5. Non-routine gynecological visits.

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, misuse or theft), and Services to determine whether you need the Prosthetic Device. If we do not cover the Prosthetic Device, we will try to help you find facilities where you may obtain what you need at a reasonable price. Coverage is limited to the standard device that adequately meets your medical needs.

Internal Prosthetics
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***) and cochlear implants, that are approved by the federal Food and Drug Administration for

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general use.

External Prosthetic & Orthotic Devices

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

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

Artificial Arms, Legs or Eyes

We cover the following when prescribed by a Plan Provider and your medical condition meets Health Plan's criteria for being Medically Necessary:

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

Ostomy and Urological Supplies and Equipment

We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets the Health Plan's criteria for medical necessity. Covered equipment and supplies include, but are not limited to:

1. Flanges;
2. Collection bags;
3. Clamps;
4. Irrigation devices;
5. Sanitizing products;
6. Ostomy rings;
7. Ostomy belts; and
8. Catheters used for drainage of urostomies.

Breast Prosthetics and Hair Prosthesis

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

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

See the benefit-specific limitations and exclusions immediately below for additional information.

Benefit-Specific Limitations:

1. Coverage for mastectomy bras is limited to a maximum of four (4) per calendar year.

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2. Coverage for hair prosthesis is limited to one (1) prosthesis per course of chemotherapy and/or radiation therapy, not to exceed a maximum benefit of $350 per prosthesis.
3. Standard Devices: Coverage is limited to standard devices that adequately meet your medical needs.
4. Therapeutic shoes and inserts are covered when deemed Medically Necessary.

Benefit-Specific Exclusions:

1. Services not preauthorized by Health Plan.
2. Internally implanted breast prosthesis for cosmetic purposes.
3. Repair or replacement of prosthetic devices due to loss, misuse or theft.
4. Microprocessor and robotic-controlled external prosthetics that do not meet the Health Plan criteria as Medically Necessary.
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 the Oral surgery section, or as provided under an ***Adult Dental Plan Rider*** or a ***Pediatric Dental Plan Rider***, if applicable.
8. Hearing aids, except as specifically provided in this section, or as provided under a ***Hearing Services Rider***, if applicable.
9. Corrective lenses and eyeglasses, except as specifically provided in this section.
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.
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; and
3. Treat congenital hemangioma known as port wine stains on the face.

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

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

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

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.

Benefit-Specific Exclusion:

1. Routine foot care Services that are not Medically Necessary.

Skilled Nursing Facility Care

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

We cover the following Services:

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

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

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

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. Custodial care (see the definition under ***Exclusions*** 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. Not all

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medical services are conducive to telemedicine, as such the provider will make a determination whether the member should instead be seen in a face-to-face medical office setting.

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

Benefit-Specific Exclusion:

1. Services delivered through electronic mail messages, or facsimile transmissions.

Therapy and Rehabilitation Services

Physical, Occupational, and Speech Therapy Services

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

1. In a Plan Medical Center;
2. In a Plan Provider's medical office;
3. In a Skilled Nursing Facility or as part of home health care per calendar year per injury, incident or condition: or
4. Via Video Visits; or
5. While confined in a Plan Hospital.

Refer to the ***Summary of Services and Cost Shares*** for visit limitations for Physical, Occupational, and Speech Therapy Services. The limits do not apply to necessary treatment of cleft lip or cleft palate.

Note: Speech therapy includes Services necessary to improve or teach speech, language, or swallowing skills, which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment and will treat communication or swallowing difficulties to correct a speech impairment.

Multidisciplinary Rehabilitation Services

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

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

Cardiac Rehabilitation Services

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

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

Pulmonary Rehabilitation Services

We cover pulmonary rehabilitation Services that are Medically Necessary.

See the benefit-specific limitations and exclusion immediately below for additional information.

