guide to

YOUR 2025 BENEFITS AND SERVICES

kaiserpermanente.org

SAMPLE

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

SMALL GROUP
EVIDENCE OF COVERAGE

MARYLAND

SELECT CARE DELIVERY SYSTEM

This plan has accreditation from the NCQA
See 2025 NCQA Guide for more information on accreditation

KAISER PERMANENTE®

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

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

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- $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.

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Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

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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.

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NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate 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 20785, telephone number: 1-800-777-7902.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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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 ኣማርኛ 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**).

Ɓǎsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyédé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn 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) સુચના: 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’dę́ę́’, 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
Your Small Group 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 Group Agreement and Evidence of Coverage (EOC) is one of them. It provides you with an overview of your Group health Plan, including the benefits you are entitled to, how to get care, what services are covered and what part of the costs of your care you will have to pay.

We ask that you review your EOC 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, religion, sex, sexual orientation, or physical or mental disability.

About This Group Agreement

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

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

Important Terms

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

Purpose of this Group Agreement and EOC

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

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

Kaiser Permanente
Your Small Group Agreement and Evidence of Coverage

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

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

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

No Waiver
Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, nor impair our right thereafter to require your strict performance of any provision.

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

No agent or other person, except an officer of the Health Plan, has the authority to bind the Health Plan in any way, verbally or otherwise, by:

1. Making any promise or representation; or
2. Giving or receiving any information.

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

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

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

Gracelyn McDermott
Vice President, Marketing, Sales & Business Development

SAMPLE

How Your Health Plan Works

The Health Plan provides health care Services to Covered Persons through an integrated medical care system, rather than reimbursement of expenses on a fee-for-service basis. Please keep the direct service nature in mind as you read this Group Agreement and EOC.

Kaiser Permanente
Your Small Group Agreement and Evidence of Coverage

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

Relations Among Parties Affected By This Group Agreement and EOC

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

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

Additionally:

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

Patient Information Obtained By Affected Parties

Patient-identifying information from the medical records of Covered Persons 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 Covered Person, except for use by the Health Plan, Plan Hospitals, Medical Group or Plan Physicians in relation to:

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

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Liability for Amounts Owed By the Health Plan

Covered Persons 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. If the Covered Person has paid the Health Care Provider for Services rendered, benefits will be payable to the Covered Person. All benefits will be paid to the Health Care Provider who rendered the Services.

Kaiser Permanente Select℠

Kaiser Permanente Select℠ provides you with health care benefits administered by Plan Providers at our Plan Medical Centers, and through affiliated Plan Providers located throughout our Service Area.

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

Eligibility for This Plan

Eligibility of a Covered Person

Covered Persons may be accepted for enrollment and continuing coverage hereunder only upon meeting all of the applicable requirements below.

1. You must live, work or reside inside our Service Area to be eligible for this Plan. However, the Subscriber and their Spouse's or Domestic Partner's eligible children who live outside of our Service Area are eligible to enroll if you are required to cover them pursuant to any court order, court-approved agreement or other testamentary appointment. A Dependent who attends school outside of our Service Area and meets the eligibility requirements listed below under ***Dependents*** is also eligible for enrollment. However, the only covered Services outside of our Service Area are:
   a. Emergency Services;
   b. Urgent Care Services;
   c. Continuity of Care for New Covered Persons;
   d. 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
   e. Approved Clinical Trials.
2. **Subscribers**
   You are eligible to enroll if you are employed by a Small Employer and that Small Employer offers you coverage under this Health Plan an eligible employee. At the option of the Small Employer an eligible employee may include:
   a. Only Full-Time Employees; or
   b. Both Full-Time Employees and Part-Time Employees.
3. **Dependents**
   If you are a Subscriber, the following persons may be eligible to enroll as your Dependents:
   a. Your lawful Spouse or Domestic Partner;
   b. You or your Spouse's or Domestic Partner's Dependent child who is under the limiting age 26 and who is:
      i. A biological child, stepchild or foster child;
      ii. A lawfully adopted child, or, from the date of placement, a child in the process of being adopted;
      iii. A grandchild under testamentary or court-appointed guardianship of the Subscriber or the Subscriber's Spouse or Domestic Partner;
      iv. A child for whom you or your Spouse or Domestic Partner have been granted legal custody (other than custody as a result of a guardianship); or
      v. A child for whom you or your Spouse or Domestic Partner have the legal obligation to provide coverage pursuant to a child support order or other court order or court-approved agreement or testamentary appointment.

An unmarried child who is covered as a Dependent when they reach the limiting age of 26 may be eligible for coverage as a disabled Dependent if they meet all of the following requirements:

1. They are incapable of self-sustaining employment because of a mental or physical incapacity that occurred prior to reaching the age limit for Dependents;
2. They must be chiefly dependent for support and maintenance from any Covered Person; and

SAMPLE

3. You provide us proof of their incapacity and dependency in accordance with the ***Disabled Dependent Certification*** requirements in the next provision.

Note: When there is a reference to the "limiting age of 26," this means that coverage will continue until the end of the Contract Year the Covered Person turns 26.

Disabled Dependent Certification

An unmarried child who is covered as a Dependent when they reach the limiting age of 26 may be eligible for coverage as a disabled Dependent as further described in this section. Proof of incapacity and dependency must be provided when requested by the Health Plan as follows:

1. If your Dependent is a Covered Person and reaches the limiting age of 26, we will send you a notice of his or her membership termination due to loss of eligibility under this Plan at least ninety (90) days before the date that coverage will end. Your Dependent's membership will terminate as described in our notice unless you provide us with documentation of his or her incapacity and dependency within sixty (60) days after your Dependent reaches the limiting age. Once proof of incapacity and dependency are received, we will make a determination as to whether he or she is eligible as a disabled Dependent. If you provide proof of incapacity and dependency to us:
    a. Prior to the termination date in the notice and we do not make an eligibility determination before the termination date, the Dependent's coverage will continue until we make a determination.
    b. Within the sixty (60) days following the Dependent reaching the limiting age and we determine that your Dependent is eligible as a disabled Dependent, then there will be no lapse in coverage.
2. If we determine that your Dependent does not meet the eligibility requirements as a disabled Dependent, we will notify you that he or she is not eligible and advise you of the child's membership termination date.
3. Beginning two (2) years after your Dependent reaches the limiting age you are required to provide us with proof of his or her continued incapacity and dependency annually. Proof must be received within sixty (60) days of our request. Once received, we will determine whether he or she remains eligible as a disabled Dependent. We reserve the right to request proof of your Dependent's incapacity and dependency less frequently than once per year; however, proof still must be received within sixty (60) days of our request.

SAMPLE

Rights and Responsibilities of Covered Persons: Our Commitment to Each Other

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

Rights of Covered Persons

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

1. **Receive information that empowers you to be involved in health care decision making. This includes the right to:**
    a. Actively participate in discussions and decisions regarding your health care options;

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

SAMPLE

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.

SAMPLE

Responsibilities of Covered Persons

As a Covered Person of Kaiser Permanente, you are responsible to:

1. **Promote your own good health:**
   a. Be active in your health care and engage in healthy habits;
   b. Select a Primary Care Plan Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics, or Family Practice as your Primary Care Plan Physician. You may also choose a personal OB/GYN in addition to Primary Care Plan Physician;
   c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you;
   d. Work with us to help you understand your health problems and develop mutually agreed upon treatment goals;
   e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment;
   f. Do your best to improve your health by following the treatment plan and instructions your Primary Care Plan Physician or health care professional recommends;
   g. Schedule the health care appointments your Primary Care Plan Physician or health care professional recommends;
   h. Keep scheduled appointments or cancel appointments with as much notice as possible; and
   i. Inform us if you no longer live within the Plan Service Area.

2. **Know and understand your Plan and benefits:**
   a. Read about your health care benefits in this contract and become familiar with them. Call us when you have questions or concerns;
   b. Pay your Plan Premium, and bring payment with you when your visit requires a Copayment, Coinsurance or Deductible;
   c. Let us know if you have any questions, concerns, problems or suggestions;
   d. Inform us if you have any other health insurance or prescription drug coverage; and
   e. Inform any network or nonparticipating provider from whom you receive care that you are enrolled in our Plan.

3. **Promote respect and safety for others:**

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

Health Savings Account-Qualified Plans

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

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

1. Individual Deductible of $1,650.00 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 Contract Year.

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

1. Covered by another health plan (for example, through your Spouse's or Domestic Partner's employer) that is not also an HSA-qualified plan, with certain exceptions;
2. Enrolled in Medicare; and/or
3. Able to be claimed as a Dependent on another person's tax return.

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

SAMPLE

Payment of Premium

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

Payment of Copayments, Coinsurance and Deductibles

In addition to your monthly Premium payment, you may also be required to pay a Cost Share when you receive certain covered Services. A Cost Share may consist of a Copayment, Coinsurance, Deductible or a combination of these. Copayments are due at the time you receive a Service. In the event that a Cost Share

amount is not collected at the point of service, then you will be billed for any Deductible and/or Coinsurance you owe.

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

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

The Health Plan will keep accurate records of each Covered Person's Cost Sharing and will notify the Covered Person in writing within thirty (30) days of when he or she has reached the Out-of-Pocket Maximum. Once you have paid the Out-of-Pocket Maximum for Services received within the Contract Year, no additional Copayments, Coinsurance or Deductibles will be charged by the Health Plan for the remainder of the Contract Year. We will promptly refund a Covered Person's Copayment, Coinsurance or Deductible if it was charged after the Out-of-Pocket Maximum was reached.

Open Enrollment

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

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

Enrollment Period and Effective Date of Coverage

Health Plan will establish an annual open enrollment period and will conduct enrollment activities such as informing you of the health plan coverage offered, eligibility requirements and enrollment activities. Health Plan will provide notice to Your Group and You about the annual open enrollment, which shall begin thirty (30) days prior to the expiration of the current Contract Year and shall end on the day before the first day of the next Contract Year. During such annual open enrollment period, You may enroll or discontinue enrollment in this health benefit plan or change Your enrollment to a different health benefit plan offered by Your Group.

SAMPLE

New Employees and Their Dependents

Employees who become eligible outside of the annual open enrollment period may enroll themselves and any eligible Dependents within thirty (30) days from the date that the employee first becomes eligible.

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

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

1. Become eligible for a special enrollment period, as described in this section; or
2. Did not enroll in any coverage through your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling at a later time. The effective date of an enrollment resulting from this provision is

no later than the 1st day of the month following the date your Group receives a Health Plan-approved enrollment or change of enrollment application from the Subscriber.

Special Enrollment Due to New Dependents

If you are covered as an existing Subscriber, you may add eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within thirty-one (31) days from the date that your Dependent becomes newly eligible. You may be required to pay additional Premium.

