guide to
YOUR 2025 BENEFITS AND SERVICES

kaiserpermanente.org

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

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

MARYLAND

ACCREDITED NCQA HEALTH PLAN ACCREDITED

See 2025 NCQA Guide for more information on accreditation

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

By: _____

Gracelyn McDermott
Vice President, Marketing, Sales & Business Development

KAISER PERMANENTE®

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

MD-DP-COVER(01-23)

NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty Corporation (the Corporation) and the protection it provides for policyholders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

The Corporation was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Corporation are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 for basic hospital, medical, and surgical insurance or major medical insurance provided by health benefit plans
  - $300,000 for disability insurance
  - $300,000 for long-term care insurance
  - $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above
- Annuities
  - $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
  - With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values.
- The maximum amount of protection for each individual, regardless of the number of policies or contracts, is:
  - $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance, or major medical insurance

- $500,000 in aggregate for basic hospital, medical, and surgical insurance, or major medical insurance

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

To learn more about the above protections, please visit the Corporation's website at www.mdlifega.org, or contact:

Maryland Life and Health
Insurance Guaranty Corporation
8817 Belair Road
Suite 208
Perry Hall, Maryland 21236
410-248-0407

or

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
1-800-492-6116, ext. 2170

Insurance companies and agents are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.

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.

In some circumstances, you may be protected from balance billing under Maryland state law. For example, if you are enrolled in a fully-insured plan and are treated by a Maryland doctor in an emergency room, the law may protect you.

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

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

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

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

You are protected from balance billing under Maryland law given that most hospital services are subject to an All-Payor Model Agreement, which means that hospital bills are the same for all payers including consumers. Maryland law also provides protection from balance billing from out-of-network providers but the protection depends on whether you are enrolled in an HMO or PPO plan and, for PPO enrollees, whether the physician is on-call or hospital based.

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 Maryland Insurance Administration at *https://insurance.maryland.gov/Consumer/Pages/FileAComplaint.aspx* or call **1-800-492-6116.**

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law. Visit *https://insurance.maryland.gov/Consumer/Documents/publications/AssignmentofBenefitsFAQ.pdf* for more information about your rights under Maryland state law.

NONDISCRIMINATION NOTICE

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

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

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

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

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 4000 Garden City Drive, Hyattsville, MD 20875, 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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

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

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-777-7902** (TTY: **711**)

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

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

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-777-7902** (TTY: **711**).

ગુજરાતી (Gujarati) સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: **711**) पर कॉल करें।

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-777-7902**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-777-7902** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں **1-800-777-7902** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-777-7902** (TTY: **711**).

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

SECTION 1: Introduction to Your Kaiser Permanente Health Plan

Welcome to Kaiser Permanente

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

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

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

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

Our Commitment to Diversity and Nondiscrimination

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

About This Agreement

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

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

Important Terms

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

Purpose of this Agreement

This Agreement serves two important purposes. It:

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

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

Acceptance of Agreement

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

Right to Reject Agreement

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

Administration of Agreement

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

No Waiver

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

Entire Contract

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

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

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

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

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

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

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

Gracelyn McDermott
Vice President, Marketing, Sales & Business Development

How Your Health Plan Works

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

Relations Among Parties Affected By This Agreement

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

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

Additionally:

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

Patient Information Obtained By Affected Parties

Patient-identifying information from Member medical records, and that is received by Plan Physicians or Plan Hospitals incident to the physician-patient or Hospital-patient relationship, is kept confidential. Patient-identifying information is not disclosed without the prior consent of a Member, except for use by the Health Plan, Plan Hospitals, Medical Group or Plan Physicians in relation to:

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

Liability for Amounts Owed By the Health Plan

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

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

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

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

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

1. Emergency Services, as described in ***Section 3: Benefits, Exclusions and Limitations***;
2. Urgent Care Services outside of our Service Area, as described in ***Section 3: Benefits, Exclusions and Limitations***;
3. Continuity of Care for New Members, as described in ***Section 2: How to Get the Care You Need***;
4. Continuing Care Patients, as described in ***Section 2: How to Get the Care You Need;***
5. Receiving Care in Another Kaiser Foundation Health Plan Service Area, as described in ***Section 2: How to Get the Care You Need;***
6. Approved referrals, as described in ***Section 2: How to Get the Care You Need*** under the ***Getting a Referral*** provision, including referrals for Clinical Trials, as described in ***Section 3: Benefits, Exclusions and Limitations;*** and
7. Non-Emergency Services, including Ancillary Services, and Services for unforeseen urgent medical needs received by a non-Participating Provider at a Plan Hospital or a Plan Facility as described in ***Section 2: How to Get the Care You Need*** under the ***Non-Emergency Services & Urgent Care Services*** provision.

Enrollment Through the Exchange

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

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

Eligibility for a Kaiser Permanente Individuals and Families Plan

This provision describes who is eligible for a Kaiser Permanente Individuals and Families Plan. See the next provision of this section for information on eligibility requirements for a Kaiser Permanente Child Only Plan.

Member Eligibility

Members may be accepted for enrollment and continuing coverage hereunder only upon meeting all of the applicable requirements below, which are set forth by the Health Plan or Exchange, depending on how you applied for coverage.

Subscribers

For Subscribers who enroll directly through the Health Plan during an annual open or a special enrollment period: To be a Subscriber you must apply during an annual open enrollment period or a special enrollment period, both of which are described within this section of your EOC.

For Subscribers who enroll through the Exchange: The Exchange will determine whether an individual is a Qualified Individual under this Plan in accordance with 45 CFR §155.305 and 45 CFR §156.265(b).

Any Subscriber under a Kaiser Permanente for Individuals and Families Plan must reside within our Service Area at the time of enrollment to be eligible for this Plan.

Dependents

To be a Dependent you must be:

1. The Subscriber's Spouse or Domestic Partner.
2. A Dependent child of the Subscriber or the Subscriber's Spouse or Domestic Partner who is under the limiting age of 26. A Dependent child under the limiting age is defined as either:
   a. A biological child, stepchild, lawfully adopted child or foster child placed for legal adoption with the Subscriber or the Subscriber's Spouse or Domestic Partner; or
   b. An unmarried grandchild, or unmarried child under testamentary or court-appointed guardianship of the Subscriber or the Subscriber's Spouse or Domestic Partner.
3. A Dependent child under the limiting age of 26 who is not a natural or adopted child, but for whom the Subscriber or the Subscriber's Spouse or Domestic Partner has received a court or administrative order.

An unmarried child who is covered as a Dependent when they reach the limiting age under requirement #2 above may continue coverage if he/she is incapable of self-support by reason of mental incapacity or physical handicap. The child must be chiefly dependent upon a Member of this Plan for support and maintenance. Proof of incapacity and dependency must be provided when requested by the Health Plan.

Note: In reference to limiting age of 26, coverage is provided through the end of the year in which the Dependent turns age 26 years.

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

Coverage is also provided for the first thirty-one (31) days after adoption or after a grandchild or a minor for whom guardianship is granted by court or testamentary appointment.

Coverage beyond the first thirty-one (31) days after birth, adoption, or after a grandchild or a minor for whom guardianship is granted by court or testamentary appointment will only continue if the child is enrolled and any additional premium payment is made to cover the child, as required in this EOC.

For Subscribers who enroll a Dependent through the Exchange: Subscribers who apply for coverage through the Exchange must notify the Exchange of any change in eligibility of a Dependent for any reason other than the child becomes age 26.

Eligible children of the Subscriber or Subscriber's Spouse or Domestic Partner who lives, works, or resides outside of our Service Area are eligible for Dependent coverage. However, the only covered Services outside of our Service Area are:

1. Approved Clinical Trials;
2. Emergency Services;
3. Urgent Care Services;
4. Continuity of Care for New Members;
5. Services received in connection with an approved referral, unless you elect to bring the Dependent within our Service Area to receive covered Services from Plan Providers; and

6. Services received when a Dependent is transitioning from a previous carrier to Kaiser Permanente.

Eligibility for a Kaiser Permanente Child Only Plan

This provision describes who is eligible for a Kaiser Permanente Child Only Plan. See the preceding provision of this section for information on eligibility requirements for a Kaiser Permanente Individuals and Families Plan.

Member Eligibility

Members may be accepted for enrollment and continuing coverage hereunder only upon meeting all of the applicable requirements below, which are set forth by the Health Plan or Exchange, depending on how you applied for coverage.

Subscribers

For Subscribers who enroll directly through the Health Plan during an annual open or a special enrollment period: To be a Subscriber you must apply during an annual open enrollment period or a special enrollment period, both of which are described within this section of your EOC.

For Members who enroll through the Exchange: The Exchange will determine if an individual is a Qualified Individual under this Plan in accordance with 45 CFR §155.305 and 45 CFR §156.265(b).

Any Subscriber under a Kaiser Permanente Child Only Plan must reside within our Service Area at the time of enrollment to be eligible for this Plan.

Additionally, for a child to become a Member under this Kaiser Permanente Child Only Plan, they must:

1. Be a child under the age of 21.
2. Have a Financially Responsible Person and/or Parent/Guardian with legal authority to enter into this Agreement on behalf of a Member who is:
   a. Under age 19; or
   b. Between the ages of 19-21 and incapable of making such decisions by reason of mental incapacity.

A minor or anyone under the age of 19 cannot apply for coverage on their own behalf without the binding written consent of a Financially Responsible Person and/or Parent/Guardian.

After the initial twelve (12) months of enrollment and at each subsequent twelve (12) month renewal period, the Parent/Guardian must prove that the Member still meets all eligibility requirements for a Kaiser Permanente Child Only Plan.

Ineligible Persons

The following people are not eligible for membership under a Kaiser Permanente Child Only Plan:

1. Any person age 21 years or older; or
2. Unborn children.

Eligibility for Catastrophic Coverage Plans

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

Member Eligibility

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

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

Member Rights and Responsibilities: Our Commitment to Each Other

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

Member Rights

As a Member of Kaiser Permanente, you or your Authorized Representative, Parent/Guardian or a Financially Responsible Person, as applicable, have the right to:

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

we will tell you why and explain your right to file a written statement of disagreement. The Member or Member's Authorized Representative will be asked to provide written permission before a Member's records are released, unless otherwise permitted by law.

2. **Receive information about Kaiser Permanente and your Plan. This includes the right to:**
   a. Receive the information you need to choose or change your Primary Care Plan Physician, including the name, professional level and credentials of the doctors assisting or treating you;
   b. Receive information about Kaiser Permanente, our Services, our practitioners and Providers, and the rights and responsibilities you have as a Member. You also can make recommendations regarding Kaiser Permanente's Member rights and responsibility policies;
   c. Receive information about financial arrangements with physicians that could affect the use of Services you might need;
   d. Receive Emergency Services when you, as a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed, and receive information regarding cost sharing, payment obligations and balance billing protections for Emergency Services;
   e. Receive covered urgently needed Services when traveling outside Kaiser Permanente's Service Area;
   f. Receive information about what Services are covered and what you will have to pay and to examine an explanation of any bills for Services that are not covered; and
   g. File a complaint, grievance or appeal about Kaiser Permanente or the care you received without fear of retribution or discrimination, expect problems to be fairly examined, and receive an acknowledgement and a resolution in a timely manner.
3. **Receive professional care and Service. This includes the right to:**
   a. See Plan Providers, get covered Health Care Services and get your prescriptions filled within a reasonable period of time and in an efficient, prompt, caring and professional manner;
   b. Have your medical care, medical records and protected health information (PHI) handled confidentially and in a way that respects your privacy;
   c. Be treated with respect and dignity;
   d. Request that a staff member be present as a chaperone during medical appointments or tests;
   e. Receive and exercise your rights and responsibilities without any discrimination based on age, gender, sexual orientation, race, ethnicity, religion, disability, medical condition, national origin, educational background, reading skills, ability to speak or read English, or economic or health status, including any mental or physical disability you may have;
   f. Request interpreter Services in your primary language at no charge; and
   g. Receive health care in facilities that are environmentally safe and accessible to all.

Member Responsibilities

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

1. **Promote your own good health:**
   a. Be active in your health care and engage in healthy habits;
   b. Select a Primary Care Plan Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics or Family Practice as your Primary Care Plan

Physician. You may also choose a personal OB/GYN in addition to Primary Care Plan Physician;

c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you;
d. Work with us to help you understand your health problems and develop mutually agreed upon treatment goals;
e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment;
f. Do your best to improve your health by following the treatment plan and instructions your Primary Care Plan Physician or health care professional recommends;
g. Schedule the health care appointments your Primary Care Plan Physician or health care professional recommends;
h. Keep scheduled appointments or cancel appointments with as much notice as possible; and
i. Inform us if you no longer live within the Plan Service Area.

2. **Know and understand your Plan and benefits:**
   a. Read about your health care benefits in this Agreement and become familiar with them. Call us when you have questions or concerns;
   b. Pay your Plan Premium, and bring payment with you when your Visit requires a Copayment;
   c. Let us know if you have any questions, concerns, problems or suggestions;
   d. Inform us if you have any other health insurance or prescription drug coverage; and
   e. Inform any network or nonparticipating provider from whom you receive care that you are enrolled in our Plan.
3. **Promote respect and safety for others:**
   a. Extend the same courtesy and respect to others that you expect when seeking Health Care Services; and
   b. Assure a safe environment for other Members, staff and physicians by not threatening or harming others.

Health Savings Account-Qualified Plans

This provision only applies if you are enrolled in a qualified High Deductible Health Plan. It does not apply to Members with catastrophic Plan coverage. A Health Savings Account is a tax-exempt account established under Section 223(d) of the Internal Revenue Code for the exclusive purpose of paying current and future Qualified Medical Expenses. Contributions to such an account are tax deductible, but in order to qualify for and make contributions to a Health Savings Account, a Member must be enrolled in a qualified High Deductible Health Plan.

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

1. Individual Deductible of $1,650.00 or greater and a family Deductible of $3,300.00 or greater; and
2. Individual Out-of-Pocket Maximum of no more than $8,300.00 and a family Out-of-Pocket Maximum of no more than $16,600.00 in the current Calendar Year.

In a qualified High Deductible Health Plan, all Deductible, Copayment and Coinsurance amounts must be counted toward the Out-of-Pocket Maximum. Review the Cost Sharing information contained within this

Agreement to see whether or not this Plan meets the High Deductible Health Plan requirements described in this paragraph. A Plan is a qualified High Deductible Health Plan only if it meets those requirements. Enrollment in a qualified High Deductible Health Plan is only one of the eligibility requirements for establishing and contributing to a Health Savings Account. Other requirements include the following prohibitions: The Member must not be:

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

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

Payment of Premium

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

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

This Plan is contributory in that the Subscriber, on behalf of his/herself and any applicable Dependents, or a Financially Responsible Person, on behalf of a child Member, is responsible for payment of all required Premium. Premium is due directly to Health Plan no later than the 1st day of the coverage month, or through the Exchange, as applicable.

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

1. Are not the same person, then this Agreement is a legally binding contract between the:
   a. Health Plan;
   b. Financially Responsible Person; and
   c. Parent/Guardian who holds the legal authority to make medical decisions for a Member under age 19 or who is age 19 or older, but incapable of making medical decisions by reason of mental incapacity.
2. Is the same person, he/she shall be recognized as having the rights and responsibilities of both the Financially Responsible Person and the Parent/Guardian under this Agreement.

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

Only Members for whom the Health Plan has received the appropriate Premium payments are entitled to

coverage under this Agreement, except as provided in ***Section 6: Extension of Benefits***, and then only for the period for which such Premium is received, in accordance with ***Section 6: Termination Due to Nonpayment of Premium***. You may be assessed a charge for any check written to Health Plan that is returned due to insufficient funds in your bank account.

The Premium due under this Agreement is determined by the Health Plan upon application for coverage. The Subscriber or Financially Responsible Person, as applicable, will be given at least sixty-two (62) days' prior notice of any Premium change upon renewal.

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

Annual Enrollment Period and Effective Date of Coverage

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

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

The annual enrollment period shall begin on November 1, 2024 and extend through January 15, 2025.

If a Qualified Individual enrolls in this Plan during the annual enrollment period for 2025, the effective date of coverage shall be:

1. January 1, 2025 for completed applications received on or before December 15, 2024; or
2. February 1, 2025 for completed applications received on or after December 16, 2024.

Special Enrollment Periods Due to Triggering Events

When a triggering event occurs, a special enrollment period will be provided. If you and/or any Dependents are eligible to enroll in this Plan or another Plan offered by us during the special enrollment period, we will process your enrollment following your Plan selection and submission of any necessary information to confirm the occurrence of a triggering event. To learn more, contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY) or visit kp.org/specialenrollment to obtain a copy of our Special Enrollment Guide.

If we do not receive the Plan selection and any other required information necessary to confirm the triggering event in a timely manner, then no changes in enrollment can be made by us, except as otherwise specified below.

A triggering event occurs when:

1. You or your Dependent:
    a. Loses Minimum Essential Coverage. The date of the loss of coverage is the last day you or Dependent would have coverage under your or their previous plan or coverage;
    b. Are enrolled in any non-calendar year group health plan, individual health plan coverage,

or qualified small employer health reimbursement arrangement (QSEHRA) even when you or your Dependent has the option to renew such coverage. The date of loss of coverage is the last day of the plan year; or

c. Loses pregnancy related coverage under Medicaid or loses access to healthcare Services through coverage provided to a pregnant person's unborn child. The date of the loss of coverage is the last day your or your Dependent would have pregnancy-related coverage or access to health care services through the unborn child coverage; or

d. Loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act. This triggering event allows you a special enrollment period only once per calendar year. The date of the loss of coverage is the last day you and/or your Dependent would have medically needy coverage.

Note: Loss of Minimum Essential Coverage does not include voluntary termination of coverage or other loss due to a) failure to pay premiums on a timely basis including, but not limited to, COBRA continuation coverage premiums prior to the expiration of COBRA continuation coverage, except for circumstances in which an employer completely ceases its contributions to COBRA continuation coverage or government subsidies of COBRA continuation coverage completely cease or b) situations allowing for a rescission of coverage pursuant to federal law.

2. You:
    a. Gain a Dependent or become a Dependent through marriage, birth, adoption, placement for adoption or placement in foster care, or through a child support order or other court order.
        i. In the case of marriage, you or your spouse must demonstrate having minimum essential coverage, medically needy coverage, pregnancy related coverage under Medicaid, or access to healthcare Services through coverage provided to a pregnant person's unborn child for one (1) or more days during the sixty (60) days preceding your date of marriage. You or your spouse can also demonstrate having lived in a foreign country or in a United States territory for one (1) or more days during the sixty (60) days preceding your date of marriage or qualify as an American Indian or Alaskan Native, as defined by §4 of the federal Indian Health Care Improvement Act or lived for (1) or more days during the sixty (60) days preceding your date of marriage or during the most recent open enrollment period or special enrollment period in a service area where no Qualified Health Plan was available through the Exchange. If you are currently enrolled in a Qualified Health Plan, your Dependent may be enrolled into your current Qualified Health Plan or may enroll with you into another Qualified Health Plan within the same level of coverage or one metal level higher or lower, if no such Qualified Health Plan is available, or may enroll in any separate Qualified Health Plan.
    b. Lose a Dependent or are no longer considered a Dependent through divorce or legal separation, as defined by state law in the state in which the divorce or legal separation occurs, or if you or your Dependent die.

3. You or your Dependent become newly eligible for enrollment in a Qualified Health Plan through the Exchange because you or your Dependent newly satisfy the requirements regarding becoming:
    a. A citizen, national, or a non-citizen who is a lawfully-present individual in the United States and is reasonably expected to be a citizen, national, or non-citizen who is lawfully present for the entire period for which enrollment is sought; or
    b. No longer incarcerated.

    Note: For the triggering event immediately listed above, enrollment is only permissible in a Qualified Health Plan through the Exchange.

4. You or your Dependent's enrollment or non-enrollment in a Qualified Health Plan is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation, misconduct or inaction of an officer, employee or agent of the Exchange or U.S. Department of Health and Human Services, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities as determined by the Exchange.

    For the triggering event immediately listed above, you or your Dependent may enroll in any Qualified Health Plan or change to any Qualified Health Plan, regardless if you or your Dependent are currently enrolled in a Qualified Health Plan.

5. You or your Dependent adequately demonstrate to the Exchange that the Qualified Health Plan in which you or your Dependent enrolled in substantially violated a material provision of its contract with respect to you or your Dependent as determined by the Exchange.

6. You or your Dependent who are enrolled in the same Plan, through the Exchange, are determined newly-eligible or ineligible for Advance Premium Tax Credit or have a change in eligibility for federal cost-sharing reductions.
    a. For Members who enroll outside of the Exchange, you or your Dependent may only enroll in any Health Plan if newly ineligible for Advanced Premium Tax Credit or newly ineligible for cost-sharing reductions.
    b. You or your Dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for Advanced Premium Tax Credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with Internal Revenue Code regulation 1.36B-2(c)(3), including as a result of your or their employer discontinuing or changing available coverage within the next sixty (60) days, provided you or your Dependent are allowed to terminate existing coverage.
    c. You were previously ineligible for Advanced Premium Tax Credit solely because of a household income below one hundred percent (100%) of the Federal poverty level (FPL) and, during the same time period, you were ineligible for Medicaid because you were living in a non-Medicaid expansion State, either experience a change in household income or moves to a different state resulting in your becoming newly eligible for advance payments of the premium tax credit.

Note: The triggering events listed above in items #6b and #6c only permits enrollment in a Qualified

Health Plan through the Exchange. If you or your Dependent are newly eligible for cost-sharing reductions and not enrolled in a silver-level Qualified Health Plan, you or your Dependent may enroll only in a silver-level Qualified Health Plan. If you or your Dependent are newly ineligible for cost-sharing reductions and enrolled in a silver-level Qualified Health Plan, you or your Dependent may enroll in a Qualified Health Plan one metal level higher or lower. If you or your Dependent become newly ineligible for Advanced Premium Tax Credit, you or your Dependent may change to a Qualified Health Plan of any metal level, if you or your Dependent elect to change Qualified Health Plan enrollment.

7. You or your Dependent gain access to new Qualified Health Plan's as a result of a permanent move and:
    a. Had minimum essential coverage, medically needy coverage, pregnancy related coverage under Medicaid, or access to healthcare Services through coverage provided to a pregnant person's unborn child for one (1) or more days during the sixty (60) days preceding the date of the permanent move; or
    b. Were living in a foreign country or in a United States territory for one (1) or more days during the sixty (60) days preceding the permanent move; or
    c. Qualify as an American Indian or Alaskan Native, as defined by §4 of the federal Indian Health Care Improvement Act; or
    d. Lived for (1) or more days during the sixty (60) days preceding your date of permanent move or during the most recent open enrollment period or special enrollment period in a service area where no Qualified Health Plan was available through the Exchange.

8. You or your Dependent:
    a. Gains or maintains status as an American Indian or Alaskan Native, as defined by section 4 of the federal Indian Health Care Improvement Act, may enroll in a Qualified Health Plan through the Exchange or change from one Qualified Health Plan to another through the Exchange one time per month; or
    b. Are or become a Dependent of an American Indian or Alaskan Native, as defined by section 4 of the federal Indian Health Care Improvement Act, may enroll in a Qualified Health Plan through the Exchange or change from one Qualified Health Plan to another through the Exchange one time per month.

    For the triggering event immediately listed above, you or your Dependent may enroll in any Qualified Health Plan or change to any Qualified Health Plan, regardless if you or your Dependent are currently enrolled in a Qualified Health Plan.

    Note: Your Dependent must have enrolled, or is enrolling, in a plan on the same application as the Member and may change from one Qualified Health Plan to another once per month at the same time as the Member.

9. You or your Dependent demonstrate to the Exchange in accordance with guidelines issued by the Department of Health and Human Services that you or your Dependent meet exceptional circumstances as the Exchange may determine.

    For the triggering event immediately listed above, you or your Dependent may enroll in any Qualified Health Plan or change to any Qualified Health Plan, regardless if you or your

Dependent are currently enrolled in a Qualified Health Plan.

Note: The triggering events listed above in items #8 and #9 only permits enrollments in a Qualified Health Plan through the Exchange.

10. You or your Dependent, including an unmarried victim within a household, are a victim of domestic abuse or spousal abandonment, enrolled in minimum essential coverage, and seeks to obtain coverage separate from the perpetrator of the abuse or abandonment. The Dependent of a victim of domestic abuse or spousal abandonment may enroll in coverage at the same time as the victim and on the same application as the victim.

    For the triggering event immediately listed above, you or your Dependent may enroll in any Qualified Health Plan or change to any Qualified Health Plan, regardless if you or your Dependent are currently enrolled in a Qualified Health Plan.

11. You or your Dependent:
    a. Apply for coverage through the Exchange during the annual open enrollment period or due to a triggering event, are assessed by the Exchange as potentially eligible for Medicaid of the Children's Health Insurance Program (CHIP) and are determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than sixty (60) days after the triggering event; or
    b. Apply for coverage at the State Medicaid or CHIP agency during the annual open enrollment period and is determined ineligible for Medicaid or CHIP after open enrollment has ended.

12. Your or your Dependent's enrollment in a QHP through the Exchange was influenced by a material error related to plan benefits, service area, cost sharing, or premium. A material error is one that is likely to have influenced your or your Dependent's enrollment in a Qualified Health Plan.

    For the triggering event immediately listed above, you or your Dependent may enroll in any Qualified Health Plan or change to any Qualified Health Plan, regardless if you or your Dependent are currently enrolled in a Qualified Health Plan.

13. At the option of the Exchange, you provide satisfactory documentary evidence to verify your eligibility for an insurance affordability program or enrollment in a Qualified Health Plan through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period prescribed by federal regulation 45 CFR §155.315 or you are below one hundred percent (100%) of the FPL and did not enroll in coverage while waiting for the Department of Health and Human Services to verify your citizenship or status as a national or lawful presence.

Note: The triggering events listed above in items #12 and #13 only permit enrollment in a Qualified Health Plan through the Exchange.

14. You or your Dependent are confirmed by a provider to be pregnant.

    For the triggering event immediately listed above, you or your Dependent may enroll in any

Qualified Health Plan or change to any Qualified Health Plan, regardless if you or your Dependent are currently enrolled in a Qualified Health Plan.

15. At the option of the Exchange, you or your Dependent experiences a decrease in household income, is determined eligible by the Exchange for Advance Premium Tax Credit and had minimum essential coverage for one or more days during the sixty (60) days preceding the date of the financial change.

    Note: For the triggering event immediately listed above, enrollment is only permissible in a Qualified Health Plan through the Exchange.

16. You or your Dependent newly gains access to an individual coverage health reimbursement account (HRA) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA). The triggering event is the first day on which coverage for you or your Dependent under the individual coverage HRA can take effect or the first day on which coverage under the QSEHRA take effect. You or your Dependent will qualify for this special enrollment period regardless if you or your Dependent were previously offered or enrolled in an individual coverage HRA or previously provided QSEHRA, as long as you or your Dependent were not enrolled in the individual coverage HRA or covered by the QSEHRA on the day immediately prior to this triggering event.