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Benefit-Specific Limitations:

1. Physical therapy is limited to treatment to restore physical function that was lost due to injury or illness. It is not covered to develop physical function, except as provided for under ***Habilitative Services*** in this ***List of Benefits***.
2. Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
3. The limitations listed above for physical, occupational and speech therapy also apply to those Services when provided within a multidisciplinary program.

Benefit-Specific Exclusion:

1. Long-term rehabilitative therapy.

Therapy: Radiation, Chemotherapy and Infusion Therapy

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

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

Coverage is also provided for oral chemotherapy drugs. For additional information on this benefit, see ***Drugs, Supplies and Supplements*** in this ***List of Benefits***.

Transplants

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

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

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

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

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

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

Benefit-Specific Exclusion:

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

Urgent Care

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

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

Inside our Service Area

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

If you require Urgent Care Services, please call your Primary Care Plan Provider as follows:

If your Primary Care Plan Physician is located at a Plan Medical Center, please contact us at 1-800-777-7902 or 711 (TTY).

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

Outside of our Service Area

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

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

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

Benefit-Specific Limitation:

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

Benefit-Specific Exclusion:

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

Vision Services

Medical Treatment

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

Eye Exams

We cover routine and necessary eye exams, including:

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

Pediatric Eye Exams

We cover the following for children until the end of the month in which the child turns age 19:

1. One (1) routine eye exam per year, including:
   a. Routine tests such as eye health and glaucoma tests; and
   b. Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.

Pediatric Lenses and Frames

We cover the following for children, until the end of the month in which the child turns age 19, at no charge:

1. One (1) pair of lenses per year;
2. One (1) pair of frames per year from a select group of frames;
3. Regular contact lenses (in lieu of lenses and frames) for the first regular supply for that contact lens per year; or
4. Medically Necessary contact lenses up to two (2) pair per eye per year.

In addition, we cover the following Services:

Eyeglass Lenses

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

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

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Contact Lenses

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

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

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

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

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

X-Ray, Laboratory and Special Procedures

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

1. Diagnostic imaging; including x-ray, diagnostic mammograms and ultrasounds;
2. Laboratory tests, including tests for specific genetic disorders such as preimplantation genetic testing (PGT), Monogenic/single gene defects (PGT-M) or inherited structural chromosome rearrangements (PGT-SR) for which genetic counseling is available;
3. Special procedures, such as:
   a Electrocardiograms, and
   b Electroencephalograms.

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4. Sleep lab and sleep studies; and
5. Specialty imaging: including CT, MRI, PET Scans, and diagnostic Nuclear Medicine studies; and interventional radiology.

Note: Routine screening mammograms are covered, but not under this provision (see ***Preventive Health Care Services)***

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 direct complications of the non-covered Service.

For example, if you have a non-covered cosmetic surgery, we would 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 would 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. **Alternative Medical Services:** Chiropractic and acupuncture Services and any other Services of a Chiropractor, Acupuncturist, Naturopath and/or Massage Therapist, unless otherwise covered under a Rider attached to this EOC.
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
   c. On court-order or required for parole or probation.
3. **Cosmetic Services:** Cosmetic Services, including surgery or related Services and other Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies. Examples of cosmetic Services include but are not limited to cosmetic dermatology, cosmetic surgical Services and cosmetic dental Services.
4. **Custodial Care:** Custodial care means assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.
5. **Dental Care:** Dental care and dental X-rays, including dental appliances, dental implants, orthodontia, shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and dental Services resulting from medical treatment such as surgery on the jawbone

SAMPLE

and radiation treatment, unless otherwise covered under a Rider attached to this EOC. This exclusion does not apply to Medically Necessary dental care covered under ***Accidental Dental Injury Services***, ***Cleft Lip, Cleft Palate or Both*** or ***Oral Surgery*** in the ***List of Benefits*** in this section.

