guide to
YOUR 2026 BENEFITS AND SERVICES

SAMPLE

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

SMALL GROUP EVIDENCE OF COVERAGE

DISTRICT OF COLUMBIA

SIGNATURE 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

KFHP-EOC COVER (01-23)DC

DHMO

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.

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

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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.

SAMPLE

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.

SAMPLE

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.

SAMPLE

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).

SAMPLE

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**).

SAMPLE

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**).

SAMPLE

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**).

SAMPLE

Kaiser Permanente
Small Group Agreement and Evidence of Coverage
District of Columbia

Table of Contents

SECTION 1 – INTRODUCTION TO YOUR KAISER PERMANENTE HEALTH PLAN	**1.1**
Welcome to Kaiser Permanente	1.1
Our Commitment to Diversity and Nondiscrimination	1.1
About This Group Agreement	1.1
How Your Health Plan Works	1.2
Kaiser Permanente Signature℠	1.3
Eligibility for this Plan	1.3
Disabled Dependent Certification	1.5
Member Rights and Responsibilities: Our Commitment to Each Other	1.5
Health Savings Account-Qualified Plans	1.8
Payment of Premium	1.8
Payment of Copayments, Coinsurance and Deductibles	1.8
Enrollment Period and Effective Date of Coverage	1.9
Special Enrollment Due to a Triggering Event	1.11
Special Enrollment Due to Reemployment After Military Service	1.13
Genetic Testing	1.13
SECTION 2 – HOW TO GET THE CARE YOU NEED	**2.1**
Making and Cancelling Appointments and Who to Contact	2.1
Advance Directives to Direct Your Care While Incapacitated	2.2
Receiving Health Care Services	2.2
Your Kaiser Permanente Identification Card	2.3
Choosing Your Primary Care Plan Physician	2.3
Getting a Referral	2.4
Continuity of Care for Members	2.5
Continuity of Care for New Members	2.6
Getting Emergency and Urgent Care Services	2.6
Hospital Admissions	2.8
Getting Assistance from Our Advice Nurses	2.8
Getting a Second Opinion	2.8
Receiving Care in Another Kaiser Foundation Health Plan Service Area	2.8
Moving to Another Kaiser Permanente or Group Health Cooperative Service Area	2.9
Extra Services	2.9
Wellness Programs	2.10
Payment Toward Your Cost Share and When You May Be Billed	2.10
SECTION 3 – BENEFITS, EXCLUSIONS AND LIMITATIONS	**3.1**
Your Benefits	3.1
Out-of-Pocket Maximums	3.1
List of Benefits	3.2
Exclusions	3.34

SAMPLE

Limitations 3.37

SECTION 4 – SUBROGATION, REDUCTIONS AND COORDINATION OF BENEFITS 4.1

Subrogation and Reductions, Explained 4.1
When Illness or Injury is Caused by a Third Party 4.1
Failure to Notify the Health Plan of Responsible Parties 4.3
Pursuit of Payment from Responsible Parties 4.3
Reductions Under Medicare and TRICARE Benefits 4.4
Coordination of Benefits 4.4
Order of Benefit Determination Rules 4.5
Military Service 4.7

SECTION 5 – FILING CLAIMS, APPEALS AND GRIEVANCES 5.1

Important Definitions 5.1
Questions About Filing Claims, Appeals or Grievances 5.1
Procedure for Filing a Claim and Initial Claim Decisions 5.1
Concurrent Care Claims 5.3
Filing for Payment or Reimbursement of a Covered Service and Post-Service Claims 5.4
Internal Appeal Procedures 5.6
External Appeal Procedures 5.10

SECTION 6 – CHANGE OF RESIDENCE AND TERMINATION OF MEMBERSHIP 6.1

Change of Residence 6.1
Termination of Membership 6.1
Reinstatement 6.2
Extension of Benefits 6.2
Discontinuation of a Product or All Products 6.3
Continuation of Coverage Under Federal Law 6.3
Continuation of Coverage Under District of Columbia Law 6.3
USERRA 6.4

SECTION 7 – OTHER IMPORTANT PROVISIONS OF YOUR PLAN 7.1

Applications and Statements 7.1
Attorney Fees and Expenses 7.1
Contestability 7.1
Contracts with Plan Providers 7.1
Governing Law 7.2
Legal Actions 7.2
Mailed Notices 7.2
Named Fiduciary 7.2
Overpayment Recovery 7.2
Privacy Practices 7.2
Surrogacy Arrangements 7.3

APPENDICES

SAMPLE

Kaiser Permanente
Small Group Agreement and Evidence of Coverage
District of Columbia

Important Terms You Should Know DEF. 1
Pediatric Dental Plan B.1
Appendix - Summary of Cost Shares CS.1
Appendix - Outpatient Prescription Drug Benefit Rx.1

SAMPLE

Kaiser Permanente
Small Group Agreement and Evidence of Coverage
District of Columbia

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, gender identity or expression, 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 small Group Agreement and any attached applications, riders and amendments serves three important purposes. It:

SAMPLE

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 Signature℠ health care coverage provided under this contract.

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.

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.

This Agreement, including all appendices attached, if any, constitutes the entire contract of insurance. 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.

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 Signature[SM]

Getting the care you need is easy. Kaiser Permanente Signature[SM] provides you with health care Services administered by Plan Providers at our Plan Medical Centers, which are conveniently located throughout our Service Area. At our Plan Medical Centers, integrated teams of specialists, nurses and technicians work alongside your Primary Care Plan Physician to support your health and wellbeing. Pharmacy, optical, laboratory and X-ray facilities are also available at many Plan Medical Centers.

You must receive 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. Authorized Referrals, as described in ***Section 2: How to Get the Care You Need*** under the ***Getting a Referral*** provision, including referrals for Clinical Trials, as described in ***Section 3: Benefits, Exclusions and Limitations***; and
4. Covered Services received in other Kaiser Permanente regions and Group Health Cooperative service areas.

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Eligibility for This Plan

The SHOP Exchange will determine if an individual is a Qualified Employee under this plan in accordance with 45 CFR §155.715 and 45 CFR §156.710. The Qualified Employee under this plan is the "Subscriber." The Subscriber may enroll their eligible Dependents. In order to be eligible to enroll and to remain enrolled, you must work or reside in our Service Area (our Service Area is described in the ***Important Term You Should Know*** section). However, you or your Spouse's, Domestic Partner's or Legal Partner's eligible children who live outside our Service Area may be eligible to enroll if you are required to cover them pursuant to a qualified medical child support order (QMCSO). Please note that coverage for Services provided outside our Service Area is limited to only:

1. Emergency Services;
2. Urgent Care Services;
3. Services received in connection with an approved referral; and
4. Covered Services received in other Kaiser Permanente Regions and Group Health Cooperative service areas, unless you elect to bring the Dependent within our Service Area to receive covered Services.

Subscribers

You may be eligible to enroll if you are employed by a Qualified Employer and the Qualified Employer offers you coverage as a Qualified Employee.

Dependents

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

1. Your Spouse, Domestic Partner or Legal Partner;
2. Your or your Spouse's, Domestic Partner's or Legal Partner's children (including adopted children or children placed with you for adoption) who are under age 26;
3. Other Dependent persons who are under the age 26, (but not including foster children) who:
   a. Are in the court-ordered custody of you or your Spouse, Domestic Partner or Legal Partner; or
   b. You or your Spouse, Domestic Partner or Legal Partner have received a court or administrative order; or
   c. Are under testamentary or court-appointed guardianship.
4. For the purpose of age appropriate health screening only, eligible children shall include all children, from birth to age 21, in the District of Columbia, regardless of their insurance status, who:
   a. Reside in the District;
   b. Are wards of the District; or
   c. Are children with special needs who reside or are receiving services in another state.
5. If you are the subscriber, your minor grandchild, niece, or nephew under your primary care if the legal guardian (other than you) of the minor grandchild, niece, or nephew, if other than you, is not covered by an accident or sickness policy. For the purposes of this paragraph, the term "primary care" means that the insured provides food, clothing, and shelter, on a regular and continuous basis, for the minor grandchild, niece, or nephew during the time that the District of Columbia public schools are in regular session.

Your Group determines which persons are eligible to be enrolled as your Dependents. Please contact your

SAMPLE

Group's benefits administrator for questions regarding Dependent eligibility.

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

You or your Spouse's, Domestic Partner's or Legal Partner'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, Domestic Partner or Legal Partner; and
3. You give us proof of their incapacity and dependency within sixty (60) days after we request it (see ***Disabled Dependent Certification*** below in this section).

Disabled Dependent Certification

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

1. If your Dependent is a Member, we will send you a notice of his or her membership termination due to loss of eligibility at least 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

SAMPLE

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 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 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

SAMPLE

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 identity or expression, sexual orientation, race, ethnicity, religion, disability, medical condition, national origin, educational background, reading skills, ability to speak or read English, or economic or health status, including any mental or physical disability you may have;
   f. Request interpreter Services in your primary language at no charge; and
   g. Receive health care in facilities that are environmentally safe and accessible to all.

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

SAMPLE

e. Inform any network or nonparticipating provider from whom you receive care that you are enrolled in our Plan.

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

Health Savings Account-Qualified Plans

This provision only applies if you are enrolled in a qualified High Deductible Health Plan. A Health Savings Account is a tax-exempt account established under Section 223(d) of the Internal Revenue Code for the exclusive purpose of paying current and future Qualified Medical Expenses. Contributions to such an account are tax deductible, but in order to qualify for and make contributions to a Health Savings Account, 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 $1,700.00 or greater and a family Deductible of $3,400.00 or greater; and
2. Individual Out-of-Pocket Maximum of no more than $8,500.00 and a family Out-of- Pocket Maximum of no more than $17,000.00 in the current 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 or Domestic Partner'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

The SHOP Exchange will collect Premium from the Small Employer and make payments to the Health Plan. Members are entitled to health care coverage only for the period for which we have received the appropriate Premium through the SHOP Exchange. 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

SAMPLE

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 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 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.

Enrollment and Effective Date of Coverage

Annual Open Enrollment

The SHOP Exchange will provide an annual open enrollment period from November 1 until December 15th of the contract year. During the annual open enrollment period a Qualified Employee may enroll in this health benefit plan; a Subscriber may 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 Qualified Employer.

The SHOP Exchange will let you know when the open enrollment period begins and ends. Your membership at 12:00 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 first day of the Contract Year.

New Employees and Their Dependents

The SHOP Exchange will provide an enrollment period for employees who become eligible outside the annual open enrollment period. The enrollment period will begin on the first day of eligibility as a Qualified Employee and will extend for a minimum of thirty (30) days. Your memberships will become effective as determined by SHOP Exchange.

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during the annual open enrollment as described above, unless you:

1. Become eligible for a special enrollment as described in this section.

Special Enrollment Due to New Dependents

A Qualified Employee may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, within thirty (30) days after:

1. Marriage, Domestic Partnership or Legal Partnership; or
2. Birth, adoption or placement for adoption.

The effective date of an enrollment resulting from marriage, Domestic Partnership or Legal Partnership is no later than the first day of the month following plan selection.

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

1. **For newborn children, the moment of birth.**

   The newborn child will be covered automatically but only for the first thirty-one (31) days

SAMPLE

following the newborn child's date of birth. The Subscriber must enroll such a Dependent within thirty-one (31) days of the newborn child's date of birth and submit additional premium due for the subsequent month for the continued enrollment of the newborn child. Otherwise, the newborn child will not be covered and cannot be enrolled until the next annual open enrollment period.

When a Subscriber has enrolled a newborn child as described above in item #1, subrogation and coordination of benefits, as described in Section 4: Subrogation, Reductions and Coordination of Benefits, will not apply. If the Subscriber has not attempted to enroll a newborn child as described in item #1, we will provide coverage for the newborn child thirty-one (31) days following the newborn child's date of birth but, after claims are paid, we may request subrogation from another insurer where applicable.

2. **For newly adopted children (including children newly placed for adoption)**, the date of adoption.

   The date of adoption means the earlier of:
   a. A judicial decree of adoption; or
   b. 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 (30) days from the date of adoption, notification of adoption and payment of additional Premium must be provided within thirty (30) days of the date of adoption, otherwise coverage for the newly adopted child will terminate thirty (30) days from the date of adoption.

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

3. **For children who are newly eligible for coverage as the result of guardianship granted by court or testamentary appointment, the date of court or testamentary appointment.**

   If payment of additional Premium is required to provide coverage for the child, notification of the court or testamentary appointment may be provided at any time but, payment of Premium must be provided within thirty (30) days of the enrollment of the child, otherwise, enrollment of the child terminates thirty (30) days from the date of court or testamentary appointment.

Special Enrollment Due to Court or Administrative Order

Within thirty (30) days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse, Domestic Partner, Legal Partner or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse, Domestic Partner, Legal Partner or child as a Dependent by submitting to the Shop Exchange 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 unenrolled unless we receive satisfactory written proof that:

1. The court or administrative order is no longer in effect; and
   a. The child is or will be enrolled in comparable health coverage that will take effect not later

SAMPLE

than the effective date of termination under this EOC; or

b. Family coverage has been eliminated under this EOC.

The Shop Exchange 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 1st day of the month following the date of the order.

Special Enrollment Due to Loss of Other Coverage

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

1. The Qualified Employee or at least one of the Dependents had other coverage when he or she previously declined all coverage through the Group;
2. The loss of the other coverage is due to one of the following:
   a. Exhaustion of COBRA coverage;
   b. Termination of employer contributions for non-COBRA coverage;
   c. Loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (non-group) plan for nonpayment. (For example, this loss of eligibility may be due to legal separation or divorce (or termination of a Domestic Partnership or Legal Partnership), reaching the age limit for Dependent children, or the Subscriber's death, termination of employment, or reduction in hours of employment); or
   d. Loss of eligibility for Medicaid coverage or Child Health Insurance Program (CHIP) coverage, but not termination for cause.

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

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to the Shop Exchange within thirty (30) days after loss of other coverage, except that the timeframe for submitting the application is thirty (30) days if you are requesting enrollment due to loss of eligibility for Medicaid or CHIP coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the 1st day of the month following the date the Shop Exchange receives an enrollment or change of enrollment application from the Subscriber.

SAMPLE

Special Enrollment Due to a Triggering Event

The SHOP Exchange will provide a special enrollment period for each individual who experiences a triggering event during which the individual may enroll in this health benefit plan or change from one health benefit plan offered by the qualified employer to another health benefit plan offered by the qualified employer through the SHOP Exchange.

The special enrollment period shall be for thirty (30) days beginning from the date of the triggering event, except as otherwise stated.

In the case of the event described in item #6, the SHOP Exchange will provide a special enrollment period of sixty (60) days from the date of the triggering event.

A "triggering event" occurs when:

1. A Qualified Employee or Dependent:
   a. Loses Minimum Essential Coverage. The date of the loss of coverage is the last day the eligible

employee or dependent would have coverage under his or her previous plan or coverage;

b. Loses pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)). The date of the loss of coverage is the last day the eligible employee or dependent would have pregnancy-related coverage;

c. Loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year. The date of the loss of coverage is the last day the eligible employee or dependent would have medically needy coverage; or

Loss of coverage described in items a through d above does not include loss of coverage due to:

i. Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or

ii. A rescission of coverage authorized under 45 C.F.R. §147.128.

2. A Qualified Employee's or Dependent's enrollment or non-enrollment in a Qualified Health Plan is, as evaluated and determined by the Exchange:
   a. Unintentional, inadvertent or erroneous; and
   b. The result of the error, misrepresentation, misconduct or inaction of an officer, employee or agent of the Exchange or the U.S. Department of Health and Human Services (HHS), its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities.