If you are otherwise eligible as a Subscriber, but you are not enrolled for coverage at the time you gain a newly-eligible Dependent, you may enroll:

1. Yourself by submitting a Health Plan-approved enrollment application to your Group within thirty-one (31) days after a Dependent becomes newly-eligible; or
2. Both yourself and any or all eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within thirty-one (31) days from the date that your Dependent becomes newly-eligible.

If you are not enrolled as a Subscriber at the time we receive a court order to add a newly-eligible Dependent child, we will enroll you and the child pursuant to the requirements and timeframes established by §15-405(c) of the Maryland Insurance Article. (Refer to the ***Special Enrollment for Child Due to Order*** provision below). The Spouse or Domestic Partner of an eligible Subscriber may enroll:

1. At the birth or adoption of a child;
2. Upon court order to add a child; or
3. Upon placement of a foster child, provided the Spouse or Domestic Partner is otherwise eligible for coverage.

Effective Date of Coverage

The membership effective date for a Subscriber or a Spouse or Domestic Partner, who enrolls at the time a Dependent becomes newly-eligible, will be the date the Dependent's coverage would become effective, as described below, regardless of whether or not the new Dependent is enrolled.

The membership effective date for adding a new Dependent will be:

1. For a new Spouse or Domestic Partner and any children who become eligible through a marriage, the Group shall notify you of the effective date of membership. It shall be no later than the 1st day of the 1st month following the date your Group receives the enrollment application.
2. For newborn children, the moment of birth.
3. For newly born or newly adopted children or grandchildren from the moment of birth or "date of adoption" of the child or grandchild. The "date of adoption" means the earlier of:
   a. A judicial decree of adoption; or
   b. The assumption of custody, pending the prospective adoptive parent's adoption of a prospective adoptive child.
4. For a newborn or child or grandchild, who are newly-eligible for coverage, the date they become a Dependent of the covered employee as the result of guardianship granted by court or testamentary appointment.

SAMPLE

5. For children who are newly-eligible for coverage as the result of a child support order or other court or administrative order received by you or your Spouse or Domestic Partner, the date of the court or administrative order.
6. For other children who are newly-eligible for coverage as the result of guardianship granted by court or testamentary appointment, the date of court or testamentary appointment.
7. For a newly-eligible foster child, coverage is effective the date of placement in foster care.

Coverage is automatic for thirty-one (31) days for a:

1. Newborn or newly-adopted child;
2. Grandchild; or
3. Minor for whom guardianship is newly granted by court or testamentary appointment, as described under items 4 and 6, above.

If no additional Premium is required, coverage will continue beyond the thirty-one (31)-day period. If additional Premium is required to provide coverage, the additional Premium is due within thirty-one (31) days. If the Health Plan does not receive the additional Premium within thirty-one (31) days, coverage will terminate on the 32nd day.

Special Enrollment Due to Pregnancy

You, or your Spouse or Dependent, may enroll for coverage if you become pregnant, as confirmed by a health care practitioner, or if your Spouse or Dependent becomes pregnant, as confirmed by a health care practitioner, provided your Spouse or Dependent is otherwise eligible for coverage. The coverage shall become effective on the first day of the month in which the individual receives confirmation of pregnancy. This special enrollment period shall be open for a period of 90 days and begin on the date a health care practitioner confirms the pregnancy.

SAMPLE

Special Enrollment for Child Due to Order

If a parent eligible for family coverage is required under an order to provide coverage for a child, then the child may be enrolled by the insuring parent regardless of enrollment period restrictions. If the insuring parent does not enroll the child, then the non-insuring parent, child support enforcement agency, or Maryland Department of Health may apply for enrollment on behalf of the child regardless of enrollment period restrictions. The child's coverage may not be terminated unless written evidence is provided to the Health Plan that the:

1. Order is no longer in effect;
2. Child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective termination date;
3. Employer has eliminated family member coverage for all of its employees; or
4. Employer no longer employs the insuring parent, except that if the parent elects to exercise the provisions of COBRA, coverage shall be provided for the child consistent with the employer's postemployment health insurance coverage for Dependents under COBRA.

Special Enrollment Due to Loss of Other Coverage

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

1. Yourself, as a new Subscriber, along with any of your eligible Dependents; or

2. Eligible Dependents, if you are already an existing Subscriber, as long as the:
   a. Enrolling person or at least one (1) of the Dependents had other coverage when you previously declined all coverage through your Group, and
   b. Loss of the other coverage is due to either:
      i. Exhaustion of coverage under COBRA continuation provision under Maryland law;
      ii. Loss of eligibility for non-COBRA coverage, or termination from an individual (non-group) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, reaching the age limit for Dependent children, death, termination of employment or reduction in hours of employment, or employer contributions towards the coverage were terminated.

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

To request enrollment, the Subscriber must submit a Health Plan-approved enrollment or change of enrollment application to your Group within thirty (30) days after loss of other coverage. The effective date of an enrollment resulting from loss of other coverage the 1st day of the following month when selection is made between the 1st and 15th day of any month; and the 1st day of the 2nd month when a selection is made between the 16th and last day of the month your Group receives an enrollment or change of enrollment application from the Subscriber.

SAMPLE

Special Enrollment Due to a Triggering Event

The Health Plan provides a special enrollment period of thirty (30) days from the date an individual experiences a triggering event. During the special enrollment period, the individual may enroll in this Health Plan or change from one plan to another plan offered by the Health Plan. You may also be able to change to another plan offered by Your Group.

A "triggering event" occurs when:

1. An eligible employee or Dependent:
   a. Loses Minimum Essential Coverage. The date of the loss of coverage is the last day the eligible employee or Dependent would have coverage under his or her previous plan or coverage;
   b. Loses pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) or loses access to health care services through coverage provided to a pregnant person's unborn child (based on the definition of child in 42 CFR 457.10). The date of the loss of coverage is the last day the eligible employee or Dependent would have pregnancy-related coverage, or access to health care services through the unborn child coverage; or,
   c. Loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per person per Contract Year. The date of the loss of coverage is the last day the eligible employee or Dependent would have medically needy coverage.

Note: Loss of Minimum Essential Coverage does not include loss of coverage due to a) voluntary termination of coverage; b) failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA; or c) a rescission authorized under 45 C.F.R. § 147.128.

2. An eligible employee or Dependent gains access to new Qualified Health Plans as a result of a permanent move, provided the eligible employee or Dependent 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 or more days during the 60 days preceding the move, or the employee or Dependent can demonstrate that (i) they lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the move, (ii) are an Indian as defined by §4 of the federal Indian Health Care Improvement Act, or (iii) lived for one or more days during the 60 days preceding the triggering event or during the most recent annual enrollment period (of the Group) or during a special enrollment period, in a Service Area where no Qualified Health Plan was available through the Exchange.
3. An eligible employee or Dependent, who is enrolled in a Qualified Health Plan on the SHOP Exchange, adequately demonstrates to the SHOP Exchange that the Qualified Health Plan in which an eligible employee or Dependent is enrolled substantially violated a material provision of the Qualified Health Plan's contract in relation to an eligible employee or Dependent.
4. An eligible employee or dependent:
   a. Loses eligibility for coverage under a Medicaid plan under Title XIX of the Social Security Act or a State Child Health Plan under Title XXI of the Social Security Act.
5. An eligible employee is a victim of domestic abuse or spousal abandonment, including a Dependent within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or is a Dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, and seeks to enroll in coverage at the same time as the victim.
6. An eligible employee or Dependent applies for coverage on the Individual Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event OR applies 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.

SAMPLE

An eligible employee or a Dependent who meets the requirements for a triggering event under #4, above shall have sixty (60) days from the triggering event to select a Qualified Health Plan.

Effective Date of Coverage Due to a Triggering Event

If an eligible employee or Dependent enrolls as the result of a triggering event, the effective date of coverage shall be:

1. In the case of loss of minimum essential coverage, loss of pregnancy related coverage, loss of medically needy coverage, loss of unborn child coverage, gaining access to new plans due to a permanent move, if the plan selection is made on or before the date of the triggering event, the 1st day of the month following the date of the triggering event and if plan selection is made after the date of the triggering event, the 1st day of the month after the individual selects a plan.

2. For all other triggering events, is the 1st day of the month after the individual selects a plan.

Enrollment Due to Reemployment After Military Service

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

Genetic Testing

We will not use, require or request a genetic test, the results of a genetic test, genetic information or genetic Services for the purpose of rejecting, limiting, canceling or refusing to renew a health insurance policy or contract. Additionally, genetic information or the request for such information will not be used to increase the rates or affect the terms or conditions of, or otherwise affect the coverage of a Covered Person.

We will not release identifiable genetic information or the results of a genetic test without prior written authorization from the Covered Person from whom the test results or genetic information was obtained to:

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

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

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

SAMPLE

SECTION 2: How to Get the Care You Need

Making and Cancelling Appointments and Who to Contact

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

Medical Emergencies

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

Medical Advice

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

Making or Canceling Appointments

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

You may also make or cancel an appointment with a Primary Care Plan Physician in one of our Plan Medical Centers by phone. To do so, please have your Kaiser Permanente identification card with you and contact us at 1-800-777-7904 or 711 (TTY). We are available to assist you 24/7.
If your Primary Care Plan Physician is in our Network of Plan Providers, but not located in a Plan Medical Center, please contact his/her office directly for assistance making or canceling an appointment. The telephone number for their office is located on your Kaiser Permanente identification card.

Choosing or Changing Your Primary Care Plan Physician

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

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

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

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. To reach Member Services, please call 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.

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:

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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 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).

Using 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 Covered Person 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.

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Your Medical Record Number is used to identify your medical records and status as a Covered Person. 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 status as a Covered Person.

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 Covered Person 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).

Primary Care Plan Physicians are located within our Plan Medical Centers or through our Network of Primary Care Plan Physicians located in our Service Area.

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 Covered Persons, 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, Covered Persons may choose a Plan Physician who practices in the specialty of obstetrics or gynecology (OB/GYN) as their personal OB/GYN.

Getting a Referral

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

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

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

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

If your Provider decides that you need covered Services from a Specialist, your Provider will request a referral for you. To check whether the referral is approved or denied, please call Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

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.

The Cost Shares for approved referral Services provided by a Non-Plan Provider are the same as those required for Services provided by a Plan Provider.

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

Services that Do Not Require a Referral

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

Except for Emergency Services, these Services include the following:

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 Health Access Unit may be reached at 1-866-530-8778;
2. OB/GYN Services provided by an OB/GYN, a certified nurse-midwife or any other Plan Provider authorized to provide OB/GYN Services, including 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-Participating Provider.

If a Covered Person 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 Covered Person 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 Covered Person 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 Covered Person 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.

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 Covered Person before the Health Plan will cover a prescription drug prescribed by a prescriber.

For a step therapy exception request submitted electronically in accordance with a process established under § 15-142(f) of the Maryland Insurance Article or a Prior Authorization request submitted electronically for pharmaceutical Services, a private review agent shall make a determination:

1. in real time if:

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    a. no additional information is needed by the private review agent to process the request; and
    b. the request meets the private review agent's criteria for approval; or
2. if a request is not approved in real time under item #1 immediately listed above, within one (1) working day after the private review agent receives all of the information necessary to make the determination.