6. **Disposable Supplies:** Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices, not specifically listed as covered in the ***List of Benefits*** in this section.
7. **Durable Medical Equipment:** Except for Services covered under ***Durable Medical Equipment*** in the ***List of Benefits*** in this section.
8. **Employer or Government Responsibility:** Financial responsibility for Services that an employer or government agency is required by law to provide.
9. **Experimental or Investigational Services:** Except as covered under ***Clinical Trials*** in the ***List of Benefits*** in this section, a Service is experimental or investigational for your condition if any of the following statements apply to it as of the time the Service is, or will be, provided to you:
   a. It cannot be legally marketed in the United States without the approval of the United States Food and Drug Administration (FDA), and such approval has not been granted; or
   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 making determinations whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:
   a. Your medical records;
   b. 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. Files and records of the IRB or a similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;
   e. 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.

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

10. **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.
11. **Services for Members in the Custody of Law Enforcement Officers:** Non-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as Out-of-Plan Emergency Services.
12. **Travel and Lodging Expenses:** Travel and lodging expenses., except that in some situations, if a Plan Physician refers you to a non-Plan Provider outside our Service Area as described under ***Getting a Referral*** in ***Section 2: How to Get the Care You Need***, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines.
13. **Vision Services:** Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia or astigmatism (for example: radial keratotomy, photo-refractive keratectomy and similar procedures.
14. **Worker's Compensation or Employer's Liability:** Charges made for the following are not covered by the Health Plan: 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 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.

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.

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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.

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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 of other types of health benefit coverage. This section provides information on these types of situations, and what to do when you encounter them.

Subrogation

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 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.

Reductions

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 there is duplicative coverage for your dependent under a primary health benefit plan purchased by your Spouse, 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 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 the 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, Maryland 20785

When notifying us, please include the third party's liability insurance company name, policy and claim

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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 you 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.

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Workers' Compensation or Employer's Liability

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

The Recovery Rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily injury or illness was sustained in the course of or resulted from your employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation Carrier;
- 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 the Health Plan of any Workers' Compensation claim you make, and that you agree to reimburse The 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, the Health Plan has a right to recover from you or your covered dependent an amount equal to the amount The 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, Maryland 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 you 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 covered Member.

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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 to tell anyone, or obtain consent from any person to do this.

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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.

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.

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Rules for a Dependent Child/Parent

1. **Dependent child with parents who are not separated:** When the Health Plan and another plan cover the same child as a Dependent of different persons, called "parents," who are married or are living together, whether or not they have ever been married, 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:** If two (2) or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   a. First, the Plan of the parent with custody of the child;
   b. Then, the Plan of the spouse of the parent with custody of the child; and
   c. Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the Plan obligated to pay or provide the benefits of that parent has actual knowledge of those terms, that Plan is primary. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payer has that actual knowledge.

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).

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

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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 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.

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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

Please see the ***Important Terms You Should Know*** section for an explanation of important, capitalized terms used within this section.

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.

Procedure for Making a Claim and Initial Claim Decisions

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

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

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

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Procedure for Making a Non-Urgent Pre-Service Claim

1. Tell Member Services that you want to make a claim for the Health Plan to provide or pay for a Service you have not yet received. Your written or oral request and any related documents you give us constitute your claim. You may write or call us at the address and number listed above.
2. We will review your claim, and if we have all the information, we need we will send you a written decision within fifteen (15) days after we receive your claim.
   If we tell you we need more time because of circumstances beyond our control, we may take an additional fifteen (15) days to send you our written decision. If we cannot make a decision because we do not have all the information we need, we will ask you for more information within fifteen (15) days of receipt of your claim.

   You will have forty-five (45) days to send us the requested information. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. We will send you our written decision within fifteen (15) days after receipt of the

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

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

Expedited Procedure for an Urgent Medical Condition

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

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

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

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

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.

When you or your Authorized Representative sends an Appeal, you or your Authorized Representative may also request simultaneous external review of our initial adverse decision. If you or your Authorized Representative wants simultaneous external review, your or your Authorized Representative's Appeal must tell us this. You will be eligible for the simultaneous external review only if your Pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your Appeal, 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*** provision for additional information about filing an external Appeal.