   In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or inaction.
3. A Qualified Employee or Dependent who is enrolled in a Qualified Health Plan in the Exchange adequately demonstrates to the SHOP Exchange that the Qualified Health Plan in which the eligible employee is enrolled substantially violated a material provision of the Qualified Health Plan's contract in relation to the eligible employee;
4. A Qualified Employee or Dependent gains access to new Qualified Health Plan's as a result of a permanent move; or
5. A Qualified Employee or Dependent demonstrates to the SHOP Exchange, in accordance with guidelines issued by the U.S. Department of Health and Human Services (HHS), that the Qualified Employee or Dependent meets other exceptional circumstances as the SHOP Exchange may provide.
6. A Qualified Employee or Dependent:
   a. Loses eligibility for coverage under a Medicaid plan under Title XIX of the Social Security Act or a State Child Health Plan under Title XXI of the Social Security Act;
   b. Becomes eligible for assistance, with respect to coverage under the SHOP Exchange, under a Medicaid Plan or State Child Health Plan, including any waiver or demonstration project conducted under or in relation to a Medicaid plan or a State Child Health Plan.
7. A Subscriber or Dependent loses a Dependent or is no longer considered a Dependent through divorce, legal separation, or termination of a Domestic Partnership or Legal Partnership.
8. A Subscriber or Dependent dies.
9. If enrollee and Dependents who are not enrolled in a silver Qualified Health Plan become newly eligible for Cost Sharing Reductions, they can change to a silver Qualified Health Plan if they elect

SAMPLE

to change their enrollment.

10. New Dependent may be added to current enrollee's Qualified Health Plan, or if the Qualified Health Plan's business rules don't allow the dependent to enroll, the enrollee and the new Dependent can change to a different Qualified Health Plan within the same metal level of coverage, or one metal level higher or lower, in no such Qualified Health Plan is available. New Dependents can also enroll in entirely separate Qualified Health Plan.
11. You or your Dependent are confirmed by a provider to be pregnant.

Effective Date of Coverage Due to a Triggering Event

If individual enrolls or changes plans as the result of a triggering event, the effective date of coverage shall be:

1. In the case of a triggering event under items #2, #3, or #5, the SHOP Exchange must ensure that coverage is effective on an appropriate date based on the circumstances of the special enrollment period.
2. In the case of the triggering event under item #7, the first day of the month following plan selection.
3. In the case of the triggering event under item #9, the first day of the month following the plan selection or the SHOP Exchange may permit the Subscriber or Dependent to elect a coverage effective date in accordance with the effective dates described in item #5 below.
4. In the case of the triggering event described in item #11, the coverage effective date shall be:
    a. The 1st of the month in which you or your Dependent are confirmed by a provider to be pregnant; or
    b. The 1st of the month following the date you or your Dependent makes a plan selection.
5. For all other triggering events, coverage will be effective the first day of the following month when plan selection is received by the SHOP Exchange between the 1st and the 15th day of any month; and the first day of the second following month when plan selection is received by the SHOP Exchange between the 16th and the last day of any month.

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 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.

SAMPLE

SECTION 2: How to Get the Care You Need

Making and Cancelling Appointments and Who to Contact

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

Medical Emergencies

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

Medical Advice

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

Making or Canceling Appointments

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

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

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

Choosing or Changing Your Primary Care Plan Physician

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

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

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

Customer Service

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

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

SAMPLE

Advance Directives to Direct Your Care While Incapacitated

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

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

For additional information about advance directives, including how to obtain forms and instructions, visit us online at **www.kp.org** or contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Receiving Health Care Services

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

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

You have your choice of Plan Physicians and Facilities within our Service Area. Except for Emergency and Urgent Care Services, Air Ambulance Services, non-Emergency Services and items received from a non-Plan Provider in a Plan Facility, Services associated with Prior Authorized referrals or other approvals, and clinical trials, covered Services are available only from the Medical Group, Plan Facilities and in-Plan Skilled Nursing Facilities. Neither the Health Plan, Medical Group nor any Plan Physicians have any liability or obligation extending from any Service or benefit sought or received by a Member from any non-Plan:

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

Emergency and Urgent Care Services, Air Ambulance Services, non-Emergency Services and items received from a non-Plan Provider in a Plan Facility, Services associated with Prior Authorized referrals or other approvals, and clinical trials are the only Services a Member may seek outside of the Service Area.

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Your Kaiser Permanente Identification Card

Digital Kaiser Permanente Identification Card

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

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

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

Using Your Kaiser Permanente Identification Card

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

Your Medical Record Number is used to identify your medical records and membership information. You should always have the same Medical Record Number.

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

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

SAMPLE

Choosing Your Primary Care Plan Physician

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

Each Member in your family should select a Primary Care Plan Physician. If you do not select a Primary Care Plan Physician upon enrollment, we will assign you one near your home. You may select or change your Primary Care Plan Physician at any time by visiting us online at **www.kp.org** or contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

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

You may select a Primary Care Plan Physician, who is available to accept new Members, from the following areas: Internal medicine, family practice and pediatrics. Within pediatrics, you may select an allopathic or

osteopathic pediatrician as the Primary Care Plan Physician for your child. In addition to selecting a Primary Care Plan Physician, Members may choose a Plan Physician who practices in the specialty of obstetrics or gynecology (OB/GYN) as their personal OB/GYN.

Getting a Referral

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

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

Receiving an Authorized Specialist or Hospital Referral

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

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

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

Post-Referral Services Not Covered

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

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

Standing Referrals to Specialists

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

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

SAMPLE

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
    a. The Health Plan 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
    b. The Health Plan cannot provide reasonable access to a Specialist or non-physician Specialist with the professional training and expertise to treat or provide health care Services for the condition or disease without unreasonable delay or travel.

You must have an approved written referral to the non-Plan Specialist or Non-Physician Specialist in order for the Health Plan to cover the Services. The Cost Share amounts for approved referral Services are the same as those required for Services provided by a Plan Provider.

Services that Do Not Require a Referral

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

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

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).

Prior Authorization for Prescription Drugs

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

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

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

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-

SAMPLE

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

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

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

Continuity of Care for New Members

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

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

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

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

Transitioning to our Services

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

Getting Emergency and Urgent Care Services

Emergency Services

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

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

SAMPLE

Limitations if you had received them from Plan Providers. Emergency Services are available from Plan Hospital emergency departments twenty-four (24) hours per day, seven (7) days per week.

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

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

Urgent Care Services

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

Bills for Emergency and Urgent Care Services

You should not receive a bill for Emergency Services directly from a Plan Provider or non-Plan Provider when the federal No Surprises Act applies. When you do receive a bill from a hospital, physician or ancillary provider for Emergency Services that were provided to you, you should either:

1. Contact the hospital, physician or other provider to inform them that the bill should be sent to us at the address or website listed below; or
2. Simply mail or submit online 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 or submitted online to us at:

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

If you have already paid the bill, then please send proof of payment and a copy of the bill to the address or website listed above. Please remember to include your medical record number on your proof.

Note: 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 Out-of-Pocket Maximum. You will not be liable for any additional payment other than your Cost Share for Ancillary Services.

SAMPLE

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: Health Care Service Review, Appeals and Grievances.***

Hospital Admissions

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

Getting Assistance from Our Advice Nurses

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

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

Getting a Second Opinion

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

Receiving Care in Another Kaiser Foundation Health Plan Service Area

This provision does not apply to Members enrolled in a High Deductible Health Plan with a Health Savings Account option. 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 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.

The following Services, including equipment and supplies, are not covered under your visiting member benefits:

1. Dental Services and Dental X-rays (non-emergent or urgent dental services/X-rays are covered under a different benefit);
2. Infertility Services;
3. Services Related to artificial conception;
4. Gender confirming surgery and related services, other than services determined to be provided by all Regions (refer to relevant policies);
5. Services related to bariatric surgery and treatment;
6. Organ and blood/marrow transplants and related care;

SAMPLE

7. Alternative medicine and complementary care;
8. Orthotics, prosthetics, hearing aids, eyeglasses, and contacts;
9. Durable medical equipment; and
10. Chronic Dialysis.

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.

Extra Services

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

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

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

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

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

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

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.

SAMPLE

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

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

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

SAMPLE

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.

SAMPLE

SECTION 3: Benefits, Exclusions and Limitations

Your Benefits

The benefits described in this section are covered only when:

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

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

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

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

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

Out-of-Pocket Maximums

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

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

SAMPLE

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

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

List of Benefits

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

Accidental Dental Injury Services
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.
Benefit-Specific Exclusion(s): An injury that results from chewing or biting is not considered an Accidental Injury under this Plan.
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 either: 1. The basic life support, advanced life support or critical care life support capabilities of an ambulance for inter-facility or home transfer; and 2. The ambulance transportation has been ordered by a Plan Provider. Coverage is also provided for Medically Necessary transportation or Services including Medically Necessary air ambulance transport to the nearest hospital able to provide needed Services, provided during an encounter with an ambulance Service, as a result of a 911 call. Cost Shares for Air Ambulance Services provided by a non-Participating Provider will not exceed that of Cost Shares for Air Ambulance Services provided by a Participating Provider and will apply toward your Deductible, if any, and Out-of-Pocket Maximum, if any. Any Cost Sharing requirement will be calculated based on the lesser of the qualifying payment amount or the billed amount for the Services. We will make payment for the Air Ambulance Services directly to the non- Participating Provider of ambulance Services. The payment amount will be equal to the amount by which the Out-

SAMPLE

of-Network Rate exceeds the Cost Sharing amount for Air Ambulance Services. You will not be liable for any additional payment other than your Cost Share for Air Ambulance Services provided by a non-Participating Provider.

We cover medically appropriate non-emergent transportation Services when ordered by a Plan Provider.

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

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

Benefit-Specific Exclusion(s):

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

Anesthesia for Dental Services

We cover general anesthesia and associated hospital or ambulatory surgical center Services for dental care provided to Members who are age:

1. Seven (7) or younger or are developmentally disabled and for whom:
   a. A successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition; and
   b. A superior result can be expected from dental care provided under general anesthesia.
2. Seventeen (17) or younger who is extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred; and for whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.
3. Seventeen (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 surgical center charges will be covered only for dental care that is provided by:

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

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

Benefit-Specific Exclusion(s):

The dentist's or Specialist's professional Services.

SAMPLE

Blood, Blood Products and Their Administration

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

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

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

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

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

Cleft Lip, Cleft Palate or Both

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

Clinical Trials

We cover routine patient costs you incur for clinical trials provided on an inpatient and an outpatient basis.

Patient costs means the cost of a Medically Necessary Service that is incurred as a result of the treatment being provided to the member for purposes of the clinical trial. Patient costs do not include:

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

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

1. The Services would be covered if they were not related to a clinical trial;
2. The Covered Person is eligible to participate in the clinical trial according to the trial protocol with respect to the prevention, early detection, treatment or monitoring of cancer, chronic disease, or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   a. A Plan Provider makes this determination; and
   b. The Subscriber or Covered Person provides us with medical and scientific information establishing this determination;

SAMPLE

3. If any Plan Providers participate in the clinical trial and will accept the Covered Person as a participant in the clinical trial, the Covered Person must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where the Covered Person lives;
4. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, treatment, or monitoring of cancer, chronic disease, or other life-threatening condition and it meets one of the following requirements:
    a. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
    b. The study or investigation is a drug trial that is exempt from having an investigational new drug application; or
    c. The study or investigation is approved or funded by at least one of the following:
        i. The National Institutes of Health;
        ii. The Centers for Disease Control and Prevention;
        iii. The Agency for Health Care Research and Quality;
        iv. The Centers for Medicare & Medicaid Services;
        v. A bona fide clinical trial cooperative group or center of any of the above entities, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS; or
        vi. The Department of Defense, the Department of Veterans Affairs, the Department of Energy; or .a qualified non-governmental research entity to which the National Cancer Institute has awarded a support grant;
        vii. A study or investigation approved by the United States Food & Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA; or
        viii. An investigation or study approved by an institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

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

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

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

Benefit-Specific Exclusion(s):

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

SAMPLE

Diabetic Equipment, Supplies and Self-Management

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

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

Covered medical supplies and equipment include the following:

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

Member cost sharing for diabetes devices shall be limited to $100 for a 30-day supply of all Medically Necessary covered diabetes devices that are in accordance with the treatment plan. Member cost sharing for diabetic ketoacidosis devices shall be limited to $100 per Contract 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 Contract Year.

The following diabetic Services and laboratory tests are covered at no charge for Members with a primary diagnosis of Type 2 diabetes:

1. Primary care office Visits; when related to a primary diagnosis of Type 2 diabetes;
2. Nutritional counseling Visits;
3. Nephrology Visit, once per year, when related to a primary diagnosis of Type 2 diabetes;
4. Dilated retinal exam, once per year;
5. Diabetic foot exam, once per year;
6. Lipid panel test, once per year;
7. Hemoglobin A1C;
8. Microalbumin urine test, once per year;
9. Basic metabolic panel, once per year; and
10. Liver function test, once per year.

SAMPLE

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

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

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

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

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

      "Health Plan preferred equipment and supplies" are those purchased from a preferred vendor.

Dialysis Services

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

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

We cover the following renal dialysis Services:

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

We cover the following self-dialysis Services:

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

We cover home dialysis, which includes:

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

SAMPLE

Members traveling outside the Service Area may receive pre-planned dialysis Services for up to twenty-six (26) dialysis sessions of travel per Contract Year. Prior Authorization is required.

Drugs, Supplies and Supplements

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

1. Oral infused or injected drugs and radioactive materials used for therapeutic purposes, including chemotherapy; This includes off-label use of a drug when the drug is recognized in Standard Reference Compendia or certain medical literature as appropriate in the treatment of the diagnosed condition;
2. Injectable devices;
3. The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
4. Medical and surgical supplies including dressing, casts, hypodermic needles, syringes or any other Medically Necessary supplies provided at the time of treatment; and
5. Vaccines and immunizations approved for use by the United States Food & Drug Administration (FDA) that are not considered part of routine preventive care.

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

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

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

Benefit-Specific Exclusion(s):

1. Drugs, supplies and supplements that 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; and
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 Health Plan criteria for medical necessity.

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***

SAMPLE

Devices for coverage of internal prosthetic devices, ostomy and urological supplies and breast prosthesis.

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

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

We cover the following types of equipment:
1. Hospital type beds;
2. Wheelchairs;
3. Traction equipment;
4. International Normalized Ratio (INR) home testing machines;
5. Walkers; and
6. Crutches.

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

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

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

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 every thirty (30) days.

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 from a Plan Provider:
1. Spacers

SAMPLE

2. Peak-flow meters
3. Nebulizers

Bilirubin Lights

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

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

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

Benefit-Specific Exclusion(s):

1. Comfort, convenience, or luxury equipment or features;
2. Exercise or hygiene equipment;
3. Non-medical items such as sauna baths or elevators;
4. Modifications to your home or car;
5. Electronic monitors of the heart or lungs, except infant apnea monitors and oximetry monitors for patients on home ventilation; and
6. Services not Prior Authorized by the Health Plan.

Emergency Services, Including Emergency Services HIV Screening Test

Coverage is provided anywhere in the world without Prior Authorization for Emergency Services should you experience an Emergency Medical Condition.

If you think you are experiencing an Emergency Medical Condition as defined in the section ***Important Terms You Should Know,*** then you should call 911 immediately. If you are not sure whether you are experiencing an Emergency Medical Condition, please contact us at the number listed on the reverse side of your ID card for immediate medical advice. You or your representative must notify the Health Plan as soon as possible, not to exceed forty-eight (48) hours or the next business day, whichever is later, if you receive care at a hospital emergency room (ER) to ensure coverage. If the emergency room Visit was not due to an "Emergency Medical Condition," as defined in the ***Important Terms You Should Know*** Section of this Agreement, and was not authorized by the Health Plan, you will be responsible for all charges. Coverage depends on our determination of the situation in which care was provided, and not solely on the advice of the non-Plan Provider.