If additional information is needed to make a determination after confirming through a complete review of the information already submitted by the Health Care Provider, the private review agent shall request the information promptly, but not later than three (3) calendar days after receipt of the initial request, by specifying:

1. the information, including any laboratory or diagnostic test or other medical information, that must be submitted to complete the request; and
2. the criteria and standards to support the need for the additional information.

If a private review agent fails to make a determination within the required time limits, the request shall be deemed approved.

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 Covered Person within the past 180 days; and
    b. Based on the professional judgement of the prescriber, was effective in treating the Covered Person's disease or medical condition; or
3. A prescription drug was approved by the FDA; and
    a. Is used to treat a Covered Person'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 Covered Person;
2. A pharmacy record that documents that a prescription has been filled and delivered to a Covered Person or a representative of a Covered Person; 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: Health Care Service Review, 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).

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Standing Referrals to Specialists

If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires Specialty Services, your Primary Care Plan Physician may determine, in consultation with you and a Specialist, that you need continuing care from that Specialist. The Specialist has expertise in treating the life-threatening, degenerative, chronic, or disabling disease or condition; and is part of the Health Plan's provider panel. 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 Covered Person may request a referral to a non-Plan Specialist or a Non-Physician Specialist if:

1. The Covered Person 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 referral to the non-Plan Specialist or Non-Physician Specialist in order for us to cover the Services. The Cost Shares for approved referral Services provided by Non-Plan Providers are the same as those required for Services provided by a Plan Provider. Services received for mental health or substance use disorders are provided at no greater cost to the Covered Person than if the covered benefit were provided by a provider on the Health Plan's provider panel.

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.

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 Covered Person who is a Continuing Care Patient at the time of termination or non-renewal on a timely basis of such termination and

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the Covered Person'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 Covered Person'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 Covered Person is no longer a Continuing Care Patient with respect to such provider or facility.

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

Continuity of Care for New Covered Persons

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

1. Accept a preauthorization issued by the Covered Person'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 Covered Person's enrollment under this Agreement.
3. Use the same cost-sharing for Services received from Non-Plan Providers as it would if the Service was received from a Plan Provider.

As described below, the Health Plan will accept the preauthorization and allow a new Covered Person 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*** 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

The 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 Covered Person'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

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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 Covered Person 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 Covered Person 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 preauthorization 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 Covered Person 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 Covered Person 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 may 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 Covered Person 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 for an opioid when the dosage for the approved prescription drug changes and the change is consistent with the FDA labeled dosages.

After receiving the consent of a Covered Person, or the Covered Person'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 Covered Person;
4. The Covered Person has been treated with the prescription drug without interruption since the initial approval of the Prior Authorization; and

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5. The prescriber attests that, based on their professional judgment, the prescription drug continue to be necessary to effectively treat the Covered Person'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 Covered Person and the Covered Person's Health Care Provider a thirty (30)-day notice prior to its removal or movement to a higher tier or Cost Share.

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 Covered Person to continue to receive covered health care Services being rendered by a Non-Plan Provider at the time of the Covered Person'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.

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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*** if you had received them from Plan Providers or Participating Emergency Facilities.

Emergency Services are available from Plan Hospital emergency departments twenty-four (24) hours per day, seven (7) days per week.

You will incur the same Cost Sharing (Deductible, Coinsurance and/or Copayment, as applicable) for Emergency Services furnished by non-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 Covered Person's Cost-Sharing as further described in this Agreement.

For emergency inpatient admissions, a private review agent may not render an Adverse Decision solely because the hospital did not notify the private review agent of the emergency admission within twenty-four (24) hours or other prescribed period time after that admission if the Covered Person's medical condition prevented the hospital from determining:

1. The Covered Person's insurance status; and
2. If applicable, the private review agent's emergency admission notification requirements.

The private review agent may not render an Adverse Decision as to an admission of a patient during the first twenty-four (24) hours after admission when:

1. The admission is based on a determination that the patient is in imminent danger to self or others;
2. The determination has been made by the Covered Person's physician or psychologist in conjunction with a member of the medical staff of the facility who has privileges to make the admission; and
3. The hospital immediately notifies the private review agent of:
    a. The admission of the Covered Person; and
    b. The reasons for the admission.

The private review agent may not render an Adverse Decision as to an admission of a patient to a hospital for up to seventy-two (72) hours, as determined to be Medically Necessary by the Covered Person's treating physician, when:

1. the admission is an involuntary admission under §§10–615 and §§10–617(a) of the Health – General Article; and
2. the hospital immediately notifies the private review agent of:
    a. the admission of the Covered Person; and
    b. the reasons for the admission.

Except as provided in the three paragraphs immediately listed above, the private review agent shall make initial determinations on whether to authorize or certify an emergency course of treatment of health care Service for a Covered Person within twenty-four (24) hours after the initial request after receipt of the information necessary to make the determination.

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The private review agent shall initiate the expedited procedure for an emergency case if the Covered Person or the Covered Person's Authorized Representative requests or if the Health Care Provider attests that the Services are necessary to treat a condition or illness that, without immediate medical attention, would:

1. seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum functions;
2. cause the Covered Person to be in danger to self or others; or
3. cause the Covered Person to continue using intoxicating substances in an imminently dangerous manner.

If the private review agent determines that additional information is needed after confirming through a complete review of the information already submitted by the Health Care Provider, the private review agent shall:

1. promptly request the specific information needed, including any laboratory or diagnostic test or other medical information; and
2. promptly, but not later than two (2) hours after receipt of the information, notify the Health Care Provider of an authorizations or certification determination when made by the private review agent.

Bills for Emergency Services

When you receive a bill from a hospital, physician or ancillary provider for Emergency Services that were provided to you, you should either:

1. Contact the hospital, physician or other provider to inform them that the bill should be sent to us at the address or website listed below; or
2. Simply mail or submit online the bill to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. You do not have to pay the bill until we determine what amount you owe, if any, for the Emergency Services. A bill from either the provider or you can be mailed or submitted online to us at:

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

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

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***, which is located at the beginning of this section.

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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.

A private review agent that requires a Health Care Provider to submit a treatment plan in order for the private review agent to conduct utilization review of proposed or delivered Services for the treatment of a mental illness, emotional disorder, or a substance abuse disorder:

1. shall accept:
    a. the uniform treatment plan form adopted by the Commissioner as a properly submitted treatment plan form; or
    b. if a Service was provided in another state, a treatment plan form mandated by the state in which the Service was provided; and
2. may not impose any requirement to:
    a. modify the uniform treatment plan form or its content; or
    b. submit additional treatment plan forms.

A uniform treatment plan form shall be properly completed by the Health Care Provider and may be submitted by electronic transfer.

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 Covered Person'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

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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 Deductibles shown in the "Summary of Cost Shares," and the exclusions, limitations and reductions described in this EOC.

For more information about receiving care in other Kaiser Foundation Health Plan service areas, including availability of Services, and provider and facility locations, please call our Away from Home Travel Line at 1-951-268-3900. Information is also available online at kp.org/travel.

Payment Toward Your Cost Share and When You May Be Billed

This provision does not apply to Covered Persons enrolled in a High Deductible Health Plan. 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.

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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 Covered Person prior to our payment of non-preventive or diagnostic Services.

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SECTION 3: Benefits, Exclusions and Limitations

Your Benefits

The benefits described in this section are covered only when:

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

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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.

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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

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 Ambulance Services when it is Medically Necessary to be transported in an ambulance to or from the nearest Hospital where needed medical Services can be appropriately provided.

Coverage is provided for Air Ambulance Services, as defined in the section ***Important Terms You Should Know***, when Services are received from a non-Participating Provider of Air Ambulance Services:

1. The copayment amount, coinsurance percentage, and/or other cost-sharing requirement for the Air Ambulance Service is the same as the copayment amount, coinsurance percentage, and/or other cost-

sharing requirement listed in the EOC for Air Ambulance Services when provided by a Participating Provider of ambulance services;

2. Any cost-sharing requirement will be calculated based on the lesser of the Qualifying Payment Amount or the billed amount for the services;
3. Any cost-sharing payments made with respect to the Air Ambulance Service will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;
4. Health plan 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; and
5. Covered person will not be liable for an amount that exceeds the Covered Person's cost-sharing requirement.

Anesthesia for Dental Services

We cover general anesthesia and associated hospital or ambulatory facility Services for dental care provided to Covered Persons who are age:

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 that dental Services be performed in a hospital or ambulatory surgical center for the safety of the Covered Person (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.

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

Benefit-Specific Limitation(s):
A Qualified Individual means an individual:

1. Who is estrogen deficient and at clinical risk for osteoporosis;

SAMPLE

2. With a specific sign suggestive of spinal osteoporosis, including roentgeno-graphic osteopenia or roentgenographic evidence suggestive of collapse, wedging or ballooning of one (1) or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
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.

Benefit-Specific Exclusion(s):
We do not cover bone mass measurement for Covered Persons who do not meet the criteria of a Qualified Individual, as specified under the benefit-specific limitation(s).

Chiropractic Services

Coverage is provided for a limited number of chiropractic visits per condition per Contract 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 Contract 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 treatments that are:
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,
    b. The Food and Drug Administration,
    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 (1) 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 (1) of the following requirements:

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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. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
   vii. 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 though 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.
   viii. An institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the National Institution of Health (NIH).

4. 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.
5. There is no clearly superior, non-investigational treatment alternative.
6. 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 Covered Person 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.

SAMPLE

Diabetes 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;
4. Continuous glucose monitor; and
5. Self-management training for diabetes.

Pursuant to IRS Notice 2019-45, coverage for glucometers and diabetic test strips for individuals diagnosed with diabetes is not subject to the Deductible. Refer to the ***Summary of Cost Shares*** appendix for Cost Sharing requirements.

Note: Insulin pumps and continuous glucose monitor 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).

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

Drugs, Supplies and Supplements

SAMPLE

We cover drugs, supplies and supplements during a covered stay in a Plan Hospital, Skilled Nursing Facility and outpatient settings, or 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:

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 Covered Persons 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 Covered Person's cost will not exceed $30 for a 30-day supply, regardless of the amount or type of insulin needed to fill the covered individual's prescription, 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 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.

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

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

Benefit-Specific Exclusion(s):

1. Drugs 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 not related to organic disease.

Durable Medical Equipment (DME), Prosthetic and Orthotic Devices

SAMPLE

Coverage for Durable Medical Equipment, Prosthetics and Orthotics 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 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 Covered Person.

Coverage is provided once per Contract 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 Covered Person;
      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.

Note: Durable medical equipment related to an Emergency Medical Condition or Urgent Care Services episode (refer to "Post-Stabilization Care" and "Outside of our Service Area").

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

SAMPLE

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 or refers or otherwise allows the Covered Person to 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.