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.

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.

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

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

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

   You will have forty-five (45) days to send us the requested information. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. We will send you our written decision within fifteen (15) days after receipt of the requested information. If we do not receive any of the requested information (including documents) within forty-five (45) days after our request, we will make a decision based on the information we have and send you a written decision within fifteen (15) days after the end of the forty-five (45) days.
2. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can appeal.
3. If we deny your claim or if we do not agree to continue approval of all the Services you requested, we will tell you in writing why we denied your claim and how you can appeal.

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

1. At least twenty-four (24) hours before the expiration of the Services or before your shortened course of care ends, you should call or write Member Services to notify them that you have an Urgent Medical Condition, or your course of treatment has been terminated early and that you want to continue your course of care. Your written or oral request and any related document you give us constitute your claim. Call or write Member Service at the address and telephone numbers listed above.
2. If you filed a request for additional services at least twenty-four (24) hours before the end of an approved course of treatment, you may continue to receive those services during the time your claim is under consideration. If your claim is then denied, you will be financially responsible for the entire cost of those services. Otherwise, if your request for additional services was not timely filed, the Health Plan will decide your request for review within a reasonable period of time appropriate to the circumstances but, in no event, later than thirty (30) calendar days from the date on which the claim was received.
3. If we determine your claim does not involve an Urgent Medical Condition, we may treat your claim as non-urgent Concurrent Care Claim.
4. We will review your claim and notify you of our decision orally or in writing within twenty-four (24) hours after we receive your claim. If we notify you orally, we will send you a written decision within three (3) days (two (2) business days if an Adverse Decision could result) after that.

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5. If we deny your claim or if we do not agree to continue approval of all the Services you requested, we will tell you in writing why we denied your claim and how you can appeal.
6. When you or your Authorized Representative sends the Appeal, you or your Authorized Representative may also request simultaneous external review of our adverse decision. If you want simultaneous external review, your or your Authorized Representative's Appeal must tell us this. You or your Authorized Representative will be eligible for the simultaneous external review only if your Concurrent Care Claim qualifies as urgent. If you or your Authorized Representative do not request simultaneous external review in the Appeal, then you or your Authorized Representative may be able to request external review after we make our decision regarding the Appeal. See the ***External Appeal Procedures*** provision for additional information about filing an external Appeal.

Filing for Payment or Reimbursement of a Covered Service and Post-Service Claims

Post-service claims are requests for payment for Services you already received, including claims for Emergency Services and Urgent Care Services rendered outside our Service Area. If you have any questions about post-service claims or Appeals, please 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).

Procedure for Making a Post-Service Claim

Claims for Emergency Services or Urgent Care Services rendered outside our Service Area or other Services received from non-Plan Providers should be filed on forms provided by the Health Plan or electronically by visiting kp.org. Paper forms may also be obtained by visiting kp.org or contacting the Member Services Contact Center Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

If you are unable to access the electronic form (or obtain the paper form), a claim can be submitted by mailing the minimum amount of information we need to process claim:

- Member/Patient Name and Medical/Health Record Number
- The date you received the Services
- Where you received the Services
- The physician or other health care provider who provided the Services
- Why you think we should pay for the Services
- A copy of the bill, your medical record(s) for these Services, and your receipt if you paid for the Services.

Notice of Claims

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible.

When you must file a claim for services inside or outside of the Plan's service area, please submit claims to the following address:

Kaiser Permanente
National Claims Administration - Mid-Atlantic States
Attention: Claims Department
P.O. Box 371860

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Claim Forms

Upon receipt of a notice of claim, we will furnish to the claimant such forms as are usually furnished by us for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of notice, the claimant shall be deemed to have complied with the requirements of this Agreement as to proof of loss upon submitting, within the time fixed in the contract for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Please note that you are not required to use a claim form to notify us of a claim. When you receive an itemized bill from a hospital, physician, or ancillary provider not contracting with us, you may forward that bill directly to us for processing. Simply indicate the medical record number of the patient on the bill and submit it directly to us.