We cover Emergency Services as follows:

Inside our Service Area

We 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

If you are injured or become ill while temporarily outside the Service Area, but within the United States, we will cover charges for Emergency Services as defined in this section. We cover emergency room professional services, including diagnostic x-ray, laboratory services, medical supplies, and advanced

SAMPLE

diagnostic imaging. We will cover Services received outside of the Service Area until you can, without medically harmful consequences, be transported to a Plan Hospital or primary care Plan Physician's office. Emergency Services provided outside of the Service Area will be reimbursed at the billed amount less your copay or coinsurance for services received in the Service Area.

Continuing Treatment Following Emergency Services

1. **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.
2. **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.
3. **Outside our Service Area:** All other continuing or follow-up care for Emergency Services received outside our Service Area must be authorized by us, until you can safely return to the Service Area.

Transport to a Service Area:

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

Note: All ambulance transportation is covered under the ***Ambulatory Services*** benefit in this section.

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

SAMPLE

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.

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 working day following the admission, unless it was not reasonably possible to notify us within that time. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us, of if you choose not to be transferred, we will not cover any Services you receive after transfer would have been possible.

Filing Claims for Non-Plan Emergency Services

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

Emergency Services HIV Screening Test

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

Covered Services include:

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

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

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

SAMPLE

Benefit-Specific Limitation(s):

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 forty-eight (48) hours or the next business day, whichever is later, or the emergency room Visit or hospital admission unless it was not reasonably possible to notify us. If you are admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate.
2. **Continuing or Follow-up Treatment**: Except as provided for under "Continuing Treatment Following Emergency Surgery," we do not cover continuing or follow-up treatment after Emergency Services unless authorized by the Health Plan. We cover only the out-of-Plan emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Foundation Health Plan or allied plan service area.
3. **Hospital Observation**: Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room Visit Copayment, if applicable, will not be waived.

Family Planning Services

We cover the following:

1. Women's Preventive Services (WPS), including:
    a. Patient education and contraceptive method counseling for all women of reproductive capacity;
    b. Coverage for FDA-approved contraceptive devices, 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; 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;
    Note: Counseling does not include instruction for fertility awareness based methods;
3. Male sterilization;
4. Elective and therapeutic termination of pregnancy and abortion care Services, including follow-up Services, as permitted under state law.

Note: Family planning Services that are defined as preventive care under the Affordable Care Act are covered at no charge.

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.

SAMPLE

Habilitative Services

We cover Medically Necessary habilitative Services. Habilitative Services are health care Services and devices that help a Member keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age.

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

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

Benefit-Specific Exclusion(s):

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

Hearing Services

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

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

Benefit-Specific Exclusion(s):

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

Home Health Care Services

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

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

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

SAMPLE

We also cover any other outpatient Services, as described in ***Section 3: Benefits, Exclusions and Limitations*** 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.

Note: If a visit lasts longer than four (4) hours, then each four (4)-hour increment counts as a separate visit. For example, if a nurse comes to your home for five (5) 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 four hours that counts as two visits.

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

Benefit-Specific Exclusion(s):

1. Custodial care (see 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. 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;
8. Services not Prior Authorized by Health Plan; and
9. Transportation and delivery service costs of Durable Medical Equipment, medications, drugs, medical supplies and supplements to the home.

SAMPLE

Hospice Care Services

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

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

1. Nursing care;
2. Physical, occupational, speech and respiratory therapy;
3. Medical social Services;
4. Home health aide Services;

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

Definitions:

Family Member means a relative by blood, marriage, domestic partnership, civil union, or adoption who lives with or regularly participates in the care of the terminally ill Member.

Hospice Care means a coordinated, inter-disciplinary program of hospice care 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.

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

Caregiver means an individual primarily responsible for the day to day care of the Member during the period in which the Member receives Hospice Care.

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

Benefit-Specific Limitation(s):

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

Hospital Inpatient Care

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

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

SAMPLE

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

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

House Calls

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

Human Immunodeficiency Virus (HIV)

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

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

Infertility & Standard Fertility Preservation Services

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

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

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

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

Benefit-Specific Exclusion(s):

1. Ovum transplants and gamete intrafallopian tube transfer (GIFT), zygote intrafallopian transfer (ZIFT), or cryogenic or other preservation techniques used in these or similar procedure.
2. Any Services or supplies, 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.

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Infusion Services

Coverage is provided for infusion Services, including:

1. Enteral nutrition, which is delivery of nutrients by tube into the gastrointestinal tract; and.
2. All medications administered intravenously and/or parenterally.

Infusion Services may be received at multiple sites of service, including facilities, professional provider offices, ambulatory infusion centers and from home infusion providers. The Cost Share amount will apply based on the place and type of Service provided.

For additional information on infusion therapy, chemotherapy and radiation, see the ***Radiation Therapy/Chemotherapy/Infusion Therapy*** benefit in this ***List of Benefits***.

Maternity Services

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

We cover outpatient maternity care, which includes:

1. Care provided for a condition not usually associated with pregnancy;
2. Care provided for conditions existing prior to pregnancy; and
3. Care provided for high risk condition(s) that develop during pregnancy.

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

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

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

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

All physician services and professional fees for your routine delivery, prenatal and postnatal care Services will be subject to a single Cost Share. Services that are preventive care will be covered with no Cost Share. Additional Cost Shares may apply to professional fees for any non-routine Services you receive. Your inpatient fees are the same as for any other inpatient stay.

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

Benefit-Specific Exclusion(s):
Services for newborn deliveries performed at home.

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Medical Foods

We cover Medically Necessary foods for the treatment of:

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

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

Medical Nutrition Therapy & Counseling

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

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

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

Mental Health Services and Substance Use Disorder

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

For the purposes of this benefit provision, “Drug and alcohol abuse” means a disease that is characterized by a pattern of pathological use of a drug and/or alcohol with repeated attempts to control its use and with

SAMPLE

significant negative consequences in at least one the following areas of life: medical, legal, financial or psycho-social.

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

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

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

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

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

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

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

Benefit-Specific Exclusion(s):

1. Services in a facility whose primary purpose is to provide treatment for alcoholism, drug abuse or drug addiction, except as described above.
2. Services for Members who, in the opinion of the Plan Provider, are seeking Services for non-therapeutic purposes.
3. Psychological testing for ability, aptitude, intelligence, or interest.

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4. Services on court order or as a condition of parole or probation, unless determined by the Plan Provider to be necessary and appropriate.
5. Evaluations that are primarily for legal or administrative purposes, and are not Medically Necessary.

Morbid Obesity Services, Including Bariatric Surgery

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

Morbid obesity is defined as:

1. A weight that is at least one-hundred (100) pounds over or twice the ideal weight for a patients 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(s) immediately below for additional information.

Benefit-Specific Exclusion(s):
Services not Prior Authorized 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.

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;
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. Surgical treatment for temporomandibular joint syndrome (TMJ) if there is clearly demonstrable radiographic evidence of joint abnormality due to an illness; and
5. Medically Necessary oral restoration after major reconstructive surgery.

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

SAMPLE

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.

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

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

Benefit-Specific Exclusion(s):

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

Outpatient Care

We cover the following outpatient care:

1. Primary care Visits for internal medicine, family practice, pediatrics, and obstetrics/gynecology Services (refer to ***Preventive Health Care Services*** for coverage of preventive care Services);
2. Specialty care Visits (refer to "Getting a Referral" in ***Section 2: How to Get the Care You Need*** for information about referrals to Plan specialists);
3. Consultations and immunizations for foreign travel;
4. Diagnostic testing for care or treatment of an illness, or to screen for a disease for which you have been determined to be at high risk for contracting, including, but not limited to:
   a. Diagnostic examinations, including digital rectal exams and prostate antigen (PSA) tests provided to persons age 40 and over who are at high risk for prostate cancer according to the most recent screening guidelines issued by the National Comprehensive Cancer Network, to include no less than one (1) prostate-specific antigen test and digital rectal exam per year;
5. Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging for persons who are at high risk of cancer, in accordance with the most recently published guidelines of the American College of Gastroenterology, in consultation with the American Cancer Society. Your initial screening colonoscopy will be preventive.;
6. Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A "qualified individual" means
   a. An estrogen deficient individual at clinical risk for osteoporosis;
   b. An individual with a specific sign suggestive of spinal osteoporosis, including roentgeno-graphic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one (1) or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an Extensive diagnostic evaluation for metabolic bone disease;
   c. An individual receiving long-term gluco-corticoid (steroid) therapy;

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d. An individual with primary hyper-parathyroidsm; or
e. An individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;

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

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

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

Preventive Health Care Services

In addition to any other preventive benefits described in this EOC, 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 for infants, children, adolescents and adults:

1. Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009. (To see an updated list of the “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: www.cdc.gov/vaccines/recs/ACIP);
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. This includes preventive Services for obesity. (Visit HRSA at: https://mchb.hrsa.gov/maternal-child-health-topics/child-health/bright-futures.html.); and
4. With respect to women, such additional preventive care and screenings, not described in paragraph (a) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (Visit HRSA at: https://www.hrsa.gov/womens-guidelines-2016); and
5. All state mandated preventive health care Services.

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

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

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

1. Preventive care exams, including:
   a. Routine physical examinations and health screening tests appropriate to your age and sex;
   b. Well-woman examinations; and
   c. Well child care examinations; including age appropriate health screening for all children, as determined by the Mayor, from birth to 21 years of age
2. Routine and Medically Necessary immunizations (travel immunizations are not preventive and are covered under Outpatient Services in this section) for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;
3. An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
4. High-risk human papillomavirus (HPV) DNA testing for women age 30 years and over whether or not they have normal Pap test results;
5. Rh incompatibility screening;
6. Screening for gestational (pregnancy-related) diabetes in pregnant women after twenty-four (24) weeks gestation and at the first prenatal Visit for pregnant women identified to be at high risk for diabetes;
7. Comprehensive lactation (breastfeeding) education and counseling, by trained clinicians during pregnancy and/or in the postpartum period in connection with each birth;
8. Breastfeeding equipment issued, per pregnancy and in accordance with Health Plan coverage guidelines;
9. Annual screening and counseling for sexually transmitted infections for all sexually active women;
10. Screening and counseling for hepatitis B and C;
11. Annual screening and counseling for human immune-deficiency virus (HIV) infection for all sexually active women;
12. Annual screening and counseling for interpersonal and domestic violence;
13. Patient education and contraceptive counseling for all women with reproductive capacity;
14. All prescribed FDA-approved contraceptive methods, including implanted contraceptive devices, hormonal contraceptive methods, barrier contraceptive methods, and female sterilization surgeries. Note that contraceptive methods that do not require clinician administration such as birth control pills will not be covered if you have outpatient drug coverage separate from your Health Plan coverage through another prescription drug provider;
15. Low dose screening mammograms, including 3-D mammograms to determine the presence of breast disease is covered as follows: (i) a baseline mammogram for women and (ii) annual screening mammogram for women:
    a. One (1) mammogram for persons age 35 through 39;
    b. One (1) mammogram biennially for persons age 40 through 49; and

SAMPLE

c. One (1) mammogram annually for person 50 and over;

16. Adjuvant breast cancer screening, including magnetic resonance imaging (MRI), ultrasound screening, or molecular breast imaging of the breast, if:
    a. A mammogram demonstrates a Class C or Class D breast density classification; or
    b. A woman is believed to be at an increased risk for cancer due to family history or prior personal history of breast cancer, positive genetic tesing, or other indications of an increased risk for cancer as determined by a woman's physician or advanced practice registered nurse;
17. Risk assessment and genetic counseling and testing using the Breast Cancer Risk Assessment tool approved by the National Cancer Institute;
18. Breast cancer chemoprevention counseling and preventive medications;
19. Bone mass measurement to determine risk for osteoporosis;
20. Prostate Cancer screening including diagnostic examinations, digital rectal examinations and prostate-specific 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;
21. Colorectal cancer screening in accordance with screening guidelines issued by the American Cancer Society including fecal occult blood tests, flexible sigmoidoscopy and screening colonoscopy;
22. Cholesterol test (lipid profile);
23. Diabetes screening (fasting blood glucose test);
24. Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis and HPV);
25. Annual chlamydia screening for:
    a. Women age 24 years and younger, if they are sexually active;
    b. Women 25 years of age or older, and men of any age, who have multiple risk factors, which include:
        i. A prior history of sexually transmitted diseases;
        ii. New or multiple sex partners;
        iii. A sex partner with concurrent partners;
        iv. A sex partner with an STI;
        v. Inconsistent use of barrier contraceptives; or
        vi. Cervical ectopy;
26. Human Papillomavirus (HPV) Screening as recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;
27. HIV tests;
28. TB tests;
29. Smoking and tobacco cessation counseling;
30. Folic acid supplementation;
31. Newborn hearing screenings that include follow up audiological examinations, as recommended by a physician or audiologist, and performed by a licensed audiologist to confirm the existence or absence of hearing loss when ordered by a Plan Provider; and
32. Associated preventive care radiological and laboratory tests not listed above.

Pursuant to IRS Notice 2019-45, coverage is provided for expanded preventive care Services for labs and

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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

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

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

Note: Refer to ***Outpatient Services*** for coverage of non-preventive diagnostic tests and other covered Outpatient Services.
See the benefit-specific limitation(s) immediately below for additional information.

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

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

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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 ill or injured. Coverage includes fitting and adjustment of these devices, repair or replacement (unless due to loss or misuse), and Services to determine whether you need the prosthetic. If we do not cover the prosthetic, we will try to help you find facilities where you may obtain what you need at a reasonable price.

Coverage is limited to the standard device that adequately meets your medical needs, including:

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

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

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

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

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

Ostomy and Urological Supplies and Equipment
We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets the Health Plan's criteria for Medical Necessity. Covered equipment and supplies include, but is not

SAMPLE

limited to flanges, collection bags, clamps, irrigation devices, sanitizing products, ostomy rings, ostomy belts and catheters used for drainage of urostomies.

Breast Prosthetics and Hair Prosthesis

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

In addition, we cover one (1) Medically Necessary hair prosthesis.

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

Benefit-Specific Limitation(s):

1. Coverage for mastectomy bras is limited to a maximum of four (4) per contract year.
2. Coverage for wigs are limited to one (1) per Contract Year.
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 by a Plan Provider.

Benefit-Specific Exclusion(s):

1. Services not Prior Authorized by Health Plan.
2. Internally implanted breast prosthetics for cosmetic purposes.
3. Repair or replacement of prosthetics devices due to loss or misuse.
4. Microprocessor and robotic controlled external prosthetics and orthotics that does not meet the Health Plan criteria as Medical 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 a ***Pediatric Dental Plan Appendix***.
8. Hearing aids, except as specifically provided in this section.
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.

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Radiation Therapy/Chemotherapy/Infusion Therapy

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

Infusion therapy means treatment by placing therapeutic agents into the vein, including therapeutic nuclear medicine and parenteral administration of medication and nutrients.

Coverage is also provided for oral chemotherapy drugs and infused, intravenous or injected drugs, prescribed by a Plan Provider and administered by medical personnel during an office Visit including urgent care and ambulatory infusion centers. For additional information on these benefits, see ***Drugs, Supplies, and Supplements*** in this List of Benefits.

For additional information on Infusion Services, see the ***Infusion Services*** benefit in this ***List of Benefits***.

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

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

Benefit-Specific Exclusion(s):
Cosmetic surgery, plastic surgery or other Services, supplies, dermatological preparations and ointments, other than those listed above, that are intended primarily to improve your appearance or are not likely to result in significant improvement in physical function, 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(s):
Routine foot care Services that are not Medically Necessary.