    For the triggering event immediately listed above, you or your Dependent may enroll in any Qualified Health Plan or change to any Qualified Health Plan, regardless if you or your Dependent are currently enrolled in a Qualified Health Plan.

17. You or your Dependent are enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to your or your Dependent's COBRA continuation coverage or government subsidies completely cease. The triggering event occurs on the last day of the period for which COBRA continuation coverage is paid for or subsidized, in whole or in part, by an employer or government entity.

18. You or your Dependent did not receive timely notice of an event that triggers eligibility for a special enrollment period, as described under this ***Special Enrollment Periods Due to Triggering Events*** provision and, otherwise, was reasonably unaware that a triggering event described under this ***Special Enrollment Periods Due to Triggering Events*** provision occurred.

19. At the option of the Exchange, you or your Dependent lose Medicaid or CHIP coverage.

20. At the option of the Exchange, you or your Dependent, who is eligible for Advance Premium Tax Credit and whose household income is expected to be no greater than one hundred and fifty percent (150%) of the FPL, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month during periods of time when the applicable taxpayer's applicable percentage for purposes of calculating the premium assistance amount, as defined in section 36B(b)(3)(A) of the Internal Revenue Code, is set at zero. If you or your Dependent qualify for this special enrollment period, the Exchange must allow you and your Dependent to change to any available silver-level Qualified Health Plan if you or your Dependent elect to

change their Qualified Health Plan enrollment. If you or your Dependent are not a Member and qualify for this special enrollment period and has one or more household members who are Members, the Exchange must allow the currently enrolled household member to add the newly enrolling household member to the currently enrolled household member's current Qualified Health Plan or to change to a silver-level Qualified Health Plan and enroll you or your Dependent in a separate Qualified Health Plan.

Length of Special Enrollment Periods

Except as specifically provided in this section with respect to specific triggering events, you will have sixty (60) days from the date of the triggering event to select a Qualified Health Plan.

1. For the triggering event associated with loss of coverage (item #1 above) or becoming eligible for Advance Premium Tax Credit due to a change in eligibility for employer sponsored coverage (item #6b above), you will have sixty (60) days before and sixty (60) days after the triggering event to select a Qualified Health Plan.
2. For the triggering event associated with a permanent move (item #7 above), you will have sixty (60) days before and sixty (60) days after the triggering event to select a Qualified Health Plan.
3. For the triggering event associated with a change in eligibility for Exchange coverage due to a permanent move to a new state (item #6c above), you will have sixty (60) days before and sixty (60) days after the triggering event to select a Qualified Health Plan.
4. For the triggering event associated with a release from incarceration (item #3b above), you will have sixty (60) days before and sixty (60) days after the triggering event to select a Qualified Health Plan.
5. For the triggering events where the Exchange determines a special enrollment period is warranted (items #4, #5 or #9 above), the length of the special enrollment period that the Exchange provides but in no event may the length of the special enrollment period exceed sixty (60) days.
6. For the triggering events listed above in items #4 and #5, if the Exchange determines a special enrollment period is warranted, then the Exchange will provide the length of the special enrollment period. However, if selection is for off-Exchange plans, you will have sixty (60) days after the date of the triggering event to enroll.
7. For the triggering event due to pregnancy (item #14 above), you or your Dependent will have (90) days from the date the provider gives confirmation of the pregnancy.
8. For the triggering event associated with gaining access to an individual coverage HRA or being newly provided a QSEHRA (item #16 above), you or your Dependent will have sixty (60) days before the triggering events to select a Qualified Health Plan, unless the HRA or QSEHRA was not required to provide the notice setting forth its terms to you or your Dependent at least ninety (90) days before the beginning of the plan year, in which case you or your Dependent will have sixty (60) days before or after the triggering event to select a Qualified Health Plan.
9. For the triggering event due to untimely notice of triggering events (item #18 above), you or your Dependent will have sixty (60) days from the date you or your Dependent knew, or reasonably should have known, of the occurrence of the triggering event to select a new plan.
10. For the triggering event due to the cessation of employer contributions to COBRA continuation coverage or cessation of a government entity providing subsidies (item #17 above), you or your Dependent has sixty (60) days before or after the triggering the event to select a plan.

11. For the triggering event due to loss of Medicaid or CHIP (item #19 above), you or your Dependent will have ninety (90) days after the loss of Medicaid or CHIP to select a QHP. If a state Medicaid or CHIP agency allows or provides for a Medicaid or CHIP reconsideration period greater than ninety (90) days, the Exchange in the state may elect to provide a Qualified Individual or their Dependent(s) whose loss of coverage is a loss of Medicaid or CHIP coverage additional time to select a QHP, up to the number of days provided for the applicable Medicaid or CHIP reconsideration period.

Effective Date for Special Enrollment Periods

For off-Exchange plans, if the plan selection is made on or before the day of the triggering event, the coverage effective date is the first day of the month following the date of the triggering event. If the plan selection is made after the date of the triggering event, the coverage effective date will be the first day of the month following the plan selection.

This rule applies to the triggering events described in items #1, #7, #17 under ***Special Enrollment Periods Due to Triggering Events***.

For on-Exchange plans, if the plan selection is made on or before the day of the triggering event, the Exchange must ensure that the coverage effective date is the first day of the month following the date of the triggering event. If the plan selection is made after the date of the triggering event, at the option of the Exchange, the coverage effective date is the first day of the following month or the first day of the month following plan selection.

This rule applies to the triggering events described in items #1, #3b, #7, #6b, and #17 under ***Special Enrollment Periods Due to Triggering Events***. This rule also applies to the triggering event of moving to a different state resulting in becoming newly eligible for advance payments of the premium tax credit as described in item #6(c) under ***Special Enrollment Period Due to Triggering Events***.

For loss of coverage (item #1 under ***Special Enrollment Periods Due to Triggering Events***), loss of eligibility for employer-sponsored coverage (item #6b under ***Special Enrollment Periods Due to Triggering Events***), or cessation of employer contributions to COBRA continuation coverage or cessation of a government entity providing subsidies (item #17 under ***Special Enrollment Periods Due to Triggering Events***), at the option of the Exchange, if the Qualified Health Plan selection is made on or before the last day of the month preceding the triggering event, the Exchange must ensure the coverage effective date is the first day of the month in which the triggering event occurs.

For the triggering events listed below:

1. For birth, adoption, or placement for adoption, coverage is effective the date the birth, adoption or placement for adoption occurs.
2. For placement in foster care, coverage is effective the date the placement in foster care occurs or, if enrollment is through and permitted by the Exchange, you may elect a coverage effective date the first day of the month following plan selection.
3. For marriage, coverage is effective on the first day of the month following plan selection.
4. For the triggering events described in items #4, #5, #9, #11, #12 or #13 under ***Special Enrollment Periods Due to Triggering Events***, the Exchange will determine the coverage effective date

based on the circumstances. For the triggering events described in items #4, #5, and #11 under ***Special Enrollment Periods Due to Triggering Events***, if enrollment is for off-exchange coverage, the coverage effective date will be the first day of the month following plan selection.

5. For a child support order or other court order (item #2a under ***Special Enrollment Periods Due to Triggering Events***), the coverage effective date shall be no later than the date the court order is effective or, if enrollment is through and permitted by the Exchange, you may elect a coverage effective date the first day of the month following plan selection or you may elect a regular coverage effective date.
6. If you or your Dependent dies (item #2b under ***Special Enrollment Periods Due to Triggering Events***), the coverage effective date shall be the first day of the month following the plan selection.
7. For confirmation of pregnancy, the coverage effective date shall be the 1st day of the month in which the confirmation of pregnancy was received.
8. For gaining access to an individual coverage health reimbursement account (HRA) or being newly provided a QSEHRA (item #16 under ***Special Enrollment Periods Due to Triggering Events***), if the plan selection coverage is made before the day of the triggering event, coverage is effective on the 1st day of the month following the date of the triggering event or if the triggering events is on the 1st day of the month, then coverage is effective on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, the coverage is effective on the 1st day of the month following the plan selection.
9. For untimely notice of triggering events (item #18 under ***Special Enrollment Periods Due to Triggering Events***), at the option of the Qualified Individual, enrollee, or Dependent, the Exchange must provide the earliest effective date that would have been available, as described under this ***Effective Date for Special Enrollment Periods*** provision, based on the applicable triggering events described under ***Special Enrollment Periods Due to Triggering Events***.
10. For a citizen, national, or a non-citizen who is a lawfully-present individual in the United States ***(item #3a under Special Enrollment Periods Due to Triggering Events)***, the Exchange must ensure that the coverage effective date is the first day of the month following plan selection.

For all other triggering events, the regular coverage effective date will apply and depends on when the plan selection is received. For a Qualified Health Plan selection received by the Exchange for coverage through the Exchange or received by us for off-Exchange coverage, the coverage effective date will be the first day of the month following the plan selection.

Restrictions on Qualified Health Plan Selection

For Members who enroll through the Exchange and are currently in a Qualified Health Plan, if you qualify for a special enrollment period or you are adding a Dependent to your Qualified Health Plan other than when the triggering event is for birth, adoption, placement for adoption or placement in foster care (item #2a under ***Special Enrollment Periods Due to Triggering Events***), inadvertent error (item #4 under ***Special Enrollment Periods Due to Triggering Events***), you or your Dependent becoming newly eligible or ineligible for cost-sharing reduction or newly ineligible for Advanced Premium Tax Credit (item #6 under ***Special Enrollment Periods Due to Triggering Events***), you or your Dependent's status as an American Indian or Alaskan Native (item #8 under ***Special Enrollment Periods Due to Triggering***

Events), exceptional circumstances (item #9 under ***Special Enrollment Periods Due to Triggering Events***), eligibility due to domestic violence (item #10 under ***Special Enrollment Periods Due to Triggering Events)***, material error (item #12 under ***Special Enrollment Periods Due to Triggering Events)***, you or your Dependent being confirmed by a provider to be pregnant (item #14 under ***Special Enrollment Periods Due to Triggering Events)*** or you or your Dependent newly gaining access to an individual coverage HRA or you or your Dependent being newly provided a QSEHRA (item #16 under ***Special Enrollment Periods Due to Triggering Events)***, you and your Dependent may make changes to your enrollment in the same Qualified Health Plan or may change to another Qualified Health Plan within the same level or coverage (or one metal level higher or lower, if no such Qualified Health Plan is available).

If a Dependent qualifies for a special enrollment period, and an enrollee who does not also qualify for a special enrollment period is adding the Dependent to his or her Qualified Health Plan, the Exchange must allow the enrollee to add the Dependent to his or her current Qualified Health Plan. If Health Plan's eligibility rules do not allow you to enroll your non-covered Dependent or Dependent to your Qualified Health Plan, the Exchange must allow you and your non-covered Dependent or Dependent to change to another Qualified Health Plan within the same level of coverage (or one metal level higher or lower, if no such Qualified Health Plan is available) or allow your non-covered Dependent or Dependent to enroll in a separate Qualified Health Plan.

In addition, if you have gained a Dependent, as described above in item #2a under ***Special Enrollment Periods Due to Triggering Events***, then you may add the Dependent to your current Qualified Health Plan or, if the eligibility rules do not allow such dependent to enroll, then you and your Dependent may change to another Qualified Health Plan within the same level of coverage (or one metal level higher or lower, if no such Qualified Health Plan is available) or, at your or your Dependent's option, your Dependent may enroll in any separate Qualified Health Plan.

If you are not enrolled in a Qualified Health Plan and qualify for a special enrollment period, and you have one or more Dependents who are enrolled in a Qualified Health Plan and do not qualify for a special enrollment period, then you may enroll yourself to your Dependent's current Qualified Health Plan or, if the Qualified Health Plan's business rules do not allow you to enroll in your Dependent's current Qualified Health Plan, you may enroll yourself and your Dependents in another Qualified Health Plan within the same level of coverage, or one metal level higher or lower, if no such Qualified Health Plan is available, or you may enroll yourself in a separate Qualified Health Plan.

You or your Dependent may enroll in any Qualified Health Plan if you or your Dependent are not currently enrolled in a Qualified Health Plan.

If you or your Dependent are enrolling in an off-Exchange plan, you may do so without any restrictions.

Premium Payment Changes Due to Special Enrollments

Your Premium may change if you:

1. Choose a new Plan;
2. Switch to coverage other than self-only by adding Dependents; or
3. Reduce the number of covered Dependents.

Premium Payment Requirements for Special Open Enrollment Periods

When No Additional Premium is Required

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

When Additional Premium is Due

If additional Premium is required following enrollment after you experience a triggering event, the Premium is due the date coverage becomes effective. The only exceptions are in the case of a triggering event involving:

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

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

Additional Special Enrollment Period for a Child Under Guardianship

A newly-eligible Dependent child for whom guardianship has been granted by court or testamentary appointment may be added outside of the Annual Enrollment Period and Special Enrollment Periods described above. The effective date of coverage for a newly-eligible Dependent child for whom guardianship has been granted by court or testamentary appointment is the date of appointment.

The newly-eligible Dependent child will be covered automatically for the first thirty-one (31) days following the newly eligible Dependent child's effective date of coverage. Coverage of a newly-eligible child shall consist of coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

When No Additional Premium is Required

If no additional Premium is required, then the coverage must continue beyond the thirty-one (31) days automatically, even if the newly-eligible Dependent child is not affirmatively enrolled. Notification and enrollment of the newly-eligible Dependent child is suggested to expedite the claims process, but it is not required.

When Additional Premium is Due

If additional Premium is due within the aforementioned thirty-one (31) day automatic coverage period in order to add the newly-eligible Dependent child to the coverage, then and only then may Health Plan require notification of appointment of the new Dependent and payment of the required additional Premium in order to continue coverage beyond the thirty-one (31) day period.

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

For American Indian and Alaska Native Members who enroll through the Exchange: This provision only applies to individuals who gain or maintain status as an American Indian or Alaska Native, who become a Dependent of an American Indian or Alaska Native, or who is an American Indian or Alaska

Native, as defined in §4 of the federal Indian Health Care Improvement Act. For individuals who gain or maintain status as an American Indian or Alaska Native, you may enroll in a QHP or change from one QHP to another one time per month. For individuals who are an American Native or Alaska Native and are enrolled or are enrolling in a QHP through the Exchange on the same application as the Subscriber, you change from one QHP to another one time per month at the same time as the Subscriber. If you enroll in a plan between the first and the fifteenth day of the month, the coverage effective date of the new Plan will be the 1st day of the following month. If you enroll in a plan between the 16th and last day of the month, the coverage effective date will be the first day of the second following month.

Notice of Your Effective Date of Coverage

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

SECTION 2: How to Get the Care You Need

Making and Cancelling Appointments and Who to Contact

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

Medical Emergencies

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

Medical Advice

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

Making or Canceling Appointments

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

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

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

Choosing or Changing Your Primary Care Plan Physician

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

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

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

Customer Service:

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

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

Advance Directives to Direct Your Care While Incapacitated

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

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

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

Receiving Health Care Services

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

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

You have your choice of Plan Physicians and Facilities within our Service Area. 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 pre-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 pre-authorized referral, or other approval, 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 pre-authorized referrals or other approvals, and clinical trials are the only Services a Member may seek outside of the Service Area. For coverage of items or Services received by a non-Participating Provider at the same Cost Share of an in-network provider, refer to the ***Provider Directory Information Requirements*** provision in ***Section 7: Other Important Provisions of Your Plan***. For continued coverage of care from a Plan Provider whose Participating Provider contract is terminated or non-renewed for reasons other than for failure to meet

applicable quality standards or fraud, refer to the ***Continuing Care Patient*** or ***Continuity of Care for New Members*** provisions below.

If a Member receives Services for an Essential Health Benefit from an out-of-network ancillary provider in an in-network setting, the Cost Share paid by the Member for those Services will apply toward the Out-of-Pocket Maximum set forth in the ***Summary of Cost Shares*** appendix of the Agreement. Health Plan will provide written notice to the Member by the longer of when we would typically respond to a Prior Authorization request timely submitted, or forty-eight (48) hours before the provision of the benefit, that additional costs may be incurred for an Essential Health Benefit provided by an out-of-network ancillary provider in an in-network setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on Cost Sharing. If Health Plan fails to provide such written notice, the Cost Share paid by the Member for an Essential Health Benefit from an out-of-network ancillary provider in an in-network setting will apply toward the Out-of-Pocket Maximum set forth in the ***Summary of Cost Shares*** appendix of the Agreement.

Your Kaiser Permanente Identification Card

Digital Kaiser Permanente Identification Card

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

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

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

Using Your Kaiser Permanente Identification Card

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

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

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

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

Choosing Your Primary Care Plan Physician

We highly encourage you to choose a Primary Care Plan Physician when you enroll. He or she will play an important role in coordinating your health care Services, including Hospital stays and referrals to

specialists. Additionally, your Primary Care Plan Physician and Plan Providers will work as a team, along with you, to ensure continuity of care and medically appropriate courses of treatment.

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

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

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

Getting a Referral

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

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

Receiving an Authorized Specialist or Hospital Referral

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

If you Plan Provider decides that you need covered Services from a Specialist, your Plan Provider will request a referral for you. If you did not receive a referral during your Visit and you would like to request one, please call Member Services at 1-800-777-7902 to start the process. You will receive a decision on your requested referral whether the referral is approved or denied.

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 preauthorization 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 who has expertise in treating the life-threatening, degenerative, chronic, or disabling condition, that you need continuing care from that Specialist. In such instances, your Primary Care Plan Physician will issue a standing referral to the Specialist.

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

Referrals to Non-Plan Specialists and Non-Physician Specialists

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

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

You must have an approved verbal or 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.

Except for Emergency Services, 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.

Emergency Services do not require a referral from your Primary Care Plan Physician regardless if the Emergency Services are received from a Plan Provider or a non-Plan Provider.

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.

Step-therapy is a process that requires a prescription drug or sequence of prescription drugs to be used by a Member before the Health Plan will cover a prescription drug prescribed by a prescriber.

We will not require step-therapy if:

1. The step-therapy drug has not been approved by the U.S. Food & Drug Administration (FDA) for the medical condition being treated; or
2. A prescriber provides supporting medical information to us that a prescription drug we cover:
    a. Was ordered by the prescriber for the Member within the past 180 days; and
    b. Based on the professional judgement of the prescriber, was effective in treating the Member's disease or medical condition; or
3. A prescription drug was approved by the FDA; and
    a. Is used to treat a Member's stage four advanced metastatic cancer; and
    b. Use of the prescription drug is:
        i. Consistent with the FDA approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer; and
        ii. Supported by peer-reviewed medical literature.

Supporting medical information means:

1. A paid claim from the Health Plan for a Member;
2. A pharmacy record that documents that a prescription has been filled and delivered to a Member or a representative of a Member; or
3. Other information mutually agreed on by the Health Plan and the prescriber.

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***.

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).

Continuing Care Patient

A Continuing Care Patient, as defined in the section ***Important Terms You Should Know***, receiving care from a Participating Provider may elect to continue to receive transitional care from such provider if the provider's Participating Provider contract is terminated or non-renewed for reasons other than for failure to meet applicable quality standards or for fraud. 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, 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) 90 days after the date of such notice; 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 preauthorization 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 preauthorization 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.

Accepting Preauthorization for Services

Health Plan shall accept a preauthorization for the procedures, treatments, medications or other Services covered under this Agreement. Health Plan shall accept a request for the preauthorization of a course of treatment including for chronic conditions, rehabilitative Services, substance use disorders, and mental health conditions for a period of time that is as long as necessary to avoid disruptions in care and, determined in accordance with applicable coverage criteria, the Member's medical history and the Health Care Provider's recommendation.

If Health Plan requires a Prior Authorization for a prescription drug, the Prior Authorization request shall allow a Health Care Provider to indicate whether a prescription drug is to be used to treat a chronic condition, rehabilitative Service, substance use disorder, or mental health condition.

If Health Care Provider indicates the prescription drug is to treat a chronic condition, rehabilitative Service, substance use disorder, or mental health condition, Health Plan may not disrupt or request a reauthorization for a repeat prescription for the prescription drug for one (1) year or for the standard course of treatment for the chronic condition being treated, whichever is less, but not less than ninety (90) days after the date of enrollment.

Health Plan shall accept Prior Authorization from a Member or their Health Care Provider for at least the lesser of ninety (90) days or the length of the course of treatment. At the end of the applicable time period,

Health Plan may elect to perform our own review to allow the Prior Authorization for the prescription drug.

Health Plan will accept Prior Authorization when a Member changes from a Kaiser Plan to another Kaiser Plan within the ninety (90) day timeframe and may not require a Health Care Provider to submit a request for another preauthorization for a prescription drug if:

1. The prescription drug is a covered benefit under the current Kaiser Plan; or
2. The dosage for the approved prescription drug changes and the change is consistent with Federal Food and Drug Administration labeled dosages.

Health Plan may require Prior Authorization for a change in dosage for an opioid. If Health Plan requires a Prior Authorization for a prescription drug, we shall provide notice of the new requirement, including that the Member may remain on the prescription drug at the time of reauthorization, at least sixty (60) days before the requirement of the new Prior Authorization:

1. in writing to any Member who is prescribed the prescription drug; and
2. either in writing or electronically to all contracted health care providers.

Health Plan will not require more than one Prior Authorization and will not require a Health Care Provider to submit a request for another Prior Authorization for the prescription drug for two (2) or more tablets of different dosage strengths of the same prescription:

1. if the Member changes health benefit plans that are both covered by Health Plan and the prescription drug is a covered benefit under the current health benefit plan; or
2. except for a change in dosage from an opioid when the dosage for the approved prescription drug changes and the change is consistent with the FDA labeled dosage.

After receiving the consent of a Member, or the Member's parent, guardian or designee, we may request a copy of the Prior Authorization by following all the laws for confidentiality of medical records. The prior carrier, managed care organization, or third-party administrator must provide a copy of the preauthorization within ten (10) days following receipt of our request.

Health Plan will not issue an Adverse Decision on a reauthorization for the same prescription drug or request additional documentation from the prescriber for the reauthorization request if:

1. The prescription drug is an immune globulin (human) as defined in 21 C.F.R. §640.100; or
2. The prescription drug is used for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association;
3. Health Plan previously approved a Prior Authorization for the prescription drug for the Member;
4. The Member has been treated with the prescription drug without interruption since the initial approval of the Prior Authorization; and
5. The prescriber attests that, based on their professional judgment, the prescription drug continue to be necessary to effectively treat the Member's condition.

If the prescription drug that is being requested has been removed from the Formulary or has been moved to a higher Cost Sharing, Health Plan will provide the Member and the Member's Health Care Provider the information required under §15–831 of the Insurance Article.

Continuity of Care Limitation for Preauthorization

With respect to any benefit or Service provided through the fee-for-services Maryland Medical Assistance Program, this subsection shall apply only to:

1. Enrollees transitioning from the Maryland Medical Assistance Program to the Health Plan; and
2. Behavioral health and dental benefits, to the extent they are authorized by a third-party administrator.

Services from Non-Plan Providers

The Health Plan shall allow a new Member to continue to receive covered health care Services being rendered by a non-Plan Provider at the time of the Member's transition to our plan for the following conditions:

1. Acute conditions;
2. Serious chronic conditions;
3. Pregnancy;
4. Mental health conditions and substance use disorders; and
5. Any other condition on which the non-Plan Provider and the Health Plan reach agreement.

Examples of acute and serious chronic conditions may include:

1. Bone fractures;
2. Joint replacements;
3. Heart attack;
4. Cancer;
5. HIV/AIDS; and
6. Organ transplants.

Getting Emergency, Non-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 Participating Providers, non-Participating Providers, Participating Emergency Facilities, or non-Participating Emergency Facilities anywhere in the world, as long as the Services would be covered under ***Emergency Services*** in ***Section 3: Benefits, Exclusions and Limitations*** as if you had received them from Participating Providers or Participating Emergency Facilities. Emergency Services are available from Participating Emergency Facilities 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-Participating Providers as Participating Providers, or for Emergency Services furnished by non-Participating Emergency Facilities as Participating Emergency Facilities, and such Cost Sharing will be calculated based on the Recognized Amount in accordance with applicable law. Any Cost Share payments made by you will apply toward your Deductible, if any, and Out-of-Pocket Maximum, if any.

If Emergency Services are provided by a non-Participating Provider or non-Participating Emergency Facility, Health Plan will make payment for the covered Emergency Services directly to the non-

Participating Provider or non-Participating Emergency Facility. 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 Cost Sharing as further described in this Agreement

Bills for Emergency Services

When you receive a bill from a Participating Provider, non-Participating Provider, or Participating Facility for Emergency Services that were provided to you, you should either:

1. Contact the Participating Provider, non-Participating Provider, or Participating Facility 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 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. For more information on the payment or reimbursement of covered services and how to file a claim, see ***Filing for Payment or Reimbursement of a Covered Service or Post-Service Claim*** in ***Section 5: Filing Claims, Appeals and Grievances***.

Non-Emergency Services & 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.

When a non-Participating Provider provides non-Emergency Services, including Ancillary Services, and Services for unforeseen urgent medical needs at a Plan Hospital or a Plan Facility, your Cost Share will be the same Cost Sharing amount for the same Service(s) from a Participating Provider unless the non-Participating Provider has satisfied the notice and consent requirements of §149.420(c) through (i) with respect to those non-Emergency Services. Any Cost Sharing requirement for the items and Services will be calculated based on the Recognized Amount. Such Cost Share shall count toward your Deductible, if any, and Out-of-Pocket Maximum. You will not be liable for any additional payment other than your Cost Share for non-Emergency Services, including Ancillary Services, or unforeseen urgent medical needs. We will make payment for the items and Services directly to the non-Participating Provider. The payment amount will be equal to the amount by which the Out-of-Network Rate exceeds the Cost Sharing amount for the items and Services.

For covered Services rendered by a Health Care Provider for which payment is required under §19-710.1 of the Health-General Article, Ancillary Services, and 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-Participating Provider satisfied the notice and consent criteria, the notice and consent criteria of 45 C.F.R.

§149.420(c) through (i) do not apply to non-Participating Providers. Additionally, when these Services are received by a non-Participating Provider they will always be subject to the conditions described in the above paragraph.

Hospital Admissions

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

Getting Assistance from Our Advice Nurses

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

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

Getting a Second Opinion

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

Receiving Care in Another Kaiser Foundation Health Plan Service Area

You may receive covered Services from another Kaiser Foundation Health Plan, if the Services are provided, prescribed, or directed by that other plan, and if the Services would have been covered under this EOC. Covered Services are subject to the terms and conditions of this EOC, including prior authorization requirements, the applicable Copayments, Coinsurance and/or Deductible shown in the "Summary of Cost Shares," and the exclusions, limitations and reductions described in this EOC.