Proof of Loss

You must send the completed claim form to us at the address listed on the claim form within one-hundred eighty (180) days, or as soon as reasonably possible after the Services are rendered. Failure to submit such a request within one-hundred eighty (180) days will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

You should attach itemized bills along with receipts if you have paid the bills. Incomplete claim forms will be returned to you. This will delay any payments which may be owed to you. Also, you must complete and submit to us any documents that we may reasonably need for processing your claim or obtaining payment from insurance companies or other payors.

Time of Payment of Claims

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

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 is 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.

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

Physical Examination and Autopsy

The Health Plan, at its own expense, shall have the right and opportunity to examine a Member when and

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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.

Internal Appeal Procedures

The Appeal procedures are designed by the Health Plan to assure that Member concerns are fairly and properly heard and resolved.

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

You or your Authorized Representative may request an informal or formal 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).

The Health Plan will also process for you or your Authorized Representative, or the prescribing physician (or other prescriber) to request a standard review of a decision that a drug is not covered by the plan.

In addition, you or your Authorized Representative, as applicable, may review (without charge) the information on which the Health Plan made its decision. You may also send additional information including comments, documents or additional medical records supporting your claim.

Additional information may be sent to:

Kaiser Permanente
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Rd NE
Atlanta, GA 30305
(404) 909-5001 (FAX)

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

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

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

Member Service Representatives are available by telephone each day during business hours to describe to

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Members how Appeals are processed and resolved and to assist the Member with filing an Appeal. The Member Service Representative can be contacted Monday through Friday between 7:30 p.m. to 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902, if calling within the local area, or 711 (TTY).

Informal Review

1. **Step 1 - Telephone number:** If you do not agree with an Adverse Decision, you may request the opportunity to discuss and review the decision with appropriate clinical staff. When requesting an informal review, the Member must include a telephone number where he/she may be contacted to discuss the case.
2. **Step 2** – **Sufficient Information:** Before accepting a request for an informal review, the Health Plan will determine if it has sufficient information readily available to reach a decision within the required time frame. If additional information is needed, the Health Plan will notify the Member to immediately proceed to initiate a formal Appeal.
3. **Step 3** – **Discussion:** All requests for informal reviews will be acted upon immediately. The Health Plan may have to contact the Member by telephone to discuss and review the Adverse Decision. When relevant, the Health Plan may arrange for you or your Authorized Representative to discuss the adverse decision with appropriate clinical staff.
4. **Step 4 – Decision:** The Health Plan must conclude the informal review as soon as possible, but no later than fourteen (14) business days after the request for an informal review was filed. The Health Plan will provide a written explanation of the review decision to the Member or Member's Representative within five (5) business days from the date of the decision.

In the case of an adverse Appeal Decision, the written explanation shall inform the Member or Member's Representative of the right to request a formal Appeal of the informal review decision.

Formal Appeal

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

Initiating a Formal Appeal

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

Kaiser Permanente
Member Relations
Nine Piedmont Center
3495 Piedmont Rd NE
Atlanta, GA 30305
(404) 949-5001 (FAX)

The Appeal must be filed in writing within one-hundred eighty (180) days from the date of receipt of the original denial notice**.**

If the Appeal is filed after the one-hundred eighty (180) days, the Health Plan will send a letter denying any further review due to lack of timely filing.

Each request for a formal Appeal will be acknowledged by the Health Plan, in writing, within ten (10)

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business days of receipt.

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

1. Notify the Member that it cannot proceed with reviewing the Appeal unless additional information is provided;
2. Specify all additional information required to be filed; and
3. Assist in gathering the necessary information without further delay.