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

Non-Emergency Services Performed by Non-Participating Providers at Participating Facilities, including Ancillary Services and Services for Unforeseen Urgent Medical Needs

We cover items and services furnished by a non-Participating Provider with respect to a covered Visit at a Participating Facility in the following manner, except when the non-Participating Provider has satisfied the notice and consent criteria of 45 C.F.R. § 149.420(c) through (i):

1. The copayment amount, coinsurance percentage, and/or other cost-sharing requirement for such items and services furnished by a non-Participating Provider with respect to a Visit in a Participating Facility is the same as the copayment amount, coinsurance percentage, and/or other cost-sharing requirement listed in the EOC for the items and services when provided by a Participating Provider;
2. Any cost-sharing requirement for the items and services will be calculated based on the Recognized Amount;
3. Any cost-sharing payments made with respect to the items and services will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;
4. Health plan 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; and
5. Covered Person will not be liable for an amount that exceeds the Covered Person's cost-sharing requirements.

Items #1-5 above are not applicable when the non-Participating Provider has satisfied the notice and consent criteria of 45 C.F.R. § 149.420(c) through (i), including providing notice to the Covered Person of the estimated charges for the items and Services and that the provider is a non-Participating Provider, and obtaining consent from the

SAMPLE

Covered Person to be treated and balance billed by the non-Participating Provider. The notice and consent criteria of 45 C.F.R. § 149.420(c) through (i) do not apply to non-Participating Providers with respect to:

1. Covered services rendered by a health care provider for which payment is required under § 19-710.1 of the Health-General Article;
2. Ancillary Services; and
3. 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.

Such items and services furnished by non-Participating Providers will always be subject to the above five (5) provisions.

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 Hospital 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. Additionally, we will not require Prior Authorization for such Post-Stabilization Care at a non-Participating Facility when you, or your Authorized Representative, are not in a condition to receive notice of nor provide informed consent to be treated by a non-Participating Provider.

SAMPLE

Non-Participating Providers may provide notice and seek your consent to provide Post-Stabilization Care Services or other covered Services as stated in the notice and consent criteria of 45 C.F.R. § 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 the 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.

SAMPLE

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

SAMPLE

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 treatment to help keep, learn or improve skills and functioning for daily living. Habilitative Services will include 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 limitation(s) and exclusion(s) immediately below for additional information.

Benefit-Specific Limitation(s):

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

Benefit-Specific Exclusion(s):
We do not cover habilitative Services delivered through early intervention and school services.

Hearing Services

Hearing Test
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.

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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 Covered Persons 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 Covered Person '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

Coverage is provided for Hospice Care Services.

Infertility Services

Coverage is provided for Medically Necessary infertility Services, including:

1. Services for diagnosis and treatment of involuntary infertility for females and males. Involuntary infertility may be demonstrated by a history of:
   a. Intercourse of at least a two (2) year duration that fails to result in a successful pregnancy, for spouses of the opposite sex only; or
   b. Six (6) attempts of artificial insemination over the course of two (2) years that fails to result in a successful pregnancy, for spouses of the same sex only; or
   c. Infertility that is associated with any of the following medical conditions:
      i. Endometriosis;
      ii. Exposure in utero to diethylstilbestrol, commonly known as DES;

iii. Blockage of, or surgical removal of, one (1) or both fallopian tubes (lateral or bilateral salpingectomy); or
iv. Abnormal male factors, including oligospermia, contributing to the infertility.

2. Diagnostic procedures and any covered drugs administered by or under the direct supervision of a Plan Provider. Refer to the Outpatient Prescription Drug Benefit Appendix, if applicable, for coverage of outpatient infertility drugs;
3. Artificial insemination; Intracytoplasmic Sperm Injection if the Covered Person meets medical guidelines; and Preimplantation Genetic Diagnosis if the Covered Person meets medical guidelines.

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

Benefit-Specific Exclusions:

1. In vitro fertilization (IVF), ovum transplants and gamete intrafallopian tube transfer (GIFT), zygote intrafallopian transfer (ZIFT), or cryogenic or other preservation techniques used in these or similar procedure;
2. Prescription drugs related to the treatments listed above in item #1;
3. To reverse voluntary, surgically induced infertility.

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*** 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 Covered Person's

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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***, the Deductible must be met first. For all insulin, the Covered Person's cost will not exceed $30 for a 30-day supply, regardless of the amount or type of insulin needed to fill the covered individual's prescription, in accordance with §15-822.1 of the Insurance Article. Insulin is not subject to the Deductible.

Inpatient Hospital Services

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 Patient Protection and Affordable Care Act are covered under preventive care Services at no charge. For HSA/HDHP Plans, only those specified maternity Services identified by the Patient Protection and Affordable Care Act ("PPACA") 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

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office visits and ancillary Services provided during those visits such as Medically Necessary laboratory tests and diagnostic Services.

Medical Food

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, 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 Covered Persons 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:

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   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 at a facility approved by the Health Plan, 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 Covered Person'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 Treatment

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.

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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

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.

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Outpatient Hospital

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 Care Services

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

Coverage is provided for preventive care Services, including:

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 Covered Persons annually. Written feedback provided to Covered Persons 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; and
9. Medically Necessary digital tomosynthesis, commonly referred to as three-dimensional "3-D" mammography;
10. Prostate specific cancer screening. Medically recognized diagnostic examinations including prostate-specific antigen (PSA) tests and digital rectal exams:
    i. For men who are between forty (40) and seventy-five (75) years of age;
    ii. When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;
    iii. When used for staging in determining the need for a bone scan for patients with prostate cancer; or,
    iv. When used for male Covered Persons who are at high risk for prostate cancer.

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

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

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*** benefits 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

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in this ***List of Benefits***.

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 Contract Year that begins on the date that is one (1) year after the date of the recommendation or guideline is issued.

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.

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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.

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Routine Foot Care

Coverage is provided for Medically Necessary routine foot care.

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

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 Contract Year.

Telemedicine Services

We cover interactive telemedicine services.

Telemedicine means the delivery of Health Care Services through the use of audio-only telephone conversation and interactive audio, video or other telecommunications or electronic media 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

Coverage is provided for therapy and rehabilitation Services, including:

1. Unlimited Medically Necessary Hospital inpatient rehabilitative Services;
2. Outpatient rehabilitative Services. Covered Persons 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 Covered Persons 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 Contract Year of physical therapy, speech therapy and occupational therapy for Cardiac Rehabilitation.
4. Pulmonary rehabilitation for Covered Persons diagnosed with significant pulmonary disease.

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

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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.

Benefit-Specific Exclusion(s):
We do not cover maintenance programs for cardiac and pulmonary rehabilitation. Maintenance programs for cardiac and pulmonary rehabilitation 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.

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 eighteen (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 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 charges for Urgent Care Services as shown in ***Summary of Cost Shares*** appendix. All follow-up care must be provided by a Plan Provider

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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 Covered Person 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 limitation(s) and exclusion(s) immediately below for additional information.

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.

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

Vision Services

Coverage is provided for Vision Services for:

1. Pediatric Covered Persons, up until the end of the month they turn age nineteen (19), who may receive:
   a. One (1) routine eye examination each Contract Year, including dilation if professionally indicated; and
   b. One (1) pair of prescription eyeglass lenses and one (1) frame each Contract 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 Contract Year or multiple pairs of disposable prescription contact lenses from a select group per Contract Year; or
      ii. Two (2) pair per eye for Medically Necessary contact lenses per Contract 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.

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  b. Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.
2. Adult Covered Persons age nineteen (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 Covered Person meets medical guidelines;
4. Sleep laboratory and sleep studies; and
5. Specialty imaging, including computerized tomography (CT), magnetic resonance imaging, (MRI), positron emission tomography (PET) scans, diagnostic Nuclear Medicine studies and interventional radiology.
6. Biomarker testing for the purpose of 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 Covered Person'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.

Benefits for biomarker testing are available to the same extent as benefits provided for other similar Services.

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

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

The following services are excluded from coverage:

1. 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 Covered Person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.

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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 Covered Person'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 Covered Person.
13. Services incurred after a Covered Person's termination of coverage, except as provided in ***Section 6: Extension of Benefits***.
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 Covered Person's job to the extent the Covered Person 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; and
    b. Air travel in connection with a covered transplant for the recipient and a companion or two companions if recipient is under age 18, to and from the site of a covered organ transplant.
22. Except for Emergency Services and Urgent Care Service, services received while the Covered Person 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 Kids SG Embedded Dental EPO Plan Appendix, Kaiser Permanente Smile Kids SG Embedded Dental PPO Plan Appendix, Kaiser Permanente Smile SG Dental EPO Adult Dental Plan Rider, Kaiser Permanente Smile SG Dental POS Adult Dental Plan Rider, or Kaiser Permanente Smile SG Dental PPO Adult Dental Plan Rider; as applicable***: Dental work or treatment which includes Hospital or professional care in connection with:
    a. The operation or treatment for the fitting or wearing of dentures;

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    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 Kids SG Embedded Dental EPO Plan Appendix, Kaiser Permanente Smile Kids SG Embedded Dental PPO Plan Appendix, Kaiser Permanente Smile SG Dental EPO Adult Dental Plan Rider, Kaiser Permanente Smile SG Dental POS Adult Dental Plan Rider, or Kaiser Permanente Smile SG Dental PPO Adult Dental Plan Rider, as applicable***: 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. Services to reverse voluntary, surgically induced infertility.
29. Treatment of sexual dysfunction not related to organic disease.
30. Services that duplicate benefits provided under federal, state or local laws, regulations or programs.
31. Non-human organs and their implantation.
32. Non-replacement fees for blood and blood products.
33. Lifestyle improvements or physical fitness programs, unless included in ***List of Benefits*** in this section.
34. Wigs or cranial prosthesis, except for one (1) Medically Necessary hair prosthesis as noted above in the ***List of Benefits*** in this section.
35. Weekend admission charges, except for emergencies and maternity, unless authorized by the Health Plan.
36. Outpatient orthomolecular therapy, including nutrients, vitamins and food supplements.
37. 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.
38. Services for conditions that State or local laws, regulations, ordinances or similar provisions require to be provided in a public institution.
39. Services for, or related to, the removal of an organ from a Covered Person 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.
40. Physical examinations required for obtaining or continuing employment, insurance or government licensing.
41. Non-medical ancillary Services such as vocational rehabilitation, employment counseling or educational therapy.
42. A private Hospital room unless Medically Necessary and authorized by the Health Plan.
43. Private duty nursing, unless authorized by the Health Plan.
44. 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.
45. Worker's Compensation or Employer Liability: Services for injuries or diseases related to a Covered Person's job to the extent the Covered Person is required to be covered by a workers' compensation law.

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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 Covered Person in procuring the Services through other providers, to the extent prescribed by the Commissioner of Insurance.

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

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SECTION 4: Subrogation, Reductions and Coordination of Benefits

There may be occasions when we will seek reimbursement of the Health Plan's costs of providing care to you, or your benefits are reduced as the result of the existence 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.