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

Payment Toward Your Cost Share and When You May Be Billed

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

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

1. **You receive non-preventive Services during a preventive Visit**. For example, you go in for a routine physical exam, and at check-in you pay your Cost Share for the preventive exam (your Cost

Share may be "no charge"). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem, such as laboratory tests. You may be asked to pay your Cost Share for these additional non-preventive diagnostic Services.

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

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

SECTION 3: Benefits, Exclusions and Limitations

Your Benefits

The benefits described in this section are covered only when:

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

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

1. Emergency Services, as described in this section;
2. Urgent Care Services outside of our Service Area, as described in this section;
3. Continuity of Care for New Members, as described in ***Section 2: How to Get the Care You Need***;
4. Continuing Care Patients, as described in ***Section 2: How to Get the Care You Need;***
5. Receiving Care in Another Kaiser Foundation Health Plan Service Area, as described in ***Section 2: How to Get the Care You Need***;
6. 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; and
7. Non-Emergency Services, including Ancillary Services, and Services for unforeseen urgent medical needs received by a non-Participating Provider at a Plan Hospital or a Plan Facility as described in ***Section 2: How to Get the Care You Need*** under the ***Non-Emergency Services & Urgent Care Services*** provision.

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

For authorized Services provided within our Service Area by a Plan Provider or a non-Plan Provider, including from a non-Plan Provider as the result of a referral, you will not incur any additional cost sharing beyond that which is indicated in your ***Summary of Cost Shares***.

If you are balance billed by a hospital, urgent care center, physician or ancillary provider for covered Services that were provided to you, simply mail a copy of the bill or submit online to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. Please mail or submit online your proof to us at the following address:

Kaiser Permanente National Claims Administration - Mid-Atlantic States

PO Box 371860
Denver, CO 80237-9998
Website: www.kp.org

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

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.

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 are provided to repair or replace sound natural teeth that have been damaged or lost due to injury as a result from an external force or trauma resulting in damage to a tooth or teeth, surrounding bone, and/or jaw. Treatment must begin within six (6) months of the injury or, if due to the nature of the injury, treatment could not begin within six (6) months of the injury, treatment must begin within six (6) months of the earliest date that it would be medically appropriate to begin such treatment.

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

Benefit-Specific Exclusion(s):
An injury that results from chewing or biting is not considered an Accidental Injury under this Plan.

Benefit-Specific Limitation(s):
Coverage is limited to Medically Necessary dental Services such as restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury.

Acupuncture Services

Coverage is provided for Medically Necessary acupuncture Services when provided by a provider licensed to perform such Services.

Allergy Services

Coverage is provided for allergy testing and treatment, including the administration of injections and allergy serum.

Ambulance Services

Coverage is provided for Medically Necessary ground ambulance Services and Air Ambulance Services to or from the nearest Hospital able to provide needed Services, provided during an encounter with an ambulance Service, as a result of a 911 call, or when ground or water transportation is not appropriate.

Cost Shares for Air Ambulance Services provided by a non-Participating Provider will not exceed that of Cost Shares for Air Ambulance Services provided by a Participating Provider and will apply toward your Deductible, if any, and Out-of-Pocket Maximum, if any. Any Cost Sharing requirement will be calculated based on the lesser of the Qualifying Payment Amount or the billed amount for the Services. We will make payment for the Air Ambulance Services directly to the non-

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

Anesthesia for Dental Care Services

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

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

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

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

Benefit-Specific Exclusion(s):
The dentist or specialist's dental care Services.

Blood, Blood Products and their Administration

Coverage is provided for all cost recovery expenses for blood, blood products, derivatives, components, biologics and serums, including autologous Services, whole blood, red blood cells, platelets, plasma, immunoglobulin and albumin.

Bone Mass Measurement

Coverage is provided for bone mass measurement for the prevention, diagnosis and treatment of osteoporosis when requested by a Health Care Provider for a Qualified Individual. We do not cover bone mass measurement for Members who do not meet the criteria of a Qualified Individual.

A Qualified Individual means an individual:

1. Who is estrogen deficient and at clinical risk for osteoporosis;
2. With a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
3. Receiving long-term gluco-corticoid (steroid) therapy;
4. With primary hyper-parathyroidism; or
5. Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Chiropractic Services

Coverage is provided for a limited number of chiropractic Visits per condition per Calendar Year.

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

Benefit-Specific Limitation(s):
Coverage is limited to up to twenty (20) chiropractic Visits per condition per Calendar Year.

Cleft Lip, Cleft Palate or Both

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

Clinical Trials

Clinical trials are defined as treatment that is:

1. Approved by an institutional review board;
2. Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and
3. Approved by:
   a. An institute or center of the National Institutes of Health; or
   b. The Food and Drug Administration; or
   c. The Department of Veterans' Affairs; or
   d. The Department of Defense.

Coverage is provided for 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. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   a. A Plan Provider makes this determination;
   b. You, or your beneficiary, provide us with medical and scientific information establishing this determination;
3. The clinical trial is a phase I, phase II, phase III or phase IV clinical trial related to the prevention, detection or treatment of cancer 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 FDA;
   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, including funding through in-kind contributions, by at least one (1) 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 cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs;
      vi. An institutional review board of an institution in the state which has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the National Institutes of Health;
      vii. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
      viii. The Department of Veterans Affairs, Department of Defense or the Department of Energy; but only if the study or investigation has been reviewed and approved through a system of peer review that the United States Secretary of Health and Human Services determines meets all of the following requirements:

a) It is comparable to the National Institutes of Health system of peer review of studies and investigations; and
b) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

5. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise;
6. There is no clearly superior, non-investigational treatment alternative; and
7. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.

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

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

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

Benefit-Specific Exclusion(s):
We do not cover:
1. The investigational service.
2. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

Diabetes Treatment, Equipment, Supplies and Self-Management Training

Coverage is provided for:
1. Diabetes treatment, equipment and supplies, including needles and test strips for glucose monitoring equipment;
2. Insulin syringes;
3. Insulin pumps; and
4. Self-management training for diabetes.

For Members enrolled in a Value Plan, 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 diagnoses 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.

For high deductible health plans (HDHP) plans, pursuant to IRS Notice 2019-45, the Deductible does not apply to coverage for glucometers and glucometer supplies, including diabetic test strips, for individuals diagnosed with diabetes. Refer to the ***Summary of Cost Shares*** appendix for Cost Sharing requirements.

For non-HDHP plans, Cost Shares do not apply to diabetic test strips.

Note: Insulin pumps are not covered under this benefit. Refer to the ***Durable Medical Equipment (DME) and Prosthetic Devices*** benefit under the ***Summary of Cost Shares*** appendix.

Dialysis

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

1. You satisfy all medical criteria developed by Medical Group and by the facility providing the dialysis; and
2. A Plan Physician provides a written referral for care at the facility.

We cover the following renal dialysis Services:

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

Note: Inpatient dialysis is covered under the ***Inpatient Hospital Services and Obstetrical Admissions*** benefit.

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).

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

Drugs, Supplies and Supplements

We cover drugs, supplies and supplements during a covered stay in a Plan Hospital, Skilled Nursing Facility or in an outpatient setting. We also cover drugs, supplies and supplements if they require administration or observation by medical personnel and are administered to you in a Plan Medical Center or during a home health visit. Such Services include:

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;
    a. **Note:** If a drug covered under this benefit meets the criteria for a Specialty Drug, in accordance with §15-847 of the Insurance Article, or is a prescription drug to treat diabetes, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS), as described in §15-847.1 of the Insurance Article, then the Member's cost for the drug will not exceed $150 for a thirty (30)-day supply. If this benefit is subject to the Deductible, as shown in the ***Summary of Cost Shares*** appendix, the Deductible must be met first. For all insulin, the Member's cost will not exceed $30 for a thirty (30)-day supply, regardless of the amount or type of

insulin, in accordance with §15-822.1 of the Insurance Article. Insulin is not subject to the Deductible.

b. **Note:** As permitted under §15-846 of the Insurance Article, oral chemotherapy drugs will be provided at the same or better level than intravenous or injectable chemotherapy drugs.

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 FDA that are not considered part of routine preventive care.

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

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

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

Benefit-Specific Exclusion(s):

1. Drugs for which a prescription is not required by law.
2. Drugs, supplies, and supplements that can be self-administered or do not require administration or observation by medical personnel.
3. Drugs for the treatment of sexual dysfunction disorders.
4. Drugs for the treatment of infertility. Refer to ***Infertility Services*** for coverage of administered drugs necessary for in vitro fertilization (IVF).

Durable Medical Equipment (DME) and Prosthetic Devices

Coverage for Durable Medical Equipment and Prosthetic Devices includes:

1. Durable Medical Equipment such as nebulizers and peak flow meters;
2. International normalized ratio (INR) home testing machines when deemed Medically Necessary by a Plan Physician;
3. Leg, arm, back or neck braces and the training necessary to use these prosthetics;
4. Internally implanted devices such as monofocal intraocular lens implants;
5. Artificial legs, arms or eyes and the training to use these prosthetics;
6. One (1) Medically Necessary hair prosthesis; and
7. Ostomy equipment and urological supplies.

Prosthetics means an artificial device to replace, in whole or in part, a leg, an arm, or an eye. Prosthetics includes a custom-designed, custom-fabricated, custom-fitted, or custom-modified device to treat partial or total limb loss for purposes of restoring physiological function. Coverage for prosthetics is provided when determined by a treating Health Care Provider to be Medically Necessary for completing activities of daily living, essential job-related activities, or performing physical activities including running, biking, swimming, strength training, and other activities to maximize the whole-body health and lower or upper limb function of the Member.

Coverage is provided once per calendar year for:

1. Prosthetics;
2. Components of prosthetics;
3. Repairs to prosthetics; and
4. Replacements of prosthetics or prosthetic components if:
   a. An ordering Health Care Provider determines that the provision of a replacement prosthetic or component of the prosthetic is necessary:
      i. Because of a change in the physiological condition of the Member;
      ii. Unless necessitated by misuse, because of an irreparable change in the condition of the prosthetic or a component of the prosthetic; or
      iii. Unless necessitated by misuse, because the condition of the prosthetic requires repairs, and the cost of the repairs would be more than 60% of the cost of replacing the prosthetic or the component of the prosthetic.

Note: For coverage of breast prosthesis, see the ***Reconstructive Breast Surgery and Breast Prosthesis*** benefit in this ***List of Benefits***.

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

Emergency Services

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, where available, 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 Kaiser Permanente identification card for immediate medical advice. Any emergency department/room Visit that is not attributed to an Emergency Medical Condition, as defined in the section ***Important Terms You Should Know***, will not be authorized by the Health Plan and the Services will be covered as non-Emergency Services. In situations where the Health Plan authorizes, directs, refers, or otherwise allows the Member to use the emergency room for a condition that is later determined not to meet the definition of an Emergency Medical Condition, the Health Plan would become responsible for charges.

In situations when the Health Plan authorizes, directs, refers, or otherwise allows a Member access to a Hospital emergency facility or other Urgent Care facility for a medical condition that requires emergency surgery, the Health Plan will reimburse the physician, oral surgeon, periodontist or podiatrist who performed the surgical procedure for any follow-up care that is:

1. Medically Necessary;
2. Directly related to the condition for which the surgical procedure was performed; and
3. Provided in consultation with the Member's Primary Care Plan Physician.

The Health Plan will not impose any Copayment or other Cost-Sharing requirement for follow-up care that exceeds that which a Member would be required to pay had the follow-up care been rendered in-network, using members of the Health Plan's provider panel.

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 Maryland, 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-Participating 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-Participating 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-Participating Provider. If we determine that you require Post-Stabilization Care, we will authorize your care from the non-Participating Provider or arrange to have a Participating Provider, or other designated provider, provide the care. If we decide to have a Participating Facility, Plan Skilled Nursing Facility, or designated non-Participating Provider provide your care, we may authorize special transportation Services that are non-Participating Providers. If you receive care from a non-Participating Provider that we have not authorized, you may have to pay the full cost of that care.

When you receive Emergency Services from non-Participating 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-Participating Facility when your attending non-Participating 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 Participating Provider located within a reasonable travel distance taking into account your medical condition. We also will not require Prior Authorization for Post-Stabilization Care received at a non-Participating Facility or by a non-Participating Provider when you or your Authorized Representative are not in a condition to receive the information in the notice, described in 45 CFR §149.410(b)(3), and to provide informed consent.

Non-Participating Providers may provide notice and seek your consent to provide Post-Stabilization Care Services or other covered Services, as described in §149.420(c) through (i). 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-Participating 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.

Family Planning Services

Coverage is provided for family planning Services, including:

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 care counseling;
   Note: Counseling does not include instruction for fertility awareness based methods;
3. Male sterilization;

4. Abortion care Services: ending a pregnancy, as permitted under Maryland state law;
   Note: We may prescribe medicine, perform an in-office procedure, or refer you for a procedure.
   For non-HDHP plans, abortion care Services are covered at no charge. For HDHP/HSA plans, you may have to pay for abortion care Services because your plan is a Health Savings Account (HSA)-compatible high deductible health plans. Refer to ***Abortion care Services*** under ***Family Planning Services*** in the ***Summary of Cost Shares*** appendix for Cost Sharing requirements; and
5. Instruction by a licensed health care provider on fertility awareness–based methods, which are methods of identifying times of fertility and infertility by an individual to avoid pregnancy, including cervical mucous methods, sympto-thermal or sympto-hormonal methods, the standard days methods, and the lactational amenorrhea method.

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

Note: We also cover Services for interruption of pregnancy, limited to the following circumstances:

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.

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

Benefit-Specific Exclusion(s):
Services:

1. To reverse voluntary, surgically induced infertility.
2. To reverse a voluntary sterilization procedure for a Dependent minor, except FDA approved sterilization procedures for women with reproductive capacity; or
3. For sterilization for a Dependent minor, except FDA approved sterilization procedures for women with reproductive capacity.

Fertility Services

We cover standard fertility preservation procedures performed on you or your Dependent and that are Medically Necessary to preserve fertility for you or your Dependent due to a need for medical treatment that may directly or indirectly cause iatrogenic infertility. These procedures include sperm and oocyte collection and cryopreservation, evaluations, laboratory assessments, medications, and treatments associated with sperm and oocyte collection and cryopreservation.

Definitions:
Iatrogenic infertility: An impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affective the reproductive organs or process.

Medical treatment that may directly or indirectly cause iatrogenic infertility: Medical treatment with a likely side effect of infertility as established by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.

Standard fertility preservation procedures: Procedures to preserve fertility that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.

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

Benefit-Specific Exclusion(s):

1. Any charges associated with the storage of female Member's eggs (oocytes) and/or male Member's sperm.

Habilitative Services and Devices

Coverage is provided for Medically Necessary habilitative Services. Habilitative Services means Health Care Services and devices, including Services and devices for the treatment of a person to keep, learn or improve skills and functioning for daily living. Habilitative Services includes Medically Necessary therapeutic care, behavioral health treatment, orthodontics, oral surgery, otologic therapy, audiological therapy, cleft lip and cleft palate and other Services for people with disabilities in a variety of both inpatient and outpatient settings.

Therapeutic care means services provided by a speech-language pathologist, occupational therapist or physical therapist.

Behavioral health treatment means professional counseling and treatment programs, including applied behavior analysis, that are necessary to develop, maintain or restore, to the maximum extent practicable, the functioning of an individual.

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

Benefit-Specific Exclusion(s):

We do not cover habilitative Services delivered through early intervention and school services.

Benefit-Specific Limitation(s):

The Health Plan will only reimburse for covered habilitative Services provided in the Member's educational setting when the Member's educational setting is identified by the Member's treating provider in a treatment goal as the location of the habilitative Services.

Hearing Services

Hearing Tests

We cover hearing tests to determine the need for hearing correction, when ordered by a Plan Provider.

Hearing Aids

Coverage is provided for one (1) hearing aid for each hearing-impaired ear every thirty-six (36) months.

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

Benefit-Specific Exclusion(s):

Replacement batteries to power hearing aids are not covered.

Home Health Care Services

Coverage is provided for Home Health Care Services:

1. As an alternative to otherwise covered Services in a Hospital or related institution; and
2. For Members who receive less than forty-eight (48) hours of inpatient hospitalization following a mastectomy or removal of a testicle, or who undergo a mastectomy or removal of a testicle on an outpatient basis, including:
   a. One (1) home visit scheduled to occur within twenty-four (24) hours after discharge from the Hospital or outpatient health care facility; and
   b. An additional home visit, if prescribed by the Member's attending physician.

For Home Health Care Services related to obstetrical admissions due to childbirth, see the ***Inpatient Hospital Services and Obstetrical Admissions*** benefit in this ***List of Benefits***.

Hospice Care Services

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

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

1. Nursing care;
2. Physical, occupational, speech and respiratory therapy;
3. Medical social Services;
4. Home health aide Services;
5. Homemaker Services;
6. Medical supplies, equipment and medication required to maintain the comfort and manage the pain of the terminally ill Member;
7. Palliative drugs in accordance with our drug formulary guidelines;
8. Physician care;
9. Short-term inpatient care; including care for pain management and acute symptom management as Medically Necessary;
10. Respite Care limited to five (5) consecutive days for any one inpatient stay;
11. Counseling Services for the Member and his Family Members, including dietary counseling for the Member; and bereavement counseling for the Member's Family; and
12. Services of hospice volunteers.

Infertility Services

We cover the following Services for diagnosis and treatment of involuntary infertility:

1. Artificial insemination; and
2. In vitro fertilization (IVF), if:
    a. For a married Member whose Spouse is of the opposite sex, the married Member's oocytes are fertilized with the married Member's Spouse's sperm; unless:
        i. The Spouse is unable to produce and deliver functional sperm and the inability to produce and deliver functional sperm does not result from:
            a) A vasectomy; or
            b) Another method of voluntary sterilization;
    b. The married Member and the married Member's Spouse have a history of involuntary infertility which may be demonstrated by a history of:
        i. Intercourse of at least one (1) year's duration failing to result in a successful pregnancy when the Member and the Member's Spouse are of opposite sexes;
    c. For an unmarried Member or if the married Member and the married Member's Spouse are of the same sex, three (3) attempts of artificial insemination over the course of one (1) year failing to result in a successful pregnancy; or
    d. The infertility of the unmarried Member or of the Member or the Member's Spouse is associated with any of the following:
        i. Endometriosis;

ii. Exposure in utero to diethylstilbestrol, commonly known as DES;
iii. Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
iv. Abnormal male factors, including oligospermia, contributing to the infertility.

e. The unmarried Member or the married Member has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this EOC; and
f. The in vitro fertilization (IVF) procedures are performed at medical facilities that conform to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine; and

3. Intracytoplasmic Sperm Injection (ICSI) if the Member meets medical guidelines.

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

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

Benefit-Specific Exclusion(s):

1. Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member's eggs and/or male Member's sperm for future attempts;
2. Any charges associated with obtaining donor eggs, donor sperm or donor embryos;
3. Services to reverse voluntary, surgically induced infertility;
4. Infertility Services when the infertility is the result of an elective male or female sterilization surgical procedure;
5. Gamete intrafallopian transfers (GIFT); zygote intrafallopian transfers (ZIFT); and prescription drugs related to such procedures.

Benefit-Specific Limitation(s):

Coverage for in vitro fertilization (IVF) embryo transfer cycles, including frozen embryo transfer procedure, is limited to three (3) in vitro fertilization (IVF) attempts per live birth.

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.

Refer to ***Infusion Therapy*** under ***Radiation Therapy/Chemotherapy/Infusion Therapy - Outpatient*** in the ***Summary of Cost Shares*** appendix for Cost Sharing requirements.

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

Infusion Therapy, Chemotherapy and Radiation

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

We cover Services for infusion therapy which is treatment by placing therapeutic agents into the vein including therapeutic nuclear medicine and parenteral administration of medication and nutrients. Infusion Services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These Services include coverage of all medications administered intravenously and/or parentally. We will also provide coverage for Medically Necessary diagnosis, evaluation, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy.

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

Note: If a drug covered under this benefit meets the criteria for a Specialty Drug, in accordance with §15-847 of the Insurance Article, or is a prescription drug to treat diabetes, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS), as described in §15-847.1 of the Insurance Article, then the Member's cost for the drug will not exceed $150 for a thirty (30)-day supply. If this benefit is subject to the Deductible, as shown in the ***Summary of Cost Shares*** appendix, the Deductible must be met first. For all insulin, the Member's cost will not exceed $30 for a thirty (30)-day supply, regardless of the amount or type of insulin, in accordance with §15-822.1 of the Insurance Article. Insulin is not subject to the Deductible.

Inpatient Hospital Services and Obstetrical Admissions

Coverage is provided for inpatient Hospital Services, including:

1. Room and board, such as:
   a. A ward, semi-private or intensive care accommodations. (A private room is covered only if Medically Necessary);
   b. General nursing care; and
   c. Meals and special diets.

Coverage is also provided for other Services and supplies provided by a Hospital and Services approved by our case management program.

For obstetrical admissions, inpatient hospitalization coverage is provided at no charge, from the time of delivery, for at least forty-eight (48) hours for a normal vaginal delivery or ninety-six (96) hours for a normal cesarean section.

For a mother and newborn child who chooses in consultation with her attending provider to remain in the Hospital for less than the minimum period specified above, the Health Plan will provide, at no charge, coverage for and arrange one (1) home health visit to be provided within twenty-four (24) hours after Hospital discharge and an additional home health visit, if prescribed by the attending provider, in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child.

For a mother and newborn child who remain in the Hospital for at least the minimum period described above, the Health Plan will provide, at no charge, coverage for a home health visit if prescribed by the attending provider.

If the mother is required to remain hospitalized after childbirth for medical reasons, and the mother requests that the baby remain in the Hospital, coverage is provided for the newborn for up to four (4) days.

Maternity Services

The Health Plan considers all maternity as routine, including all high-risk pregnancy. Coverage is provided for pre-natal

and post-natal Services, which includes routine and non-routine office Visits, telemedicine Visits, x-ray, laboratory and specialty tests. Coverage is also provided for:

1. Birthing classes (offered one course per pregnancy);
2. Breastfeeding support, supplies, and counseling from trained providers during pregnancy and/or in the postpartum period; and
3. Inpatient delivery, birthing centers, and hospitalization.

Note: All pregnancy and maternity Services that are defined as preventive care by the Affordable Care Act are covered under preventive care Services at no charge. For HSA/HDHP Plans, only those specified maternity Services identified by the Affordable Care Act ("ACA") as preventive care Services will be covered at no charge and not subject to the Deductible. Non-preventive care Services will be covered at no charge after the Deductible. Non-preventive care Services include outpatient obstetrical care and professional Services for all pre-natal and postpartum complications. Services include pre-natal and postpartum office Visits and ancillary Services provided during those Visits such as Medically Necessary laboratory tests and diagnostic Services.

Medical Foods

Coverage is provided for medical food for persons with metabolic disorders when ordered by a Health Care Practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders.

Medical Nutrition Therapy and Counseling

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

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

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

Mental Health and Substance Abuse Services

Coverage is provided for Medically Necessary Services for mental disorders, mental illness, psychiatric conditions and substance abuse for Members including:

1. Professional Services by providers who are licensed, registered, certified or otherwise authorized professional mental health and substance use practitioners when acting within the scope of their license, registration, or certification, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors or marriage and family therapists.
    a. Diagnosis and treatment of psychiatric conditions, mental illness or mental disorders. Services include:
        i. Diagnostic evaluation;
        ii. Crisis intervention and stabilization for acute episodes;
        iii. Medication evaluation and management (pharmacotherapy);
        iv. Treatment and counseling, including individual and group therapy;
        v. Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling;
        vi. Opioid treatment Services; and
        vii. Professional charges for intensive outpatient treatment in a provider's office or other professional

setting.
   b. Electroconvulsive therapy (ECT);
   c. Inpatient professional fees;
   d. Outpatient diagnostic tests provided and billed by a licensed, registered, certified, or otherwise authorized mental health and substance abuse practitioner;
   e. Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility; and
   f. Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment.
2. Inpatient hospital and inpatient residential treatment centers Services, which includes room and board, such as:
   a. Ward, semi-private or intensive care accommodations. A private room is covered only if Medically Necessary. If a private room is not Medically Necessary, we will only cover the hospital's average charge for semiprivate accommodations;
   b. General nursing care;
   c. Meals and special diets; and
   d. Other Services and supplies provided by a hospital or residential treatment center.
3. Outpatient Services such as partial hospitalization or intensive day treatment programs provided in a licensed or certified facility or program, which is equipped to provide mental health and substance abuse Services; and
4. Emergency room Services.

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

Benefit-Specific Exclusion(s):
We do not cover:
1. Services by pastoral or marital counselors;
2. Therapy for the improvement of sexual functioning and pleasure;
3. Treatment for learning disabilities and intellectual disabilities;
4. Travel time to the Member's home to conduct therapy;
5. Services rendered or billed by schools or halfway houses or members of their staffs;
6. Marriage counseling; and
7. Services that are not Medically Necessary.

Morbid Obesity Services (including Bariatric Surgery)

Morbid obesity means a body mass index that is:
1. Greater than forty (40) kilograms per meter squared; or
2. Equal to or greater than thirty-five (35) kilograms per meter squared with a comorbid condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

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

Coverage is provided for diagnostic and surgical treatment of morbid obesity that is:
1. Recognized by the National Institutes of Health as effective for long-term reversal of morbid obesity; and
2. Consistent with guidelines approved by the National Institutes of Health.

Such treatment is covered to the same extent as for other Medically Necessary surgical procedures under this Agreement.

Surgical treatment of morbid obesity shall occur in a facility that is:

1. Designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence; and
2. Designated by the Health Plan.

If the Health Plan does not designate a facility for the surgical treatment of morbid obesity, then the Health Plan shall cover the surgical treatment of morbid obesity at any facility that is designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence with an approved referral.

Obstetric/Gynecological Care

Coverage is provided for obstetric/gynecological care from an obstetrician/gynecologist or other Plan Provider authorized to perform obstetric and/or gynecological Services, without requiring the woman to Visit the Primary Care Plan Physician first, if:

1. The care is Medically Necessary, including the ordering of related obstetrical and gynecological Services; and
2. After each Visit for gynecological care, the obstetrician/gynecologist communicates with the woman's Primary Care Plan Physician about any diagnosis or treatment rendered.

Oral Surgery/Temporomandibular Joint Services (TMJ)

Coverage is provided for:

1. Orthognathic surgery, including inpatient and outpatient surgery to correct temporomandibular joint (TMJ) pain dysfunction syndrome and craniomandibular joint Services, that are required because of a medical condition or injury that prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part;
2. Maxillary or mandibular frenectomy when not related to a dental procedure;
3. Surgical Services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures;
4. Treatment of non-dental lesions, such as removal of tumors and biopsies;
5. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses;
6. Removable appliances for TMJ repositioning;
7. Therapeutic injections for TMJ; and
8. Medically Necessary oral restoration after major reconstructive surgery.

Outpatient Hospital Services

Coverage is provided for outpatient Hospital Services and Services approved by our case management program.

Outpatient Office Visits

Coverage is provided for care in medical offices for treatment of illness or injury.