Skilled Nursing Facility Care

SAMPLE

We cover up to sixty (60) days of skilled inpatient Services in a licensed Skilled Nursing Facility per episode of care. 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 elsewhere in this section:

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

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

Benefit-Specific Exclusion(s):

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

Telemedicine Services

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

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

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

Benefit-Specific Exclusion(s):

Services delivered through electronic mail messages or facsimile transmissions.

Therapy and Rehabilitation Services

Coverage is provided for:

1. Physical, Occupation, and Speech Therapy including video face-to-face visits: We cover Medically Necessary inpatient and outpatient physical, occupational and speech therapy.
2. Spinal Manipulation Services: For musculoskeletal illness or injury only, we cover spinal manipulation and other manual medical interventions.
3. Multidisciplinary Rehabilitation: If, in the judgment of a Plan Provider, significant improvement is achievable within a two-month period, we cover multidisciplinary rehabilitation Services in a Plan Hospital, Plan Medical Center, Plan Provider's medical office, or a Skilled Nursing Facility.

SAMPLE

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 therapy at a time in the rehabilitation treatment.

4. Cardiac Rehabilitation Services: We cover Medically Necessary cardiac rehabilitation Services following coronary surgery, a myocardial infarction or for members who have been diagnosed with significant cardiac disease for up to ninety (90) consecutive days. Cardiac rehabilitation Services must be provided or coordinated by a facility approved by the Health Plan, and that offers the process of restoring, maintaining, teaching, or improving physiological, psychological, exercise stress testing, counseling, and social and vocational capabilities of patients with heart disease.
5. Pulmonary Rehabilitation Services: We cover pulmonary rehabilitation Services that are Medically Necessary.

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

Benefit-Specific Limitation(s):

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

Benefit-Specific Exclusion(s):

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

Transplant Services

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

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

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

1. Unless otherwise authorized by Medical Group, transplants are covered only in our Service Area.
2. If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for transplant, we will pay only for covered Services you receive before that determination was made.
3. 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.

SAMPLE

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

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

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

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

Urgent Care Services

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

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

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

If your primary care Plan Physician is located at a Plan Medical Office Center 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)

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

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

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

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

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

Vision Services

Coverage is provided for:

SAMPLE

1. Medical Treatment: We will provide coverage for Medically Necessary treatment for diseases of or injuries to the eye. Such treatment shall be covered to the same extent as for other Medically Necessary treatments for illness or injury.
2. Pediatric Vision Services: We provide Pediatric Vision Services for Members up to the end of the month they turn age 19. Services include:
   a. One (1) routine eye examination each calendar year, including dilation if professionally indicated; and
   b. One (1) pair of prescription eyeglass lenses and one frame each year from an available selection of frames; or two (2) pairs of Medically Necessary contact lenses each year in lieu of eyeglasses; and
   c. Low vision Services, including one comprehensive low vision evaluation every five (5) years, four (4) follow-up Visits in any five (5) year period, and prescribed optical devices such as high-power spectacles, magnifiers and telescopes.

In addition, we cover the following Services:

1. Eye Exams: We cover routine and necessary eye exams, including:
   a. Routine tests such as eye health and glaucoma tests; and
   b. Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.
2. Eyeglass Lenses: We provide a discount on the purchase of regular eyeglass lenses, including add-ons, when purchased at a Kaiser Permanente Optical Shop. Regular eyeglass lenses are any lenses with a refractive value. If only one eye needs correction, we also provide a balance lens for the other eye.
3. Frames: We provide a discount on the purchase of eyeglass frames, when purchased at a Kaiser Permanente Optical Shop. The discount includes the mounting of eyeglass lenses in the frame, original fitting of the frames, and subsequent adjustment.

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

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

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

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

SAMPLE

Benefit-Specific Exclusion(s):

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

X-Ray, Laboratory and Special Procedures

We cover the following Services only when prescribed as part of care covered in other parts of ***Section 3: Benefits*** (for example, diagnostic imaging and laboratory tests are covered for outpatient Services only to the extent the outpatient Services are covered under ***Outpatient Care***):

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

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

See ***Diabetic Equipment, Suplies, and Self-Management Training*** for laboratory tests that are covered at no charge for Members with a primary diagnosis of Type 2 diabetes.

SAMPLE

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

The following Services are excluded from coverage:

1. **Certain Alternative Medical Services**, except when used for anesthesia: acupuncture Services and any other Services of an Acupuncturist, Naturopath, and Massage Therapist.
2. **Certain Exams and Services:** Physical examinations and other Services:
   a. Required for obtaining or maintaining employment or participation in employee programs;
   b. Required for insurance, or licensing; or
   c. On court-order or required for parole or probation.
3. **Cosmetic Services**, including surgery or related Services and other Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies. Examples of Cosmetic Services include but are not limited to cosmetic dermatology, cosmetic surgical Services and cosmetic dental Services.
4. **Custodial Care,** meaning assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.
5. **Disposable Supplies** for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances, or devices not specifically listed as covered in this Section.
6. **Durable Medical Equipment**, except for Services covered under ***Durable Medical Equipment*** in the ***List of Benefits*** in this Section.
7. **Employer or Government Responsibility:** Financial responsibility for Services that an employer or government agency is required by law to provide.
8. **Experimental or Investigational Services:** Except as covered under Clinical Trials in this section, a Service is experimental or investigational for your condition if any of the following statements apply to it at the time the Service is or will be provided to you:
   a. It cannot be legally marketed in the United States without the approval of the United States Food & 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

SAMPLE

c. It is subject to the approval or review of an Institutional Review Board (IRB) of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of Services; or
d. It is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

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

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

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

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

10. **Infertility Services:**
    a. Except for artificial insemination or in vitro fertilization, Services for any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures.
    b. Any Services or supplies, after an embryon 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).

11. **Prohibited Referrals:** Payment of any claim, bill, or other demand or request for payment for covered Services determined to be furnished as the result of a referral prohibited by law.

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

13. **Travel and Lodging Expenses.**

SAMPLE

14. **Worker's Compensation or Employer Liability:** Any illness or injury related to employment or self-employment including any illness or injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the Services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or 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: means a public disturbance involving an assemblage of five (5) or more persons which by tumultuous and violent conduct or the threat thereof creates grave danger of damage or injury to property or persons. An exclusion or limitation for riot shall apply only when a person willfully engages in a riot or willfully incites or urges other persons to engage in a riot;
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.

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, they 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.

SAMPLE

SECTION 4: Subrogation, Reductions and Coordination of Benefits

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

Subrogation

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

Reductions

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

The above scenarios are a couple of examples of when:

1. We would seek 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 medical expenses 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

SAMPLE

Hyattsville, Maryland 20785

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

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

The Health Plan's Right to Recover Payments

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

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

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

Except for any benefits that would be payable under either Personal Injury Protection; 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.

SAMPLE

Medicare

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

Workers' Compensation or Employer's Liability

If benefits are paid by 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:

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

You hereby agree that, in consideration for the coverage provided by this policy, you will notify 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 provide your attorney's name and contact information, including their business address and telephone number. If you change attorneys during the legal process, you are required to inform the Health Plan of your change in representation.

Health Plan Not Liable for Illness or Injury to Others

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

SAMPLE

Failure to Notify the Health Plan of Responsible Parties

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

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

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

Pursuit of Payment from Responsible Parties

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

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

Reductions Under Medicare and TRICARE Benefits

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

TRICARE benefits are secondary by law.

Coordination of Benefits

Coordination of Benefits Overview

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

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

Right to Obtain and Release Needed Information

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

SAMPLE

Primary and Secondary Plan Determination

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

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

Coordination of Benefits Rules

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

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

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

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

Assistance with Questions about the Coordination of Your Benefits

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

Order of Benefit Determination Rules

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

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

Rules for a Non-Dependent and Dependents

1. Subject to #2 (immediately below), a plan that covers a person other than as a Dependent, such as an employee, Member, Subscriber, policyholder, or retiree, is the primary plan and the plan that covers the person as a Dependent is the secondary plan.

SAMPLE

2. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:
   a. Secondary to the plan covering the person as a Dependent; and
   b. Primary to the plan covering the person as other than a Dependent:
      i. Then the order of benefits is reversed so that the plan covering the person as an employee, Member, Subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a Dependent is the primary plan.

Rules for a Dependent Child/Parent

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

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

1. For a Dependent child covered under more than one (1) plan of individuals who are not the Parents of the child, the order of benefits shall be determined, as applicable, under the Dependent child

SAMPLE

provisions above, as if those individuals were Parents of the child.

Dependent Child Who Has Their Own Coverage

1. For a Dependent child who has coverage under either or both Parents' plans and also has his or her own coverage as a Dependent under a Spouse's Domestic Partner's or Legal Partner's plan, the rule in this provision for ***Longer / Shorter Length of Coverage*** applies.
2. In the event the Dependent child's coverage under the Spouse's Domestic Partner's or Legal Partner's plan began on the same date as the Dependent child's coverage under either or both Parents' plans, the order of benefits shall be determined by applying the "Birthday Rule".

Active/Inactive Employee Coverage

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

COBRA or State Continuation Coverage

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

Longer/Shorter Length of Coverage

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

Effect of Coordination of Benefits on the Benefits of this Plan

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

Coordination with the Health Plan's Benefits

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

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

SAMPLE

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

Facility of Payment

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

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

Right of Recovery of Payments Made Under Coordination of Benefits

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

Military Service

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

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

SAMPLE

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 Filing a Claim and Initial Claim Decisions

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

SAMPLE

Procedure for Filing a Non-Urgent Pre-Service Claim

1. Tell Member Services that you want to file 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.
2. We will review your claim, and if we have all the information we need we will communicate our decision within two (2) working days after we receive your claim. If we cannot make a determination because we do not have all of the information we need, we will ask you for more information within fifteen (15) days of receipt of your claim. 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 then make a decision within fifteen (15) days of the due date or the receipt date, whichever is earlier, based on the information we have.

3. We will make a good faith attempt to obtain information from the treating provider before we make any Adverse Decision. At any time before we make our decision, the provider shall be entitled to review the issue of Medical Necessity with a physician advisor or peer of the treating provider. A physician reviewer will review the issue of Medical Necessity with the provider prior to making any Adverse Decision relating to cancer pain medication.
4. If we make an Adverse Decision regarding your claim, we will notify the treating provider:
   a. In writing within two (2) working days of the decision; or
   b. Orally by telephone within twenty-four (24) hours of the decision if the claim is for cancer pain medication.

   The notice will include instructions for the provider on behalf of the member to seek a reconsideration of the Adverse Decision, including the name, address, and telephone number of the person responsible for making the Adverse Decision.
5. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can Appeal.

Expedited Procedure for an Urgent Medical Condition

1. If you or your treating provider feels that you have an Urgent Medical Condition, you may request an expedited review of your Pre-Service claim.
2. If our clinical peer determines your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Pre-Service Claim.
3. We will review your claim, and if we have all the information we need we will notify you of our decision as soon as possible taking into account your medical condition(s) but no later than twenty-four (24) hours after receiving your claim. We will send a written or electronic confirmation within three (3) days after making our 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 twenty-four (24) hours of receipt of your claim. You will have forty-eight (48) hours from the time of notification by us to provide the missing information. We will make a decision forty-eight (48) hours after the earlier of:
   a. Our receipt of the requested information; or
   b. The end of the forty-eight (48)-hour period we have given you to provide the specified additional information.
4. 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.
5. 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 ***Section C*** Bureau of Insurance Independent External Appeals for additional information about filing an external Appeal.

SAMPLE

Concurrent Care Claims

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

1. Expire; or
2. Be shortened.

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

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

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

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

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

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

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

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

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

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

At least twenty-four (24) hours before the expiration of the Services or before your shortened course of care ends, you should call or write to Member Services and advise that you have an Urgent Medical Condition or your course of treatment has been terminated early and that you want to continue your course of care.

SAMPLE

Your written or oral request and any related document you give us constitute your claim. Call or write the Member Service Department at the address and telephone numbers listed above.

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

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

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

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

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

SAMPLE

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 Filing 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. Paper forms may be obtained 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).

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

If you are unable to access the electronic form or obtain the paper form, you may also file your claim by

mailing the minimum amount of information we need to process claim:

- Member Name;
- Member Medical Record Number (MRN);
- The date the Member received the Services;
- Where the Member received the Services;
- The Physician or other health care provider who provided the Services;
- Reason you believe Health Plan should pay for the Services; and
- A copy of the bill, the Member's medical record(s) for the Services, and the receipt, if you paid for the Services.

Kaiser Permanente
National Claims Administration - Mid-Atlantic States
Attention: Claims Department
P.O. Box 371860
Denver, CO 80237-9998

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
Denver, CO 80237-9998

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

SAMPLE

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. 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.

Payment of Claims

In the event of loss of life, all benefits will be paid to you, if living, or to the beneficiary. If no beneficiary is living, benefits will be paid to your estate. If benefits are payable to your estate, we may pay up to $1,000 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 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.

SAMPLE

Our Internal Grievance Process

This process applies to a utilization review determination made by us that a proposed or delivered Health Care Service is or was not Medically Necessary, appropriate, or efficient (health care setting, level of care or effectiveness of a covered benefit is at issue); is or was experimental or investigational; involves a nonquantitative treatment limitation or other provision of the mental health parity requirements or involves consideration of the application of federal law regarding coverage of Emergency Services, thereby resulting in non-coverage of the Health Care Service.

Initiating a Grievance

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

Kaiser Permanente
Attention: Member Relations

Nine Piedmont
3495 Piedmont Rd NE
Atlanta, GA 30305
Fax: 1-404-949-5001

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

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

Grievance Acknowledgment

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

Pre-service Grievance

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

Post-service Grievance

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

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

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

SAMPLE

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

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

Grievance Decision Time Periods and Complaints to the Commissioner

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

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

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

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

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

Expedited Grievances for Emergency Cases

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

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

If the clinical review determines that you do not have the requisite medical condition, the request will be managed as a non-expedited Grievance pursuant to the procedure outlined above. If we determine that an

SAMPLE

Emergency Case does not exist, we will verbally notify you or your Authorized Representative within twenty-four (24) hours, and provide notice of the right to file a Complaint with the Commissioner.

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

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

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

Notice of Adverse Grievance Decision

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

1. The specific factual basis for the decision in clear and understandable language;
2. References to any specific criteria or standards on which the decision was based, including but not limited to interpretive guidelines used by us. Additionally, you or your Authorized Representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of the associated claim;
3. A statement that you or your Parent/Guardian, as applicable, is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If any specific criteria were relied upon, either a copy of such criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, we will provide either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or a statement that such explanation will be supplied free of charge, upon request;
4. The name, business address and business telephone number of the medical director who made the Grievance Decision:

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

SAMPLE

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

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

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 s 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.

The initial response of the Health Plan may be to request additional information from the prescribing provider in order to make a determination. The Health Plan will make its determination on a standard exception and notify you or your Authorized Representative, and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than seventy-two (72) hours following receipt of the necessary clinical information from the prescribing provider.

The Health Plan will provide coverage of the drug for the duration of the prescription, including refills if the Health Plan grants a standard exception.

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 Road, NE
Atlanta, GA 30305-1736

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1-404-949-5001 (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 Members how Appeals are processed and resolved and to assist the Member with filing an Appeal. The Member Service Representative can be contacted Monday through Friday from 7:30 p.m. to 9 p.m. Eastern Standard Time (EST) at (301) 468-6000, if calling within the local area, or TTY 711.

Formal Appeal

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

Initiating a Formal Appeal

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

Kaiser Permanente
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305-1736
1-404-949-5001 (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) business days of receipt.