Appeal Review

Each formal Appeal will be reviewed by a health care professional selected by the Health Plan based upon the specific issued presented in the Appeal, and who was not involved in the initial Adverse Decision.

If the review requires medical expertise, the reviewer or panel will include at least one medical reviewer in the same specialty as the matter at issue.

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

Formal Appeal Decisions

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

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

Extension of Review Period

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

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) or faxing the request to (404) 949-5001.

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

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

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by telephone or facsimile.

Expedited Appeal Decisions

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

Notification of Adverse Appeal Decisions

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

1. The specific factual basis for the decision in clear understandable language;
2. References to any specific criteria or standards including interpretive guidelines on which the decision was based (including reference to the specific plan provisions on which determination was based);
3. A statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge, upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request. In addition, you or your Authorized Representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of your or your Authorized Representative's claim.
4. All pertinent instruction, including the telephone numbers and titles of persons to contact, any forms required to initiate an external review, and applicable time frames to request a formal external review of the decision; and
5. A statement of your rights under section 502(a) of ERISA, if applicable.
6. If we send you a notice of an adverse decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least 10 percent of the population is literate only in the same federally mandated non-English language. You or your Authorized Representative may request translation of the notice by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

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 four (4) months after the decision.

If you are dissatisfied with the resolution reached through the Health Plan's internal Grievance system regarding medical necessity, you may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

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For Medical Necessity Cases:
Office of t Health Care Ombudsman and Bill of Rights
One Judiciary Square
441 4th Street N.W., 250 North
Washington, D.C. 20001
Phone: 202-724-7491
Toll Free: 1-877-685-6391
General Fax; 202-442-6724
Confidential Fax: 202-478-1397
E-mail: healthcareombudsman@dc.gov

Website: healthcareombudsman.dc.gov

If you are dissatisfied with the resolution reached through the Health Plan's internal Grievance system regarding all other grievances, you may contact the Commissioner at the following:

For Non-Medical Necessity Cases:
Commissioner
Department of Insurance, Securities and Banking
1050 First Street, N.E., Suite 801
Washington, D.C. 20002
Phone: 202-727-8000
Fax: 202-354-1085
E-mail: disb@dc.gov

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 of Insurance at any time, except in the following circumstances:

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

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SECTION 6: Termination of 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.

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.

Termination Due to Loss of Eligibility

If you meet the eligibility requirements, described under ***Eligibility for This Plan*** **in** ***Section 1: Introduction to Your Kaiser Permanente Health Plan***, on the 1st day of a month; but later in that month you no longer meet those eligibility requirements then your membership terminates on the last day of that month unless your Group has an agreement with us to terminate at a time other than on the last day of the month. Please check with your Group's benefits administrator to confirm your termination date.

Termination of Group Agreement

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

Termination Due to Change of Residence

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

Termination for Cause

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

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

Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Premium from

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your Group. If your Group fails to pay us the appropriate Premium for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

Extension of Benefits

In those instances when your coverage with us has terminated, we will extend benefits for covered services, subject to Premium payment, in the following instances:

1. If:
   a. You become Totally Disabled while enrolled under this EOC; and
   b. You remain so at the time your coverage ends;

   Then we will continue to provide benefits for covered services related to the condition causing the disability.

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

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

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

   Whichever comes first.

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

Limitations to Extension of Benefits

The ***Extension of Benefits*** provision listed above does not apply to the following:

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

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'

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prior written notice to the Subscriber. If we discontinue offering all products to groups in a market, we will give one hundred-eighty (180) days' prior written notice to the Subscriber.

Continuation of Coverage Under Federal Law

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Coverage Available Upon Termination

For information about non-group plans available through us with no waiting period or pre-existing condition limitations, visit our Website at: **www.kp.org** 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).

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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.

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.

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. Eastern Standard Time (EST) 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,

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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

Except as preempted by federal law, this EOC will be covered in accordance with the law of the District of Columbia. Any provision in this policy that is in conflict with the requirements of any federal or state laws that apply to this policy are automatically changed to satisfy the minimum requirements of such laws.