Prescription Drugs and Devices

Coverage is provided for prescription drugs and devices as described in the ***Outpatient Prescription Drug Benefit Appendix***.

Preventive Health Care Services

Coverage is provided, without any cost sharing requirements such as Copayments, Coinsurance amounts and Deductibles, for the following preventive care Services:

1. Evidence-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 recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography and prevention issued during or around November 2009 are not considered to be current. Visit: www.uspreventiveservicestaskforce.org;
2. Immunizations for routine use in children, adolescents and adults that have a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. A recommendation from the Advisory Committee on Immunization Practices of the CDC is considered to be: in effect after it has been adopted by the director of the CDC and for routine use if it is listed on the immunization schedules of the CDC. Visit: 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. To see the current guidelines, visit: http://mchb.hrsa.gov;
4. With respect to women (to the extent not described in item #1 above), evidence-informed preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. To see the current guidelines, visit: http://mchb.hrsa.gov;
5. A voluntary Health Risk Assessment that can be completed by Members annually. Written feedback provided to Members will include recommendations for addressing identified risks;
6. All United States Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity;
7. Routine prenatal care;
8. BRCA counseling and genetic testing. Any follow up Medically Necessary treatment is covered at the applicable Cost Share based upon type and place of Service;
9. Medically Necessary digital tomosynthesis, commonly referred to as three-dimensional "3_D" mammography; and
10. Prostate cancer screening. Medically recognized diagnostic examinations including prostate-specific antigen (PSA) tests and digital rectal examinations:
    a. For men who are between forty (40) and seventy-five (75) years of age;
    b. When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;
    c. When used for staging in determining the need for a bone scan for patients with prostate cancer; or
    d. When used for male Members who are at high risk for prostate cancer.

Note: If a new recommendation or guideline described in paragraphs "1" through "4" is issued after the effective date of the Plan, the new recommendation or guideline shall apply the first Calendar Year that begins on the date that is one (1) year after the date of the recommendation or guideline is issued.

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

1. Retinopathy screening for diabetics
2. Hemoglobin A1C (HbA1C) for diabetics
3. Low density Lipoprotein (LDL) laboratory test for people with heart disease
4. INR laboratory test for liver failure and bleeding disorders

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

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

For coverage of diagnostic breast examinations, supplemental breast examinations, and follow-up diagnostic imaging to assist in the diagnosis of lung cancer, please see the ***X-Ray, Laboratory and Special Procedures*** benefit in this ***List of Benefits***.

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.

Reconstructive Breast Surgery and Breast Prosthesis

Reconstructive breast surgery means surgery performed as a result of a mastectomy to reestablish symmetry between both breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

Mastectomy means the surgical removal of all or part of a breast.

Coverage is provided for:

1. Breast prosthesis;
2. All stages of reconstructive breast surgery performed on the non-diseased breast to achieve symmetry with the diseased breast when reconstructive surgery is performed on the diseased breast; regardless of the patient's insurance status at the time the mastectomy or the time lag between the mastectomy and reconstruction; and
3. Physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Note: For breast prosthesis, refer to the ***Durable Medical Equipment (DME) and Prosthetic Devices*** benefit under the ***Summary of Cost Shares*** appendix.

Reconstructive Surgery

We cover reconstructive surgery to:

1. Correct significant disfigurement resulting from an illness, injury, previous treatment, 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 or at the same time of a 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 breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

We also cover the following inpatient and outpatient Services:

1. Surgeries and procedures to correct congenital abnormalities that cause functional impairment and congenital abnormalities in newborn children;
2. Surgeries and procedures to correct significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery;

3. Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
4. Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, and laparoscopy;
5. Treatment of fractures and dislocation, including splints; and
6. Pre-operative and post-operative care.

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 will not result in significant improvement in bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.

Routine Foot Care

Coverage is provided for Medically Necessary routine foot care.

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

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

Services Approved by the Health Plan

Coverage is provided for any other Service approved by the Health Plan's utilization management program.

Skilled Nursing Facility Services

Coverage is provided for Skilled Nursing Facility Services when deemed Medically Necessary.

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

Benefit-Specific Limitation(s):
Coverage is limited to a maximum of one-hundred (100) days per Calendar Year.

Telemedicine Services

We cover interactive telemedicine Services.

Telemedicine is the use of interactive audio, video, or telecommunications or other electronic technology used for the purpose of diagnosis, consultation or treatment as it pertains to the delivery of covered Health Care Services. We cover an audio-only telephone conversation if it results in the delivery of a billable covered Health Care Service.

Note: We cover telehealth Services regardless of the location of the patient at the time the telehealth Services are provided.

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

Benefit-Specific Exclusion(s):
We do not cover non-interactive telemedicine Services consisting of electronic mail message and/or facsimile transmission.

Therapy and Rehabilitation Services - Outpatient

Coverage is provided for therapy and rehabilitation Services, including:

1. Unlimited Medically Necessary Hospital inpatient rehabilitative Services;
2. Outpatient rehabilitative Services. Members receive up to thirty (30) combined telehealth and face-to-face Visits of each of the following Services:
   a. Physical therapy per condition, per year;

b. Speech therapy per condition, per year; and
c. Occupational therapy per condition per year.

3. Cardiac Rehabilitation for Members who have been diagnosed with significant cardiac disease, have suffered a myocardial infarction or have undergone invasive cardiac treatment immediately preceding referral for Cardiac Rehabilitation. Cardiac Rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling. Services include:
   a. Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, physician's revision of exercise prescription and follow-up examination for physician to adjust medication or change regimen; and
   b. Up to ninety (90) Visits per therapy type, per Calendar Year of physical therapy, speech therapy and occupational therapy for Cardiac Rehabilitation.
4. Pulmonary rehabilitation for Members diagnosed with significant pulmonary disease.

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

Benefit-Specific Exclusion(s):
We do not cover maintenance programs for cardiac rehabilitation and pulmonary rehabilitation. Maintenance programs consist of activities that preserve the present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional progress is apparent or expected to occur.

Benefit-Specific Limitation(s):
Cardiac Rehabilitation limitation(s):

1. Services must be provided at a facility approved by the Health Plan that is equipped to provide cardiac rehabilitation.

Pulmonary rehabilitation limitation(s):

1. Services must be provided at a facility approved by the Health Plan that is equipped to provide pulmonary rehabilitation.

Transplant Services

Coverage is provided for transplant Services for all non-experimental and non-investigational solid organ transplants and other non-solid organ transplant procedures. This includes, but is not limited to, autologous and non-autologous bone marrow, cornea, kidney, liver, heart, lung, heart/lung, pancreas and pancreas/kidney transplants.

Benefits include the cost of hotel lodging and air transportation for the covered recipient and a companion to and from the authorized site of the transplant. If the covered recipient is under age 18, hotel lodging and air transportation is provided for two (2) companions to and from the authorized site of the transplant.

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

Urgent Care Services

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

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

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

Service Area.

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

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

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

Outside our Service Area

If you are injured or become ill while temporarily outside the Service Area, we will cover Urgent Care Services as defined in this section. All follow-up care must be provided by a Plan Provider or Plan Facility except as provided under ***Follow-up Care for Emergency Surgery*** below and if follow-up treatment outside the Service Area is required in connection with covered out-of-area Emergency Services or Urgent Care and we determine that a Member could not reasonably be expected to return to the Service Area for such care.

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

Follow-up Care for Emergency Surgery

In those situations when we authorize, refer, direct, or otherwise allow you access to a hospital emergency facility or other urgent care facility for a medical condition that requires emergency surgery, we will reimburse the physician, oral surgeon, periodontist or podiatrist who performed the surgical procedure for any follow-up care that is:

1. Medically Necessary;
2. Directly related to the condition for which the surgical procedure was performed; and
3. Provided in consultation with your primary care Plan Physician.

We will not impose any Copayment or other cost-sharing requirement for follow-up care under this provision that exceeds that which you would be required to pay had the follow-up care been rendered by Plan Providers within our Service Area.

See the benefit-specific exclusion(s) and limitation(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.

Benefit-Specific Limitation(s):

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

Vision Services

Coverage is provided for Vision Services for:

1. Pediatric Members, up until the end of the month they turn age 19, who may receive:
   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 (1) frame each year from an available selection of frames; and
   c. Contact lenses limited to:

i. Either one (1) pair elective prescription contact lenses from a select group per year or multiple pairs of disposable prescription contact lenses from a select group per year; or
ii. Two (2) pair per eye for Medically Necessary contact lenses per year;

a. Low vision Services, including: one (1) comprehensive low vision evaluation every five (5) years, four (4) follow-up Visits within any five (5) year period and prescribed optical devices such as high-power spectacles, magnifiers and telescopes.
b. Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.

2. Adult Members age 19 or older, who may receive:
   a. Routine and necessary eye exams including:
   b. Routine tests such as eye health and glaucoma tests; and
   c. Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.

Note: Discounts are available for certain lenses and frames.

Wellness Benefits

Coverage is provided for wellness benefits, including:

1. A health risk assessment that is completed by each individual on a voluntary basis; and
2. Written feedback to the individual who completes a health risk assessment, with recommendations for lowering risks identified in the completed health risk assessment.

X-ray, Laboratory and Special Procedures - Outpatient

Coverage is provided for outpatient laboratory and diagnostic Services such as:

1. Diagnostic Services;
2. Laboratory tests, including preimplantation genetic tests (PGT) for specific genetic disorders such as monogenic / single gene defect (PGT-M) or inherited structural chromosome rearrangements (PGT-SR), for which genetic counseling is available;
3. Special procedures, such as electrocardiograms, electroencephalograms, and intracytoplasmic sperm injection (ICSI) in conjunction with monogenic / single gene defect (PGT-M) or inherited structural chromosome rearrangements (PGT-SR) due to chromosomal abnormalities, if the Member meets medical guidelines;
4. Sleep laboratory and sleep studies;
5. Specialty imaging, including computerized tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET) scans, diagnostic Nuclear Medicine studies and interventional radiology; and
6. Biomarker testing for the purpose diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition that is supported by medical and scientific evidence.
   a. Biomarker 1) means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention including known gene-drug interactions for medications being considered for use or already being administered and 2) includes gene mutations, characteristics of genes, or protein expressions.
   b. Biomarker testing is the analysis of a Member's tissue, blood, or other biospecimen for the presence of a biomarker and includes single-analyte tests, multi-plex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing.

We cover diagnostic breast examinations and supplemental breast examinations, including image-guided biopsies, and lung cancer screenings at no charge. For HDHP plans, if coverage for diagnostic breast examinations, supplemental breast examinations, including image-guided biopsies, and lung cancer screenings, including recommended follow-up diagnostic

imaging, such as diagnostic ultrasound, MRI, CT, and image-guided biopsy, to assist in the diagnosis of lung cancer is subject to the Deductible, as shown in the ***Summary of Cost Shares*** appendix, the Deductible must be met first.

Diagnostic breast examination means Medically Necessary and appropriate examination of the breast that is used to evaluate an abnormality that is:

1. Seen or suspected from a prior screening examination for breast cancer; or
2. Detected by another means of prior examination and includes:
    a. An examination using diagnostic mammography, breast MRI, or breast ultrasound.

Supplemental breast examination means a Medically Necessary examination of the breast that is used to screen for breast cancer when:

1. There is no abnormality seen or suspected from a prior examination; and
2. There is a personal or family medical history or additional factors that may increase a Member's risk of breast cancer and includes:
    a. An examination using breast MRI, breast ultrasound, or image-guided breast biopsy.

Lung cancer screening also includes recommended follow-up diagnostic imaging, such as diagnostic ultrasound, MRI, CT, and image-guided biopsy, to assist in the diagnosis of lung cancer for individuals for which lung cancer screening or follow-up diagnostic imaging is recommended by the United States Preventive Services Task Force (USPSTF).

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

Exclusions

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

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

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

The following Services are excluded from coverage:

1. Services that are not Medically Necessary.
2. Services performed or prescribed under the direction of a person who is not a Health Care Practitioner.
3. Services that are beyond the scope of practice of the Health Care Practitioner performing the Service.
4. Other Services to the extent they are covered by any government unit, except for veterans in Veterans Administration or armed forces facilities for Services received for which the recipient is liable.
5. Services for which a Member is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.
6. Except for the pediatric vision benefit in the ***List of Benefits*** in this section – the purchase, examination, or fitting of eye glasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for the use in the treatment of a disease or injury.
7. Personal Care services and Domiciliary Care services.

8. Services rendered by a Health Care Practitioner who is a Member's spouse, mother, father, daughter, son, brother or sister.
9. Experimental Services. This exclusion does not apply to Services covered under the clinical trials benefit in the ***List of Benefits*** in this section.
10. Practitioner, Hospital or clinical Services related to radial keratotomy, myopic keratomileusis and surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error.
11. Medical or surgical treatment for reducing or controlling weight, unless otherwise specified in the ***List of Benefits*** in this section.
12. Services incurred before the effective date of coverage for a Member.
13. Services incurred after a Member's termination of coverage, except as provided under ***Extension of Benefits*** in ***Section 6: Change of Residence, Plan Renewal and Termination, and Transfer of Plan Membership***.
14. 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.
15. Services for injuries or diseases related to a Member's job to the extent the Member is required to be covered by a workers' compensation law.
16. Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor, union, trust, or similar persons or groups.
17. Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers or physical fitness equipment.
18. Except for a covered telehealth consultation, charges for telephone consultations, failure to keep a scheduled Visit, or completion of any form.
19. Inpatient admissions primarily for diagnostic studies, unless authorized by the Health Plan.
20. The purchase, examination or fitting of hearing aids and supplies, and tinnitus maskers, unless otherwise specified in the ***List of Benefits*** in this section.
21. Travel, whether or not it is recommended by a Health Care Practitioner, except for:
    a. Covered ambulance Services (as described in ***Emergency Services***); and
    b. Travel in connection with a covered transplant (as described in ***Transplant Services***).
22. Except for Emergency Services and Urgent Care Services, Services received while the Member is outside of the United States.
23. Immunizations related to foreign travel.
24. Unless otherwise specified in the ***List of Benefits*** in this section, or the ***Kaiser Permanente Smile KPIF Dental EPO Adult Dental Plan Rider, Kaiser Permanente Smile KPIF Dental PPO Adult Dental Plan Rider, Kaiser Permanente Smile Kids KPIF Embedded Dental EPO Plan*** appendix, ***Kaiser Permanente Smile Kids KPIF Embedded Dental EPO Value Plan*** appendix, ***Kaiser Permanente Smile KPIF OrthoPlus Dental EPO Family Rider***, or ***Kaiser Permanente Smile KPIF OrthoPlus Dental PPO Family Rider***, whichever applies, dental work or treatment that includes Hospital or professional care in connection with:
    a. The operation or treatment for the fitting or wearing of dentures;
    b. Orthodontic care or malocclusion;
    c. Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within six (6) months of the accident; and
    d. Dental implants.

25. Except as provided under the ***Kaiser Permanente Smile KPIF Dental EPO Adult Dental Plan Rider, Kaiser Permanente Smile KPIF Dental PPO Adult Dental Plan Rider, Kaiser Permanente Smile Kids KPIF Embedded Dental EPO Plan*** appendix, ***Kaiser Permanente Smile Kids KPIF Embedded Dental EPO Value Plan*** appendix, ***Kaiser Permanente Smile KPIF OrthoPlus Dental EPO Family Rider***, or ***Kaiser Permanente Smile KPIF OrthoPlus Dental PPO Family Rider***, whichever applies, accidents occurring while and as a result of chewing.
26. Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports or exams for their prescription or fitting, unless these Services are deemed to be Medically Necessary.
27. Inpatient admissions primarily for physical therapy, unless authorized by the Health Plan.
28. Treatment of sexual dysfunction not related to organic disease.
29. Services that duplicate benefits provided under federal, state or local laws, regulations or programs.
30. Non-human organs and their implantation.
31. Non-replacement fees for blood and blood products.
32. Lifestyle improvements or physical fitness programs, unless included in ***List of Benefits*** in this section.
33. Wigs or cranial prosthesis, except for one (1) Medically Necessary hair prosthesis as noted above in the ***List of Benefits*** in this section.
34. Weekend admission charges, except for emergencies and maternity, unless authorized by the Health Plan.
35. Outpatient orthomolecular therapy, including nutrients, vitamins and food supplements.
36. Services resulting from accidental bodily injuries arising out of a motor vehicle accident, to the extent the Services are payable under a medical expense payment provision of an automobile insurance policy.
37. Services for conditions that State or local laws, regulations, ordinances or similar provisions require to be provided in a public institution.
38. Services for, or related to, the removal of an organ from a Member for the purposes of transplantation into another person unless the:
    a. Transplant recipient is covered under the Health Plan and is undergoing a covered transplant; and
    b. Services are not payable by another carrier.
39. Physical examinations required for obtaining or continuing employment, insurance or government licensing.
40. Non-medical ancillary Services such as vocational rehabilitation, employment counseling or educational therapy.
41. A private Hospital room unless Medically Necessary and authorized by the Health Plan.
42. Private duty nursing, unless authorized by the Health Plan.
43. Any claim, bill or other demand or request for payment for Health Care Services determined to be furnished as a result of a referral prohibited by §1-302 of the Health Occupations Article.

Limitations

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

1. A major disaster;
2. An epidemic;
3. War;
4. Riot;
5. Civil insurrection;
6. Disability of a large share of personnel of a Plan Hospital or Plan Medical Center; and/or

7. Complete or partial destruction of facilities.

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

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

SECTION 4: Subrogation, Reductions and Coordination of Benefits

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

Subrogation

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 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 Health Plan more than what you received from or on behalf of the third party for covered Services.

Notifying the Health Plan of Claims and/or Legal Action

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

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Patient Financial Services

4000 Garden City Drive
Hyattsville, MD 20785

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

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

The Health Plan's Right to Recover Payments

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

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

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

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

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

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

the Health Plan.

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

Workers' Compensation or Employer's Liability

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

The recovery rights will be applied even though:

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

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

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

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

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

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

Health Plan Not Liable for Illness or Injury to Others

Who is eligible for coverage under this Agreement is stated under the Eligibility for a Kaiser Permanente Individuals and Families Plan provision in ***Section 1: Introduction to Your Kaiser Permanente Health***

Plan. Neither the Health Plan, Plan Hospitals nor the Medical Group provide benefits or health care Services to others due to your liabilities. If you are responsible for illness or injury caused to another person, coverage will not be provided under this Agreement unless they are a Member.

Failure to Notify the Health Plan of Responsible Parties

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

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

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

Note: This provision does not apply to payments made to a covered person under personal injury protection (see §19-713.1(e) of the Maryland Health General Article.)

Pursuit of Payment from Responsible Parties

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

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

Reductions Under Medicare and TRICARE Benefits

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

TRICARE benefits are secondary by law.

Coordination of Benefits

Coordination of Benefits Overview

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

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

Right to Obtain and Release Needed Information

When information is needed to apply these coordination of benefits rules, the Health Plan will decide the information it needs, and may get that information from, or give it to, any other organization or person. The Health Plan does not need to tell anyone, or obtain consent from anyone, to do this.

Primary and Secondary Plan Determination

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

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

Coordination of Benefits Rules

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

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

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

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

Assistance with Questions about the Coordination of Your Benefits

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

Order of Benefit Determination Rules

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

1. If another plan does not have a Coordination of Benefits provision, that plan is the primary plan.

2. If another plan has a Coordination of Benefits provision, the first of the following rules that apply will determine which plan is the primary plan:

Rules for a Non-Dependent and Dependents

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

Rules for a Dependent Child/Parent

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

c) The plan covering the non-custodial parent; and then
d) The plan covering the non-custodial parent's spouse.

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

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

Dependent Child Who Has Their Own Coverage

1. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's 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 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).
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.
3. This rule does not apply if the rule above in items #1 and #2 under the provision ***Rules for a Subscriber and Dependents*** can determine the order of benefits.

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.
3. This rule does not apply if the rule above in items #1 and #2 under the provision ***Rules for a Subscriber and Dependents*** can determine the order of benefits.

Longer/Shorter Length of Coverage

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

Effect of Coordination of Benefits on the Benefits of this Plan

When the Health Plan is the primary Plan, coordination of benefits has no effect on the benefits or Services provided under this Agreement. When the Health Plan is a secondary Plan to one or more other plans, its benefits may be coordinated with the primary plan carrier using the guidelines below. This ***Coordination of Benefits*** provision shall in no way restrict or impede the rendering of Services covered

by the Health Plan. At the request of the Member or Parent/Guardian, when applicable, the Health Plan will provide or arrange for covered Services and then seek coordination with a primary plan.

Coordination with the Health Plan's Benefits

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

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

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

Facility of Payment

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

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

Right of Recovery of Payments Made Under Coordination of Benefits

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

Military Service

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

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

SECTION 5: Filing Claims, Appeals and Grievances

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

Important Definitions

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

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

Questions About Filing Claims, Appeals or Grievances

If you have questions about how to file a claim, Appeal or Grievance with the Health Plan, please contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY). Member Services representatives can also help you submit a request for payment and/or reimbursement for Emergency Services and Urgent Care Services outside of our Service Area.

Notice of Claim

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

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

Notice of Claim and Proof of Loss Requirements

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

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

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

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

You may 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 Department at the number listed above.

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

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

Paper forms, supporting documentation, and any other information can be mailed or submitted online to:

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

Your Health Care Provider must submit within one-hundred and eighty days (180) from the date of a covered Service a claim for reimbursement of the covered Service.

Each Member claiming reimbursement under this Agreement shall complete and submit any consents, releases, assignments and/or other documents to the Health Plan that we may reasonably request for the purpose of acting upon a claim.

Health Plan Claim Evaluation and Payment

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

1. Member, for non-child only plans; or

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

Claim Denial

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

The Health Education and Advocacy Unit, Office of the Attorney General

The Health Education and Advocacy Unit is available to assist you, your Authorized Representative, or your Health Care Provider with filing an Appeal or Grievance under the Health Plan's internal Appeal and Grievance processes, however, the Health Education and Advocacy Unit is not available to represent or accompany you, your Authorized Representative, or your Health Care Provider during any associated proceedings, and in mediating a resolution of the Adverse Decision or Coverage Decision with the Health Plan.

1. You, your Authorized Representative, or your Health Care Provider may file an Appeal or Grievance; and
2. You, your Authorized Representative or a Health Care Provider acting on your behalf may file a Complaint with the Commissioner, without first filing a Grievance with the Health Plan and receiving a final decision on the Grievance, if:
    a. The Health Plan waives the requirement that our internal grievance process must be exhausted before filing a Complaint with the Commissioner;
    b. The Health Plan has failed to comply with any of the requirements of the internal grievance process as described below in ***Our Internal Grievance Process***; or
    c. You, your Authorized Representative or a Health Care Provider acting on your behalf provides sufficient information and supporting documentation in the Complaint that demonstrated a compelling reason to do so; or
3. You, your Authorized Representative or a Health Care Provider acting on your behalf may file a Complaint with the Commissioner, without first filing an Appeal with the Health Plan only if the Coverage Decision involves an urgent medical condition for which Services have not been rendered.

The Health Education and Advocacy Unit may be contacted at:
Office of the Attorney General
Consumer Protection Division
Attention: Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 1-410-528-1840
Toll-free: 1-877-261-8807
Fax: 1-410-576-6571
Website: www.oag.state.md.us
Email: mailto:consumer@oag.state.md.us

Maryland Insurance Commissioner

You or your Authorized Representative must exhaust our internal Appeal or Grievance process as described in this section prior to filing a Complaint with the Insurance Commissioner except when:

1. You, your Authorized Representative, or Health Care Provider provides sufficient information and documentation in the Complaint that supports a compelling reason to not exhaust our internal process for resolving Grievances (protests regarding Adverse Decisions), such as, when a delay in receiving the Service could result in loss of life, serious impairment to a bodily function, or serious dysfunction to a bodily organ or part, or the Member remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Member to be a danger to him/herself or others, or the Member continuing to experience severe withdrawal symptoms. A Member is considered to be in danger to self or others if the Member is unable to function in activities of daily living or care for self without imminent dangerous consequences;
2. We failed to make a Grievance Decision for a pre-service Grievance within thirty (30) working days after the Filing Date or forty-five (45) working days after the Filing Date for a post-service Grievance;
3. We or our representative failed to make a Grievance Decision for an expedited Grievance for an Emergency Case within twenty-four (24) hours after you or your Authorized Representative filed the Grievance;
4. We have waived the requirement that our internal Grievance process must be exhausted before filing a Complaint with the Commissioner; or
5. We have failed to comply with any of the requirements of our internal Grievance process.

The Maryland Insurance Commissioner may be contacted at:

Maryland Insurance Administration
Attention: Consumer Complaint Investigation
Life and Health/Appeal and Grievance
200 St. Paul Place
Suite 2700
Baltimore, MD 21202
Phone: 1-410-468-2000
Toll free/out-of-area: 1-800-492-6116
TTY: 1-800-735-2258
Fax: 1-410-468-2260 or 1-410-468-2270

Our Internal Grievance Process

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

Initiating a Grievance

You or your Authorized Representative may initiate a Grievance by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY) or 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 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.

After confirming through a complete review of any information already submitted by your Health Care Provider, 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, your Authorized Representative, or Health Care Provider that we cannot proceed with review of the Grievance unless we receive the additional information, request the specific information, including any lab or diagnostic test or other medical information that must be submitted to complete the internal Grievance process, and provide the specific reference, language, or requirements from the criteria and standards used by us to support the need for the additional information. If you, your Authorized Representative, or Health Care Provider 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) calendar days after 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 Health Care Services already rendered to you, an acknowledgment letter will be sent requesting additional information that may be necessary within five (5) working days after the Filing Date. We will also inform you or your Authorized Representative that a decision regarding the Grievance will be made and provided in writing. Such written notice will be sent within forty-five (45) working days of the Filing Date of the Grievance or within five (5) working days 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 do 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.

In the case of an agreed upon extension, we will communicate our decision to you or your Authorized Representative and provide written notice of the decision by no later than the end of the extension period or within five (5) working days from the date of the decision, whichever comes first.

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 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 1-404-364-4862 or TTY/TDD 1-800-255-0056.

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

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

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

We will initiate the expedited review of the Emergency Case if you or your Authorized Representative requests the expedited review or if you, your Authorized Representative, or your Health Care Provider attests that:

1. the Adverse Decision was rendered for Health Care Services that are proposed but have not been provided; and
2. the Services are necessary to treat a condition or illness that, without immediate medical attention, would:
    a. seriously jeopardize the life or health of you or your ability to regain maximum functions;
    b. cause you to be in danger to yourself or others; or
    c. cause you to continue using intoxicating substances in an imminently dangerous manner.