SAMPLE

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 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).

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 by telephone or facsimile.

SAMPLE

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.

Expedited Appeals for Exigent Circumstances for Use of a Drug

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

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

Notification of Adverse Appeal Decisions

If the review results in a denial, the Health Plan will notify you 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).

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External Appeal Procedures

If you receive an adverse decision on your appeal, you have a right to seek a formal external review of the decision within sixty (60) days after the decision.

If 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:

For Medical Necessity Cases:
Government of the District of Columbia
Office of Health Care Ombudsman and Bill of Rights
441 4th St. N.W., Suite 250 North
Washington, D.C. 20001
Phone: 1 (877) 685-6391 or (202) 724-7491
FAX: (202) 442-6724
Email: healthcareombudsman@dc.gov
Website: www.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, DC 20002
Phone: 202-727-8000
FAX: 202-671-0650
Email: disbcomplaints@dc.gov

SAMPLE

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, placing the Member's life or health in serious jeopardy, the inability of the Member to regain maximum function, serious impairment to a bodily function, serious dysfunction of a bodily organ or the member remaining seriously mentally ill with symptoms that causes the Member to be a danger to self and others; or
3. The Health Plan failed to make a decision for an Expedited Appeal within twenty-four (24) hours after the Appeal was filed.

SECTION 6: Change of Residence and 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.

Change of Residence

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

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

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

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

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:

1. 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
2. Later in that month you no longer meet those eligibility requirements; then your membership terminates on the last day of that month, unless your Group has an agreement with us to terminate at a time other than on the last day of the month. Please check with your Group's benefits administrator to confirm your termination date.

Termination of Group Agreement

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

Termination for Cause

We may terminate your membership for cause if you:

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

SAMPLE

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

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

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

Termination for Nonpayment

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

Reinstatement

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

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

The reinstated Agreement shall cover only loss resulting from the (accidental loss) benefits listed in the policy as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the Group and Health Plan shall have the same rights under the reinstated Agreement as they had under the contract immediately before the due date of the defaulted premium, subject to any provisions endorsed on the Agreement or attached to the Agreement in connection with the reinstatement.

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

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

SAMPLE

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.

SAMPLE

Discontinuation of a Product or All Products

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

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 COBRA continuation coverage even if they live in another Kaiser Foundation Health Plan or allied plan service area. Please contact your Group if you want to know whether you or your Dependents are eligible for COBRA coverage, how to elect COBRA coverage, or how much you will have to pay your Group for it.

Continuation of Coverage Under District of Columbia Law

Employers maintaining a health benefits plan for fewer than twenty (20) employees must offer you and your Dependents who are eligible for state continuation coverage, and who would otherwise lose coverage, uninterrupted coverage for a period of fifteen (15) continuous months in compliance with applicable

District of Columbia law, unless you:

1. Are terminated for gross misconduct;
2. Are eligible for an extension of coverage under federal COBRA law; or
3. Fail to complete the appropriate election forms and provide proper payment in a timely manner.

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

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

Continuation coverage continues only upon payment of applicable monthly charges, which may include an allowable reasonable administrative fee, and terminates on the earliest of the following:

1. You establish residence outside of the Health Plan's Service Area;
2. You fail to make timely payment of the required cost of coverage;
3. You violate a material condition of this contract;
4. You become covered under another group health benefits plan that does not contain any exclusion or limitation with respect to pre-existing conditions that affects the covered Member;
5. You become entitled to Medicare; or
6. Your employer no longer offers group health benefits coverage to any employee.

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

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

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

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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.

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 years from the effective date of this Agreement. After this three-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

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

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

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

Governing Law

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 Actions

No legal action or in equity 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.
4000 Garden City Drive
Hyattsville, MD 20785

Named Fiduciary

Under our Agreement with your Group, we have assumed the role of a named fiduciary, which is a party

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

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 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 or, 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

SAMPLE

Charges for any Services that the baby (or babies) receive(s) (the legal parents are financially responsible for any Services that the baby receives).

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

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

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

You must send this information to:

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

SAMPLE

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

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

Kaiser Permanente
Small Group Agreement and Evidence of Coverage
District of Columbia

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

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

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

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

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

Allowable Charges: means either for:

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

SAMPLE

Allowable Expense: (For use in relation to Coordination of Benefits provisions only, which are located in ***Section 4: Subrogation, Reductions and Coordination of Benefits***): A health care Service or expense, including Deductibles, Copayments or Coinsurance, that is covered in full or in part by any of the Plans covering the Member. This means that an expense or health care Service or a portion of an expense or health care Service that is not covered by any of the Plans is not an Allowable Expense. For example, if a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room usually is not an Allowable Expense.

Ancillary Service: Services that are:

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

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

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

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

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

C

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

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***.

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

SAMPLE

5. Is or was determined to be terminally ill, as determined under section 1861(dd)(3)(A) of the Social Security Act, and is receiving treatment for such illness from such provider or facility.

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***.

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

Cost Sharing: Any expenditure required by or on behalf of a Member with respect to Essential Health Benefits. Such term includes Deductibles, Coinsurance, Copayments or similar charges, but excludes premiums, balance billing amounts for non-network providers, amounts for Post-Stabilization Care to which the Member consented (agreed) to pay and spending for non-covered services.

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

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

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

D

Deductible: The 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*** for the Services that are subject to Deductible and the amount of the Deductible.

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

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

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***).

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

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

1. An appropriate medical screening examination, as required federal under the Emergency Medical Treatment and Active Labor Act (EMTALA), section 1867 of the Social Security Act, that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department, to evaluate such Emergency Medical Condition;
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment required under EMTALA, or would be required under EMTALA if EMTALA applied to an Independent Freestanding Emergency Department, to Stabilize the patient, regardless of the department of the hospital in which such further examination or treatment is furnished; and
3. Except as further described in this paragraph 3, covered Services, also referred to as Post-Stabilization Care, that are furnished by a Non-Plan Provider after you are Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Visit in which the Emergency Services are furnished:
    a. When, under applicable federal law, the covered Services described in item #3 are not included as Emergency Services if all of the following conditions are met:
        i. The attending emergency physician or Treating Provider determines that the Member is able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Hospital or Plan Facility located within a reasonable travel distance, taking into account the Member's medical condition;
        ii. The provider or facility furnishing such additional covered Services satisfies the notice and consent requirements set forth in federal regulation 45 C.F.R § 149.420(c) through (g) with respect to such covered Services, provided that the written notice additionally (1) identifies Plan Providers to whom you can be referred when a non-Plan Provider proposes to furnish covered Services at a Plan Hospital or Plan Facility when a non-Plan Provider proposes to provide such covered Services and (2) includes a good faith estimate of the charges for covered Services to be furnished at a non-Plan Hospital or non-Plan Facility by non-Plan Providers during the Visit; and
        iii. The Member, or an Authorized Representative of such Member, is in a condition to receive the information in the consent as described in item #3, as determined by the attending emergency physician or Treating Provider using appropriate medical

SAMPLE

judgment, and to provide informed consent in accordance with applicable State law; or

b. When the covered Services are rendered by a Health Care Provider who is subject to state law prohibiting balance billing (§19-710(p) of the Health-General Article).

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.

Exchange: The District of Columbia Health Benefit Exchange Authority.

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.

G

Grievance: A protest filed by a Member or parent/guardian, as applicable, or by a provider or other Authorized Representative on behalf of the Member, with the Health Plan, through our internal grievance process regarding an Adverse Decision concerning the Member. A Grievance does not include a verbal request for reconsideration of a Utilization Review determination.

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

H

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

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

Health Plan: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 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 Health Savings Account by an eligible individual are tax Deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified High Deductible Health

SAMPLE

Plan and meet other tax law requirements. Kaiser Permanente does not provide tax advice. Consult your financial or tax advisor for more information about your eligibility for a Health Savings Account.

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 EOC has been designed to be a High Deductible Health Plan qualified for use with a Health Savings Account.

Hospital: Any hospital:

1. In the Service Area to which a Member is admitted to receive Hospital Services pursuant to arrangements made by a physician; or
2. Outside of the Service Area for clinical trials, Emergency or Urgent Care Services or upon receiving an approved referral.

I

Independent Freestanding Emergency Department: A health care facility that is geographically separate and distinct and licensed separately from a Hospital under applicable State law and provides any Emergency Services.

K

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

L

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

M

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

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

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

SAMPLE

Note: The fact that a Plan Physician may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by this Plan.

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

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

Minimum Essential Coverage: The type of coverage an individual needs to have to meet the individual responsibility requirement of the Patient Protection and Affordable Care Act.

O

Out-of-Pocket Maximum: The maximum amount of Copayments, Deductibles and Coinsurance that an individual or Family Unit is obligated to pay for covered Services per contract 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. Medicare supplement policies;
8. A state plan under Medicaid; or
9. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

SAMPLE

Plan Facility: A Plan Medical Center, a Plan Hospital or another freestanding facility that is:

1. Operated by us or contracts, directly or indirectly, to provide Services and supplies to Members; and
2. Included in your Signature care delivery system.

Plan Hospital: A hospital that:

1. Contracts, directly or indirectly, to provide inpatient and/or outpatient Services to Members; and
2. Is included in your Signature care delivery system.

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, and is included in the Signature care delivery system.

Plan Physician: Any licensed physician who is an employee of Medical Group, or any licensed physician (except for those physicians who contract only to provide Services upon referral) who:

1. Contracts, directly or indirectly, to provide Services and supplies to Members; and
2. Is included in your Signature care delivery system.

Plan Provider: A Plan Physician, or other health care provider including but not limited to a non-physician specialist, and Plan Facility that:

1. Is employed by or operated by an entity that participates in the Kaiser Permanente Medical Care Program; or
2. Contracts, directly or indirectly, with an entity that participates in the Kaiser Permanente Medical Care Program.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive after your attending emergency physician or Treating Provider determines that your Emergency Medical Condition is Stabilized. We cover Post-Stabilization Care only when (1) it is considered to be Emergency Services under federal law, without Prior Authorization, or (2) we determine that such Services are Medically Necessary pursuant to a request for Prior Authorization for the Service(s).

Premium: Periodic membership charges paid by Group.

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

1. General internal medicine;
2. Family practice medicine;
3. Pediatrics; or
4. Obstetrics/gynecology.

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.

SAMPLE

Q

Qualified Employee: Any employee or former employee of a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP for himself or herself and, if the qualified employer offers dependent coverage through the SHOP, for his or her dependents. 80 FR 10864, § 155.20.

Qualified Employer: A Small Employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP Exchange, and, at the option of the employer, some or all of its part-time employees; provided, that the employer:

1. Has its principal place of business in the District of Columbia and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or
2. Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in the District of Columbia. 155.20 and DC Ins §31-3171.01.

Qualified Health Plan: A health plan that has in effect a certification that it meets the standards recognized by the Exchange through which such plan is offered.

Qualifying Payment Amount: The amount calculated using the methodology described in federal regulation (45 C.F.R. § 149.140(c)), which is based on the median contracted rate for all individual plans issued by Health Plan for the same or similar Service that is:

1. Provided by a provider in the same or similar specialty or facility of the same or similar facility type; and
2. Provided in the geographic region in which the item or Service is furnished.

The median contracted rate is subject to additional adjustments specified in the applicable federal regulation.

S

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

SHOP Exchange: A Small Business Health Options Program established pursuant to §31-3171.04, and Section 1311(b) of the Affordable Care Act. DC Ins §31-3171.01.

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.

Small Employer: A single employer that employed an average of fifty (50) or fewer employees during the preceding calendar year. DC Ins §31-3301.01(42)(A)(ii).

Specialist: A Health Care Practitioner who is not providing Primary Care Services.

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

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

T

Totally Disabled:

1. **For Subscribers and Adult Dependents:** In the judgment of a Medical Group Physician, a 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.
2. **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.

SAMPLE

Urgent Medical Condition: As used in ***Section 5: Filing Claims, Appeals and Grievances***, a condition that satisfies either of the following:

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

V

Visit: The instance of going to or staying at a health care facility, and, with respect to Services furnished to a Member at a health care facility, includes, in addition to Services furnished by a provider at the health care facility, equipment and devices, telemedicine Services, imaging Services, laboratory Services, and preoperative and postoperative Services, regardless of whether the provider furnishing such Services is at the health care facility.

SAMPLE

Kaiser Permanente
Your Small Group Agreement and Evidence of Coverage

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

Kaiser Permanente Smile Kids SG Embedded Dental EPO Plan Appendix

Under this Appendix, Members up to age 19 are eligible for Pediatric Dental Benefits as of the effective date of your Kaiser Permanente Membership Agreement (Agreement). This coverage will end on the earlier of the date your Agreement terminates, or the end of the month on which the Member turns 19.

Definitions

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

Covered Dental Services: A set of dental services that can include a range of diagnostic, preventive, restorative, endodontic, periodontic, prosthetic, orthodontic and oral surgery services that are benefits of your Pediatric Dental Plan.

Dental Administrator: The entity that provides or arranges for the provision of Covered Dental Services on behalf of the Health Plan. The name and information about the Dental Administrator can be found under "General Provisions" below.

Dental Specialist: A dentist that has received advanced training in one of the dental specialties approved by the American Dental Association, and practices as a specialist. Dental specialties include Endodontists, Oral Surgeon, Periodontists and Pediatric Dentists.

General Dentist: A dentist who provides your basic care and coordinates the care you need from other dental specialty providers.

Member Copayments: The amount listed on the Schedule of Benefits that is charged to a member at the time of service for covered dental plan benefits. Member Copayments are directly paid to the Participating Dental Provider at the time services are rendered. The Participating Dental Provider has agreed to accept that Member Copayment as payment in full of the Member's responsibility for that procedure. Neither the Health Plan nor Dental Administrator are responsible for payment of these Copayments or for any fees incurred as the result of receipt of non-Covered Dental Services or any other non-covered dental service. Participating Dental Providers have agreed to accept Member Copayments as payment in full of the Member's responsibility for that procedure.

Non-Participating Dental Provider or Out-of-Network Dentist: A licensed dentist who has not entered into an agreement with the Dental Administrator for the purposes of providing dental services to Members. When your plan does not include Out-of-Network benefits, other than in the case of an emergency or referral to a Non-Participating Specialist, Covered Dental Services performed by an Out-of-Network Dentist will not be covered and you will be responsible for the entire cost.

Participating Dental Provider or In-Network Dentist: A licensed dentist who has signed a contract with the Dental Administrator to provide services to our members in accordance with the Dental Administrator's guidelines and criteria. When a Participating Dental Provider is selected for care, Covered Dental Services for "In-Network" benefits will apply.

Pediatric Dental Benefits or Pediatric Dental Plan: Refers to a dental plan provided to children only.

SAMPLE

General Provisions

As a current Kaiser Permanente Member under this Plan, the Dental Administrator agrees to provide and arrange Pediatric Dental Benefits in accordance with the terms, conditions, limitations, and exclusions specified in this Agreement and Appendix.

This Appendix includes a Schedule of Dental Benefits, which lists what you will be charged for each Covered Dental Service you receive.

You have the freedom to select any General Dentist from our network. Your covered family members may select the same or a different General Dentist. Your General Dentist will refer you to a Dental Specialist in our network.

To find a dentist in your area, you can go to our website at www.kp.org, or call us toll-free at 1-888-798-9868/TTY: 1-877-855-8039, Monday through Friday from 8 a.m. to 8 p.m. Eastern Standard Time (EST). Once you have located a Participating Provider, you can call the office to schedule an appointment. The dental office will contact us to verify your eligibility. Be sure to identify yourself as a Kaiser member when you call the dentist for an appointment. We also suggest that you take this information with you when you go to your appointment. You can then reference benefits and applicable charges which are the out-of-pocket costs associated with your plan.