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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 Covered Person 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, Maryland 20785

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

If you are represented by an attorney in relation to the loss for which you have brought legal action against a third party, please ensure that 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 Covered Person that are applicable to the portion of the settlement returned to the Health Plan.

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Medicare

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

Workers' Compensation or Employer's Liability

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

The Recovery Rights will be applied even though:

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

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

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

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

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

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

Health Plan Not Liable for Illness or Injury to Others

Who is eligible for coverage under this Agreement is stated in ***Section 1: Introduction to Your Kaiser Permanente Health Plan***. Neither the Health Plan, Plan Hospitals nor the Medical Group provide benefits

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or health care Services to others due to your liabilities. If you are responsible for illness or injury caused to another person, coverage will not be provided under this Agreement unless they are a Covered Person.

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 Covered Person 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 Covered Person who received the settlement as compensation.

No Covered Person, 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 Covered Person 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 Covered Person 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 Covered Persons 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 Covered Person 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

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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.

Covered Persons 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

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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, Covered Person, 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: ***Dependent Child with Parents Who Are Not Separated or Divorced***, shall determine the order of benefits; or
   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph #1: ***Dependent Child with Parents Who Are Not Separated or Divorced***, shall determine the order of benefits; or
      i. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         a) The plan covering the custodial parent;
         b) The plan covering the custodial parent's spouse;
         c) The plan covering the non-custodial parent; and then

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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 Covered Person or Parent/Guardian, when applicable, the Health Plan will

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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 Covered Person, 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.

Covered Persons with a High Deductible Health Plan with a Health Savings Account option who receive health benefits from the Department of Veterans Affairs: If a Covered Person 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.

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SECTION 5: Health Care Service Review, 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;
9. Emergency Case;
10. Filing Date;
11. Grievance;
12. Grievance Decision;
13. Health Care Provider;
14. Health Care Service;
15. Health Education and Advocacy Unit;
16. Notice of Appeal Decision;
17. Notice of Coverage Decision; and
18. Urgent Medical Condition.

Questions About Health Care Service Review, Appeals or Grievances

If you have questions about our Health Care Service Review Program or how to file an 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).

The Health Care Service Review Program

Pre-Service Reviews

If you do not have an Emergency Case and you have not received the health care Service or course of treatment you are requesting, including pharmaceutical Services not submitted electronically, then within two (2) working days of receiving all necessary information, the Health Plan will promptly notify the Health Care Provider of the determination. If we do not have the necessary information to make our decision, we will notify you or your Authorized Representative and your Health Care Provider within three (3) calendar days of the initial request and explain in detail what information is required. Once the necessary information has been received, the Health Plan will make its determination within two (2) working days. Necessary information includes, but is not limited to, the results of any face-to-face clinical evaluation or any second opinion that may be required. We must receive the information requested by the notice, within forty-five (45) calendar days from the receipt of the notice identifying the additional necessary information, or we will make our decision based upon the information we have available to us at that time.

After receipt of the initial request for health care Services and confirming through a complete review of information already submitted by the Health Care Provider, if the private review agent determines that the private review agent does not have sufficient information to make a determination, the private review agent shall promptly, but not later than three (3) calendar days after receipt of the initial request, inform the Health Care Provider that additional information must be provided by specifying:

i. the information, including any lab or diagnostic test or other medical information, that must be submitted to complete the request; and
ii. the criteria and standards to support the need for additional information.

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If a private review agent fails to make a determination within the required time limits listed above, the request shall be deemed approved.

If an admission, procedure or Service is preauthorized, the Health Plan will:

1. Notify the provider promptly by telephone as soon as the decision is made; and
2. Confirm the pre-authorization with you and the provider in writing within five (5) working days of our decision.

If pre-authorization is denied or an alternate treatment or Service is recommended, the Health Plan will:

1. Notify the provider promptly by telephone as soon as the decision is made; and
2. Confirm the denial decision with you and your Authorized Representative and a Health Care Provider acting on behalf of the member in writing within five (5) working days of making our decision.

You or your Authorized Representative may then file an Appeal or Grievance, as appropriate, and as described below.

If pre-authorization is required for an emergency inpatient admission, or an admission for residential crisis services as defined in §15-840 of the Maryland Insurance Article, for the treatment of a mental, emotional, or substance abuse disorder, the Health Plan shall:

1. Make all determinations on whether to authorize or certify an inpatient admission, or an admission for residential crisis services as defined in §15-840 of the Maryland Insurance Article, within two (2) hours after receipt of the information necessary to make the determination; and
2. Promptly notify the Health Care Provider of the determination.

If additional information is needed, a private review agent will promptly request the specific information needed, including any laboratory or diagnostic test or other medical information.

If a private review agent fails to make a determination within the required time limits listed above, the request shall be deemed approved.

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<u>Expedited Pre-Service Reviews</u>

If you have an Emergency Case and you have not received the health care Service for which you are requesting review, we will notify your Health Care Provider if we need additional information to make a decision. If additional information is requested, your Health Care Provider will have only forty-eight (48) hours to submit the requested information. We will make a decision for this type of claim within forty-eight (48) hours following the earlier of the:

1. Receipt of the information from you; or
2. End of the period for submitting the requested information.

Decisions regarding pre-service review for Covered Persons who have an Emergency Case will be communicated to you, your Authorized Representative, and the Health Care Provider by telephone within twenty-four (24) hours of the request. Such decisions will be confirmed in writing to you, your Authorized Representative, and the Health Care Provider acting on behalf of the Covered Person within one (1) calendar day after a decision has been orally communicated to you, your Authorized Representative, or the Health Care Provider.

If an initial determination is made to not to authorize or certify a health care Service and the Health Care Provider believes the determination warrants an immediate reconsideration, we will provide the opportunity to the Health Care Provider to speak with the physician that rendered the determination, by telephone on an expedited basis, within a period of time not to exceed twenty-four (24) hours of the Health Care Provider seeking the reconsideration. If the physician is unable to immediately speak with the Health Care Provider seeking the reconsideration, the physician shall provide the Health Care Provider with the following contact information for the Health Care Provider to use to contact the physician:

1. a direct telephone number that is not the general customer call number; or
2. a monitored e-mail address that is dedicated to communication related to utilization review.

Concurrent Reviews

When you make a request for additional treatment, Visits, or days of care, when we had previously approved a course of treatment or treatment plan that is about to end, the Health Plan will make concurrent review determinations within one (1) working day of receiving the request or within one (1) working day of obtaining all the necessary information. In the event that our review results in the end or limitation of health care Services, we will make a determination within one (1) working day after receipt of the information necessary to make the determination so that you can file a timely Grievance or Appeal of our decision. If you have an Emergency Case, then a request for concurrent review will be handled like any other pre-service request for review when an Emergency Case is involved, except that our decision will be made within twenty-four (24) hours of the request. Health Plan will promptly notify the Health Care Provider of the determination.

After receipt of the initial request for health care Services and confirming through a complete review of information already submitted by the Health Care Provider, if the private review agent determines that the private review agent does not have sufficient information to make a determination, the private review agent shall promptly, but not later than three (3) calendar days after receipt of the initial request, inform the Health Care Provider that additional information must be provided by specifying:

i. the information, including any lab or diagnostic test or other medical information, that must be submitted to complete the request; and
ii. the criteria and standards to support the need for additional information.

If a private review agent fails to make a determination within the required time limits listed above, the request shall be deemed approved.

If Health Plan authorizes or certifies an extended stay or additional health care Services under the concurrent review, the Health Plan will:

1. Promptly notify the Health Care Provider of the determination;
2. Notify the provider by telephone within one (1) working day after receipt of the information necessary to make the determination; and
3. Confirm the authorization in writing with you or your Authorized Representative within five (5) working days after the decision was made. The written notification will include the number of extended days or next review date, or the new total number of health care Services approved.

If the request for extended stay or additional health care Services is denied, the Health Plan will:

1. Notify the provider and/or you or your Authorized Representative of the denial by telephone within

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one (1) working day after receipt of the information necessary to make the determination; and

2. Confirm the denial in writing with you or your Authorized Representative and/or the provider within five (5) working days of the denial. Coverage will continue for health care Services until you or your Authorized Representative and the provider rendering the health care Service have been notified of the denial decision in writing.

After receipt of the initial request for health care Services and confirming through a complete review of information already submitted by the Health Care Provider, if the private review agent determines that the private review agent does not have sufficient information to make a determination, the private review agent shall promptly, but not later than three (3) calendar days after receipt of the initial request, inform the Health Care Provider that additional information must be provided by specifying:

i. the information, including any lab or diagnostic test or other medical information, that must be submitted to complete the request; and
ii. the criteria and standards to support the need for additional information.

If a private review agent fails to make a determination within the required time limits listed above, the request shall be deemed approved.

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

<u>**Post-Service Claim Reviews**</u>

The Health Plan will make its determination on post-service review within thirty (30) days of receiving a claim. If Health Plan approves the claim, benefits payable under your contract will be paid within thirty (30) days of receiving the receipt of written proof of loss. If we determine we cannot reimburse the claim because of the:

1. Legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary; or
2. Claim is not clean and, therefore, we need more information to process the claim.

We will notify you of the extension within the initial thirty (30)-day period. Our notice will explain the circumstances requiring the extension and the date upon which we expect to render a decision. If such an extension is necessary because we need information from you, then our notice of extension will specifically describe the required information which you need to submit. You must respond to requests for additional information within forty-five (45) calendar days or we will make our decision based upon the information we have available to us at that time.

We will send a notice to you or your Authorized Representative explaining that:

1. The claim was paid; or

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2. The claim is being denied in whole or in part; or
3. Additional information is needed to determine if all or part of the claim will be reimbursed and what specific information must be submitted; or
4. The claim is incomplete and/or unclean and what information is needed to make the claim complete and/or clean.

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

Notice of Claim

We do not require a written notice of claim. Additionally, Covered Persons 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 a 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 request 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 Covered Person'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 below.

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

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

1. Covered Person's Name;
2. Medical Record Number (MRN);
3. The date the Covered Person received the Services;
4. Where the Covered Person received the Services;
5. Who provided the Services;
6. Reason you believe we should pay for the Services; and
7. A copy of the bill, the Covered Person's medical record(s) for the Services, and the receipt, if you paid for the Services.

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

Each Covered Person claiming reimbursement under this contract 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.

The Health Care Provider has a minimum of one-hundred and eighty (180) days from the date a covered Service is rendered to submit a claim for reimbursement for the Service.

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

The Health Education and Advocacy Unit is available to assist your or your Authorized Representative:

1. 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 or your Authorized Representative during any associated proceedings; and
   a. In mediating a resolution of the Adverse Decision or Coverage Decision with the Health Plan.You or your Authorized Representative may file an Appeal or Grievance; and
   b. 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:
      i. The Health Plan waives the requirement that our internal grievance process must be exhausted before filing a Complaint with the Commissioner;
      ii. 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
      iii. 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
   c. In the case of a Coverage Decision, 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 if the Coverage Decision involves an Urgent Medical Condition for which the health care Service has not yet been rendered.