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 provide you, or your Authorized Representative, and your Health Care Provider acting on your behalf communication of our Grievance Decision orally by telephone or, with the affirmative consent from you, your Authorized Representative, and your Health Care Provider acting on your behalf, by text, facsimile, e-mail, an online portal, or other expedited means. Within five (5) business days after the Grievance Decision has been made, or within one (1) calendar day after a decision has been orally communicated for an expedited Grievance, we will provide you, your Authorized Representative, and your Health Care Provider acting on your behalf written notice of our Grievance Decision. This written notice shall include:

1. The specific factual basis for the decision in clear and understandable language and the reasoning used to determine that the Health Care Service is not Medically Necessary and did not meet our criteria and standards used in conducting the utilization review;

2. The specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines, on which the decision was based, and may not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "Service included under another procedure", or "not Medically Necessary" or language directing the member to review the additional coverage criteria in your Evidence of Coverage;
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: 1-301-816-6482

5. A description of your or your Authorized Representative's right to file a complaint with the Commissioner within four (4) months following receipt of our Grievance Decision;
6. The Commissioner's address and telephone and facsimile numbers;
7. A statement the Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a complaint about the Health Plan with the Commissioner; and
8. The Health Education and Advocacy Unit's address, telephone and facsimile numbers and email address.

Notice of Adverse Decision

If our review of your referral request for a Service, including an expedited request, results in an Adverse Decision, we will provide you, your Authorized Representative, or your Health Care Provider acting on your behalf communication of our Adverse Decision orally by telephone or, with the affirmative consent from you, your Authorized Representative, or your Health Care Provider acting on your behalf, by text, facsimile, e-mail, an online portal, or other expedited means. Within five (5) business days after the Adverse Decision has been made, we will provide you, your Authorized Representative, or your Health Care Provider acting on your behalf written notice of the Adverse Decision. This written notice shall include:

1. The specific reason for the decision states in detail in clear understandable language the specific factual basis for our decision and the reasoning used to determine that the Health Care Service is not Medically Necessary and did not meet our criteria and standards used in conducting the utilization review;

2. The specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines, on which the decision was based, and may not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "Service included under another procedure", or "not Medically Necessary" or language directing the member to review the additional coverage criteria in your Evidence of Coverage;
3. A statement that you, your Authorized Representative, or Health Care Provider acting on your behalf, as applicable, are entitled to receive, upon request and free of charge, the specific criteria we relied upon to make the decision. A request from you, your Authorized Representative, or Health Care Provider acting on your behalf to receive a copy of the specific criteria used in this decision can be made by contacting Member Services at 301-468-6000 or 1-800-777-7902 or (TTY:711);
4. The name, business address, and business telephone number of the medical director or associate medical director who made the decision, as follows:

   Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
   Attention: Office of the Medical Director
   4000 Garden City Drive
   Hyattsville, MD 20785
   Phone: 1-800-810-4766

   Your provider may contact the utilization management physician at 1-800-810-4766 to discuss your Adverse Decision.

5. Written details of our internal grievance process;
6. A description of your, your Authorized Representative's, or, acting on your behalf, your Health Care Provider's right to file a complaint with the Commissioner within four (4) months following receipt of our Grievance Decision;
7. A description that you, your Authorized Representative, or your Health Care Provider acting on your behalf may file a complaint without first filing a Grievance if you, your Authorized Representative, or your Health Care Provider acting on your behalf can demonstrate a Compelling Reason to do so, as determined by the Commissioner;
8. The Commissioner's address, telephone, and facsimile numbers;
9. A statement that the Health Education and Advocacy Unit is available to assist you or your Authorized Representative in both mediating and filing a Grievance under our internal Grievance process; and
10. The Health Education and Advocacy Unit's address, telephone and facsimile numbers and email address.

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).

Notice of Coverage Decision

Within thirty (30) calendar days after a Coverage Decision has been made, we will send a written notice of the Coverage Decision to you, your Authorized Representative, and your Health Care Provider notice of the Coverage Decision. This written notice shall:

1. state in detail, in clear, understandable language, the specific factual basis for our decisions; and
2. include the following information:
    a. that you, your Authorized Representative, or your Health Care Provider acting on your behalf has a right to file an appeal with us;
    b. that you, your Authorized Representative, or your Health Care Provider acting on your behalf may file a Complaint with the Commissioner without first filing an Appeal if the Coverage Decision involves an Urgent Medical Condition for which care has not been rendered;
    c. the Commissioner's address, telephone number, and fax number;
    d. a statement that the Health Advocacy Unit is available to assist the you or your Authorized Representative in both mediating and filing an Appeal under our internal Appeal process; and
    e. the address, telephone number, fax number, and email address of the Health Advocacy Unit.

Our Internal Appeal Process

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

Initiating an Appeal

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

Kaiser Foundation Health Plan of Georgia, Inc.
Attention: Appeals Coordinator
Nine Piedmont Center
3495 Piedmont Rd, NE
Atlanta, GA 30305-1736
Fax: 1-404-364-4743

You or your Authorized Representative may also initiate an Appeal by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or

711 (TTY). Member Services Representatives are also available to describe to you or your Authorized Representative how Appeals are processed and resolved.

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

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

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

After the Health Plan receives the Appeal, we will respond to you, your Authorized Representative, and Health Care Provider acting on behalf of the Member in writing within:

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

We will notify you, or your Authorized Representative, and Health Care Provider in writing within five (5) working days after the Appeal Decision has been verbally communicated. Written notice of the Appeal Decision will be sent no more than thirty (30) calendar days after the decision has been made. This notification will include:

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

6. The Health Education and Advocacy Unit's address, telephone and facsimile numbers and email address.

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).

Filing Complaints About the Health Plan

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

Maryland Insurance Administration
Attention: Consumer Complaint Investigation
Life and Health
200 St. Paul Place
Suite 2700
Baltimore, MD 21202
Phone: 1-410-468-2000
Toll-free/out-of-area: 1-800-492-6116
TTY: 1-800-735-2258
Fax: 1-410-468-2260 or 1-410-468-2270

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

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

Change of Residence

You are responsible to inform us if you move outside of the Health Plan's Service Area, which is defined in the section ***Important Terms You Should Know***.

For Members who enrolled for coverage directly through the Health Plan: If you move to another Kaiser Foundation Health Plan region, you must promptly apply to a Health Plan Office in that region to transfer your membership. Identical coverage may not be available in the new region. If you are no longer eligible for coverage in either the region you are moving from or the new region in which you have moved, the Health Plan will provide you with at least ninety (90) days' notice of the termination of your coverage.

For Members who enrolled for coverage through the Exchange: If you move outside of the Exchange service area, you are no longer eligible for coverage through the Exchange. The Health Plan will provide you with at least ninety (90) days' notice of the termination of your coverage.

Depending on the type of Plan in which you are enrolled, you may be able to obtain benefits while temporarily visiting another Health Plan region. For more information, see the provisions ***Receiving Care in Another Kaiser Foundation Health Plan Service Area*** and ***Payment Toward Your Cost Share and When You May Be Billed*** in ***Section 2: How to Get the Care You Need***.

However, you have no right to benefits, except for Emergency Services and out-of-area Urgent Care Services 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 a continuation of the prolonged temporary status in writing. Before your coverage is terminated, the Health Plan will provide you with at least ninety (90) days' notification of the termination of your coverage.

Plan Renewal

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

Termination of Membership

Except as expressly provided in this section, all rights to Services and other benefits hereunder terminate as of the effective date of termination, except when the ***Extension of Benefits*** provision in this section applies.

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

Termination of Agreement

This Agreement continues in effect from the effective date hereof and from month-to-month thereafter, subject to:

1. **Termination Due to Loss of Eligibility for Catastrophic Plans**
   This provision applies only to Members with catastrophic coverage. For catastrophic plans, Subscribers and Dependent(s) will not be terminated from coverage during the current Calendar Year following proper enrollment in catastrophic Plan coverage, and provided that the Subscriber and any Dependent(s) reach age 30 on or after the 1st day of coverage, but before the current Calendar Year expires. Any Member who reaches age 30 before the Calendar Year expires will not be eligible for catastrophic Plan coverage for the next succeeding Calendar Year due to age requirements.
2. **Termination by Members Who Enrolled Through the Exchange**
   a. **For Members who enroll through the Exchange:** Members who enroll through the Exchange may terminate membership under this Agreement for any reason, including as a result of obtaining other Minimum Essential Coverage, by providing reasonable notice of the termination to the Exchange. The request will be reasonable if it is received at least fourteen (14) days prior to the requested effective date of termination or sooner, if required by applicable law. To the extent the Member has the right to terminate their membership under applicable state laws, including "free look" cancellation laws, the Member may do so, in accordance with such laws.

   b. At the time of plan selection, Members who enroll through the Exchange may choose to remain enrolled in a QHP if they become eligible for other Minimum Essential Coverage and do not request termination in accordance with item #2(a) listed above. If the Member does not choose to remain enrolled in a QHP in such situation, the Exchange must initiate termination of their enrollment in the QHP upon completion of the process outlined in 45 CFR §155.330(e)(2).

   c. Individuals, including the Member's Authorized Representative, may report to the Exchange the death of a Member to initiate termination of the Member's enrollment through the Exchange. The Exchange may require the reporting individual to provide documentation of the Member's death. Any applicable premium refund, or premium due, must be processed by the deceased Member's QHP in accordance with state law.

The effective date of termination will be:

1. The date requested by the Member if reasonable notice was given to the Exchange; or
   a. if less than fourteen (14) days' notice was given, the termination will be fourteen (14)days

after the termination was requested by the Member; or

b. if the Health Plan is able to effectuate termination in less than fourteen (14) days and the Member requested an earlier termination date, the date determined by the Health Plan.

2. At the option of the Exchange, the date termination is requested by the Member or another prospective date selected by the Member, regardless if fourteen (14) days' notice was given.
3. If the Exchange does not require an earlier termination date in accordance with item #2 immediately listed above, at the option of Health Plan, on a date on or after the termination is requested by the Member that is less than fourteen (14) days after the termination is requested by the Member, if the Member requests an earlier termination date.
4. At the option of the Exchange, should the Member be newly eligible for Medicaid, CHIP, or the Basic Health Program, if a Basic Health Program is operating in the Service Area of the Exchange, the day before the Member's date of eligibility for Medicaid, CHIP, or the Basic Health Program;
5. The retroactive termination date requested by the Member, if specified by applicable State laws; or
6. The date of Member's death.

Members may retroactively terminate or cancel their coverage or enrollment in a Qualified Health Plan in the following circumstances:

1. The Member demonstrates to the Exchange that they attempted to terminate their coverage or enrollment in a Qualified Health Plan and experienced a technical error that did not allow them to terminate their coverage or enrollment through the Exchange, and requests retroactive termination within sixty (60) days after they discovered the technical error.

   In the case of retroactive termination described in #1 above, the termination date will be no sooner than the date that would have applied under items #1(a), #1(b), #2, #4, and #5 described above immediately following item #2(c) under ***Termination by Members Who Enrolled Through the Exchange***.

2. The Member demonstrates to the Exchange that their enrollment in a Qualified Health Plan through the Exchange was unintentional, inadvertent or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Exchange or U.S. Department of Health and Human Services, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. Such Member must request cancellation within sixty (60) days of discovering the unintentional, inadvertent or erroneous enrollment.

3. The Member demonstrates to the Exchange that they were enrolled in a Qualified Health Plan without their knowledge or consent by any third party, including third parties who have no connection with the Exchange, and requests cancellation within sixty (60) days of discovering the enrollment.

   In the case of the retroactive termination, as described immediately above in #2 or #3, the cancellation date or termination date will be the original coverage effective date or a later date, as determined appropriate by the Exchange, based on the circumstances of the cancellation or termination.

Termination by the Exchange and the Health Plan

For Members who enroll through the Exchange: The Exchange may initiate termination of coverage in a Qualified Health Plan through the Exchange, and the Health Plan may terminate coverage and enrollment with the Health Plan and in such Qualified Health Plan:

1. When you are no longer eligible for coverage through the Exchange;
2. For non-payment of Premium and:
   a. The three (3)-month grace period required for Members receiving advance payments of the Advance Premium Tax Credit has been exhausted as described in 45 CFR 156.270(g); or
   b. The thirty-one (31) day grace period described under ***Termination Due to Nonpayment of Premium*** (in this provision) has been exhausted;
3. When you perform an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact. If required by the Exchange, the Health Plan must demonstrate, to the reasonable satisfaction of the Exchange, that rescission is appropriate;
4. When the Qualified Health Plan terminates or is decertified;
5. When you change from one Qualified Health Plan to another during an annual open enrollment period or a special enrollment period as described in ***Section 1: Introduction to Your Kaiser Permanente Health Plan***;
6. When you were enrolled in the Qualified Health Plan without your knowledge or consent by a third party, including by a third party with no connection with the Exchange; or
7. Any other reason for termination of coverage described in 45 CFR §147.106.

The Health Plan will provide notice of the termination of your coverage, including the effective date of and reason for the termination, promptly and without undue delay, except as stated otherwise in this section.

In the case of the Member being enrolled in the Qualified Health Plan without his or her knowledge or consent by a third party, including a third party with no connection with the Exchange, the Exchange may cancel your enrollment upon its determination that the enrollment was performed without your knowledge or consent and following reasonable notice to you (where possible). The termination date will be the original coverage effective date.

In the event that:

1. You are no longer eligible for coverage through the Exchange as stated in item #1, above; or
2. The Qualified Health Plan terminates or is decertified as stated in item #4, above:
   a. The Health Plan will continue coverage for you and your Dependents in the same health benefit plan outside of the Exchange, but without the availability of Advance Premium Tax Credit or cost-sharing reductions, meaning that you will be fully liable for all applicable Premium, Deductibles, Copayments and Coinsurance for such coverage, whereupon the terms and conditions of the Membership Agreement applicable to such coverage shall apply.

Termination Due to Loss of Eligibility

For Members who enroll through the Exchange: If you are no longer eligible for coverage through the Exchange, you will be terminated on the last day of eligibility in a Qualified Health Plan through the Exchange, unless you request an earlier termination date.

Termination Due to Nonpayment of Premium for Members Who Receive Advance Premium Tax Credit

For Members who receive APTC: We will provide a grace period of three (3) months for a Member, who when failing to timely pay Premium, is receiving advance payments of the premium tax credit.

We will send written notice stating when the grace period begins. We will pay claims for benefits you receive during the 1st month of the grace period. For the second (2nd) and third (3rd) months of the grace period, we are not required to pay any claims for Services rendered in the second (2nd) and third (3rd) months of the grace period unless we receive all outstanding Premium – including Premium due during the grace period – by the end of the three (3)-month grace period. If we do not receive all outstanding Premium by the end of the three (3)-month grace period, your membership will end at 11:59 p.m. Eastern Standard Time (EST) on the last day of the 1st month of the grace period.

If applicable law does not require a three (3)-month grace period, then the grace period will be as it is explained in the ***Termination Due to Nonpayment of Premium for All Other Members*** provision in this section. Our notice regarding your failure to pay Premium on time will inform you about the grace period (the time frame in which you must pay overdue Premium to avoid termination) and whether or not coverage continues during the grace period.

Termination Due to Nonpayment of Premium for All Other Members

If we do not receive your full Premium on time, we will provide a thirty-one (31) day grace period for the payment of each Premium falling due after the 1st Premium, during which time this Agreement will remain in force. If we do not receive all outstanding Premium by the end of the thirty-one (31) day grace period, your membership will end at 11:59 p.m. Eastern Standard Time (EST) on the last day of the grace period.

Upon the payment of a claim under this Agreement, any Premium then due and unpaid or covered by any note or written order may be deducted from the claim payment.

Termination When a Member Changes Plans

If you change from one Qualified Health Plan to another, your membership will terminate on the day before the effective date of coverage in the new Qualified Health Plan.

Termination for Cause

We may terminate your membership for cause if you:

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

If the fraud or intentional misrepresentation was made by:

1. The Subscriber, we may terminate the memberships of the Subscriber and all Dependents in your Family Unit.
2. 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 fraud committed by any Member to the appropriate authorities for prosecution.

Discontinuance of Coverage

If the Health Plan elects to discontinue offering this particular health benefit product in the individual market, the Health Plan shall:

1. Give you notice of its decision at least ninety (90) days in advance of the effective date of discontinuation; and
2. Offer you the option to purchase any other individual health benefit offered by the Health Plan in the state; and
3. Act uniformly without regard to any health status related factor of enrolled individuals or individuals who may become ineligible for the coverage.

If the Health Plan elects not to renew all of its individual health benefit Plans in the state, the Health Plan:

1. Shall give notice of its decision to the affected individuals at least one-hundred eighty (180) days before the effective date of non-renewal;
2. At least thirty (30) working days before that notice, shall give notice to the Commissioner; and
3. May not write new business for individuals in the state for a five (5) year period beginning on the date of notice to the Commissioner.

Extension of Benefits

If your coverage with us has terminated, we will extend benefits for covered Services, without receipt of Premium, in the following instances:

1. If you have a claim in progress at the time your coverage terminates, the Health Plan will continue to provide benefits for Services related to the claim, in accordance with the policy in effect at the time coverage terminates. Coverage will cease at the point that you are released from the care of a physician for the condition that is the basis of the claim, or twelve (12) months from the date your coverage ends, whichever comes first.
2. If you have ordered eyeglasses or contact lenses before the date your coverage ends, we will provide benefits for covered eyeglasses or contact lenses received within thirty (30) days following the date you placed the order.
3. 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 the Agreement in effect at the time your coverage ended, for a period of ninety (90) days following the date your coverage ended.
4. 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 the Agreement 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, we encourage you to notify us in writing.

Limitations on Extension of Benefits:
The Extension of Benefits provisions listed above do not apply if:

1. Coverage is terminated due to you or a Financially Responsible Person's failure to pay required Premium;
2. Coverage is terminated due to fraud or material misrepresentation by the you or your Parent/Guardian or a Financially Responsible Person; or
3. Any coverage provided by a succeeding health benefit plan:
   a. Is provided at a cost to the individual that is less than or equal to the cost to the individual of the extended benefit available under this Agreement; and
   b. Does not result in an interruption of benefits to you.

Return of Pro Rata Portion of Premium in Certain Cases

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

Age Limit/Misstatement of Age

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

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

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

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

Spousal Conversion Privileges Upon Death of the Subscriber

Agreements written to include coverage for the spouse of the Subscriber shall, in the event of the death of the Subscriber, allow the spouse to become the successor Subscriber, if the spouse is eligible for coverage through the Health Plan or Exchange, as applicable. This conversion privilege does not apply to a Domestic Partner.

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

A Member who enrolled as a Dependent under this Kaiser Permanente for Individuals and Families

Membership Agreement, but ceases to qualify as a Dependent for any reason except those described in the either ***Termination for Cause*** or ***Termination for Nonpayment of Premium*** provisions in this section, may enroll as a Subscriber under this Agreement within thirty-one (31) days after ceasing to qualify as a Dependent.

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

This provision does not apply to Members enrolled in a Kaiser Permanente for Individuals and Families Plan. A Member who reaches age 21 and ceases to qualify for this Kaiser Permanente Child Only Membership Agreement will remain covered under this Agreement until the last day of the Calendar Year. The Member may then enroll as a Subscriber under the same Plan offered as a Kaiser Permanente for Individuals and Families Membership Agreement within thirty-one (31) days after ceasing to qualify under this Kaiser Permanente Child Only Membership Agreement. The Member will be given notice of their option to transfer to a Kaiser Permanente Individuals and Families Membership Agreement at least thirty-one (31) days prior to the Member reaching age 21.

Reinstatement of Membership

If any renewal Premium is not paid in full within the time granted the Subscriber 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 Subscriber in writing of its disapproval of the reinstatement application.

In all respects the Subscriber and the 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, or attached to the Agreement in connection with the reinstatement.

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

SECTION 7: Other Important Provisions of Your Plan

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

Applications and Statements

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

Assignment

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

The claim for payment is considered proof of having received the service. We request that the claim be submitted to us within one (1) year from the date of service. Late submission of your proof of the service will not reduce the amount of nor invalidate your claim. If it is not reasonably possible to submit the claim within one (1) year, then we will accept it up two (2) years from the date of service. A Member's legal incapacity suspends any time requirements regarding timely submission of a claim. If legal capacity is regained, the suspension of any time requirement for claim submission ends, and the aforementioned requirements will become enforceable under this Agreement.

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

Attorney Fees and Expenses

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

Contestability

This Agreement may not be contested, except for non-payment of Premium, after it has been in force for two (2) years from the date it was issued.

Absent of fraud, each statement made by a Subscriber or Member is considered a representation; not a warranty. Therefore, a statement made to effectuate coverage may not be used to avoid coverage or reduce benefits under the Agreement unless:

1. The statement is documented in writing and signed by the Subscriber, Member, Parent/Guardian or Financially Responsible Person; and
2. A copy of the statement is provided to the Subscriber, Member, Parent/Guardian or Financially Responsible Person.

Contracts with Plan Providers

Plan Provider Relationship and Compensation

The relationship between the Health Plan and Plan Providers are those of independent contractors. Plan Providers are paid in various ways, including salary, capitation, per diem rates, case rates, fee for service

and incentive payments. If you would like additional information about the way Plan Providers are paid to provide or arrange medical and Hospital Services for Members, please refer to your Provider Directory or contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Plan Provider Termination

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

Primary Care Plan Physician Termination

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

Provider Directory Information Requirements

If a Member is furnished, by a non-Participating Provider, an item or Service that would otherwise be covered if provided by a Participating Provider, and the Member relied on a database, provider directory, 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.

Governing Law

This Agreement will be administered under the laws of the State of Maryland, except when preempted by federal law. Any provision that is required to be in this Agreement by federal or state law shall bind both Members and the Health Plan, regardless of whether or not it is set forth in this Agreement.

Legal Action

No legal action may be brought to recover on this Agreement:

1. Before the expiration of sixty (60) days after you have provided us with proof of loss in accordance with the terms of this Agreement; or

2. After the expiration of three (3) years from the date that proof of loss was required to be provided.

Mailed Notices

Our notices to you will be sent to the most recent address we have on file for the Subscriber. You are responsible for notifying us of any change in address. Subscribers who move should promptly contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).
You may mail a change of address notice to the Health Plan by postage prepaid U.S. Mail to:

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

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.

Important Terms You Should Know

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

A

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

Adverse Decision: means:

1. A utilization review decision made by a private review agent, Health Plan, or a Health Care Provider that:
    a. A proposed or delivered Service is or was not Medically Necessary, appropriate or efficient; and
    b. May result in non-coverage of the Health Care Service; or
2. A denial by the Health Plan of a request by a Member for an alternative standard or a waiver of a standard to satisfy the requirements of a wellness program.

An Adverse Decision includes a utilization review determination based on a Prior Authorization or step-therapy requirement.

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

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

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

Allowable Charges: means either for:

1. Services provided by the Health Plan or Medical Group: The amount in the Health Plan's schedule of Medical Group and the Health Plan charges for Services provided to Members;
2. Items obtained at a Plan Pharmacy. For items covered under the ***Outpatient Prescription Drug Benefit*** appendix and:
    a. Obtained at a pharmacy owned and operated by Health Plan, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item. This amount is an estimate of the cost of acquiring, storing and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan.
    b. Obtained at a Plan Pharmacy other than a pharmacy owned and operated by Health Plan, the cost of the item calculated on a discounted wholesale price plus a dispensing fee;
3. Emergency Services from a non-Participating Provider, including Post-Stabilization Care that constitutes Emergency Services under federal law, the amount by which the Out-of-Network Rate exceeds the Cost Sharing amount for Services.

4. For Services received from Participating Providers, the amount the Participating 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-Participating Provider pursuant to state law, when it is applicable, or federal law, including the amount by which the Out-of-Network Rate exceeds the Cost Sharing amount for Services, 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.

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

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

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

Ancillary Service: Services that are:

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

Appeal: A protest filed by a Member, an Authorized Representative, or a Health Care Provider with a carrier under its internal appeal process regarding a coverage decision concerning a Member.

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 under state law to provide consent on behalf of a Member provided that the individual is not a provider affiliated with the facility or employee of the facility unless such provider or employee is a family member of the patient.

Authorized Representative: (For use in relation to ***Section 5: Filing Claims, Appeals and Grievances***): An individual authorized by the Member or Parent/Guardian, as applicable, or otherwise authorized under State of Maryland law to act on the Member's behalf to file claims or complaints and to submit Appeals or Grievances to the Health Plan. A Health Care Provider may act on behalf of a Member with the Member's express consent, or without such consent.

C

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

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

Coinsurance: The percentage of Allowable Charges allocated to the Health Plan and to the Member.

Commissioner: The Maryland Insurance Commissioner.

Compelling Reason: Includes demonstrating that the potential delay in receipt of a health care Service until the Member, the Member's Authorized Representative, or health care provider exhausts the Health Plan's internal grievance process and obtains a final decision under the grievance process could result in:

1. Loss of life;
2. Serious impairment to a bodily function;
3. Serious dysfunction of a bodily organ;
4. The Member remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Member to be in danger to self or others; or
5. The Member continuing to experience severe withdrawal symptoms.

Complaint: A protest filed with the Commissioner involving an Adverse Decision, Coverage Decision or Grievance Decision.

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

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

Copayment: The specified charge that a Member must pay each time Services of a particular type or in a designated setting are received.

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

Cost Sharing: Any expenditure required by or on behalf of a Member with respect to this Plan. Such term includes Deductibles, Copayments, Coinsurance or similar charges, but excludes Premiums, balance billing amounts for non-network providers, and spending for non-covered Services.

Cost-Sharing Reductions: Reductions in Cost Sharing for certain Members enrolled in a Silver level plan in the Exchange or for an individual who is an American Indian/Alaska Native enrolled in a Qualified Health Plan on the Exchange.

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: This definition applies only to Members with health benefit Plans that require the Member to meet a Deductible. The amount of Allowable Charges that must be incurred by an individual or a family per year before the Health Plan begins payment. This definition only applies to Deductible Health Maintenance Organization and High Deductible Health Plan plans.

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

Domestic Partner: An individual in a relationship with another individual of the same or opposite sex, provided both individuals:

1. Are at least age 18;
2. Are not related to each other by blood or marriage within four (4) degrees of consanguinity under civil law rule;
3. Are not married or in a civil union or domestic partnership with another individual;
4. 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
5. Share a common primary residence.

Domiciliary Care: Services that are provided to aged or disabled individuals in a protective, institutional or home-type environment. Domiciliary care includes shelter, housekeeping services, board, facilities and resources for daily living, and personal surveillance or direction in the activities of daily living.

Durable Medical Equipment: Equipment furnished by a supplier or a home health agency that:

1. Can withstand repeated use;

2. Is primarily and customarily used to serve a medical purpose;
3. Generally, is not useful to an individual in the absence of a disability, illness or injury; and
4. Is appropriate for use in the home.

E

Eligible Individual: An individual determined to be eligible for enrollment through the Individual Exchange in accordance with 45 CFR §155.305 and 45 CFR §156.265(b). This definition only applies to plans on the Exchange.

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

1. Seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function; or
2. Cause the Member to be in danger to self or others; or
3. Cause the Member to continue using intoxicating substances in an imminently dangerous manner.