Alternate Treatment

If a condition can be corrected or treated by a professionally acceptable service at a lower cost, your plan will cover the lower-cost service. If you decide to choose a more costly service or treatment, you will be responsible for the difference in cost. Alternate benefits may include, but are not limited to, the use of porcelain or gold, crowns, inlays, fixed partial dentures, and removable complete and partial dentures.

Dental Administrator

The Health Plan has entered into an agreement with LIBERTY Dental Plan Corporation (LIBERTY), to provide Covered Dental Services as described in this Pediatric Dental Appendix. For assistance concerning dental coverage questions or for help finding a Participating Dental Provider, you can go to our website at www.kp.org, or call us toll-free at 1-888-798-9868/TTY: 1-877-855-8039, Monday through Friday from 8 a.m. to 8 p.m. Eastern Standard Time (EST).

SAMPLE

Specialist Referrals

Participating Specialist Referrals

Your General Dentist may recommend a Specialist if the services are medically necessary and out of the scope of general dentistry. If your General Dentist requires you to get covered services from a Specialist, you may directly refer to a Specialist in our network. This Appendix includes a Schedule of Dental Benefits, which lists what you will be charged for each Covered Dental Service you receive.

Non-Participating Specialist Referrals

Benefits may be provided for referrals to Non-Participating Dental Provider specialists when you have been diagnosed by a Participating Dental Provider with a condition or disease that requires care from a dental specialist, and:

1. The Dental Administrator does not have a Participating Dental Provider who possesses the professional training and expertise to treat the condition or disease; or

2. The Dental Administrator is not able to provide reasonable access to a Participating Dental Provider with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

The Member's Cost Share will be calculated as if the Non-Participating Dental Provider specialist rendering the Covered Dental Services were a Participating Dental Provider.

Extension of Benefits

In those instances when your coverage with the Health Plan has terminated, we will extend Covered Dental Services, without payment of premium, in the following instances:

1. If you are in the midst of a course of covered dental treatment at the time your coverage ends, we will continue to provide benefits, in accordance with this Agreement and Dental Appendix in effect at the time your coverage ended, for a period of ninety (90) days following the date your coverage ended.
2. If you are in the midst of a course of covered orthodontic treatment at the time your coverage ends, we will continue to provide benefits, in accordance with this Agreement and Dental Appendix in effect at the time your coverage ended, for a period of:
   a. Sixty (60) days following the date your coverage ended, if the orthodontist has agreed to or is receiving monthly payments; or
   b. Until the later of sixty (60) days following the date your coverage ended, or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

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

Extension of Benefits Limitations

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

1. When coverage ends because of your failure to pay premium;
2. When coverage ends as the result of you committing fraud or material misrepresentation;
3. When coverage is provided by another health plan and that health plan's coverage:
   a. Is provided at a cost to you that is less than or equal to the cost to you of the extended benefit available under this Appendix; and
   b. Will not result in an interruption of the Covered Dental Services you are receiving.

Dental Emergencies

Out of Service Area

When a dental emergency occurs when you are more than fifty (50) miles from your General Dentist, the Dental Administrator will reimburse you for the reasonable charges for Covered Dental Services that may be provided, less any discounted fee, upon proof of payment, not to exceed $100 per incident. Proof of loss must be submitted to the Dental Administrator within ninety (90) days of treatment. Proof of loss should be mailed to:

LIBERTY Dental Plan
Claims Department
P.O. Box 15149
Tampa, FL 33684-5149

SAMPLE

Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. Coverage is limited to those procedures not excluded under Plan limitations and exclusions. You must receive all post-emergency care from your Participating Dental Provider.

Failure to provide proof of loss for a dental emergency, or as may be required under "Non-Participating Specialist Referrals," within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than one (1) year from the time proof is otherwise required.

Within Service Area

When you have a dental emergency within the Service Area but are unable to make arrangements to receive care through your General Dentist, contact the Dental Administrator at 1-888-798-9868, TTY: 1-877-855-8039, Monday through Friday from 8 a.m. to 8 p.m. Eastern Standard Time (EST) for assistance in locating another Participating Dental Provider.

Submission of Claims

When you receive Covered Dental Services from a Non-Participating Dental Provider, the Dental Administrator will reimburse the Non-Participating Provider directly. If the Member has already paid the charges, the Dental Administrator will reimburse the Member (upon proof of payment) instead of paying the provider directly for Covered Dental Services that may have been provided.

The Dental Administrator will accept a recognized ADA claim form from the dental provider's office. Claims can be submitted to:

LIBERTY Dental Plan
Claims Department
P.O. Box 15149
Tampa, FL 33684-5149

A claim form is available to download at www.kp.org. Once you have completed the claim form, you must include any copies of all itemized bills and proof of payment.

If you do not receive the claim form within fifteen (15) days after you notified the Dental Administrator, you may submit written proof of the occurrence, character, and extent of the loss for which the claim is made, including any copies of itemized bills and proof of payment.

All itemized bills and/or proof of payment must be submitted within ninety (90) days of treatment. Failure to submit the itemized bill and/or proof of payment within the time required does not invalidate or reduce Benefits payable if it was not reasonably possible for you to submit the itemized bills and/or proof of payment within the one-year period. If you submit the itemized bill and/or proof of payment as soon as reasonably possible and, except in the absence of legal capacity, no later than one (1) year from the time proof is otherwise required, Benefits will be payable.

Benefits payable under the Small Group Evidence of Coverage for any loss will be paid within the time required by state regulations after receipt of written proof of loss. If the Dental Administrator fails to pay a claim within the time required by state regulations, it will pay interest from the date on which payment is required to the date the claim is paid. If a claim is denied in whole or in part, the written notice of the denial

SAMPLE

will contain the reasons for denial and reference to the pertinent provisions of the Small Group Evidence of Coverage and this Rider.

Appeals

If a claim is denied, you or your Authorized Representative may file an appeal with the Dental Administrator in accordance with the ***Getting Assistance, Health Care Service Review, Appeals and Grievances*** section of the Small Group Evidence of Coverage.

Submit your Appeal to:

LIBERTY Dental Plan
Attn: Grievances and Appeals
Quality Management Department
PO BOX 26110
Santa Ana, CA 92799-6110

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

By: _____

Gracelyn McDermott
Vice President, Marketing, Sales & Business Development

SAMPLE

Kaiser Permanente
Your Small Group Agreement and Evidence of Coverage

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Kaiser Permanente Smile Kids SG Embedded Dental EPO
2026 Schedule of Dental Benefits (up to 19)

This Schedule of Dental Benefits lists procedures covered under your Dental Plan. These services are available to you until the end of the month you turn 19 years old and only apply when performed by a participating General Dentist or Dental Specialist.

You must visit a contracted dental office to utilize covered benefits. For services performed by a Dental Specialist, your dental office will initiate a treatment plan or recommend you see a participating Dental Specialist if the services are medically necessary and outside the scope of general dentistry. You may directly refer to a participating Dental Specialist in the network. For information on locating a Participating Dental Provider, please contact us Toll Free at 1-888-798-9868 or TTY: 1-877-855-8039, Monday through Friday, 8 a.m. to 8 p.m. Eastern Standard Time (EST).

This Schedule does not guarantee benefits. All services are subject to eligibility and dental necessity at the time of service. Dental procedures not listed are available at the dental office's usual and customary fee.

Annual Out-of-Pocket Maximum

Any Member Copayment you pay for covered dental services will accrue towards your medical plan's Out-of-Pocket Maximum. You will not be charged more than the amount of your Out-of-Pocket Maximum for any covered dental services. Please refer to your medical plan for specific details.

Refer to the ***Kaiser Permanente Smile Kids SG Embedded Dental EPO Plan Appendix*** for a complete description of the terms and conditions of your covered dental benefit.

SAMPLE

CDT Code	Description	Member Copayment	Limitations
TYPE I - DIAGNOSTIC & PREVENTIVE SERVICES			
D0120	Periodic oral evaluation	$5	2 of (D0120, D0145, D0150) every 12 months, per provider or location. Coverage begins with the eruption of the first tooth
D0140	Limited oral evaluation	$5	1 of (D0140) per date of service
D0145	Oral evaluation under age 3	$5	2 of (D0120, D0145, D0150) every 12 months, per provider or location
D0150	Comprehensive oral evaluation	$5	2 of (D0120, D0145, D0150) every 12 months, per provider or location
D0160	Oral evaluation, problem focused	$10	
D0170	Re-evaluation, limited, problem focused	$5	
D0171	Re-evaluation, post operative office visit	$0	
D0180	Comprehensive periodontal evaluation	$5	
D0210	Intraoral, comprehensive series of radiographic images	$10	1 of (D0210, D0330, D0701, D0709) every 36 months, per provider or location
D0220	Intraoral, periapical, first radiographic image	$0	
D0230	Intraoral, periapical, each add 'l radiographic image	$0	
D0240	Intraoral, occlusal radiographic image	$0	

CDT Code	Description	Member Copayment	Limitations
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	$0	
D0270	Bitewing, single radiographic image	$0	
D0272	Bitewings, two radiographic images	$0	2 of (D0272-D0274, D0277) every 12 months, per provider or location
D0273	Bitewings, three radiographic images	$5	2 of (D0272-D0274, D0277) every 12 months, per provider or location
D0274	Bitewings, four radiographic images	$5	2 of (D0272-D0274, D0277) every 12 months, per provider or location
D0277	Vertical bitewings, 7 to 8 radiographic images	$10	2 of (D0272-D0274, D0277) every 12 months, per provider or location
D0310	Sialography	$37	
D0320	TMJ arthrogram, including injection	$45	
D0321	Other TMJ radiographic images, by report	$0	
D0330	Panoramic radiographic image	$10	1 of (D0210, D0330, D0701, D0709) every 36 months, per provider or location
D0340	2D cephalometric radiographic image, measurement and analysis	$10	
D0350	2D oral/facial photographic image, intra-orally/extra-orally	$5	
D0391	Interpretation, diagnostic image by a practitioner, not associated with image, including report	$0	
D0460	Pulp vitality tests	$0	
D0470	Diagnostic casts	$10	
D0486	Accession of transepithelial cytologic sample, prep, written report	$10	
D0601	Caries risk assessment and documentation, low risk	$0	2 of (D0601-D0603) every 12 months
D0602	Caries risk assessment and documentation, moderate risk	$0	2 of (D0601-D0603) every 12 months
D0603	Caries risk assessment and documentation, high risk	$0	2 of (D0601-D0603) every 12 months
D0701	Panoramic radiographic image, image capture only	$0	1 of (D0701, D0709, D0210, D0330) every 36 months, per provider or location
D0702	2-D cephalometric radiographic image, image capture only	$0	
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally, image capture only	$0	
D0705	Extra-oral posterior dental radiographic image, image capture only	$0	
D0706	Intraoral, occlusal radiographic image, image capture only	$0	
D0707	Intraoral, periapical radiographic image, image capture only	$0	

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D0708	Intraoral, bitewing radiographic image, image capture only	$0	
D0709	Intraoral, comprehensive series of radiographic images, image capture only	$0	1 of (D0701, D0709, D0210, D0330) every 36 months, per provider or location
D1110	Prophylaxis, adult	$10	2 of (D1110, D1120, D4346) every 12 months
D1120	Prophylaxis, child	$5	2 of (D1110, D1120, D4346) every 12 months
D1206	Topical application of fluoride varnish	$0	2 of (D1206, D1208) every 12 months
D1208	Topical application of fluoride, excluding varnish	$0	2 of (D1206, D1208) every 12 months
D1310	Nutritional counseling for control of dental disease	$0	
D1320	Tobacco counseling, control/prevention oral disease	$0	
D1321	Counseling for the control and prevention of adverse oral, behavioral, health effects associated with high-risk substance use	$0	
D1330	Oral hygiene instruction	$0	
D1351	Sealant, per tooth	$5	1 of (D1351) per tooth every 36 months, limited to unrestored permanent molars
D1352	Preventive resin restoration, permanent tooth	$5	
D1354	Application of caries arresting medicament, per tooth	$0	1 of (D1354) per tooth every 6 months, no more than twice per tooth in a lifetime
D1355	Caries preventive medicament application, per tooth	$0	
D1510	Space maintainer, fixed, unilateral, per quadrant	$25	1 of (D1510, D1520, D1575) per quadrant when medically necessary due to the premature loss of a posterior primary tooth
D1516	Space maintainer, fixed, bilateral, maxillary	$36	1 of (D1516, D1517, D1526, D1527) per arch when medically necessary due to the premature loss of a posterior primary tooth
D1517	Space maintainer, fixed, bilateral, mandibular	$36	1 of (D1516, D1517, D1526, D1527) per arch when medically necessary due to the premature loss of a posterior primary tooth
D1520	Space maintainer, removable, unilateral, per quadrant	$26	1 of (D1510, D1520, D1575) per quadrant when medically necessary due to the premature loss of a posterior primary tooth

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D1526	Space maintainer, removable, bilateral, maxillary	$40	1 of (D1516, D1517, D1526, D1527) per arch when medically necessary due to the premature loss of a posterior primary tooth
D1527	Space maintainer, removable, bilateral, mandibular	$40	1 of (D1516, D1517, D1526, D1527) per arch when medically necessary due to the premature loss of a posterior primary tooth
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	$5	
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	$5	
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	$0	
D1556	Removal of fixed unilateral space maintainer, per quadrant	$0	1 of (D1556) per quadrant when medically necessary due to the premature loss of a posterior primary tooth
D1557	Removal of fixed bilateral space maintainer, maxillary	$0	1 of (D1557, D1558) per arch when medically necessary due to the premature loss of a posterior primary tooth
D1558	Removal of fixed bilateral space maintainer, mandibular	$0	1 of (D1557, D1558) per arch when medically necessary due to the premature loss of a posterior primary tooth
D1575	Distal shoe space maintainer, fixed, per quadrant	$26	1 of (D1510, D1520, D1575) per quadrant when medically necessary due to the premature loss of a posterior primary tooth
D9995	Teledentistry, synchronous; real-time encounter	$0	Must be accompanied by a covered procedure
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review	$0	Must be accompanied by a covered procedure
TYPE II - ROUTINE (Basic) SERVICES			
D2140	Amalgam, one surface, primary or permanent	$28	
D2150	Amalgam, two surfaces, primary or permanent	$36	
D2160	Amalgam, three surfaces, primary or permanent	$44	
D2161	Amalgam, four or more surfaces, primary or permanent	$51	
D2330	Resin-based composite, one surface, anterior	$36	
D2331	Resin-based composite, two surfaces, anterior	$46	

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D2332	Resin-based composite, three surfaces, anterior	$52	
D2335	Resin-based composite, four or more surfaces	$56	
D2390	Resin-based composite crown, anterior	$63	
D2391	Resin-based composite, one surface, posterior	$40	
D2392	Resin-based composite, two surfaces, posterior	$51	
D2393	Resin-based composite, three surfaces, posterior	$62	
D2394	Resin-based composite, four or more surfaces, posterior	$71	
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	$134	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 36 months
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	$59	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 36 months
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	$48	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 36 months
D4240	Gingival flap procedure, four or more teeth per quadrant	$169	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 36 months
D4241	Gingival flap procedure, one to three teeth per quadrant	$106	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 36 months
D4249	Clinical crown lengthening, hard tissue	$187	Prior Authorization Required
D4260	Osseous surgery, four or more teeth per quadrant	$282	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 36 months
D4261	Osseous surgery, one to three teeth per quadrant	$190	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 36 months
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	$101	
D4264	Bone replacement graft, retained natural tooth, each additional site	$86	
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	$101	
D4268	Surgical revision procedure, per tooth	$0	
D4270	Pedicle soft tissue graft procedure	$201	
D4273	Autogenous connective tissue graft procedure, first tooth	$245	
D4274	Mesial/distal wedge procedure, single tooth	$139	
D4275	Non-autogenous connective tissue graft, first tooth	$234	