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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: 410-528-1840
Toll-free: 877-261-8807
Fax: 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 or your Authorized Representative, and your Health Care Provider provides sufficient information or 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 Covered Person remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Covered Person to be a danger to him/herself or others; or the Covered Person continuing to experience severe withdrawal symptoms. A Covered Person is considered to be in danger to self or others if the Covered Person is unable to function in activities or daily living or care 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: 410-468-2000
Toll free/out-of-area: 1-800-492-6116

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TTY: 1-800-735-2258
Fax: 410-468-2260 or 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 file 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. All supporting documentation that relates to the Grievance should be mailed to:

Kaiser Permanente
Attention: Member Relations
Nine Piedmont Center
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

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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 the earlier of 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 requested by

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calling Member Services at 1-800-777-7902 or 711 (TTY).

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 the Covered Person or the Covered Person's representative requests the expedited review or the Health Care Provider or the Covered Person or the Covered Person's representative 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 Covered Person 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

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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) day after a decision has been orally communicated or by text, facsimile, e-mail, an online portal, or other expedited means for expedited Grievances, 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 used by the Health Plan, 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 and your Authorized Representative 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 Covered Person'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 and associate 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, Maryland 20785
   Phone: 301-816-6482

   The business telephone number will be a dedicated number for Grievance Decisions and will not be the Health Plan's general customer call number.

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.

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<u>**Notice of Adverse Decision**</u>

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. Provides 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, Maryland 20785
   Phone: 1-800-810-4766

   The business telephone number will be a dedicated number for Adverse Decisions and will not be the Health Plan’s general customer call number. 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;

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8. Commissioner's address, telephone number, and facsimile number;
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 include:

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 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 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.

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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 Permanente
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305-1736
Fax: 1-404-949-5001

You or your Authorized Representative may also request 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 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 Covered Person 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, 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 30 calendar days after the decision has been made. This notification will

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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: 410-468-2000
Toll-free/out-of-area: 1-800-492-6116
TTY: 1-800-735-2258
Fax: 410-468-2260 or 410-468-2270

SAMPLE

SECTION 6: Termination of Membership

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

If a Subscriber's membership ends, both the Subscriber's and any applicable Dependents memberships will end at the same time. We will inform you of the date your coverage terminates and the reason for the termination. This termination notice will be provided at least thirty (30) days before the termination date. If your membership terminates, all rights to benefits end at 11:59 p.m. Eastern Time (the time at the location of the administrative office of Health Plan at 4000 Garden City Drive, Hyattsville, Maryland 20785) on the termination date. The Health Plan and Plan Providers have no further responsibility under this contract after a membership terminates, except as provided under ***Extension of Benefits*** in this section.

Termination

Termination of Your Group Agreement

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

Termination Due to Loss of Eligibility

Your membership will terminate if you no longer meet the conditions under which you became eligible to be enrolled, as described in ***Eligibility for This Plan*** in ***Section 1: Introduction to Your Kaiser Permanente Health Plan***.

If you are eligible on the 1st day of a month, but later in that month you no longer meet those eligibility requirements, your membership terminates on the last day of that month unless your Group has an arrangement with us to terminate at a time other than the last day of the month. Please check with the Group's benefits administrator to confirm your termination date.

Termination Due to Change of Residence

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

Termination for Cause

By sending written notice to the Subscriber at least thirty (30) days before the termination date, we may terminate the Subscriber or any Dependent's membership for cause if you or your Dependent(s):

1. Knowingly perform an act, practice or omission that constitutes fraud, which under certain circumstances may include, but is not limited to, presenting a fraudulent prescription or physician order, selling your prescription or allowing someone else to obtain Services using your Kaiser Permanente identification card; or
2. Make an intentional misrepresentation of material fact.

SAMPLE

Additionally, if the fraud or intentional misrepresentation was committed by:

1. The Subscriber, we may terminate the memberships of the Subscriber and all Dependents in the Family Unit.
2. A Dependent, we may terminate the membership of only that Dependent.

We may report fraud committed by any Covered Person to the appropriate authorities for prosecution.

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

Extension of Benefits

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

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

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

1. Failure to pay Premium by the Covered Person;
2. Covered Persons whose coverage ends because of fraud or material misrepresentation by the Covered Person;
3. When coverage is provided by a succeeding health plan and that health plan's coverage:
   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 EOC; and

SAMPLE

b. Will not result in an interruption of benefits to the Covered Person.

Discontinuation of a Product or All Products

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

Continuation of Group Coverage Under Federal Law

COBRA

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

USERRA

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. Covered Persons are not ineligible for USERRA continuation coverage solely because they move or live outside our Service Area. For Covered Persons who serve in the military, you must submit a USERRA election form to your Group within sixty (60) days following your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

Continuation of Coverage Under State Law

Death of the Subscriber

Upon the Subscriber's death, the spouse of the Subscriber and any Dependent children of the Subscriber (including any of the Subscriber's children born after the Subscriber's death), may continue uninterrupted coverage hereunder, upon arrangement with the Group in compliance with applicable Maryland law.

The election period for such coverage provided under Maryland law shall begin with the date on which there has been an applicable change in status and end no sooner than forty-five (45) days after such date.

Group coverage under this section continues for those Dependents who are eligible for state continuation coverage, only upon payment of applicable monthly charges, which may include an allowable reasonable administrative fee, not to exceed two percent of the entire cost to the employer, to your Group's Premium charge at the time specified by Group, and terminates on the earliest of:

1. Termination of this Agreement;
2. Eligibility of the Covered Person for hospital, medical or surgical benefits under an insured or self-insured group health benefit program or plan, other than the group contract, that is written on an expense-incurred basis or is with a health maintenance organization;
3. Entitlement of the Covered Person to benefits under Title XVIII of the Social Security Act;
4. Acceptance by the Covered Person of any hospital, medical or surgical coverage under a non-group contract or policy that is written on an expense-incurred basis or is with a health maintenance

SAMPLE

organization;
5. Ceasing to qualify as a Dependent child (in which case only the coverage of the affected formerly Dependent child would be impacted); or
6. The expiration of eighteen (18) calendar months following the death of the Subscriber.

Divorce of the Subscriber and His/Her Spouse

If a Covered Person would otherwise lose coverage due to divorce from the Subscriber, the former spouse of the Subscriber and any Dependent children of the Subscriber (including any of the Subscriber's children born after the divorce), may continue uninterrupted coverage hereunder, upon arrangement with the Group in compliance with applicable Maryland law. The notification period for the applicable change in status provided under Maryland law shall begin with the date on which there has been a change in status and end no sooner than sixty (60) days after such date.

Group coverage under this section continues for those Dependents who are eligible for state continuation coverage, only upon payment of applicable monthly charges to Group at the time specified by Group, and terminates on the earliest of:

1. Termination of this Agreement;
2. Eligibility of the Covered Person for hospital, medical or surgical benefits under an insured or self-insured group health benefit program or plan, other than the group contract, that is written on an expense-incurred basis or is with a health maintenance organization;
3. Entitlement of the Covered Person to benefits under Title XVIII of the Social Security Act;
4. Acceptance by the Covered Person of any hospital, medical or surgical coverage under a non-group contract or policy that is written on an expense-incurred basis or is with a health maintenance organization;
5. Ceasing to qualify as a Dependent child (in which case only the coverage of the affected formerly Dependent child would be impacted); or
6. Remarriage of the Covered Person who is the divorced former spouse of the Subscriber (in which case only the coverage of the divorced former spouse of the Subscriber would be impacted).

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Voluntary or Involuntary Termination of a Subscriber's Employment for Reasons Other Than for Cause

If you would otherwise lose coverage due to the voluntary or involuntary termination of the Subscriber's employment, for any reason other than for cause, the Subscriber's spouse and any Dependent children who were covered under this contract before the change in employment status of the Subscriber, may continue uninterrupted coverage hereunder, upon arrangement with Group in compliance with applicable Maryland law, if the Subscriber resides in Maryland.

Group coverage under this section continues for those Dependents who are eligible for state continuation coverage, only upon payment of applicable monthly charges, which may include an allowable reasonable administrative fee, not to exceed two percent of the entire cost to the employer, to your Group's Premium charge at the time specified by Group, and terminates on the earliest of:

1. Termination of this Agreement; or
2. Eligibility of the Covered Person for hospital, medical or surgical benefits under an insured or self-insured group health benefit program or plan, other than the group contract, that is written on a expense-incurred basis or is with a health maintenance organization;

3. Entitlement of the Covered Person to benefits under Title XVIII of the Social Security Act;
4. Acceptance by the Covered Person of any hospital, medical or surgical coverage under a non-group contract or policy that is written on an expense-incurred basis or is with a health maintenance organization;
5. Ceasing to qualify as a Dependent (in which case only the coverage of the affected formerly Dependent child would be impacted); or
6. The expiration of eighteen (18) calendar months after the termination of the Subscriber's employment.

Coverage Under the Continuation Provision of Group's Prior Plan

An individual who previously had continued group coverage with a health benefits carrier or health maintenance organization other than the Health Plan and who becomes, by virtue of applicable Maryland law, eligible to continue Group coverage with the Health Plan, may enroll in Health Plan coverage and continue that coverage as set forth in this section.

For purposes of this section, Covered Person or Dependent includes a child born to a surviving or divorced spouse who is enrolled under this section.

Unless otherwise agreed to by your Group, subject to these provisions, a person who is a Covered Person hereunder on the 1st day of a month is covered for the entire month.

SAMPLE

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 EOC, or that we request in our normal course of business, must be completed by you or your Authorized Representative.

Assignment

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

Attorney Fees and Expenses

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

Certificates

A certificate is a statement that summarizes the benefits and rights that pertain to each Covered Person under this contract. We will provide you with a certificate, which will be delivered either:

1. Directly to each Subscriber, as only one statement per Family will be issued when Dependents are enrolled under this Plan; or
2. To your Group, for distribution to each Subscriber of the Group.

Contestability

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

A statement made by a Covered Person in relation to insurability may not be used to contest the validity of their coverage if the statement was made after coverage was in force for a period of two (2) years before the contest.

Absent of fraud, each statement made by an applicant, employer or Covered Person is considered a representation; not a warranty. Therefore, a statement made to effectuate coverage may not be used to void coverage or reduce benefits under the contract unless:

1. The statement is documented in writing and signed by the applicant, employer or Covered Person; and
2. A copy of the statement is provided to the applicant, employer or Covered Person.

Contracts with Plan Providers

Plan Provider Relationship and Compensation

The Health Plan and Plan Providers are independent contractors. Your 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).

SAMPLE

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 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 Covered Person is furnished, by a non-Participating Provider, an item or Service that would otherwise be covered if provided by a Participating Provider, and the Covered Person 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 Covered Person 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.