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, including those that are provided in specialized facilities that are staffed by behavioral health providers trained to provide crisis Services, as required under the Emergency Medical Treatment and Active Labor Act (EMTALA), section 1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, 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 item #3a immediately listed below, covered Services, also referred to as Post-Stabilization Care, that are furnished by a non-Participating Provider or non-Participating Emergency Facility 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 non-medical transportation or non-emergency medical transportation to a Participating Provider or an available Participating 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) in the case of a Participating Emergency Facility and a non-Participating Provider, the written notice must also include a list of any Participating Providers at the facility who are able to furnish such items and Services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a Participating Provider and (2) in the case of a non-Participating Emergency Facility, the written notice must include a good faith estimate of the charges for covered items or Services to be furnished by a non-Participating Provider at a non-Participating Emergency Facility or by non-Participating Providers during the Visit, including any item or Service that is reasonably expected to be furnished by the non-Participating Provider or non-Participating Emergency Facility in conjunction with such items or Services; 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(a)(ii), as determined by the attending emergency physician or Treating Provider using appropriate medical judgment, and to provide informed consent in accordance with applicable State law; and
b. When the covered Services are not 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 Maryland Health Benefit Exchange established as a public corporation under § 31-102 of Title 31 of the Maryland Insurance Code. This definition applies only to plans offered on the Exchange.

Experimental Services: Services that are not recognized as efficacious as that term is defined in the Institute of Medicine Report on Assessing Medical Technologies that is current when the care is rendered.

"Experimental Services" do not include clinical trials, as provided in ***Section 3: Benefits, Exclusions and Limitations***.

F

Family: An individual and:

1. Spouse;
2. Dependent minor(s);
3. Spouse and Dependent minor(s); or
4. Domestic Partner.

Family Coverage: Any coverage other than Self-Only Coverage.

Family Planning Services: Counseling, implanting or fitting of contraceptive devices and follow-up Visits after a Member selects a birth control method, voluntary sterilization for males and females, and abortion care Services.

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

Filing Date: The earlier of five (5) days after the date of mailing or the date of receipt by the Health Plan when you mail information to us.

Financially Responsible Person or **Guarantor:** The person who contractually agrees to pay the Premium due. This definition only applies to Child Only Plans.

G

Genetic Birth Defect: A defect existing at or from birth, including a hereditary defect, which includes, but is not limited to, autism or an autism spectrum disorder and cerebral palsy.

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 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 Care Facility: A medical facility as defined in Health-General Article, §19-114, Annotated Code of Maryland.

Health Care Practitioner: An individual as defined in Health-General Article, §19-132, Annotated Code of Maryland.

Health Care Provider: An individual or facility as defined in Health-General Article, §19-132, Annotated Code of Maryland.

Health Care Service: A health or medical care procedure or Service rendered by a Health Care Provider that:

1. Provides testing, diagnosis or treatment of a human disease or dysfunction; or
2. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction; or
3. Provides any other care, Service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well-being of individuals.

Health Education and Advocacy Unit: The Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.

Health Maintenance Organization: An organization as defined in Health-General Article, §19-701, Annotated Code of Maryland.

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

Health Plan Region: Each of the specific geographic areas where Kaiser Foundation Health Plan, Inc. or a related organization conducts a direct service health care program.

Health Savings Account: This definition only applies if you are enrolled in a qualified High Deductible Health Plan. It does not apply to Members with catastrophic Plan coverage. A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, the Member must be covered under a qualified High Deductible Health Plan and meet other tax law requirements. Kaiser Permanente does not provide tax advice. Consult with a financial or tax advisor for more information about your eligibility for a Health Savings Account. This definition only applies to qualified High Deductible Health Plans.

High Deductible Health Plan: This definition applies only to Members with a High Deductible Health Plan. A health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. This definition only applies to High Deductible Health Plans.

Home Health Care: The continued care and treatment of a Member in the home if:

1. The institutionalization of the Member in a Hospital or related institution or Skilled Nursing Facility would otherwise have been required if Home Health Care Services were not provided; and
2. The plan of treatment covering the home Health Care Service is established and approved in writing by the Health Care Practitioner.

Hospice Care: Medical Services defined in 42 U.S.C. §1395x(dd).

Hospital: Any hospital:

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

I

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

K

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

M

Medical Group: Mid-Atlantic Permanente Medical Group, Inc.

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***.

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

Member: A person who is eligible and enrolled under this Agreement as a Subscriber or a Dependent, and for whom we have received applicable Premium. Members are sometimes referred to as "you" within this Agreement. Under no circumstances should the term "you" be interpreted to mean a Financially Responsible Person, Parent/Guardian or any other nonmember reading or interpreting this Agreement on behalf of a Member.

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

Monthly Payments: Periodic membership charges paid by a Subscriber; or for Child Only Plans, a Parent/Guardian or Financially Responsible Person.

Multiple Risk Factors: Having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives or cervical ectopy.

N

Network: Participating Providers who have entered into a provider service contract with Kaiser Permanente to provide Services on a preferential basis.

Non-Physician Specialist: A Health Care Provider who is:

1. Not a physician;
2. Licensed or certified under the Health Occupations Article; and
3. Certified or trained to treat or provide Health Care Services for a specified condition or disease in a manner that is within the scope of the license or certification of the Health Care Provider; or
4. Licensed as a Behavioral Health Program under §7.5-401 of the Maryland Health-General Article.

Notice of Appeal Decision: Notice of the Appeal Decision required to be sent per ***Section 5: Filing Claims, Appeals and Grievances*** shall:

1. States in detail in clear, understandable language the specific factual bases for the Health Plan's Appeal Decision; and
2. Includes the following information:
   a. That the Member, Member's Authorized Representative or a Health Care Provider acting on behalf of the Member has a right to file a complaint with the Commissioner within four (4) months after receipt of a Health Plan's Appeal decision;
   b. The Commissioner's address, telephone and facsimile numbers;
   c. A statement that the Health Advocacy Unit is available to assist the member in filing a complaint with the Commissioner; and
   d. The address, telephone and facsimile numbers and email address of the Health Advocacy Unit.

Notice of Coverage Decision: Notice of Coverage Decision required to be sent per ***Section 5: Filing Claims, Appeals and Grievances*** shall:

1. States in detail in clear, understandable language, the specific factual bases for the Health Plan's Coverage Decision; and
2. Includes the following information:
   a. That the Member, Member's Authorized Representative, or a Health Care Provider acting on behalf of the Member has a right to file an Appeal with the carrier;
   b. That the Member, Member's Authorized Representative or a Health Care Provider acting on behalf of the Member may file a complaint with the Commissioner without first filing an

Appeal, if the Coverage Decision involves an Urgent Medical Condition for which care has not been rendered;

c. The Commissioner's address and telephone and facsimile numbers;
d. That the Health Advocacy Unit is available to assist the Member or Member's Authorized Representative in both mediating and filing an Appeal under the carrier's internal Appeal process; and
e. The address, telephone and facsimile numbers and email address of the Health Advocacy Unit.

O

Out-of-Network Rate: With respect to an item or Service furnished by a non-Participating Provider, non-Participating Emergency Facility, or non-Participating Provider of Air Ambulance Services, means:

1. In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to the Plan or carrier, non-Participating Provider or non-Participating Emergency Facility, and item or Service, the amount Health Plan is required to pay under the All-Payer Model Agreement for such item or Service. For certain items or Services billed by Maryland hospitals, this is the amount for the item or Service under the All-Payer Model Agreement as approved by the Health Services Cost Review Commission (HSCRC).
2. If there is no such All-Payer Model Agreement amount applicable to the covered item or Service, then under Maryland law, the amount Health Plan is required to pay pursuant to §19-710.1 of the Maryland Health-General Article.
3. If no All-Payer Model Agreement or State law amount, as described in items #1 and #2 above, applies to the covered Service, an amount agreed upon by Health Plan and the non-Participating Provider or non-Participating Emergency Facility.
4. If items #1, #2, and #3 above does not apply, then an amount determined by a certified independent dispute resolution (IDR) entity under the federal IDR process, as described in section 2799A–1(c) or 2799A–2(b) of the federal Public Health Service Act, as applicable.

Out-of-Pocket Maximum: The maximum amount of Deductibles, Copayments and Coinsurance that an individual or family is obligated to pay for covered Services per Calendar Year.

Outpatient Rehabilitative Services: Occupational therapy, speech therapy and physical therapy, provided to Members not admitted to a Hospital or related institution.

P

Parent/Guardian: The person who has legal authority to make medical decisions for a Member under age 19 or a Member age 19 or older who is incapable of making such decisions by reason of mental incapacity. This definition applies only to Child Only plans.

Partial Hospitalization: The provision of medically-directed intensive or intermediate short-term psychiatric treatment for a period more than four (4) hours, but less than twenty-four (24) hours in a day for an individual patient in a Hospital, psychiatric day-care treatment center, community mental health facility or any other authorized facility.

Participating Emergency Facility: Any Emergency Facility that has contracted directly with health

plan or an entity contracting on behalf of Health Plan to provide Health Care Services to Health Plan's Members. A single case agreement between an Emergency Facility and Health Plan that is used to address unique situations in which a Member requires Services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Participating Facility: A Health Care Facility that has contracted directly with Health Plan or an entity contracting on behalf of Health Plan to provide Health Care Services to Health Plan's Members. A single case agreement between a health care facility and Health Plan that is used to address unique situations in which a Member requires Services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement. Additionally, for purposes of this definition and in the context of non-Emergency Services, "Health Care Facility" is limited to a hospital, as defined in section 1861(e) of the Social Security Act; a hospital outpatient department; a critical access hospital, as defined in section 1861(mm)(1) of the Social Security Act; and an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Participating Provider: A physician or other Health Care Provider that has contracted directly with Health Plan or an entity contracting on behalf of Health Plan to provide health care Services to Health Plan's Members.

Personal Care: Service that an individual normally would perform personally, but for which the individual needs help from another because of advanced age, infirmity, or physical or mental limitation. Personal care includes help in walking; help in getting in and out of bed, help in bathing, help in dressing, help in feeding, and general supervision and help in daily living.

Plan: The health benefit Plan described in this Agreement.

Plan: (For use in relation to Coordination of Benefits provisions only, which are located in ***Section 4: Subrogation, Reductions and Coordination of Benefits***): Any of the following that provides benefits or services for, or because of, medical care or treatment: Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepaid group practice or individual practice coverage. "Plan" does not include an individually underwritten and issued, guaranteed renewable, specified disease policy or intensive care policy, that does not provide benefits on an expense-incurred basis. "Plan" also does not include the medical benefits under an automobile policy, including benefits for personal injury protection. "Plan" also does not include:

1. Accident only coverage;
2. Hospital indemnity coverage benefits or other fixed indemnity coverage;
3. Intensive care policy;
4. Specified disease or specified accident coverage;
5. Limited benefit health coverage, as provided for by Maryland state law;
6. 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;
7. 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;

8. Medicare supplement policies;
9. A state plan under Medicaid; or
10. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

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

1. Operated by us or contracts, directly or indirectly, to provide Services to Members; and
2. Included in the Signature provider network.

A single case agreement between a Health Care Facility and Health Plan that is used to address unique situations in which a Member requires Services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement. Additionally, for purposes of this definition and in the context of non-Emergency Services, "Health Care Facility" is limited to a hospital (as defined in section 1861(e) of the Social Security Act); a hospital outpatient department; a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Plan Hospital: A Hospital that:

1. Contracts, directly or indirectly, to provide inpatient and/or outpatient Services to Members; and
2. Is included in the Signature provider network.

A single case agreement between an emergency facility and Health Plan that is used to address unique situations in which a Member requires Services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Plan Medical Centers: Medical office and specialty care facilities such as imaging centers operated by us in which Medical Group and other Health Care Providers including Non-Physician Specialists employed by us provide Primary Care, specialty care and ancillary care Services to Members.

Plan Pharmacy: Any pharmacy that:

1. Is located at a Plan Medical Office; or
2. Contracts, directly or indirectly, to provide Services to Member, and is included in the Signature provider network.

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

1. Contracts, directly or indirectly, to provide Services and supplies to Members; and
2. Is included in the Signature provider network.

Plan Provider: A Plan Physician or other Health Care Provider including but not limited to a Non-Physician Specialist, and Plan Facility that:

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

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

Premium: The amount a Subscriber owes for coverage under this Agreement for his/her self and any covered Dependents; or for Child Only Plans, a Parent/Guardian or Financially Responsible Person.

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

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

Prior Authorization: Our determination that a proposed Service is covered and Medically Necessary pursuant to Our Quality Resource Management Program in advance of your receipt of the Service.

Q

Qualified Health Plan: Any health plan that has an effective certification that it meets the standards recognized by the Exchange through which such plan is offered. This definition applies only to plans offered on the Exchange.

Qualified Individual: An individual (including a minor) who at the time of enrollment:

1. Is seeking to enroll in a Qualified Health Plan offered to individuals through the Individual Exchange;
2. Resides in the State of Maryland;
3. Is not incarcerated, other than incarceration pending disposition of charges; and
4. Is, and reasonably is expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

Note: This definition applies only to plans offered on the Exchange. Items #1 through #4, with the exception of item #2, applies to all individuals including minors.

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.

R

Recognized Amount: With respect to an item or Service furnished by a non-Participating Provider or

non-Participating Emergency Facility, means an amount that is determined as follows:

1. In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to the Plan or carrier, non-Participating Provider or non-Participating Emergency Facility, and item or Service, the amount Health Plan is required to pay under the All-Payer Model Agreement for such Service. For certain Services billed by Maryland hospitals, this is the amount for the Service under the All-Payer Model Agreement as approved by the HSCRC.
2. If there is no such All-Payer Model Agreement applicable to the Service, then under Maryland law, the amount that Health Plan is required to pay pursuant to §19-710.1 of the Maryland Health-General Article.
3. If no All-Payer Model Agreement or State law amount, as described in items #1 and #2 above, applies to the covered Service, then the lesser of the amount billed by the non-Participating Provider, non-Participating Emergency Facility, or the Qualifying Payment Amount.

Related Institution: An institution defined in the Health-General Article, §19-301, Annotated Code of Maryland.

S

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

Serious or Complex Condition: In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm or, in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time.

Service: A health care item or Service that is covered under this Agreement and Medically Necessary to prevent, diagnose, or treat a medical condition .

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

Skilled Nursing Facility: An institution, or a distinctive part of an institution, licensed by the Department of Health and Mental Hygiene, which is primarily engaged in providing:

1. Primarily engaged in providing:
   a. Skilled nursing care, and related Services, for residents who require medical or nursing care, or
   b. Rehabilitation Services for the rehabilitation of injured, disabled, or sick persons; and
2. Certified by the Medicare Program as a Skilled Nursing Facility.

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

Specialty Services: Care provided by a Health Care Practitioner who is not providing Primary Care Services.

Spouse: The Member's legal husband or wife.

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. 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 a Kaiser Permanente Individuals and Families 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 Member is totally disabled by reason of injury or sickness if the Member is unable to perform each and every duty pertaining to his or her occupation during the first fifty-two (52) weeks of the disability. After the first fifty-two (52) weeks, a Member is totally disabled if he or she is unable to perform each and every duty of any business or occupation for which the Member is reasonably fitted by education, training and experience.
2. **For Dependent Children and Members covered under a Child Only Plan:** In the judgment of a Plan Physician, an illness or injury which makes the child unable to substantially engage in any of the normal activities of children in good health and like age.

Treating Provider: A physician or other health care provider who has evaluated the Member's Emergency Medical Condition.

U

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

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

1. A medical condition, including a physical, mental health or dental condition, where the absence of medical attention within seventy-two (72) hours could reasonably be expected by an individual, acting on behalf of the Health Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
   a. Placing the Member's life or health in serious jeopardy;
   b. The inability of the Member to regain maximum function;
   c. Serious impairment to bodily function;
   d. Serious dysfunction of any bodily organ or part; or
   e. The Member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others.

2. A medical condition, including a physical, mental health or dental condition, where the absence of medical attention within seventy-two (72) hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Coverage Decision.

V

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

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

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Kaiser Permanente Smile Kids KPIF Embedded Dental EPO Plan Appendix

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

Definitions

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

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

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

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

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

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

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

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

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

General Provisions

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

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

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

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

Alternate Treatment

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

Dental Administrator

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

Specialist Referrals

Participating Specialist Referrals

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

Standing Referrals to Dental Specialists

If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires specialized care, your General Dentist may determine, in consultation with you and a Specialist, that you will benefit from continued care from a Specialist in our network. In such instances, you or your General Dentist may directly contact a Specialist from our network who possesses the professional training and expertise to treat the condition or disease. Once a Specialist is selected, the General Dentist will issue a standing referral along with a written treatment plan developed by the General Dentist, the Specialist and

you. The treatment plan may limit the number of visits to the Specialist or the period of time in which visits to the Specialist are needed. The Dental Administrator retains the right to require the Specialist to provide the General Dentist with ongoing communication regarding your treatment and dental health status.

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 or provide health care services for 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 or provide health care services for 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 by the provider within 180 days after the date of treatment. Proof of loss should be mailed to:

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

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

Failure to provide proof of loss for a dental emergency, or as may be required under "Non-Participating Specialist Referrals," within one (1) year after the dates of treatment, 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 two (2) years from the time proof is otherwise required. A Member's legal incapacity shall suspend the time to submit a claim, and the suspension period will end when legal capacity is regained.

Within Service Area

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

Submission of Claims

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

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

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

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

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

You may submit itemized bills and/or proof of payment within one (1) year of treatment. Failure to submit the itemized bill and/or proof of payment within one (1) year will 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 two (2) years from the time proof is otherwise required, Benefits will be payable.

Benefits payable under the Evidence of Coverage for any loss will be paid within 30 days after receipt of written proof of loss. If the Dental Administrator fails to pay a claim within 30 days after receipt of written proof of loss, it will pay interest from the date on which payment is required to the date the claim is paid. If a claim is denied in whole or in part, the written notice of the denial will contain the reasons for denial and reference to the pertinent provisions of the Evidence of Coverage and this Rider.

Appeals

If a claim is denied, you or your Authorized Representative may file an appeal with the Dental Administrator in accordance with the ***Section 5 – Filing Claims, Appeals and Grievances*** of this Evidence of Coverage.

Submit your Appeal to:

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

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

By: _____

Gracelyn McDermott
Vice President, Marketing, Sales & Business Development

Kaiser Permanente for Individuals and Families
Kaiser Permanente Membership Agreement and Evidence of Coverage

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Kaiser Permanente Smile Kids KPIF Embedded Dental EPO
2025 Schedule of Dental Benefits (up to 19)

This Schedule of Dental Benefits lists procedures covered under your Dental Plan and only apply when performed by a participating General Dentist or Dental Specialist.

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

This Schedule does not guarantee benefits. All services are subject to eligibility and dental necessity at the time of service.

Covered Dental Services are limited to the least costly treatment. Dental procedures not listed are available at the dental office's usual and customary fee.

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

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

CDT Code	Description	Member Copayment	Limitations
TYPE I - DIAGNOSTIC & PREVENTIVE SERVICES			
D0120	Periodic oral evaluation	$5	2 of (D0120, D0145, D0150) every 12 months, per provider or location, coverage begins with the eruption of the first tooth
D0140	Limited oral evaluation	$5	
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	

CDT Code	Description	Member Copayment	Limitations
D0230	Intraoral, periapical, each add 'l radiographic image	$0	
D0240	Intraoral, occlusal radiographic image	$0	
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	$0	
D0270	Bitewing, single radiographic image	$0	
D0272	Bitewings, two radiographic images	$0	2 of (D0272-D0274, D0277) every 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	

CDT Code	Description	Member Copayment	Limitations
D0706	Intraoral, occlusal radiographic image, image capture only	$0	
D0707	Intraoral, periapical radiographic image, image capture only	$0	
D0708	Intraoral, bitewing radiographic image, image capture only	$0	
D0709	Intraoral, comprehensive series of radiographic images, image capture only	$0	1 of (D0701, D0709, D0210, D0330) every 36 months, per provider or location
D1110	Prophylaxis, adult	$10	2 of (D1110, D1120, D4346) every 12 months
D1120	Prophylaxis, child	$5	2 of (D1110, D1120, D4346) every 12 months
D1206	Topical application of fluoride varnish	$0	Age 0-2: 8 (D1206) every 12 months per provider or per location; Age 3 over: 4 (D1206,) every 12 months per provider or per location
D1208	Topical application of fluoride, excluding varnish	$0	2 (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 (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 (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 every 2 years
D1516	Space maintainer, fixed, bilateral, maxillary	$36	1 of (D1516, D1517, D1526, D1527) per arch every 2 years
D1517	Space maintainer, fixed, bilateral, mandibular	$36	1 of (D1516, D1517, D1526, D1527) per arch every 2 years
D1520	Space maintainer, removable, unilateral, per quadrant	$26	1 of (D1510, D1520, D1575) per quadrant every 2 years
D1526	Space maintainer, removable, bilateral, maxillary	$40	1 of (D1516, D1517, D1526, D1527) per arch every 2 years

CDT Code	Description	Member Copayment	Limitations
D1527	Space maintainer, removable, bilateral, mandibular	$40	1 of (D1516, D1517, D1526, D1527) per arch every 2 years
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	
D1557	Removal of fixed bilateral space maintainer, maxillary	$0	
D1558	Removal of fixed bilateral space maintainer, mandibular	$0	
D1575	Distal shoe space maintainer, fixed, per quadrant	$26	1 of (D1510, D1520, D1575) per quadrant every 2 years
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			
Guideline: Posterior Composite Fillings - Payable at the least expensive covered material			
D2140	Amalgam, one surface, primary or permanent	$28	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2150	Amalgam, two surfaces, primary or permanent	$36	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2160	Amalgam, three surfaces, primary or permanent	$44	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2161	Amalgam, four or more surfaces, primary or permanent	$51	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2330	Resin-based composite, one surface, anterior	$36	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2331	Resin-based composite, two surfaces, anterior	$46	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2332	Resin-based composite, three surfaces, anterior	$52	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2335	Resin-based composite, four or more surfaces	$56	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2390	Resin-based composite crown, anterior	$63	
D2391	Resin-based composite, one surface, posterior	$40	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2392	Resin-based composite, two surfaces, posterior	$51	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2393	Resin-based composite, three surfaces, posterior	$62	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2394	Resin-based composite, four or more surfaces, posterior	$71	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months

CDT Code	Description	Member Copayment	Limitations
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	$134	1 of (D4210, D4211, D4212, D4230, D4231, D4240, D4241, D4260, D4261) per site/quadrant every 24 months
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	$59	1 of (D4210, D4211, D4212, D4230, D4231, D4240, D4241, D4260, D4261) per site/quadrant every 24 months
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	$48	1 of (D4210, D4211, D4212, D4230, D4231, D4240, D4241, D4260, D4261) per site/quadrant every 24 months
D4230	Anatomical Crown Exposure- Four or More Contiguous Teeth per Quadrant	$661	1 of (D4210, D4211, D4212, D4230, D4231, D4240, D4241, D4260, D4261) per site/quadrant every 24 months
D4231	Anatomical Crown Exposure- One to Three Teeth per Quadrant	$396	1 of (D4210, D4211, D4212, D4230, D4231, D4240, D4241, D4260, D4261) per site/quadrant every 24 months
D4240	Gingival flap procedure, four or more teeth per quadrant	$169	1 of (D4210, D4211, D4212, D4230, D4231, D4240, D4241, D4260, D4261) per site/quadrant every 24 months
D4241	Gingival flap procedure, one to three teeth per quadrant	$106	1 of (D4210, D4211, D4212, D4230, D4231, D4240, D4241, D4260, D4261) per site/quadrant every 24 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, D4230, D4231, D4240, D4241, D4260, D4261) per site/quadrant every 24 months
D4261	Osseous surgery, one to three teeth per quadrant	$190	1 of (D4210, D4211, D4212, D4230, D4231, D4240, D4241, D4260, D4261) per site/quadrant every 24 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	

CDT Code	Description	Member Copayment	Limitations
D4274	Mesial/distal wedge procedure, single tooth	$139	
D4275	Non-autogenous connective tissue graft, first tooth	$234	
D4276	Combined connective tissue and pedicle graft	$275	
D4277	Free soft tissue graft, first tooth	$208	
D4278	Free soft tissue graft, each additional tooth	$124	
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	$209	
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	$157	
D4322	Splint, intra-coronal; natural teeth or prosthetic crowns	$23	
D4323	Splint, extra-coronal; natural teeth or prosthetic crowns	$23	
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	$58	1 of (D4341, D4342) per site/ quadrant, every 24 months
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	$39	1 of (D4341, D4342) per site/ quadrant, every 24 months
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	$25	2 of (D1110, D1120, D4346) every 12 months
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit	$35	1 (D4355) every 12 months
D4910	Periodontal maintenance	$32	2 (D4910) every 12 months
D4920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist or Their Staff)	$55	
D4921	Gingival irrigation with a medicinal agent, per quadrant	$19	1 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	
D9420	Hospital or ambulatory surgical center call	$44	Prior Authorization Required
D9440	Office visit, after regularly scheduled hours	$28	

CDT Code	Description	Member Copayment	Limitations
TYPE III - MAJOR SERVICES			
Guideline: Single Crowns - Payable at the least expensive covered material. Copayment includes all costs for lab bills and materials			
D2510	Inlay, metallic, one surface	$271	1 of (D2510-D2794) per tooth every 60 months
D2520	Inlay, metallic, two surfaces	$322	1 of (D2510-D2794) per tooth every 60 months
D2530	Inlay, metallic, three or more surfaces	$350	1 of (D2510-D2794) per tooth every 60 months
D2542	Onlay, metallic, two surfaces	$343	1 of (D2510-D2794) per tooth every 60 months
D2543	Onlay, metallic, three surfaces	$386	1 of (D2510-D2794) per tooth every 60 months
D2544	Onlay, metallic, four or more surfaces	$405	1 of (D2510-D2794) per tooth every 60 months
D2610	Inlay, porcelain/ceramic, one surface	$315	1 of (D2510-D2794) per tooth every 60 months
D2620	Inlay, porcelain/ceramic, two surfaces	$339	1 of (D2510-D2794) per tooth every 60 months
D2630	Inlay, porcelain/ceramic, three or more surfaces	$366	1 of (D2510-D2794) per tooth every 60 months
D2642	Onlay, porcelain/ceramic, two surfaces	$356	1 of (D2510-D2794) per tooth every 60 months
D2643	Onlay, porcelain/ceramic, three surfaces	$404	1 of (D2510-D2794) per tooth every 60 months
D2644	Onlay, porcelain/ceramic, four or more surfaces	$421	1 of (D2510-D2794) per tooth every 60 months
D2650	Inlay, resin-based composite, one surface	$252	1 of (D2510-D2794) per tooth every 60 months
D2651	Inlay, resin-based composite, two surfaces	$282	1 of (D2510-D2794) per tooth every 60 months
D2652	Inlay, resin-based composite, three or more surfaces	$305	1 of (D2510-D2794) per tooth every 60 months
D2662	Onlay, resin-based composite, two surfaces	$288	1 of (D2510-D2794) per tooth every 60 months
D2663	Onlay, resin-based composite, three surfaces	$338	1 of (D2510-D2794) per tooth every 60 months
D2664	Onlay, resin-based composite, four or more surfaces	$355	1 of (D2510-D2794) per tooth every 60 months
D2710	Crown, resin-based composite (indirect)	$168	1 of (D2510-D2794) per tooth every 60 months
D2712	Crown, ¾ resin-based composite (indirect)	$165	1 of (D2510-D2794) per tooth every 60 months
D2720	Crown, resin with high noble metal	$400	1 of (D2510-D2794) per tooth every 60 months
D2721	Crown, resin with predominantly base metal	$375	1 of (D2510-D2794) per tooth every 60 months