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D4276	Combined connective tissue and pedicle graft	$275	
D4277	Free soft tissue graft, first tooth	$208	
D4278	Free soft tissue graft, each additional tooth	$124	
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	$209	
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	$157	
D4322	Splint, intra-coronal; natural teeth or prosthetic crowns	$23	
D4323	Splint, extra-coronal; natural teeth or prosthetic crowns	$23	
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	$58	1 of (D4341, D4342) per site/ quadrant, every 24 months;
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$39	1 of (D4341, D4342) per site/ quadrant, every 24 months;
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	$25	2 of (D1110, D1120, D4346) every 12 months
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit	$35	1 of (D4355) per lifetime
D4910	Periodontal maintenance	$32	4 of (D4910) per 12 months
D4921	Gingival irrigation with a medicinal agent, per quadrant	$19	1 of (D4921) per quadrant every 36 months, not payable within 4 weeks of periodontal scaling and root planing
D7111	Extraction, coronal remnants, primary tooth	$26	
D7140	Extraction, erupted tooth or exposed root	$34	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	$60	
D7220	Removal of impacted tooth, soft tissue	$72	
D7230	Removal of impacted tooth, partially bony	$95	
D7240	Removal of impacted tooth, completely bony	$115	
D7241	Removal impacted tooth, complete bony, complication	$137	
D7250	Removal of residual tooth roots (cutting procedure)	$60	
D9110	Palliative treatment of dental pain, per visit	$23	1 of (D9110) per date of service
D9420	Hospital or ambulatory surgical center call	$44	Prior Authorization Required
D9440	Office visit, after regularly scheduled hours	$28	
TYPE III - MAJOR SERVICES			
Guideline: Single Crowns - Copayment includes all costs for lab bills and materials			
D2510	Inlay, metallic, one surface	$271	1 of (D2510-D2794) per tooth every 60 months
D2520	Inlay, metallic, two surfaces	$322	1 of (D2510-D2794) per tooth every 60 months
D2530	Inlay, metallic, three or more surfaces	$350	1 of (D2510-D2794) per tooth every 60 months

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D2542	Onlay, metallic, two surfaces	$343	1 of (D2510-D2794) per tooth every 60 months
D2543	Onlay, metallic, three surfaces	$386	1 of (D2510-D2794) per tooth every 60 months
D2544	Onlay, metallic, four or more surfaces	$405	1 of (D2510-D2794) per tooth every 60 months
D2610	Inlay, porcelain/ceramic, one surface	$315	1 of (D2510-D2794) per tooth every 60 months
D2620	Inlay, porcelain/ceramic, two surfaces	$339	1 of (D2510-D2794) per tooth every 60 months
D2630	Inlay, porcelain/ceramic, three or more surfaces	$366	1 of (D2510-D2794) per tooth every 60 months
D2642	Onlay, porcelain/ceramic, two surfaces	$356	1 of (D2510-D2794) per tooth every 60 months
D2643	Onlay, porcelain/ceramic, three surfaces	$404	1 of (D2510-D2794) per tooth every 60 months
D2644	Onlay, porcelain/ceramic, four or more surfaces	$421	1 of (D2510-D2794) per tooth every 60 months
D2650	Inlay, resin-based composite, one surface	$252	1 of (D2510-D2794) per tooth every 60 months
D2651	Inlay, resin-based composite, two surfaces	$282	1 of (D2510-D2794) per tooth every 60 months
D2652	Inlay, resin-based composite, three or more surfaces	$305	1 of (D2510-D2794) per tooth every 60 months
D2662	Onlay, resin-based composite, two surfaces	$288	1 of (D2510-D2794) per tooth every 60 months
D2663	Onlay, resin-based composite, three surfaces	$338	1 of (D2510-D2794) per tooth every 60 months
D2664	Onlay, resin-based composite, four or more surfaces	$355	1 of (D2510-D2794) per tooth every 60 months
D2710	Crown, resin-based composite (indirect)	$168	1 of (D2510-D2794) per tooth every 60 months
D2712	Crown, ¾ resin-based composite (indirect)	$165	1 of (D2510-D2794) per tooth every 60 months
D2720	Crown, resin with high noble metal	$400	1 of (D2510-D2794) per tooth every 60 months
D2721	Crown, resin with predominantly base metal	$375	1 of (D2510-D2794) per tooth every 60 months
D2722	Crown, resin with noble metal	$383	1 of (D2510-D2794) per tooth every 60 months
D2740	Crown, porcelain/ceramic	$474	1 of (D2510-D2794) per tooth every 60 months
D2750	Crown, porcelain fused to high noble metal	$468	1 of (D2510-D2794) per tooth every 60 months
D2751	Crown, porcelain fused to predominantly base metal	$403	1 of (D2510-D2794) per tooth every 60 months
D2752	Crown, porcelain fused to noble metal	$427	1 of (D2510-D2794) per tooth every 60 months

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D2753	Crown, porcelain fused to titanium and titanium alloys	$477	1 of (D2510-D2794) per tooth every 60 months
D2780	Crown, ¾ cast high noble metal	$426	1 of (D2510-D2794) per tooth every 60 months
D2781	Crown, ¾ cast predominantly base metal	$372	1 of (D2510-D2794) per tooth every 60 months
D2782	Crown, ¾ cast noble metal	$401	1 of (D2510-D2794) per tooth every 60 months
D2783	Crown, ¾ porcelain/ceramic	$444	1 of (D2510-D2794) per tooth every 60 months
D2790	Crown, full cast high noble metal	$454	1 of (D2510-D2794) per tooth every 60 months
D2791	Crown, full cast predominantly base metal	$389	1 of (D2510-D2794) per tooth every 60 months
D2792	Crown, full cast noble metal	$425	1 of (D2510-D2794) per tooth every 60 months
D2794	Crown, titanium and titanium alloys	$400	1 of (D2510-D2794) per tooth every 60 months
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	$36	
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	$21	
D2920	Re-cement or re-bond crown	$36	
D2928	Prefabricated porcelain/ceramic crown, permanent tooth	$123	
D2929	Prefabricated porcelain/ceramic crown, primary tooth	$144	
D2930	Prefabricated stainless steel crown, primary tooth	$103	
D2931	Prefabricated stainless steel crown, permanent tooth	$112	
D2932	Prefabricated resin crown	$119	
D2933	Prefabricated stainless steel crown with resin window	$137	
D2934	Prefabricated esthetic coated stainless steel crown, primary tooth	$137	
D2940	Placement of interim direct restoration	$38	
D2950	Core buildup, including any pins when required	$96	
D2951	Pin retention, per tooth, in addition to restoration	$21	
D2952	Post and core in addition to crown, indirectly fabricated	$161	
D2954	Prefabricated post and core in addition to crown	$119	
D2955	Post removal	$92	
D2962	Labial veneer (porcelain laminate), indirect	$355	1 of (D2962) per tooth every 60 months

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D2980	Crown repair necessitated by restorative material failure	$84	
D2981	Inlay repair necessitated by restorative material failure	$70	
D2982	Onlay repair necessitated by restorative material failure	$72	
D2983	Veneer repair necessitated by restorative material failure	$70	
D2990	Resin infiltration of incipient smooth surface lesions	$25	
D3110	Pulp cap, direct (excluding final restoration)	$30	
D3120	Pulp cap, indirect (excluding final restoration)	$24	
D3220	Therapeutic pulpotomy (excluding final restoration)	$76	1 (D3220) in a lifetime, per tooth
D3221	Pulpal debridement, primary and permanent teeth	$68	
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	$72	
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	$79	1 (D3230) in a lifetime, per tooth
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	$87	1 (D3240) in a lifetime, per tooth
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$318	1 of (D3310-D3330) in a lifetime, per tooth
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$374	1 of (D3310-D3330) in a lifetime, per tooth
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$472	1 of (D3310-D3330) in a lifetime, per tooth
D3333	Internal root repair of perforation defects	$95	
D3346	Retreatment of previous root canal therapy, anterior	$395	1 of (D3346-D3348) in a lifetime, per tooth
D3347	Retreatment of previous root canal therapy, premolar	$454	1 of (D3346-D3348) in a lifetime, per tooth
D3348	Retreatment of previous root canal therapy, molar	$542	1 of (D3346-D3348) in a lifetime, per tooth
D3351	Apexification/recalcification, initial visit	$149	
D3352	Apexification/recalcification, interim medication replacement	$67	
D3353	Apexification/recalcification, final visit	$205	
D3355	Pulpal regeneration, initial visit	$149	
D3356	Pulpal regeneration, interim medication replacement	$67	
D3357	Pulpal regeneration, completion of treatment	$149	
D3410	Apicoectomy, anterior	$295	
D3421	Apicoectomy, premolar (first root)	$328	
D3425	Apicoectomy, molar (first root)	$371	

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D3426	Apicoectomy (each additional root)	$126	
D3430	Retrograde filling, per root	$93	
D3450	Root amputation, per root	$192	
D3471	Surgical repair of root resorption, anterior	$295	
D3472	Surgical repair of root resorption, premolar	$295	
D3473	Surgical repair of root resorption, molar	$295	
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption, anterior	$295	
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption, premolar	$295	
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption, molar	$295	
D3920	Hemisection, not including root canal therapy	$150	
D3921	Decoronation or submergence of an erupted tooth	$50	
D3950	Canal preparation and fitting of preformed dowel or post	$67	
Guideline: Removable Prosthodontics (Complete/Partial Dentures) - Copayment includes all costs for lab bills and materials			
D5110	Complete denture, maxillary	$593	1 of (D5110-D5120, D5863, D5865) per arch every 60 months
D5120	Complete denture, mandibular	$593	1 of (D5110-D5120, D5863, D5865) per arch every 60 months
D5130	Immediate denture, maxillary	$602	
D5140	Immediate denture, mandibular	$602	
D5211	Maxillary partial denture, resin base	$423	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months
D5212	Mandibular partial denture, resin base	$482	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months
D5213	Maxillary partial denture, cast metal, resin base	$630	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months
D5214	Mandibular partial denture, cast metal, resin base	$627	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months
D5221	Immediate maxillary partial denture, resin base	$454	
D5222	Immediate mandibular partial denture, resin base	$525	
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	$669	

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	$669	
D5225	Maxillary partial denture, flexible base	$592	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months
D5226	Mandibular partial denture, flexible base	$590	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	$316	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	$316	1 of (D5211-D5214, D5225-D5283, D5864, D5866)) per arch every 60 months
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	$244	1 of (D5284, D5286) per quad every 60 months
D5286	Removable unilateral partial denture, one piece resin, per quadrant	$182	1 of (D5284, D5286) per quad every 60 months
D5410	Adjust complete denture, maxillary	$29	Not payable within first 6 months of initial placement by same provider
D5411	Adjust complete denture, mandibular	$30	Not payable within first 6 months of initial placement by same provider
D5421	Adjust partial denture, maxillary	$30	Not payable within first 6 months of initial placement by same provider
D5422	Adjust partial denture, mandibular	$29	Not payable within first 6 months of initial placement by same provider
D5511	Repair broken complete denture base, mandibular	$85	Not payable within first 6 months of initial placement by same provider
D5512	Repair broken complete denture base, maxillary	$85	Not payable within first 6 months of initial placement by same provider
D5520	Replace missing or broken teeth, complete denture, per tooth	$67	Not payable within first 6 months of initial placement by same provider
D5611	Repair resin partial denture base, mandibular	$63	Not payable within first 6 months of initial placement by same provider
D5612	Repair resin partial denture base, maxillary	$63	Not payable within first 6 months of initial placement by same provider
D5621	Repair cast partial framework, mandibular	$70	Not payable within first 6 months of initial placement by same provider
D5622	Repair cast partial framework, maxillary	$70	Not payable within first 6 months of initial placement by same provider
D5630	Repair or replace broken retentive clasping materials, per tooth	$77	Not payable within first 6 months of initial placement by same provider
D5640	Replace missing or broken teeth, partial denture, per tooth	$54	Not payable within first 6 months of initial placement by same provider
D5650	Add tooth to existing partial denture, per tooth	$70	Not payable within first 6 months of initial placement by same provider
D5660	Add clasp to existing partial denture, per tooth	$87	Not payable within first 6 months of initial placement by same provider

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	$219	Not payable within first 6 months of initial placement by same provider
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	$223	Not payable within first 6 months of initial placement by same provider
D5710	Rebase complete maxillary denture	$200	Not payable within first 6 months of initial placement by same provider
D5711	Rebase complete mandibular denture	$190	Not payable within first 6 months of initial placement by same provider
D5720	Rebase maxillary partial denture	$188	Not payable within first 6 months of initial placement by same provider
D5721	Rebase mandibular partial denture	$188	Not payable within first 6 months of initial placement by same provider
D5730	Reline complete maxillary denture, direct	$112	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5731	Reline complete mandibular denture, direct	$112	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5740	Reline maxillary partial denture, direct	$103	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5741	Reline mandibular partial denture, direct	$103	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5750	Reline complete maxillary denture, indirect	$163	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5751	Reline complete mandibular denture, indirect	$162	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5760	Reline maxillary partial denture, indirect	$148	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5761	Reline mandibular partial denture, indirect	$148	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5810	Interim complete denture, maxillary	$427	
D5811	Interim complete denture, mandibular	$428	
D5820	Interim partial denture, maxillary	$205	
D5821	Interim partial denture, mandibular	$201	

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D5850	Tissue conditioning, maxillary	$54	
D5851	Tissue conditioning, mandibular	$53	
D5863	Overdenture, complete, maxillary	$796	1 of (D5110, D5120, D5863, D5865) per arch every 60 months
D5864	Overdenture, partial, maxillary	$788	1 of (D5211-D5214, D5225-D5283, D5864, D5866) per arch every 60 months
D5865	Overdenture, complete, mandibular	$1,271	1 of (D5110, D5120, D5863, D5865) per arch every 60 months
D5866	Overdenture, partial, mandibular	$788	1 of (D5211-D5214, D5225-D5283, D5864, D5866) per arch every 60 months
D5951	Feeding aid	$125	Prior Authorization Required
D5992	Adjust maxillofacial prosthetic appliance, by report	$37	1 (D5992) per arch every 6 months
D5993	Maintenance & cleaning, maxillofacial prosthesis, other than required adjustments, by report	$0	1 (D5993) per arch every 6 months
Guideline: Implants and Implant Related Services - Copayment includes all costs for lab bills and materials			
D6010	Surgical placement of implant body, endosteal	$872	Prior Authorization Required
D6012	Surgical placement of interim implant body, transitional prosthesis: endosteal implant	$855	Prior Authorization Required
D6040	Surgical placement: eposteal implant	$2,819	Prior Authorization Required
D6050	Surgical placement: transosteal implant	$2,104	Prior Authorization Required
D6055	Connecting bar, implant supported or abutment supported	$270	Prior Authorization Required
D6056	Prefabricated abutment, includes modification and placement	$250	Prior Authorization Required
D6057	Custom fabricated abutment, includes placement	$358	Prior Authorization Required
D6058	Abutment supported porcelain/ceramic crown	$655	Prior Authorization Required
D6059	Abutment supported porcelain fused to high noble crown	$648	Prior Authorization Required
D6060	Abutment supported porcelain fused to base metal crown	$578	Prior Authorization Required
D6061	Abutment supported porcelain fused to noble metal crown	$606	Prior Authorization Required
D6062	Abutment supported cast metal crown, high noble	$635	Prior Authorization Required
D6063	Abutment supported cast metal crown, base metal	$546	Prior Authorization Required
D6064	Abutment supported cast metal crown, noble metal	$595	Prior Authorization Required
D6065	Implant supported porcelain/ceramic crown	$673	Prior Authorization Required