SAMPLE

Governing Law

This contract 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 contract by state or federal law shall bind both Covered Persons and the Health Plan, regardless of whether or not set forth in this contract.

Legal Action

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

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

Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

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

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

Notice of Non-Grandfathered Group Plan

We believe that this Plan is a non-grandfathered health plan under the Patient Protection and Affordable Care Act (PPACA).

Overpayment Recovery

We may recover any overpayment we make for covered 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 following 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. In addition, member-identifiable health information is shared with your Group only with your authorization or as otherwise permitted by law. 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**.

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Important Terms You Should Know

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

A

Adverse Decision: 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.
2. A denial by the Health Plan of a request by a Covered Person 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 Covered Person under the Health Plan.

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

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

Allowable Charges: Means either for:

1. Services provided by the Health Plan or Medical Group: The amount in the Health Plan's schedule of Medical Group and the Health Plan charges for Services provided to Covered Persons;
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 Covered Person for the item if a Covered Person'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 Covered Persons, 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 Plan Providers, the amount the Plan Provider has agreed to accept as payment;

SAMPLE

5. All other Services: The amount:
   a. The provider has contracted or otherwise agreed to accept;
   b. The provider has negotiated with the Health Plan;
   c. Health Plan must pay the Non-Plan Provider pursuant to state law, when it is applicable, or federal law, including the 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 stated; 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 Covered Person. 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 Covered Person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room usually is not an Allowable Expense.

Ancillary Service: Services that are:

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

SAMPLE

Appeal: A protest filed by a Covered Person, an Authorized Representative, or a Health Care Provider with the Health Plan under its internal Appeal process regarding a Coverage Decision concerning a Covered Person.

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 Covered Person.

Authorized Representative: An individual authorized under state law to provide consent on behalf of a Covered Person 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: Health Care Service Review, Appeals, and Grievances***): An individual authorized by the Covered Person or parent/guardian, as applicable, or otherwise authorized under State of Maryland law is permitted to file a claim, a Grievance, an Appeal or a

Complaint on behalf of the Covered Person to the Health Plan. A Health Care Provider may act on behalf of a Covered Person with the Covered Person's express consent, or without such consent.

C

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

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

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 a Coverage Decision, Adverse Decision or a Grievance Decision.

Continuing Care Patient is a Covered Person 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.

Contract Year: A consecutive 12-month period during which the Health Maintenance Organization (HMO) provides coverage for benefits. The Contract Year is shown on the Group Agreement Face Sheet.

Copayment: The specified charge that a Covered Person 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.

SAMPLE

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

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

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

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

Covered Person: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premium.

D

Deductible: The amount of Allowable Charges that must be incurred by an individual or a family per year before the Health Plan begins payment.

Dependent: A Covered Person 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 This 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.

SAMPLE

E

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

1. Seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function; or
2. Cause the Covered Person to be in danger to self or others;
3. Cause the Covered Person 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 paragraph 3.a., covered Services, also referred to as Post-Stabilization Care, that are furnished by a non-Participating Provider, non-Participating Emergency Facility or non-Participating 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 nonmedical transportation or nonemergency medical transportation to an available Participating Facility or Participating

SAMPLE

Provider 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 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 Emergency Facility or non-Participating Providers in conjunction with such items or Services);

iii. The Covered Person, or an Authorized Representative of such Covered Person, is in a condition to receive the information in the consent as described in item 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 the Maryland Insurance Code.

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 described in ***Section 3: Benefits, Exclusions and Limitations***.

F

Family: An:

1. Individual and spouse;
2. Individual and dependent minor or minors;
3. Individual, spouse, and dependent minor or minors; or

SAMPLE

4. Individual and Domestic Partner; or
5. Individual, Domestic Partner, and dependent minor or minors.

Family Planning Services: Counseling, implanting or fitting of contraceptive devices and follow-up visits after a Covered Person selects a birth control method; and 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.

Full-Time Employee: With respect to a calendar month, an employee of a Small Employer who works, on average, at least thirty (30) hours per week. A Full Time Employee is not a seasonal employee as defined in federal law.

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 Covered Person or parent/guardian, as applicable, or by a provider or other Authorized Representative on behalf of the Covered Person, with the Health Plan, through our internal grievance process regarding an Adverse Decision concerning the Covered Person. 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 Covered Person.

H

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

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

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

SAMPLE

Health Maintenance Organization (HMO): 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.

Home Health Care: The continued care and treatment of a Covered Person in the home if:
1. The institutionalization of the Covered Person 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 Covered Person 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.

SAMPLE

M

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

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 Covered Person's condition or clinical symptoms;
2. In accordance with generally accepted standards of medical practice;
3. Not solely for the convenience of the Covered Person, the Covered Person's family and/or the Covered Person's provider; and
4. The most appropriate level of Service which can safely be provided to the Covered Person. 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 Covered Person's right to appeal, or go to court, as set forth in ***Section 5: Health Care Service Review, 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).

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

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

Non-Physician Specialist: A health care provider who is:
1. Not a physician;
2. Licensed or certified under the Health Occupations Article;
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: Health Care Service Review, 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 Covered Person, Covered Person's Authorized Representative or a Health Care Provider acting on behalf of the Covered Person 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 Covered Person 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: Health Care Service Review, Appeals and Grievances*** shall:

SAMPLE

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 Covered Person, Covered Person's Authorized Representative, or a Health Care Provider acting on behalf of the Covered Person has a right to file an Appeal with the carrier;
   b. That the Covered Person, Covered Person's Authorized Representative or a Health Care Provider acting on behalf of the Covered Person 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 Covered Person or Covered Person'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 item or 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 Copayments, Deductibles and Coinsurance that an individual or Family Unit is obligated to pay for covered Services per Contract Year.

Outpatient Rehabilitative Services: Occupational therapy, speech therapy and physical therapy, provided to Covered Persons not admitted to a Hospital or related institution.

P

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

SAMPLE

for an individual patient in in a Hospital, psychiatric day-care treatment center, community mental health facility or any other authorized facility.

Participating Emergency Facility: means any emergency facility that has contracted directly with Kaiser Permanente Medical Care Program or an entity contracting on behalf of Kaiser Permanente Medical Care Program to provide health care services to Kaiser Permanente Medical Care Program's Covered Persons. A single case agreement between an emergency facility and Kaiser Permanente Medical Care Program that is used to address unique situations in which a Covered Person 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: means a health care facility that has contracted directly with Kaiser Permanente Medical Care Program or an entity contracting on behalf of Kaiser Permanente Medical Care Program to provide health care services to Kaiser Permanente Medical Care Program's Covered Persons. A single case agreement between a health care facility and Kaiser Permanente Medical Care Program that is used to address unique situations in which a Covered Person 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. For purposes of this definition, non-emergency services, "health care facility" is limited to a hospital; a hospital outpatient department; a critical access hospital; and an ambulatory surgical center.

Participating Provider: means a physician or other health care provider that has contracted directly with Kaiser Permanente Medical Care Program or an entity contracting on behalf of Kaiser Permanente Medical Care Program to provide health care services to Kaiser Permanente Medical Care Program's Covered Persons.

Part-Time Employee: An employee of a Small Employer who:

1. Has a normal workweek of at least seventeen-and-a-half (17.5) hours; and
2. Is not a Full-Time Employee.

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 EOC.

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;

SAMPLE

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. Personal injury protection under a motor vehicle insurance policy;
9. Medicare supplement policies;
10. A state plan under Medicaid; or
11. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

Plan Facility: A Plan Medical Center, a Plan Provider's medical office, a Plan Provider's facility, or a Plan Hospital.

A single case agreement between a Health Care Facility and Health Plan that is used to address unique situations in which an enrollee 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: Any hospital in our Service Area where you receive hospital care pursuant to our arrangements made by a Plan Physician.

A single case agreement between an emergency facility and Health Plan that is used to address unique situations in which an enrollee 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 Covered Persons.

Plan Pharmacy: Any pharmacy that:

1. Is located at a Plan Medical Office; or
2. Contracts, directly or indirectly, to provide Services to Members, and is included in the Signature care delivery system.

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

1. Contracts, directly or indirectly, to provide Services and supplies to Covered Persons; and
2. Is included in your 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:

SAMPLE

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

Point-of-Service Option: An additional benefit offered by the Health Plan that permits a Covered Person enrolled in Health Plan to receive Services outside the Network that are otherwise covered under this EOC when received in the Network.

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 monthly premiums shown on the Small Group Agreement Face Sheet.

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.

Product: a discrete package of health benefits that are offered using a particular product network type within a geographic area.

Q

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 small group 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

SAMPLE

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 or 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 Plan.

Serious or Complex Condition: In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm or, in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time

Service: A health care item or service that is covered under this Agreement and Medically Necessary to prevent, diagnose, or treat a medical condition.

Service Area: The areas of the District of Columbia; the following Virginia counties – Arlington, Fairfax, King George, 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 Maryland Department of Health, which is:

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.

Small Employer: An employer that, during the preceding calendar year, employed an average of not more than (50) employees or another number of employees as provided under federal law. All persons treated as a single employer under § 414(b), (c), or (o) of the Internal Revenue Code shall be treated as a single employer; an employer and any predecessor employer shall be treated as a single employer; the number of employees of an employer shall be determined by adding 1) the number of full–time employees; and 2) the number of full–time equivalent employees, which shall be calculated for a particular month by dividing the aggregate number of hours of service of employees who are not full–time employees for the month by 120.

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

SAMPLE

Specialty Services: Care provided by a Health Care Practitioner who is not providing Primary Care Services.

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

T

Totally Disabled:

1. **For Subscribers and Adult Dependents:** In the judgment of a Medical Group Physician, a Covered Person is totally disabled by reason of injury or sickness if the Covered Person 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 Covered Person is totally disabled if he or she is unable to perform each and every duty of any business or occupation for which the Covered Person is reasonably fitted by education, training and experience.
2. **For Dependent Children:** 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 Covered Person's Emergency Medical Condition.

SAMPLE

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: Health Care Service Review, 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 Covered Person's life or health in serious jeopardy;
   b. The inability of the Covered Person to regain maximum function;
   c. Serious impairment to bodily function;
   d. Serious dysfunction of any bodily organ or part; or

e. The Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person 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 Covered Person's medical condition, would subject the Covered Person 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 Covered Person at a Health Care Facility, includes, in addition to Services furnished by a provider at the Health Care Facility, equipment and devices, telemedicine Services, imaging Services, laboratory Services, and preoperative and postoperative Services, regardless of whether the provider furnishing such Services is at the Health Care Facility.

SAMPLE

KAISER PERMANENTE®
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
4000 Garden City Drive, Hyattsville, MD 20785
301-816-2424

ADDED CHOICE: A POINT-OF-SERVICE AMENDMENT

This Point-of-Service Amendment is effective as of the date of your Small Group Agreement and Small Group Evidence of Coverage and shall terminate as of the date your Small Group Agreement and Small Group Evidence of Coverage terminates.