Legal Action

No legal action may 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. Eastern Standard Time (EST) 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

Notice of Non-Grandfathered Group Plan

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. believes that your Plan is a grandfathered health plan" non-grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA).

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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. Eastern Standard Time (EST) 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**.

Surrogacy Arrangements

A surrogacy/gestational carrier 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).

SAMPLE

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:

1. Names, addresses, and telephone numbers of the other parties to the arrangement;
2. Names, addresses, and telephone numbers of any escrow agent or trustee;
3. 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;
4. A signed copy of any contracts and other documents explaining the arrangement; and
5. Any other information we request in order to satisfy our rights.

SAMPLE

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

Kaiser Permanente
District of Columbia Large Group 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

Adverse Decision: Any determination by Health Plan that:

1. An admission, availability of care, continued stay, or other Service is or is not a covered benefit; or if it is a covered benefit, that such service has been reviewed and does not meet the Health Plan's requirements for medical necessity, appropriateness, health care settings, level of care or effectiveness, and therefore payment is not provided or made by Health Plan, for the service, thereby making the Member responsible in whole, or in part; or
2. Cancels or terminates a Member's membership retroactively for a reason other than a failure to pay premiums or contributions toward the cost of coverage.

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:

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 "Pharmacy Services" 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 that:
    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.

SAMPLE

Non-Plan Providers: The Allowable Charge shall not be less than the out-of-network amount the Health Plan must pay pursuant to §19-710.1 of the Health General Article of the Annotated Code of Maryland, when such statutory provision (state law) is applicable.

Allowable Expense: 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. Allowable Expense does not include coverage for dental care except as provided under ***Accidental Dental Injury Services*** in ***Section 3: Benefits, Exclusions and Limitations***.

Ancillary Service: Services that are:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner
- Items and services provided by assistant surgeons, hospitalists, and intensivists
- Diagnostic services, including radiology and laboratory services
- 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.

Applied Behavioral Analysis (ABA): The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior; including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

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

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

C

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 the ***Coordination of Benefits*** provision in ***Section 4: Subrogation, Reductions and Coordination of Benefits*** or a similar

SAMPLE

provision takes effect.

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

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

1. Expire, or
2. Be shortened.

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

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.

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

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

D

Deductible: The Deductible is an amount of Allowable Charges you must incur during a contract year for certain covered Services before we will provide benefits for those Services. Please refer to the ***Summary of Services and Cost Shares*** section of the Appendix, for the Services that are subject to Deductible and the amount of the Deductible.

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

Diabetes Device: A legend device or non-legend device used to cure, diagnose, mitigate, prevent or treat diabetes or low blood sugar. This includes a blood glucose test strip, glucometer, continuous glucometer, lancet, lancing device, or insulin syringe.

Diabetic Ketoacidosis Device: A device that is a legend or non-legend device ad used to screen for or prevent diabetic ketoacidosis. The term includes diabetic ketoacidosis devices prescribed and dispensed once during a policy year.

SAMPLE

E

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

Emergency Services: with respect to an Emergency Medical Condition, means:

1. An appropriate medical screening examination (as required federal Emergency Medical Treatment and Active Labor Act (section 1867 of the Social Security Act) ("EMTALA")) 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 this paragraph 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 this paragraph 3, as determined by the attending emergency physician or Treating Provider using

SAMPLE

appropriate medical judgment, and to provide informed consent in accordance with applicable State law.

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

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

H

Habilitative Services: Services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, and shall include Services that enhance functional ability without effecting a cure.

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

Health Savings Account (HSA): 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 HSA 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, you must be covered under a qualified High-Deductible Health Plan (HDHP) and meet other tax law requirements. Kaiser Permanente does not provide tax advice. Consult with your financial or tax advisor for more information about your eligibility for a HSA.