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D6066	Implant supported crown, porcelain fused to high noble alloys	$649	Prior Authorization Required
D6067	Implant supported crown, high noble alloys	$626	Prior Authorization Required
D6068	Abutment supported retainer, porcelain/ceramic FPD	$659	Prior Authorization Required
D6069	Abutment supported retainer, metal FPD, high noble	$641	Prior Authorization Required
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	$572	Prior Authorization Required
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	$603	Prior Authorization Required
D6072	Abutment supported retainer, cast metal FPD, high noble	$633	Prior Authorization Required
D6073	Abutment supported retainer, cast metal FPD, base metal	$541	Prior Authorization Required
D6074	Abutment supported retainer, cast metal FPD, noble	$587	Prior Authorization Required
D6075	Implant supported retainer for ceramic FPD	$656	Prior Authorization Required
D6076	Implant supported retainer for FPD, porcelain fused to high noble alloys	$642	Prior Authorization Required
D6077	Implant supported retainer for metal FPD, high noble alloys	$619	Prior Authorization Required
D6080	Implant maintenance procedures, prosthesis removed/reinserted, including cleansing	$50	Prior Authorization Required
D6081	Scaling and debridement of a single implant in the presence of inflammation or mucositis	$39	Prior Authorization Required
D6087	Implant supported crown, noble alloys	$617	Prior Authorization Required
D6090	Repair of implant/abutment supported prosthesis, by report	$0	
D6091	Replacement of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	$186	Prior Authorization Required
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	$591	Prior Authorization Required
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	$623	Prior Authorization Required
D6100	Surgical removal of implant body	$51	
D6110	Implant/abutment supported removable denture, maxillary	$822	Prior Authorization Required
D6111	Implant/abutment supported removable denture, mandibular	$822	Prior Authorization Required
D6112	Implant/abutment supported removable denture, partial, maxillary	$884	Prior Authorization Required
D6113	Implant/abutment supported removable denture, partial, mandibular	$884	Prior Authorization Required
D6114	Implant/abutment supported fixed denture, maxillary	$1,000	Prior Authorization Required

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D6115	Implant/abutment supported fixed denture, mandibular	$1,000	Prior Authorization Required
D6116	Implant/abutment supported fixed denture for partial, maxillary	$400	Prior Authorization Required
D6117	Implant/abutment supported fixed denture for partial, mandibular	$400	Prior Authorization Required
D6121	Implant supported retainer for metal FPD, predominantly base alloys	$562	Prior Authorization Required
D6122	Implant supported retainer for metal FPD, noble alloys	$611	Prior Authorization Required
Guideline: Bridge Services - Copayment includes all costs for lab bills and materials			
D6205	Pontic, indirect resin based composite	$400	Prior Authorization Required
D6210	Pontic, cast high noble metal	$457	Prior Authorization Required
D6211	Pontic, cast predominantly base metal	$391	Prior Authorization Required
D6212	Pontic, cast noble metal	$425	Prior Authorization Required
D6214	Pontic, titanium, and titanium alloys	$400	Prior Authorization Required
D6240	Pontic, porcelain fused to high noble metal	$469	Prior Authorization Required
D6241	Pontic, porcelain fused to predominantly base metal	$398	Prior Authorization Required
D6242	Pontic, porcelain fused to noble metal	$435	Prior Authorization Required
D6243	Pontic, porcelain fused to titanium and titanium alloys	$480	Prior Authorization Required
D6245	Pontic, porcelain/ceramic	$471	Prior Authorization Required
D6250	Pontic, resin with high noble metal	$439	Prior Authorization Required
D6251	Pontic, resin with predominantly base metal	$382	Prior Authorization Required
D6252	Pontic, resin with noble metal	$409	Prior Authorization Required
D6545	Retainer, cast metal for resin bonded fixed prosthesis	$178	Prior Authorization Required
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis	$179	Prior Authorization Required
D6549	Resin retainer, for resin bonded fixed prosthesis	$106	Prior Authorization Required
D6600	Retainer inlay, porcelain/ceramic, two surfaces	$326	Prior Authorization Required
D6601	Retainer inlay, porcelain/ceramic, three or more surfaces	$349	Prior Authorization Required
D6602	Retainer inlay, cast high noble metal, two surfaces	$325	Prior Authorization Required
D6603	Retainer inlay, cast high noble metal, three or more surfaces	$343	Prior Authorization Required
D6604	Retainer inlay, cast base metal, two surfaces	$316	Prior Authorization Required
D6605	Retainer inlay, cast base metal, three or more surfaces	$340	Prior Authorization Required
D6606	Retainer inlay, cast noble metal, two surfaces	$318	Prior Authorization Required
D6607	Retainer inlay, cast noble metal, three or more surfaces	$344	Prior Authorization Required

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D6608	Retainer onlay, porcelain/ceramic, two surfaces	$338	Prior Authorization Required
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	$400	Prior Authorization Required
D6610	Retainer onlay, cast high noble metal, two surfaces	$337	Prior Authorization Required
D6611	Retainer onlay, cast high noble metal, three or more surfaces	$397	Prior Authorization Required
D6612	Retainer onlay, cast base metal, two surfaces	$335	Prior Authorization Required
D6613	Retainer onlay, cast base metal, three or more surfaces	$382	Prior Authorization Required
D6614	Retainer onlay, cast noble metal, two surfaces	$328	Prior Authorization Required
D6615	Retainer onlay, cast noble metal three or more surfaces	$382	Prior Authorization Required
D6634	Retainer onlay, titanium	$250	Prior Authorization Required
D6710	Retainer crown, indirect resin based composite	$400	Prior Authorization Required
D6720	Retainer crown, resin with high noble metal	$390	Prior Authorization Required
D6721	Retainer crown, resin with predominantly base metal	$370	Prior Authorization Required
D6722	Retainer crown, resin with noble metal	$377	Prior Authorization Required
D6740	Retainer crown, porcelain/ceramic	$477	Prior Authorization Required
D6750	Retainer crown, porcelain fused to high noble metal	$470	Prior Authorization Required
D6751	Retainer crown, porcelain fused to predominantly base metal	$402	Prior Authorization Required
D6752	Retainer crown, porcelain fused to noble metal	$437	Prior Authorization Required
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	$483	Prior Authorization Required
D6780	Retainer crown, ¾ cast high noble metal	$411	Prior Authorization Required
D6781	Retainer crown, ¾ cast predominantly base metal	$377	Prior Authorization Required
D6782	Retainer crown, ¾ cast noble metal	$395	Prior Authorization Required
D6783	Retainer crown, ¾ porcelain/ceramic	$436	Prior Authorization Required
D6784	Retainer crown ¾, titanium and titanium alloys	$422	Prior Authorization Required
D6790	Retainer crown, full cast high noble metal	$458	Prior Authorization Required
D6791	Retainer crown, full cast predominantly base metal	$389	Prior Authorization Required
D6792	Retainer crown, full cast noble metal	$426	Prior Authorization Required
D6794	Retainer crown, titanium and titanium alloys	$400	Prior Authorization Required
D6930	Re-cement or re-bond fixed partial denture	$52	
D6980	Fixed partial denture repair, restorative material failure	$88	

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D6999	Unspecified fixed prosthodontic procedure, by report	$0	Prior Authorization Required
D7251	Coronectomy, intentional partial tooth removal	$192	1 of (D7251) in a lifetime, per tooth
D7260	Oroantral fistula closure	$609	
D7261	Primary closure of a sinus perforation	$254	
D7270	Tooth reimplantation and/or stabilization, accident	$190	
D7272	Tooth transplantation	$254	1 of (D7272) in a lifetime, per tooth
D7280	Exposure of an unerupted tooth	$178	
D7282	Mobilization of erupted/malpositioned tooth	$198	
D7283	Placement, device to facilitate eruption, impaction	$39	
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	$356	
D7286	Incisional biopsy of oral tissue, soft	$152	
D7288	Brush biopsy, transepithelial sample collection	$61	
D7290	Surgical repositioning of teeth	$152	1 of (D7290) in a lifetime, per tooth
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$24	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	$91	1 of (D7310-D7321) in a lifetime, per quadrant
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	$80	1 of (D7310-D7321) in a lifetime, per quadrant
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	$149	1 of (D7310-D7321) in a lifetime, per quadrant
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	$126	1 of (D7310-D7321) in a lifetime, per quadrant
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	$629	
D7350	Vestibuloplasty, ridge extension	$1,829	
D7410	Excision of benign lesion, up to 1.25 cm	$274	
D7411	Excision of benign lesion, greater than 1.25 cm	$120	
D7413	Excision of malignant lesion, up to 1.25 cm	$121	
D7414	Excision of malignant lesion, greater than 1.25 cm	$158	
D7440	Excision of malignant tumor, up to 1.25 cm	$150	
D7441	Excision of malignant tumor, greater than 1.25 cm	$164	
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	$274	
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	$375	
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	$125	

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	$151	
D7471	Removal of lateral exostosis, maxilla or mandible	$340	
D7472	Removal of torus palatinus	$404	
D7473	Removal of torus mandibularis	$381	
D7485	Reduction of osseous tuberosity	$340	
D7510	Incision & drainage of abscess, intraoral soft tissue	$98	
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	$149	
D7520	Incision & drainage of abscess, extraoral soft tissue	$468	
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	$125	
D7880	Occlusal orthotic device, by report	$253	
D7910	Suture of recent small wounds up to 5 cm	$25	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot, stabilization, per site	$13	
D7961	Buccal/labial frenectomy (frenulectomy)	$148	1 of (D7961) in a lifetime, per arch
D7962	Lingual frenectomy (frenulectomy)	$148	1 of (D7962) in a lifetime
D7963	Frenuloplasty	$124	1 of (D7963) In a lifetime, per arch
D7970	Excision of hyperplastic tissue, per arch	$183	
D7971	Excision of pericoronal gingiva	$70	1 of (D7971) in a lifetime, per tooth
D7972	Surgical reduction of fibrous tuberosity	$256	
D7979	Nonsurgical sialolithotomy	$75	
D7999	Unspecified oral surgery procedure, by report	$0	
D9210	Local anesthesia not in conjunction, operative or surgical procedures	$15	
D9211	Regional block anesthesia	$17	
D9212	Trigeminal division block anesthesia	$26	
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0	Not payable as separate service
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$0	
D9222	Deep sedation/general anesthesia, first 15 minute increment	$72	Prior Authorization Required
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	$72	Prior Authorization Required
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$25	Not allowed on same date of service as D9248
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	$68	Prior Authorization Required

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	$68	Prior Authorization Required
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	$125	Not allowed on same date of service as D9222, D9223, D9230
D9310	Consultation, other than requesting dentist	$45	
D9311	Consultation with a medical health care professional	$40	
D9610	Therapeutic parenteral drug, single administration	$39	Prior Authorization Required
D9612	Therapeutic parenteral drugs, two or more administrations, different meds.	$39	Prior Authorization Required
D9630	Drugs or medicaments dispensed in the office for home use	$39	Prior Authorization Required
D9910	Application of desensitizing medicament	$0	
D9920	Behavior management, by report	$5	
D9930	Treatment of complications, post surgical, unusual, by report	$0	
D9941	Fabrication of athletic mouthguard	$125	1 of (D9941) every 12 months
D9944	Occlusal guard, hard appliance, full arch	$223	1 of (D9944-D9946) every 12 months
D9945	Occlusal guard, soft appliance, full arch	$223	1 of (D9944-D9946) every 12 months
D9946	Occlusal guard, hard appliance, partial arch	$170	1 of (D9944-D9946) every 12 months
D9950	Occlusion analysis, mounted case	$111	
D9951	Occlusal adjustment, limited	$50	2 of (D9951) every 12 months
D9952	Occlusal adjustment, complete	$234	1 of (D9952) every 12 months
D9986	Missed appointment	$0	
TYPE IV - MEDICALLY NECESSARY ORTHODONTIC SERVICES - Prior Authorization required for Orthodontic Services			
Guideline: Medically Necessary Orthodontic Services Orthodontic needs are limited to 1 course of treatment per lifetime and must meet medically necessary requirements as determined by a verified score of 26 or higher (or other qualify conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.			
D8010	Limited orthodontic treatment of the primary dentition	$765	Prior Authorization Required for medically necessary benefits
D8020	Limited orthodontic treatment of the transitional dentition	$815	Prior Authorization Required for medically necessary benefits
D8030	Limited orthodontic treatment of the adolescent dentition	$965	Prior Authorization Required for medically necessary benefits
D8040	Limited orthodontic treatment of the adult dentition	$965	Prior Authorization Required for medically necessary benefits
D8070	Comprehensive orthodontic treatment of the transitional dentition	$2,169	Prior Authorization Required for medically necessary benefits
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2,169	Prior Authorization Required for medically necessary benefits
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,169	Prior Authorization Required for medically necessary benefits

SAMPLE

CDT Code	Description	Member Copayment	Limitations
D8210	Removable appliance therapy	$299	Prior Authorization Required for medically necessary benefits, for thumb sucking and tongue thrusting
D8220	Fixed appliance therapy	$300	Prior Authorization Required for medically necessary benefits, for thumb sucking and tongue thrusting
D8660	Pre-orthodontic treatment examination to monitor growth and development	$47	Prior Authorization Required for medically necessary benefits
D8670	Periodic orthodontic treatment visit	$54	Prior Authorization Required for medically necessary benefits
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$204	Prior Authorization Required for medically necessary benefits
D8681	Removable orthodontic retainer adjustment	$246	Prior Authorization Required for medically necessary benefits
D8698	Re-cement or re-bond fixed retainer, maxillary	$32	Prior Authorization Required for medically necessary benefits
D8699	Re-cement or re-bond fixed retainer, mandibular	$32	Prior Authorization Required for medically necessary benefits
D8701	Repair of fixed retainer, includes reattachment, maxillary	$94	Prior Authorization Required for medically necessary benefits
D8702	Repair of fixed retainer, includes reattachment, mandibular	$94	Prior Authorization Required for medically necessary benefits
D8703	Replacement of lost or broken retainer, maxillary	$94	Prior Authorization Required for medically necessary benefits
D8704	Replacement of lost or broken retainer, mandibular	$94	Prior Authorization Required for medically necessary benefits
D8999	Unspecified orthodontic procedure, by report	$0	Prior Authorization Required for medically necessary benefits

SAMPLE

General Exclusions:
The following services are not covered under this Dental Plan

- Any procedures not listed on this Plan
- Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.
- Dental procedures or services performed solely for Cosmetic purposes or that is not Dentally Necessary and/or medically necessary; unless the member has the additional Cosmetic Ortho Plus Plan and services are within the benefit guidelines listed in the Cosmetic Ortho Plus Plan.
- Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving You or Your Dependent's dental health, as determined by the Plan based on generally accepted dental standards of care.
- For elective procedures, including prophylactic extraction of third molars.
- Replacement of Dentures, Crowns, appliances or Bridgework that have been lost, stolen or damaged.
- Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.

- Treatment required due to an accident from an external force or are intentionally self-inflicted, unless otherwise listed as Covered Service.
- Services that restore tooth structure due to attrition, erosion or abrasion are not covered.
- Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed.
- Procedures, appliances, or restoration to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
- Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.
- Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonable should have known that an Emergency Care situation did not exist.
- Composite or ceramic brackets, lingual adaptation of Orthodontic bands and other specialized or Cosmetic alternatives to standard fixed and removable Orthodontic appliances. Invisalign services are excluded from Orthodontic benefits.
- Broken appointments unless specifically covered.

SAMPLE