CDT Code	Description	Member Copayment	Limitations
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
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	Protective restoration	$38	

CDT Code	Description	Member Copayment	Limitations
D2941	Interim therapeutic restoration, primary dentition	$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	
D2960	Labial veneer (resin laminate), direct	$300	1 (D2960-D2962) per tooth every 60 months
D2961	Labial veneer (resin laminate), indirect	$374	1 (D2960-D2962) per tooth every 60 months
D2962	Labial veneer (porcelain laminate), indirect	$355	1 (D2960-D2962) per tooth every 60 months
D2980	Crown repair necessitated by restorative material failure	$84	
D2981	Inlay repair necessitated by restorative material failure	$70	
D2982	Onlay repair necessitated by restorative material failure	$72	
D2983	Veneer repair necessitated by restorative material failure	$70	
D2990	Resin infiltration of incipient smooth surface lesions	$25	
D3110	Pulp cap, direct (excluding final restoration)	$30	
D3120	Pulp cap, indirect (excluding final restoration)	$24	
D3220	Therapeutic pulpotomy (excluding final restoration)	$76	
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	
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	$87	
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	

CDT Code	Description	Member Copayment	Limitations
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	
D3426	Apicoectomy, (each additional root)	$126	
D3430	Retrograde filling, per root	$93	
D3450	Root amputation, per root	$192	
D3470	Intentional reimplantation (including necessary splinting)	$381	
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) per arch every 60 months
D5120	Complete denture, mandibular	$593	1 of (D5110-D5120) per arch every 60 months

CDT Code	Description	Member Copayment	Limitations
D5130	Immediate denture, maxillary	$602	
D5140	Immediate denture, mandibular	$602	
D5211	Maxillary partial denture, resin base	$423	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5212	Mandibular partial denture, resin base	$482	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5213	Maxillary partial denture, cast metal, resin base	$630	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5214	Mandibular partial denture, cast metal, resin base	$627	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5221	Immediate maxillary partial denture, resin base	$454	
D5222	Immediate mandibular partial denture, resin base	$525	
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	$669	
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	$669	
D5225	Maxillary partial denture, flexible base	$592	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5226	Mandibular partial denture, flexible base	$590	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	$316	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	$316	1 of (D5211-D5214, D5225-D5283, D5863-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	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5411	Adjust complete denture, mandibular	$30	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5421	Adjust partial denture, maxillary	$30	Member not responsible for cost share during the first 6 months of initial placement by the same provider

CDT Code	Description	Member Copayment	Limitations
D5422	Adjust partial denture, mandibular	$29	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5511	Repair broken complete denture base, mandibular	$85	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5512	Repair broken complete denture base, maxillary	$85	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5520	Replace missing or broken teeth, complete denture	$67	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5611	Repair resin partial denture base, mandibular	$63	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5612	Repair resin partial denture base, maxillary	$63	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5621	Repair cast partial framework, mandibular	$70	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5622	Repair cast partial framework, maxillary	$70	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5630	Repair or replace broken retentive clasping materials, per tooth	$77	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5640	Replace broken teeth, per tooth	$54	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5650	Add tooth to existing partial denture	$70	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5660	Add clasp to existing partial denture, per tooth	$87	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	$219	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	$223	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5710	Rebase complete maxillary denture	$200	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5711	Rebase complete mandibular denture	$190	Member not responsible for cost share during the first 6 months of initial placement by the same provider

CDT Code	Description	Member Copayment	Limitations
D5720	Rebase maxillary partial denture	$188	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5721	Rebase mandibular partial denture	$188	Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5730	Reline complete maxillary denture, direct	$112	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5731	Reline complete mandibular denture, direct	$112	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5740	Reline maxillary partial denture, direct	$103	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5741	Reline mandibular partial denture, direct	$103	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5750	Reline complete maxillary denture, indirect	$163	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5751	Reline complete mandibular denture, indirect	$162	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5760	Reline maxillary partial denture, indirect	$148	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5761	Reline mandibular partial denture, indirect	$148	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by the same provider
D5810	Interim complete denture, maxillary	$427	
D5811	Interim complete denture, mandibular	$428	
D5820	Interim partial denture, maxillary	$205	
D5821	Interim partial denture, mandibular	$201	
D5850	Tissue conditioning, maxillary	$54	
D5851	Tissue conditioning, mandibular	$53	
D5863	Overdenture, complete, maxillary	$796	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months

CDT Code	Description	Member Copayment	Limitations
D5864	Overdenture, partial, maxillary	$788	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5865	Overdenture, complete, mandibular	$1,271	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5866	Overdenture, partial, mandibular	$788	1 of (D5211-D5214, D5225-D5283, D5863-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 - Payable at the least expensive covered material. 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
D6066	Implant supported crown, porcelain fused to high noble alloys	$649	Prior Authorization Required

CDT Code	Description	Member Copayment	Limitations
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 in the presence of inflammation or mucositis of a single implant	$39	Prior Authorization Required
D6087	Implant supported crown, noble alloys	$617	Prior Authorization Required
D6090	Repair implant supported prosthesis, by report	$0	
D6091	Replacement of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	$186	Prior Authorization Required
D6095	Repair implant abutment, by report	$0	
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

CDT Code	Description	Member Copayment	Limitations
D6114	Implant/abutment supported fixed denture, maxillary	$1,000	Prior Authorization Required
D6115	Implant/abutment supported fixed denture, mandibular	$1,000	Prior Authorization Required
D6116	Implant/abutment supported fixed denture for partial, maxillary	$400	Prior Authorization Required
D6117	Implant/abutment supported fixed denture for partial, mandibular	$400	Prior Authorization Required
D6121	Implant supported retainer for metal FPD, predominantly base alloys	$562	Prior Authorization Required
D6122	Implant supported retainer for metal FPD, noble alloys	$611	Prior Authorization Required
Guideline: Bridge Services - Payable at the least expensive covered material. 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

CDT Code	Description	Member Copayment	Limitations
D6606	Retainer inlay, cast noble metal, two surfaces	$318	Prior Authorization Required
D6607	Retainer inlay, cast noble metal, three or more surfaces	$344	Prior Authorization Required
D6608	Retainer onlay, porcelain/ceramic, two surfaces	$338	Prior Authorization Required
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	$400	Prior Authorization Required
D6610	Retainer onlay, cast high noble metal, two surfaces	$337	Prior Authorization Required
D6611	Retainer onlay, cast high noble metal, three or more surfaces	$397	Prior Authorization Required
D6612	Retainer onlay, cast base metal, two surfaces	$335	Prior Authorization Required
D6613	Retainer onlay, cast base metal, three or more surfaces	$382	Prior Authorization Required
D6614	Retainer onlay, cast noble metal, two surfaces	$328	Prior Authorization Required
D6615	Retainer onlay, cast noble metal three or more surfaces	$382	Prior Authorization Required
D6634	Retainer onlay, titanium	$250	Prior Authorization Required
D6710	Retainer crown, indirect resin based composite	$400	Prior Authorization Required
D6720	Retainer crown, resin with high noble metal	$390	Prior Authorization Required
D6721	Retainer crown, resin with predominantly base metal	$370	Prior Authorization Required
D6722	Retainer crown, resin with noble metal	$377	Prior Authorization Required
D6740	Retainer crown, porcelain/ceramic	$477	Prior Authorization Required
D6750	Retainer crown, porcelain fused to high noble metal	$470	Prior Authorization Required
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

CDT Code	Description	Member Copayment	Limitations
D6794	Retainer crown, titanium and titanium alloys	$400	Prior Authorization Required
D6930	Re-cement or re-bond fixed partial denture	$52	
D6980	Fixed partial denture repair, restorative material failure	$88	
D6999	Unspecified fixed prosthodontic procedure, by report	$0	Prior Authorization Required
D7251	Coronectomy, intentional partial tooth removal	$192	
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	
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 (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	
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	$80	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	$149	
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	$126	
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	

CDT Code	Description	Member Copayment	Limitations
D7441	Excision of malignant tumor, greater than 1.25 cm	$164	
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	$274	
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	$375	
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	$125	
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	$151	
D7471	Removal of lateral exostosis, maxilla or mandible	$340	
D7472	Removal of torus palatinus	$404	
D7473	Removal of torus mandibularis	$381	
D7485	Reduction of osseous tuberosity	$340	
D7510	Incision & drainage of abscess, intraoral soft tissue	$98	
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	$149	
D7520	Incision & drainage of abscess, extraoral soft tissue	$468	
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	$125	
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$106	
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 (D7961) in a lifetime, per arch
D7962	Lingual frenectomy (frenulectomy)	$148	1 (D7962) in a lifetime
D7963	Frenuloplasty	$124	1 (D7963) In a lifetime, per arch
D7970	Excision of hyperplastic tissue, per arch	$183	
D7971	Excision of pericoronal gingiva	$70	
D7972	Surgical reduction of fibrous tuberosity	$256	
D7979	Non – surgical 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	

CDT Code	Description	Member Copayment	Limitations
D9222	Deep sedation/general anesthesia, first 15 minute increment	$72	Prior Authorization Required
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	$72	Prior Authorization Required
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$25	Not allowed on same date of service asD9248
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	$68	Prior Authorization Required
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	$68	Prior Authorization Required
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	$125	Not allowed on same date of service as D9222, D9223, D9230
D9310	Consultation, other than requesting dentist	$45	
D9311	Consultation with a medical health care professional	$40	
D9410	House/extended care facility call	$79	
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 (D9941) every 12 months
D9944	Occlusal guard, hard appliance, full arch	$223	
D9945	Occlusal guard, soft appliance, full arch	$223	
D9946	Occlusal guard, hard appliance, partial arch	$170	
D9950	Occlusion analysis, mounted case	$111	
D9951	Occlusal adjustment, limited	$50	
D9952	Occlusal adjustment, complete	$234	
D9986	Missed appointment	$0	
TYPE IV - MEDICALLY NECESSARY ORTHODONTIC SERVICES - Prior Authorization required for Orthodontic Services			
Guideline: Medically Necessary Orthodontic Services Orthodontic needs are limited to 1 course of treatment and must meet medically necessary requirements as determined by a verified score of 26 or higher (or other qualify conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.			
D8010	Limited orthodontic treatment of the primary dentition	$765	Prior Authorization Required for medically necessary benefits

CDT Code	Description	Member Copayment	Limitations
D8020	Limited orthodontic treatment of the transitional dentition	$815	Prior Authorization Required for medically necessary benefits
D8030	Limited orthodontic treatment of the adolescent dentition	$965	Prior Authorization Required for medically necessary benefits
D8040	Limited orthodontic treatment of the adult dentition	$965	Prior Authorization Required for medically necessary benefits
D8070	Comprehensive orthodontic treatment of the transitional dentition	$2,169	Prior Authorization Required for medically necessary benefits
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2,169	Prior Authorization Required for medically necessary benefits
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,169	Prior Authorization Required for medically necessary benefits
D8210	Removable appliance therapy	$299	Prior Authorization Required for medically necessary benefits, for thumb sucking and tongue thrusting
D8220	Fixed appliance therapy	$300	Prior Authorization Required for medically necessary benefits, for thumb sucking and tongue thrusting
D8660	Pre-orthodontic treatment examination to monitor growth and development	$47	Prior Authorization Required for medically necessary benefits
D8670	Periodic orthodontic treatment visit	$54	Prior Authorization Required for medically necessary benefits
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$204	Prior Authorization Required for medically necessary benefits
D8681	Removable orthodontic retainer adjustment	$246	Prior Authorization Required for medically necessary benefits
D8698	Re-cement or re-bond fixed retainer, maxillary	$32	Prior Authorization Required for medically necessary benefits
D8699	Re-cement or re-bond fixed retainer, mandibular	$32	Prior Authorization Required for medically necessary benefits
D8701	Repair of fixed retainer, includes reattachment, maxillary	$94	Prior Authorization Required for medically necessary benefits
D8702	Repair of fixed retainer, includes reattachment, mandibular	$94	Prior Authorization Required for medically necessary benefits
D8703	Replacement of lost or broken retainer, maxillary	$94	Prior Authorization Required for medically necessary benefits
D8704	Replacement of lost or broken retainer, mandibular	$94	Prior Authorization Required for medically necessary benefits
D8999	Unspecified orthodontic procedure, by report	$0	Prior Authorization Required for medically necessary benefits

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

- Any procedures not listed on this Plan
- Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.

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

Appendix – Summary of Cost Shares

Cost Share is the general term used to refer to your out-of-pocket costs (e.g., Deductible, Coinsurance, and Copayments) for the covered Services you receive. The Cost Shares listed here apply to Services provided to Members enrolled in this Silver Metal plan. In addition to the monthly Premium, you may be required to pay a Cost Share for some Services.

The Cost Share is the Copayment, Deductible, and Coinsurance, if any, listed in this Appendix for each Service.†

You are responsible for payment of all Cost Shares. Copayments are due at the time you receive a Service. You will be billed for any Deductible and Coinsurance you owe.

This summary does not describe benefits. For the description of benefits, including exclusions and limitations, please refer to:

1. ***Section 3. Benefits, Exclusions and Limitations***
2. ***Appendix - Outpatient Prescription Drug Benefit***
3. ***Appendix - Kaiser Permanente Smile Kids KPIF Embedded Dental EPO Plan***

†When a non-Participating Provider provides non-Emergency Services, including Ancillary Services, and Services for unforeseen urgent medical needs at a Participating Facility, your Cost Share will be the same Cost Sharing amount for the same Service(s) from a Participating Provider unless the non-Participating Provider has satisfied the notice and consent requirements of §149.420(c) through (i) with respect to those non-Emergency Services, including Ancillary Services, or unforeseen urgent medical needs. Any Cost Sharing requirement for the items and Services will be calculated based on the Recognized Amount. Such Cost Share shall count toward your Deductible, if any, and Out-of-Pocket Maximum. You will not be liable for any additional payment other than your Cost Share for non-Emergency Services, including Ancillary Services, or unforeseen urgent medical needs. We will make payment for the items and Services directly to the non-Participating Provider. The payment amount will be equal to the amount by which the Out-of-Network Rate exceeds the Cost Sharing amount for the items and Services.

For covered Services rendered by a Health Care Provider for which payment is required under §19-710.1 of the Health-General Article, Ancillary Services, and 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-Participating Provider satisfied the notice and consent criteria, the notice and consent criteria of 45 C.F.R. §149.420 (c) through (i) do not apply to non-Participating Providers. Additionally, when these Services are received by a non-Participating Provider they will always be subject to the conditions described in the above paragraph.

Deductible

The Deductible is the amount of Allowable Charges you must incur during a Calendar Year for certain benefits before the Health Plan will provide benefits for those Services.

For benefits that are subject to a Deductible, you must pay the full charge for the Services when you receive them, until you meet your Deductible. The only amounts that count toward your Deductible are the Allowable Charges you incur for Services that are subject to the Deductible, but only if the Service would otherwise be covered. After you meet the Deductible, you pay the applicable Copayment or Coinsurance for these Services.

Self-Only Deductible

If you are covered as a Subscriber, and you do not have any Dependents covered under the plan, you must meet the Self-Only Deductible indicated below.

Family Deductible

If you have one or more Dependents covered under this Agreement, either the Self-Only or Family Deductible must be met. No one family member's medical expenses may contribute more than the Self-Only Deductible shown below. After one member of a Family Unit has met the Self-Only Deductible, this Member will start paying Copayments or Coinsurance for the remainder of the Calendar Year. Other family members will continue to pay full charges for Services that are subject to the Deductible until the Family Deductible is met. After two or more members of your Family Unit combined have met the Family Deductible, the Deductible will be met for all members of the Family Unit for the rest of the Calendar Year.

Keep Your Receipts

When you pay an amount toward your Deductible, we will give you a receipt. Keep your receipts. Also, if you have met your Deductible, and we have not received and processed all of your claims, you can use your receipts to prove that you have met your Deductible. You can also obtain a statement of the amounts that have been applied toward your Deductible from our Member Services Department.

Deductible	You Pay
Self-Only Deductible	$6,000 per individual per Calendar Year
Family Deductible	$12,000 per Family Unit per Calendar Year

Covered Service	You Pay
Outpatient Office Visits	
Outpatient office Visit Services that are required by the Affordable Care Act are covered under Preventive Health Care Services at no charge.	
Primary Care office Visits (Internal medicine, family practice, pediatrics or obstetrics/gynecology)	$40 per Visit
Specialty care office Visits (All other covered practitioner office Visits unless listed separately below)	$60 per Visit
Outpatient Hospital Services	
Outpatient surgery facility fee (freestanding ambulatory surgical center or outpatient Hospital)	35% of AC* after Deductible
Outpatient surgery physician Services	35% of AC* after Deductible
Hospital-based outpatient department and office (non-surgical)	Applicable cost share will apply based on type of Service

Covered Service	You Pay
Inpatient Hospital Services and Obstetrical Admissions	
Hospital admission	35% of AC* after Deductible
Services provided by physicians while a Member is in a Hospital or related institution	35% of AC* after Deductible
Accidental Dental Injury Services	
Office Visit	$60 per Visit
All other related Services	The applicable Cost Share will apply based on type and place of Service
Acupuncture Services	
Covered when Medically Necessary	
Acupuncture	$50 per Visit
Allergy Services	
Evaluation and treatment	$60 per Visit
Injection Visit and serum	$40 per Visit
Ambulance Services	
By a licensed ambulance Service, per encounter	No charge after Deductible
Non-emergent transportation Services (ordered by a Plan Provider)	No charge
Anesthesia for Dental Care Services	
Anesthesia for Dental Services	The applicable Cost Share will apply based on type and place of Service
Blood, Blood Products and Their Administration	
Blood, Blood Products and Their Administration	35% of AC* after Deductible
Bone Mass Measurement	
Preventive screening	No charge
Diagnostic	$70 per Visit

Covered Service	You Pay
Chiropractic Services	
Limited to twenty (20) Visits per condition per Calendar Year	
Chiropractic Services	$50 per Visit
Cleft Lip, Cleft Palate or Both	
Cleft Lip, Cleft Palate or Both	The applicable Cost Share will apply based on type and place of Service
Clinical Trials	
Clinical Trials	The applicable Cost Share will apply based on type and place of Service
Diabetic Treatment, Equipment, Supplies and Self-Management Training	
Insulin pumps and continuous glucose monitors	Refer to "Durable Medical Equipment (DME) and Prosthetic Devices" benefit below
Glucometers	35% of AC*
Diabetic test strips	No charge
All other diabetic equipment and supplies	35% of AC* after Deductible
Self-management training	The applicable Cost Share will apply based on type and place of Service
Dialysis	
Inpatient Services	Refer to the "Inpatient Hospital Services" benefit above
Outpatient Services	$60 per Visit
Drugs, Supplies and Supplements	
Administered by or under the supervision of a Plan Provider	
Drugs, Supplies and Supplements	The applicable Cost Share will apply based on type and place of Service
Durable Medical Equipment (DME) and Prosthetic Devices	
Durable Medical Equipment (DME) and Prosthetic Devices, including breast prosthesis	35% of AC* after Deductible

Covered Service	You Pay
Peak Flow Meters	35% of AC*
Home UV Light Box	No charge
Emergency Services	
Emergency Services **Note:** Your Cost Share will be the same Deductible, Copayment, or Coinsurance, as applicable, for Emergency Services provided by Plan Providers and non-Plan Providers. Calculation of the Cost Share will be in accordance with the requirements of state law or, in the event that state law is inapplicable, then federal law.	35% of AC* after Deductible
Family Planning Services	
Family planning Services that are defined as preventive care under the Affordable Care Act are covered at no charge. Women′s Preventive Services (WPS), including all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity are covered under Preventive Health Care Services at no charge.	
Male Sterilization	No charge
Abortion care Services	No charge
Fertility Services	
Standard fertility preservation Visits and procedures for iatrogenic infertility	$60 per Visit
All other covered Services	The applicable Cost Share will apply based on type and place of Service
Habilitative Services and Devices	
Physical, Occupational or Speech Therapy	$50 per Visit
Applied Behavioral Analysis (ABA)	$40 per Visit
Assistive Devices	35% of AC* after Deductible
All other Services	The applicable Cost Share will apply based on type and place of Service.

Covered Service	You Pay
Hearing Services	
Newborn hearing screening tests are covered under Preventive Health Care Services at no charge	
Hearing Tests	The applicable Cost Share will apply based on type and place of Service
Hearing Aids • Hearing aid testing and fitting • Hearing aids (limited to a single hearing device per hearing impaired ear, every 36 months)	• $60 per Visit • 35% of AC* after Deductible
Home Health Care Services	
Home Health Care Services	No charge after Deductible
Hospice Care Services	
Hospice Care Services	No charge after Deductible
Infertility Services	
Infertility Services (inpatient treatment, outpatient surgery or outpatient Visits)	The applicable Cost Share will apply based on type and place of Service
Maternity Services	
Maternity Services that are required by the Affordable Care Act are covered under Preventive Health Care Services at no charge.	
Pre-natal and post-natal Services (includes routine and non-routine office Visits, telemedicine Visits, x-ray, laboratory, and specialty tests), including: • Birthing Classes (offered one course per pregnancy) • Breastfeeding support and equipment	No charge
Inpatient and Birthing Center Delivery	35% of AC* after Deductible
Postpartum home health Visits	No charge
Medical Foods	
Medical Foods (including amino-acid-based elemental formula)	35% of AC* after Deductible

Covered Service	You Pay
Medical Nutrition Therapy and Counseling	
Medical Nutrition Therapy & Counseling	$40 per Visit
Mental Health and Substance Abuse Services	
Inpatient psychiatric and substance abuse Services, including detoxification	35% of AC* after Deductible
Residential Treatment Center Services	35% of AC* after Deductible
Outpatient psychiatric and substance abuse Services • Individual therapy • Group therapy • Intensive therapy • Diagnostic evaluation • Medication evaluation and management Visits • Psychological and Neuropsychological Testing	 • $40 per Visit • $20 per Visit • $40 per Visit • $40 per Visit • $40 per Visit • $40 per Visit
All other Outpatient Services • Partial Hospitalization Treatment • Electroconvulsive Therapy (ECT) • Crisis Intervention and Stabilization	 • $40 per Visit • $40 per Visit • $40 per Visit
Morbid Obesity Services (including Bariatric Surgery)	
Morbid Obesity Services, including Bariatric Surgery	The applicable Cost Share will apply based on type and place of Service
Oral Surgery/Temporomandibular Joint Services (TMJ)	
Oral surgery, including treatment of the temporomandibular joint and therapeutic injections	The applicable Cost Share will apply based on type and place of Service.
TMJ appliances	35% of AC* after Deductible
Preventive Health Care Services	
Preventive Health Care Services	No charge

Covered Service	You Pay
While treatment may be provided in the following situations, the following Services, exams and screening tests or interpretations are not considered "Preventive Health Care Services" and shall be subject to the applicable Cost Share under other sections of the Agreement: 1. Monitoring chronic disease or follow-up testing, once you have been diagnosed with a disease, except for those listed under Preventive Health Care Services in ***Section 3: Benefits, Exclusions and Limitations***. 2. Testing for specific diseases for which you have been determined to be at high risk for contracting, except for those listed under Preventive Health Care Services in ***Section 3: Benefits, Exclusions and Limitations***. 3. Medically Necessary Services when you show signs or symptoms of a specific disease or disease process, except for those listed under Preventive Health Care Services in ***Section 3: Benefits, Exclusions and Limitations***.	
Radiation Therapy/Chemotherapy/Infusion Therapy - Outpatient	
Radiation Therapy	$60 per Visit
Chemotherapy	$60 per Visit
Infusion Therapy	The applicable Cost Share will apply based on type and place of Service
Reconstructive Breast Surgery & Reconstructive Surgery	
Reconstructive Breast Surgery & Reconstructive Surgery	The applicable Cost Share will apply based on type and place of Service
Routine Foot Care	
Routine Foot Care	$60 per Visit
Skilled Nursing Facility Services	
Maximum of one hundred (100) days per Calendar Year	
Skilled Nursing Facility Services	35% of AC* after Deductible
Telemedicine Services	
Telemedicine Services	No charge
Therapy and Rehabilitation Services - Outpatient	
Therapy and Rehabilitation Services – Outpatient	$50 per Visit
Transplant Services	
Transplant Services	The applicable Cost Share will apply based on type and place of Service

Covered Service	You Pay
Pre-transplant dental Services • Dental Services Office Visit • All other related Services	• $60 per Visit • The applicable Cost Share will apply based on type and place of Service
Urgent Care Services	
Office Visit during regular office hours	The applicable Cost Share will apply based on type and place of Service
After-hours Urgent Care or Urgent Care center	$60 per Visit
Vision Services (for adults age 19 or older)	
Eye exam by an Optometrist	$35 per Visit
Eye exam by an Ophthalmologist	$60 per Visit
Eyeglass lenses and frames	You receive a $90 combined discount off retail price** for eyeglass lenses and for eyeglass frames (Discount is available once per Calendar Year)
Contact lenses	You receive a $25 discount off retail price** on initial fit and first purchase of contact lenses (Discount is available once per Calendar Year)
Vision Services (for children until the end of the month in which the Member turns age 19)	
Eye exam by an Optometrist	$40 per Visit
Eye exam by an Ophthalmologist	$60 per Visit
Vision Hardware (for children until the end of the month in which the Member turns age 19)	
A child may select any pair of glasses in lieu of, or in addition to, the eyeglasses or contact lenses available below at no charge and receive the discount under Vision Services (for adults age 19 or older) at any Plan vision center.	
Eyeglass lenses and frames (Limited to a select group)	No charge for one (1) pair per Calendar Year

Covered Service	You Pay
Elective Prescription Contact Lenses (in lieu of eyeglass lenses and frames) Limited to a select group, based on standard packaging for type of lenses. Standard packaging may be: • One (1) pair up to a twelve (12)-month supply for non-disposable contacts • Twelve (12)-month supply for disposable contacts	No charge for initial fitting and first purchase based on standard packaging per Calendar Year
Medically Necessary contact lenses (in lieu of eyeglass lenses and frames) (Limited to a select group)	No charge for up to two (2) pair per eye per Calendar Year
Low vision aids (Limited to available supply at Plan Provider only)	No charge
Wellness Benefits	
Wellness Benefits	No charge
X-Ray, Laboratory and Special Procedures - Outpatient	
Laboratory Outpatient and Professional Services	$50 per Visit
X-rays and Diagnostic Imaging	$70 per Visit
Specialty Imaging (including CT, MRI, PET Scans and Diagnostic Nuclear Medicine)	35% of AC* after Deductible
Sleep laboratory	35% of AC* after Deductible
Sleep studies	$60 per Visit
Interventional Radiology	35% of AC* after Deductible

*"AC" means Allowable Charge as defined in the ***Important Terms You Should Know*** section of this Agreement.