High-Deductible Health Plan (HDHP): A health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. The health care coverage under this Agreement has been designed to be an HDHP qualified for use with a Health Savings Account (HSA).

Hospice Care Services: A coordinated, inter-disciplinary program of Hospice Care Services for meeting the special physical, psychological, spiritual and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing and other health Services through home or inpatient care during the illness and bereavement to:

1. Individuals who have no reasonable prospect of cure as estimated by a physician; and
2. Family Members and Caregivers of those individuals.

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

SAMPLE

Emergency Services.

K

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

L

Legal Partner/Legal Partnership: Any same-sex relationship, other than marriage, that is recognized as valid by any other jurisdiction, such as civil union.

M

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

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

1. Medically required to prevent, diagnose or treat your condition or clinical symptoms;
2. In accordance with generally accepted standards of medical practice;
3. Not solely for the convenience of you, your family and /or your provider; and
4. The most appropriate level of Service which can safely be provided to you. The fact that a physician may prescribe, authorize, or direct a Service does not of itself make it Medically Necessary or covered by the Group policy. For purposes of this definition, "generally accepted standards of medical practice" means:

a. Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
b. Physician specialty society recommendations;
c. The view of physicians practicing in the Kaiser Permanente Medical Care Program; and/or
d. Any other relevant factors reasonably determined by us. Unless otherwise required by law, we decide if a Service (described in ***Section 3: Benefits, Exclusions and Limitations***) is Medically Necessary and our decision is final and conclusive subject to your right to appeal as set forth in ***Section 5: Filing Claims, Appeals and Grievances***.

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

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

N

Non-Physician Specialist: A health care provider who:

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

O

Orthotic Device: An appliance or apparatus used to support, align, prevent or correct deformities, or to

SAMPLE

improve the function of movable parts of the body.

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

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

Plan: Kaiser Permanente.

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. Personal injury protection under a motor vehicle insurance policy;
8. Medicare supplement policies;
9. A state plan under Medicaid; or
10. 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, a Plan Provider's medical office, a Plan Provider's facility, or a Plan Hospital.

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

Plan Medical Center: Medical office and specialty care facilities such as imaging center**s** 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.

SAMPLE

Plan Physician: Any licensed physician who is an employee of Medical Group, or any licensed physician who contracts with us to provide Services and supplies to Members.

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

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

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.

Pre-Service Claim: A request that the Health Plan provide or pay for a Service for which coverage is conditioned on Health Plan approving payment for the Service before you receive that Service.

Primary Care: Services rendered by a Health Care Practitioner in the following disciplines:

1. General internal medicine;
2. Family practice medicine;

Pediatrics; or 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.

Premium: Periodic membership charges paid by Group.

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

R

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

S

Self-Only Coverage: Coverage for a Subscriber only, with no Dependents covered under this plan.

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

SAMPLE

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

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 board-eligible or board-certified.

Spouse: A person of the same or opposite sex who is legally married to the insured under the laws of the state or jurisdiction in which the marriage took place.

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

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber. For Subscriber eligibility requirements, see the ***Eligibility for This Plan*** provision in ***Section 1: Introduction to your Kaiser Permanente Health Plan***.

T

Totally Disabled:

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

For Dependent Children: In the judgment of a Medical Group Physician, an illness or injury which makes the child unable to substantially engage in any of the normal activities of children in good health and like age. **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 medical condition for which care has not been rendered, and which if not treated within twenty-four (24) hours:

1. Could reasonably be expected to result in:
    a. Placing your life or health in serious jeopardy;

SAMPLE

b. Serious impairment to bodily function; or
c. Serious dysfunction of any bodily organ or part; or

2. Would, in the opinion of a physician with knowledge of your medical condition, subject the Member to severe pain that cannot be adequately managed without the Services which are the subject of the claim.

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.

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Kaiser Foundation Health Plan of
the Mid-Atlantic States, Inc.
4000 Garden City Drive
Hyattsville, Maryland 20785

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