**"Retail price" means the price that would otherwise be charged for the lenses, frames or contacts at the Plan vision center on the day purchased.

Out-of-Pocket Maximum

Self-Only Out-of-Pocket Maximum	$8,200 per individual per Calendar Year
Family Out-of-Pocket Maximum	$16,400 per Family Unit per Calendar Year

The Out-of-Pocket Maximum is the maximum amount of Copayments, Deductibles and Coinsurance that an individual or family is obligated to pay for covered Services, except as excluded below, per Calendar Year. Once you or your Family Unit together have met your Out-of-Pocket Maximum, you will not be required to pay any additional Cost Shares for covered Services that apply toward the Out-of-Pocket Maximum for the rest of the Calendar Year.

Self-Only Out-of-Pocket Maximum

If you are covered as a Subscriber, and you do not have any Dependents covered under the plan, your medical expenses for covered Services apply toward the Self-Only Out-of-Pocket Maximum indicated above.

Family Out-of-Pocket Maximum

If you have one or more Dependents covered under this Agreement, the covered medical expenses incurred by all family members together apply toward the Family Out-of-Pocket Maximum indicated above. No one family member's medical expenses may contribute more than the Self-Only Out-of-Pocket Maximum shown above. After one member of a Family Unit has met the Self-Only Out-of-Pocket Maximum, this Member will not be required to pay any additional Cost Shares for covered Services for the rest of the Calendar Year. Other family members will continue to pay Cost Shares until the Family Out-of-Pocket Maximum is met. After two or more members of your Family Unit combined have met the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be met for all members of the Family Unit for the rest of the Calendar Year.

Out-of-Pocket Maximum Exclusions

The following Service(s) *do not* apply toward your Out-of-Pocket Maximum:

- Adult eyeglass lenses and frames and contact lenses that are available with a discount only; and
- Dental Services under the ***Kaiser Permanente Smile KPIF Dental EPO Adult Dental Plan Rider***, ***Kaiser Permanente Smile KPIF Dental PPO Adult Dental Plan Rider***, ***Kaiser Permanente Smile KPIF OrthoPlus Dental EPO Family Rider,*** or ***Kaiser Permanente Smile KPIF OrthoPlus Dental PPO Family Rider***, if applicable.

Appendix – Outpatient Prescription Drug Benefit

The Health Plan will provide coverage for prescription drugs as follows:

Definitions

Allowable Charge: Has the same meaning as defined in the ***Important Terms You Should Know*** section of your Membership Agreement and Evidence of Coverage.

Authorized Representative: Has the same meaning as defined in the ***Important Terms You Should Know*** section of your Membership Agreement and Evidence of Coverage.

Biosimilar: FDA-approved biologics that are highly similar to a brand biologic product.

Brand Name Drug: A prescription drug that has been patented and is produced by only one (1) manufacturer.

Coinsurance: A percentage of the Allowable Charge that you must pay for each prescription or prescription refill.

Complex or Chronic Medical Condition: A physical, behavioral, or developmental condition that:

1. May have no known cure;
2. Is progressive; or
3. Can be debilitating or fatal if left untreated or undertreated.

Complex or Chronic Medical Conditions include, but are not limited to: Multiple Sclerosis, Hepatitis C, and Rheumatoid Arthritis.

Contraceptive Drug: A drug or device that is approved by the Food & Drug Administration for use as a contraceptive with or without a prescription.

Copayment: The specific dollar amount that you must pay for each prescription or prescription refill.

Deductible: The Deductible is the amount of Allowable Charges you must incur during a Calendar Year for certain benefits before the Health Plan will provide benefits for those Services.

Food & Drug Administration/FDA: The United States Food & Drug Administration.

Formulary: A list of prescription drugs covered by this Plan.

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

Health Care Provider: Has the same meaning as defined in the ***Important Terms You Should Know*** section of your Membership Agreement and Evidence of Coverage.

Limited Distribution Drug (LDD): A prescription drug that is limited in distribution by the manufacturer or the Food & Drug Administration.

Mail Service Delivery Program: A program operated or arranged by the Health Plan that distributes prescription drugs to Members via postal mail. Some medications are not eligible for the Mail Service Delivery Program. These may include, but are not limited to, drugs that are time or temperature sensitive, drugs that cannot legally be sent by U.S. Mail, and drugs that require professional administration or

observation. The Mail Service Delivery Program can mail to addresses in Maryland, Virginia, Washington, D.C. and certain locations outside of the Service Area.

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

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

Nicotine Replacement Therapy: A product that:

1. Is used to deliver nicotine to an individual attempting to cease the use of tobacco products; and
2. Can be obtained only by a written prescription.

Nicotine Replacement Therapy does not include any over-the-counter products that may be obtained without a prescription.

Non-Formulary Drug: Includes all other Generic and Brand Name Drugs on Tier 3.

Non-Plan Pharmacy: A pharmacy that has not contracted with the Health Plan, or the Health Plan's agent, to provide pharmacy Services.

Oral Chemotherapy Drug: A drug that can be taken by mouth that is prescribed by a licensed physician to kill or slow the growth of cancer cells.

Participating Network Pharmacy: Any pharmacy that has entered into an agreement with Health Plan or the Health Plan's agent to provide pharmacy Services to its Members.

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

Preferred Drug: Generic or Brand Name Drug that is on the Formulary on Tier 1 or Tier 2.

Rare Medical Condition: A disease or condition that affects fewer than 200,000 individuals in the United States or approximately one (1) in 1,500 individuals worldwide. Rare Medical Conditions include, but are not limited to: Cystic Fibrosis, Hemophilia, and Multiple Myeloma.

Smoking Cessation Drugs: Over-the-counter and prescription drugs approved by the Food & Drug Administration to treat tobacco dependence.

Specialty Drug: A prescription drug that:

1. Is prescribed for an individual with a Complex or Chronic Medical Condition, or a Rare Medical Condition;
2. Costs $600 or more for up to a thirty (30)-day supply;
3. Is not typically stocked at retail pharmacies; and
4. Requires a difficult or unusual process of delivery to the Member in the:
    a. Preparation;
    b. Handling;
    c. Storage;
    d. Inventory; or
    e. Distribution of the drug; or
    f. Requires enhanced patient education, management, or support, beyond those required for

traditional dispensing, before or after administration of the drug.

Note: Specialty Drugs do not include prescription drugs to treat diabetes, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS).

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

Standard Reference Compendia: Any authoritative compendia as recognized periodically by the federal Secretary of Health and Human Services or the Commissioner.

Benefits

Except as provided in the ***Section 3: Benefits, Limitations and Exclusions***, we cover drugs described below when prescribed by an authorized prescriber. Each prescription refill is subject to the same conditions as the original prescription. A Plan Provider prescribes drugs in accordance with Health Plan's Formulary. If the retail price of the drug is less than the Copayment, you will pay the retail price of the drug. You must obtain covered drugs from a Plan Pharmacy or Participating Network Pharmacy, however, you may obtain covered drugs from a Non-Plan Pharmacy for out-of-area Urgent Care Services and Emergency Services. You may also obtain prescription drugs using our Mail Service Delivery Program; ask for details at a Plan Pharmacy.

We cover the following prescription drugs:

1. Food & Drug Administration-approved drugs for which a prescription is required by law.
2. Compounded preparations that contain at least one ingredient requiring a prescription.
3. Insulin.
4. Oral chemotherapy drugs.
5. Drugs for the treatment of infertility.
6. Drugs that are Food & Drug Administration-approved for use as contraceptives and diaphragms, including those that are over-the-counter. For coverage of other types of contraception, including contraceptive injections, implants and devices, refer to ***"Family Planning Services"*** in ***Section 3: Benefits, Exclusions and Limitations***.
7. Any prescription drug approved by the Food & Drug Administration as an aid for the cessation of the use of tobacco products. Tobacco products include cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco, and candy-like products that contain tobacco.
8. Nicotine replacement prescription drugs for Nicotine Replacement Therapy courses and drugs that are approved by the Food & Drug Administration as an aid for the cessation of the use of tobacco products.
9. Off label use of drugs when a drug is recognized in Standard Reference Compendia or certain Medical Literature as appropriate in the treatment of the diagnosed condition.
10. Non-prescription drugs when they are prescribed by a Plan Provider and are listed on the Formulary.
11. Growth hormone therapy for treatment of children under age eighteen (18) with a growth hormone deficiency; or when prescribed by a Plan Physician, pursuant to clinical guidelines for adults.

12. Limited Distribution Drugs, regardless of where they are purchased, will be covered on the same basis as if they were purchased at a Plan Pharmacy.
13. Prescription eye drops and refills in accordance with guidance for early refills of topical ophthalmic products provided by the Centers for Medicare and Medicaid Services if the:
    a. Original prescription indicates additional quantities are needed; and
    b. Refill requested does not exceed the number of refills indicated on the original prescription.

The Health Plan Pharmacy and Therapeutics Committee sets dispensing limitations in accordance with therapeutic guidelines based on the Medical Literature and research. The Committee also meets periodically to consider adding and removing prescribed drugs on the Formulary.

Certain covered outpatient prescription drugs may be subject to utilization management such as prior authorization and step therapy. A list of drugs subject to utilization management is available to you upon request.

If you would like information about whether a particular drug is included in our Formulary, please visit us online at:

https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/mas/marketplace-formulary-mas-en-2023.pdf

You may also call Member Services Monday through Friday between 7:30a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Exclusions

Except as specifically covered under this Outpatient Prescription Drug Benefit, the Health Plan does not cover:

1. Weight management drugs solely for treatment of or prescribed for increasing or decreasing body weight;
2. Drugs prescribed solely for the treatment of sexual dysfunction drugs;
3. A drug that can be obtained without a prescription, except for over-the-counter contraceptive drugs; or
4. A drug for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to the prescription drug, unless otherwise prohibited by federal or state laws governing essential health benefits.

Where to Purchase Covered Drugs

Except for Emergency Services and Urgent Care Services, you must obtain prescribed drugs from a Plan Pharmacy, a Participating Network Pharmacy, or through Health Plan's Mail Service Delivery Program. Prescribed drugs are subject to the Cost Shares listed under "***Copayment/Coinsurance***." Most non-refrigerated prescription medications ordered through the Health Plan's Mail Service Delivery Program can be delivered to addresses in Maryland, Virginia, Washington, D.C., and certain locations outside the Service Area.

Generic and Preferred Drug Requirements

Generic vs. Brand Name Drugs

We cover Generic and Brand Name Drugs, including those for Specialty Drugs and biological drugs. Plan

Pharmacies, a Participating Network Pharmacy, and mail order pharmacies will substitute a generic equivalent for a Brand Name Drug when a generic equivalent is listed as a Preferred Drug unless one of the following is met:

1. The Provider has prescribed a Brand Name Drug and has indicated "dispense as written," also sometimes referred to as "(DAW)" on the prescription;
2. The Brand Name Drug is listed on our Formulary as a Preferred Drug;
3. The Brand Name Drug is prescribed by a:
    a. Plan Physician;
    b. Non-Plan Physician to whom you have an approved referral;
    c. Non-Plan Physician consulted due to an emergency or for out-of-area urgent care; or
    d. Dentist; and
        i. There is no equivalent prescription Generic Drug or device; or
        ii. An equivalent prescription Generic Drug or device has:
            a. Been ineffective in treating the disease or condition of the Member; or
            b. Caused or is likely to cause an adverse reaction or other harm to the Member.
4. For a contraceptive prescription drug or device, the prescription drug or device that is not on the Formulary is Medically Necessary for the Member to adhere to the appropriate use of the prescription drug or device.

If a Member requests a Brand Name Drug, not on the Formulary, for which there is a generic equivalent and items #3(d)(ii)(a) and #3(d)(ii)(b) have not been met, the Member will be responsible for the full Allowable Charge for the Brand Name Drug.

If the above conditions in items #3(d)(ii)(a) and #3(d)(ii)(b) are met and a Brand Name Drug or device is moved to a higher Cost Share, we will continue, upon the Member's or prescriber's request, the same Cost Share received when that Brand Name Drug or device was available on a lower tier if the above criteria are met.

We will provide coverage for prescription drugs or devices not on the Formulary or if a prescription drug or device is removed from the Formulary if the above criteria are met. If a prescription drug or device on the Formulary is moved to a higher tier resulting in a higher Cost Share or a prescription drug or device is removed from the Formulary resulting in a higher cost share, we will continue, upon the Member's or prescriber's request, the same Cost Share received when the prescription drug or device was available on a lower tier, if the above criteria are met. We will provide coverage for the prescription drug or device if in the judgement of the prescriber:

1. There is no equivalent prescription drug or device on the Formulary in a lower tier; or
2. An equivalent prescription drug or device on the Formulary in a lower tier:
    a. Has been ineffective in treating the disease or condition of the Member; or
    b. Has caused or is likely to cause an adverse reaction or other harm to the Member; or
3. For a contraceptive prescription drug or device, the prescription drug or device that is not on the Formulary is Medically Necessary for the Member to adhere to the appropriate use of the prescription drug or device.

For plans with one-(1) or two-(2) tiers, a Non-Formulary Drug which meets the formulary exception

criteria will be covered on the plan's highest tier. For plans with three-(3) or four-(4) tiers, these drugs will be covered on Tier 3.

If a drug or accessory is added or removed from the Formulary, or moved to a higher cost-sharing tier, a thirty (30)-day notice will be provided to you prior to its removal or movement to a higher tier or Cost Share.

Preferred Drugs vs. Non-Formulary Drugs

We cover Preferred Drugs and Non-Formulary Drugs, including those for Specialty Drugs and biological drugs. Plan Pharmacies, Participating Network Pharmacies, and mail order pharmacies will dispense a Preferred Drug unless the following criteria are met:

The Non-Formulary Drug is prescribed by an:

1. Authorized prescriber;
2. Authorized prescriber to whom you have a referral; or
3. Authorized prescriber consulted due to an emergency or for out-of-area urgent care; and
    a. There is no equivalent drug in our Formulary in a lower tier; or
    b. An equivalent Formulary drug in a lower tier has:
        i. Been ineffective in treating the disease or condition of the Member; or
        ii. Caused or is likely to cause an adverse reaction or other harm to the Member.

If the above criteria are met, the applicable Tier Cost Share will apply based on the Formulary. If the Member requests a drug, not on the Formulary, and the criteria are not met, the Member will be responsible for the full Allowable Charge.

We will provide coverage for prescription drugs or devices not on the Formulary or if a prescription drug or device is removed from the Formulary if the above criteria are met. If a prescription drug or device on the Formulary is moved to a higher tier resulting in a higher Cost Share or a prescription drug or device is removed from the Formulary resulting in a higher cost share, we will continue, upon the Member's or prescriber's request, the same Cost Share received when the prescription drug or device was available on a lower tier, if the above criteria are met. We will provide coverage for the prescription drug or device if in the judgement of the prescriber:

1. There is no equivalent prescription drug or device on the Formulary in a lower tier; or
2. An equivalent prescription drug or device on the Formulary in a lower tier:
    a. Has been ineffective in treating the disease or condition of the Member; or
    b. Has caused or is likely to cause an adverse reaction or other harm to the Member; or
3. For a contraceptive prescription drug or device, the prescription drug or device that is not on the Formulary is Medically Necessary for the Member to adhere to the appropriate use of the prescription drug or device.

For plans with one-(1) or two-(2) tiers, a Non-Formulary Drug which meets the formulary exception criteria will be covered on the plan's highest tier. For plans with three-(3) or four-(4) tiers, these drugs will be covered on Tier 3.

If a drug or accessory is added or removed from the Formulary, or moved to a higher cost-sharing tier, a thirty (30)-day notice will be provided to you prior to its removal or movement to a higher tier or Cost

Share.

The Health Plan will treat the drug(s) obtained as prescribed above, under ***Generic vs. Brand Name Drugs*** and ***Preferred Drugs vs. Non-Formulary Drugs***, as an Essential Health Benefit, including by counting any Cost Sharing towards the health benefit plan's Out-of-Pocket Maximum described in the ***Summary of Cost Shares*** Appendix of this Agreement.

Formulary Exception Process

Standard Formulary Exception Process

If you, your Authorized Representative, your Plan Provider, or other prescriber requests an exception, you, your Authorized Representative, your Plan Provider, or other prescriber may provide us a statement from your Plan Provider supporting the exception request. We will make a determination on the exception request and notify you, or your Authorized Representative, and your Plan Provider, or other prescriber of our coverage determination within seventy-two (72) hours following receipt of your, your Authorized Representative's, your Plan Provider's, or other prescriber's exception request.

Expedited Formulary Exception Process

If you are suffering from a health condition that may seriously jeopardize your life, health, or the ability to regain maximum function or you are undergoing a current course of treatment using a non-Formulary Drug and waiting up to seventy-two (72) hours for our coverage determination could be harmful to your health, you, your Authorized Representative, your Plan Provider, or other prescriber can request an expedited exception by providing us a statement from your Plan Provider supporting the expedited exception request. We will make a determination on the expedited exception request, based on the exigent circumstances, and notify you, or your Authorized Representative, and your Plan Provider, or other prescriber of our coverage determination within twenty-four (24) hours following receipt of your, your Authorized Representative's, your Plan Provider's, or other prescriber's expedited exception request.

External Formulary Exception Process

If we deny your, your Authorized Representative's, your Plan Provider's, or other prescriber's request for a standard Formulary exception or for an expedited Formulary exception, you, your Authorized Representative, your Plan Provider, or other prescriber may request that the original standard exception request or expedited exception request denial be reviewed by an independent review board. We will make a determination on the external exception request and notify you, or your Authorized Representative, and your Plan Provider, or other prescriber of our coverage determination within seventy-two (72) hours following receipt of your, your Authorized Representative's, your Plan Provider's, or other prescriber's external exception request, if the original request was a standard exception request and no later than twenty-four (24) hours following our receipt of the request, if the original request was an expedited exception request.

If you would like detailed information on the formulary exception process; please visit us at www.kp.org, or call the Member Services Call Center Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Dispensing Limitations

Except for Maintenance Medications and contraceptive drugs as described below, Members may obtain up to a thirty (30)-day supply and will be charged the applicable Copayment or Coinsurance based on:

1. The prescribed dosage;
2. Standard Manufacturers Package Size; and
3. Specified dispensing limits.

Drugs that have a short shelf life may require dispensing in smaller quantities to assure that the quality is maintained. Such drugs will be limited to a thirty (30)-day supply. If a drug is dispensed in several smaller quantities (for example, three (3) ten (10)-day supplies), you will be charged only one Cost Share at the initial dispensing for each thirty (30)-day supply.

Members may obtain a partial supply of a prescription drug and will be charged a prorated daily Copayment or Coinsurance, if the following conditions are met:

1. The prescriber or pharmacist determines dispensing a partial supply of a prescription drug to be in the best interest of the Member;
2. The prescription drug is anticipated to be required for more than three (3) months;
3. The Member requests or agrees to a partial supply for the purpose of synchronizing the dispensing of the Member's prescription drugs;
4. The prescription drug is not a Schedule II controlled dangerous substance; and
5. The supply and dispensing of the prescription drug meets all prior authorization and utilization management requirements specific to the prescription drug at the time of the synchronized dispensing.

Except for Maintenance Medications and contraceptive drugs as described below, injectable drugs that are self-administered and dispensed from the pharmacy are limited to a thirty (30)-day supply.

If a drug meets the criteria for a Specialty Drug, in accordance with §15-847 of the Insurance Article, or is a prescription drug to treat diabetes, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS), as described in §15-847.1 of the Insurance Article, then the Member's cost for the drug will not exceed $150 for a thirty (30)-day supply. For all insulin, the Member's cost will not exceed $30 for a 30-day supply, regardless of the amount or type of insulin, in accordance with §15-822.1 of the Insurance Article.

Maintenance Medication Dispensing Limitations

Members may obtain up to a ninety (90)-day supply of Maintenance Medications in a single prescription, when authorized by the prescribing Plan Provider or by a dentist or a referral physician. This does not apply to the first prescription or change in a prescription. The day supply is based on:

1. The prescribed dosage;
2. Standard Manufacturer's Package Size; and
3. Specified dispensing limits.

Contraceptive Drug Dispensing Limitations

For prescribed contraceptives, you may obtain up to a twelve (12)-month supply for a single dispense at a Plan Pharmacy or through our Mail Service Delivery Program.

Prescriptions Covered Outside the Service Area: Obtaining Reimbursement

The Health Plan covers drugs purchased at Non-Plan Pharmacies when the drug was prescribed during the course of an emergency care Visit or an urgent care Visit (see ***"Emergency Services"*** and "***Urgent***

Care Services" in ***Section 3: Benefits, Exclusions and Limitations***), or associated with a covered, authorized referral inside or outside the Health Plan's Service Area. To obtain reimbursement, Members must submit a copy of the itemized receipts for their prescriptions to the Health Plan. We may require proof that Emergency Services or Urgent Care Services were provided. Reimbursement will be made at the Allowable Charge less the applicable Copayment as shown below. Claims should be submitted to:

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

Copayment/Coinsurance

After you meet the Deductible as shown in the ***Summary of Cost Shares*** Appendix, you pay the Copayment or Coinsurance amounts set forth below when purchasing covered outpatient prescription drugs from the Kaiser Permanente Plan Pharmacy, a Participating Network Pharmacy, or mail order pharmacy. If the retail price of the drug is less than the Copayment, you will pay the retail price of the drug.

The following Copayments and Coinsurance apply to all covered prescription drugs purchased at a Kaiser Permanente Plan Pharmacy, a Participating Network Pharmacy, or through the Kaiser Permanente Mail Service Delivery Program. These Copayments and Coinsurance amounts also apply to covered prescription drugs offered at Non-Plan Pharmacies in connection with Emergency Services and Urgent Care Services.

For outpatient prescription drugs and/or items that are covered under this ***Outpatient Prescription Drug Benefit*** appendix and obtained at a pharmacy owned and operated by Health Plan, you may be able to use manufacturer coupons as payment for the Cost Sharing that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of your Cost Sharing for your prescription. When you use a coupon for payment of your Cost Sharing, the coupon amount, and any additional payment that you make, will accumulate to your Out-of-Pocket Maximum. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at https://healthy.kaiserpermanente.org/learn/pharmacy/drug-manufacturer-coupons.

Tier 1 Drugs: Includes commonly prescribed Generic Drugs.

Tier 2 Drugs: Includes commonly prescribed Brand Name Drugs and commonly prescribed higher-cost Generic Drugs on the Formulary list.

Tier 3 Drugs: Includes all other Generic and Brand Name Drugs that are on the Formulary list if the above criteria are met.

Tier 4 Drugs: Includes Specialty Drugs as defined in the ***Definitions*** section of this ***Outpatient Prescription Drug Benefit***.

Thirty (30)-Day Supply	**Plan Pharmacy and Mail Delivery**	**Participating Network Pharmacy and Mail Delivery**
Tier 1 Drugs	$30; not subject to Deductible	$70; not subject to Deductible
Tier 2 Drugs	$60; not subject to Deductible	$100; not subject to Deductible

Tier 3 Drugs	50% of AC* after Deductible	50% of AC* after Deductible
Tier 4 Drugs	50% of AC* but not to exceed $150 after Deductible	50% of AC* but not to exceed $150 after Deductible
Oral Chemotherapy Drugs	No charge; not subject to Deductible	No charge; not subject to Deductible
Preventive Care Drugs**	No charge; not subject to Deductible	No charge; not subject to Deductible
Smoking Cessation Drugs	No charge; not subject to Deductible	No charge; not subject to Deductible
All Insulin*** (Member out-of-pocket cost will not exceed $30)	Refer to applicable Cost Share above	Refer to applicable Cost Share above

Ninety (90)-Day Supply	**Plan Pharmacy and Mail Delivery**	**Participating Network Pharmacy and Mail Delivery**
Tier 1 Drugs	$60; not subject to Deductible	$140; not subject to Deductible
Tier 2 Drugs	$120; not subject to Deductible	$200; not subject to Deductible
Tier 3 Drugs	50% of AC* after Deductible	50% of AC* after Deductible
Tier 4 Drugs	50% of AC* but not to exceed $300 after Deductible	50% of AC* but not to exceed $300 after Deductible
Oral Chemotherapy Drugs	No charge; not subject to Deductible	No charge; not subject to Deductible
Preventive Care Drugs**	No charge; not subject to Deductible	No charge; not subject to Deductible
Smoking Cessation Drugs	No charge; not subject to Deductible	No charge; not subject to Deductible
All Insulin*** (Member out-of-pocket cost will not exceed $90)	Refer to applicable Cost Share above	Refer to applicable Cost Share above

Twelve (12)-Month Supply	**Plan Pharmacy and Mail Delivery**	**Participating Network Pharmacy and Mail Delivery**
Contraceptive Drugs**	No charge; not subject to Deductible	No charge; not subject to Deductible

*Allowable Charge is defined in the ***Important Terms You Should Know*** section in your Membership Agreement and Evidence of Coverage, to which this Appendix is attached.

**Contraceptive Drugs and Preventive Drugs required to be covered by the Affordable Care Act (ACA) without Cost Sharing, including over-the-counter medications when prescribed by a Plan Provider, and obtained at a Plan Pharmacy or through the Mail Service Delivery Program, are covered at no charge. You can find a list of these drugs by referring to the "PRV" indicator under "Restrictions/Limits" at:

https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/mas/marketplace-formulary-mas-en-2023.pdf

Additional information on ACA covered Preventive Care Drugs and Contraceptive Drugs can be found at:

Summary of preventive services (kaiserpermanente.org)

About the Affordable Care Act | HHS.gov

***For Insulin, please refer to the Tier 1 Drugs, Tier 2 Drugs, Tier 3 Drugs, or Tier 4 Drugs Cost Shares. For a thirty (30)-day supply of insulin, the out-of-pocket cost will not exceed $30. For a ninety (90)-day supply of insulin, the out-of-pocket cost will not exceed $90. Coverage for insulin is not subject to the Deductible.

Deductible

Covered outpatient prescription drugs are subject to the Deductible set forth in the ***Summary of Cost Shares*** Appendix of this of the Agreement except for Tier 1 Drugs, Tier 2 Drugs, Oral Chemotherapy Drugs, Preventive Care Drugs, Smoking Cessation Drugs, All Insulin, and Contraceptive Drugs.

Out-of-Pocket Maximum

The Deductible and all Cost Shares for outpatient prescription drugs apply toward the Out-of-Pocket Maximum set forth in the ***Summary of Cost Shares*** Appendix of this Agreement.