The following covered Services shall be added to the Small Group Evidence of Coverage to which this Added Choice: A Point-of-Service Amendment is attached, in consideration of Small Group's application and payment of Premium for such Services.

I. DEFINITIONS

The following terms, when capitalized and used in any part of the Small Group Evidence of Coverage, shall mean:

Coinsurance: The percentage of Usual, Customary and Reasonable charges allocated to Health Plan and to you after the required Deductible amount is satisfied. You are responsible for payment of the percentage of Usual, Customary and Reasonable charges for the covered Services as set forth in the Summary of Services and Cost Shares. The Out-of-Plan Coinsurance amounts will count toward the Out-of-Pocket Maximum.

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

Excess Charges: The difference between the Usual, Customary and Reasonable charges and the Non-Plan Provider's actual billed charges for the Services you received.

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

In-Plan: The covered Services that are provided to you that are provided by, directed by, or authorized by Plan Providers in Plan Facilities.

Non-Plan Hospital: Any hospital in our Service Area where you receive hospital care that has not contracted with Health Plan to provide hospital Services to a Covered Person.

Non-Plan Facility: A non-Plan Medical Office, a Non-Plan Provider's Medical Office, a Non-Plan Provider's Facility, or a Non-Plan Hospital.

Non-Plan Physician: Any licensed physician who is not an employee of Medical Group, or any licensed physician who does not contract with Health Plan to provide Services to a Covered Person.

Non-Plan Provider: A Non-Plan Hospital, Non-Plan Physician or other health care provider that does not contract with Health Plan to provide Services to a Covered Person.

Out-of-Plan: Those covered Services that are provided to you by Non-Plan Providers or by Plan Providers without being authorized by the Primary Care Plan Physician. The only exceptions are Emergency Services, Urgent Care Services provided outside the Service Area, optometry Services, Mental Health and Substance Abuse Services, and gynecological Services.

To receive In-Plan benefits for optometry Services, Mental Health and Substance Abuse Services, and gynecological Services, you must receive the care directly from a Plan Provider.

Out-of-Pocket Maximum: The maximum amount of Coinsurance, Copayments, and Deductibles that a Covered Person or Family Unit is obligated to pay for Out-of-Plan covered Services, under this Added Choice: Point-of-Service Amendment, per Contract Year.

Usual, Customary and Reasonable (UCR): The lesser of: (1) the billed charge; or (2) the current prevailing charge made for the billed medical service or supply by healthcare providers of the same specialty in the same geographic area, as determined by Health Plan. Such charge shall not be less than the amount Health Plan must pay pursuant to the requirements of §19-710.1 of the Health-General Article of the Annotated Code of Maryland.

SAMPLE

II. PROVISIONS

A. Subject to the terms, conditions, limitations, and exclusions specified in the Small Group Evidence of Coverage and this Added Choice: A Point-of-Service Amendment, coverage will be provided to allow you to receive covered Services from: (1) Plan Providers without a referral from your Primary Care Plan Physician; and (2) Non-Plan Providers.

B. All Services listed in the covered Services section of the Small Group Evidence of Coverage that are provided by Non-Plan Providers or Plan Providers without a referral from the Primary Care Plan Physician will be treated as Out-of-Plan benefits. The only exceptions to this are set forth in items C and D below.

C. Emergency Services and Urgent Care Services provided outside the Service Area will always be treated as In-Plan benefits.

D. Mental Health and Substance Abuse Services, and gynecological Services, and optometry Services when obtained directly from a Plan Provider without a referral from the Primary Care Plan Physician will be treated as In-Plan benefits. However, if you receive these Services from a Non-Plan Provider, those Services will be treated as Out-of-Plan benefits.

E. All Plan Providers will provide Health Plan with itemized bills for Services you receive. Health Plan will pay the Plan Provider directly for all covered Services. It is your responsibility to pay all applicable Coinsurance, Copayments, Deductibles, and any fee-for-service charges for non-covered Services directly to the Plan Provider. The Plan Provider has agreed to accept Health Plan's payment plus your Coinsurance, Copayment, and Deductible as full payment for covered Services.

F. A Non-Plan Provider, at his/her/its discretion may: (1) require payment at the time Services are received; (2) bill you directly for the Services received, or (3) bill Health Plan directly for the Services you received.

Regardless of how the Non-Plan Provider elects to collect payment for Services, it is your responsibility to pay all applicable Coinsurance, Copayments, Deductibles, Excess Charges, or fee-for-service charges for non-covered Services directly to the Non-Plan Provider.

It is also your responsibility to file a claim with Health Plan for payment and/or reimbursement. For information on how to submit a claim, please see the "Submission of Claims" section of this Point-of-Service Amendment.

III. BENEFIT LIMITATIONS

A. The "Benefit, Exclusions and Limitations" section of the Small Group Evidence of Coverage also apply to this Point-of-Service Amendment.

B. Health Plan will combine the In-Plan and Out-of-Plan usage of covered Services that have a specific visit or day limitations to reach the maximum number of days or visits allowable per Contract Year.

C. Urgent Care Services received inside the Service Area that are provided by Non-Plan Providers will be treated as Out-of-Plan benefits.

SAMPLE

IV. OUT-OF-PLAN ANNUAL DEDUCTIBLE

Each Contract Year, each Covered Person or Family Unit is responsible for the Individual or Family Deductible amount before the Health Plan will pay any portion of the Usual, Customary and Reasonable charges for covered Services received Out-of-Plan. For a Family Unit, no one Covered Person will be responsible for more than the individual Deductible. Once one (1) Covered Person has satisfied the individual Deductible, the expenses of all other Covered Persons in a Family Unit may be combined to satisfy the remaining Family Deductible. The individual Deductible and the Family Deductible for this plan can be found in the "Summary of Services and Cost Shares."

V. COINSURANCE AND EXCESS CHARGES

Coinsurance referred to in this Point-of-Service Amendment applies to the covered Services you receive Out-of-Plan. When using Out-of-Plan covered Services, you have the choice of receiving covered Services from Plan Providers and Non-Plan Providers. However, you should always be aware that by electing to receive covered Services Out-of-Plan, you are not only responsible for the annual Deductible and Coinsurances, but also for payment of the difference between the Usual, Customary and Reasonable charges and the Non-Plan Provider's actual billed charges for the Services you received. This difference is known as "Excess Charges." Any Excess Charge does not count toward your Deductible, Coinsurance, and Out-of-Pocket Maximum. Your Coinsurance amounts for each covered Services can be found on the "Summary of Services and Cost Shares."

VI. OUT-OF-POCKET MAXIMUM

Each Contract Year, each Covered Person or Family Unit is responsible for the Individual or Family Out-of-Pocket Maximum for covered Services received In-Plan and Out-of-Plan. In-Plan and Out-of-Plan Out-of-Pocket Maximum are separate (i.e. applicable expenses for services provided by In-Plan providers accumulate towards the In-Plan Out-of-Pocket Maximum, and applicable expenses for services provided by Out-Of-Plan providers accumulate towards the Out-Of-Plan Out-of-Pocket Maximum).

For a Family Unit, no one Covered Person will be responsible for more than the individual Out-of-Pocket Maximum. Once one Covered Person has satisfied the individual Out-of-Pocket Maximum, his or her Out-of-Pocket Maximum will be met for the rest of the Contract Year. Other Covered Persons will continue to pay applicable Cost Shares for Services that are subject to the Out-of-Pocket Maximum until the Family Out-of-Pocket Maximum is met. The expenses of all other Covered Persons may be combined to satisfy the remaining Family Out-of-Pocket Maximum for the rest of the Contract Year.

Only the maximum amount of the Coinsurance, Copayments and the annual Deductible payments for covered Services will count toward the Out-of-Pocket Maximum. Once you or the Family Unit have satisfied the Out-of-Pocket Maximum, you or the Family Unit will no longer be required to pay any Coinsurance or Copayment amounts for covered Services for the remainder of the Contract Year. Excess Charges do not apply toward the Out-of-Pocket Maximum, and are not covered under this Plan.

The Out-of-Pocket Maximum that you or the Family Unit are obligated to pay for covered Services in a Contract Year under this Point-of-Service Amendment can be found on the "Summary of Services and Cost Shares."

VII. PRE-CERTIFICATION/AUTHORIZATION FOR COVERED SERVICES

Health Plan requires that the following Out-of-Plan Services be pre-certified/authorized **before** you receive them:

A. Abortion Care Services, Elective/Therapeutic

B. Accidental Dental Services

C. Allergy Treatment and Injections

D. Anesthesia for Oral Surgery/Dental

E. Blood Products

F. Clinical Trials

G. Diabetic Equipment including insulin pumps

H. Dialysis

I. Durable Medical Equipment, including assistive technologies

J. Habilitative Services

K. Home Health Care Services

L. Home IV, including infusion therapy, and injectables (does not include allergy injections)

M. Hospital Inpatient Services, including short stay, observation, acute rehab, residential treatment center, and partial hospitalization

N. Hospice Care Services (inpatient and home)

O. Imaging/radiology Service – Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computed Tomography (CT), Computerized Tomography Angiography (CTA), Positron Emission Tomography (PET), Electronic Beam Computed Tomography (ECBT), SPECT, not including x-ray or ultrasound

P. Infertility Services, including assessment

Q. Infusion Therapy/Chemotherapy/Radiation Therapy

R. Medical Foods

S. Medical Nutrition Therapy and Counseling Services

T. Obstructive Sleep Apnea Treatment including sleep studies

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U. Pain Management Services (radiofrequency ablation, implantable pumps, spinal cord stimulator, injections)

V. Prosthetics/Braces/Orthotics/Appliances

W. Radiation Therapy Services, including Proton Beam Radiation Therapy

X. Rehabilitation Therapy (cardiac, occupational, physical, pulmonary, speech, vestibular)

Y. Skilled Nursing Facility (SNF)/Subacute Rehab Services

Z. Surgery including inpatient, outpatient, ambulatory surgery (includes endoscopy suite)

AA. Transplant Services

To obtain pre-certification/authorization of these Services, you must call the Health Plan at the phone number listed on the Covered Person's ID card.

If you fail to obtain pre-certification/authorization for the Services listed above, Health Plan **will not pay nor reimburse** the cost of these Services. You will be responsible for all charges you incur for these Services.

Emergency Hospital Admissions

With respect to Emergency Hospital admissions, you have the choice of using either your In-Plan benefits or Out-of-Plan benefits once a Plan Provider determines that your medical condition is stabilized and that you can be transferred to a Plan Hospital.

You will receive In-Plan benefits only if you:

A. Notify us within 48 hours or the first working day following the admission, unless it was not reasonably possible for you to notify us within that time; and

B. Agree to be transferred to a Plan Hospital.

You will receive Out-of-Plan benefits if you:

A. Notify us within 48 hours or the first working day following the admission, unless it was not reasonably possible for you to notify us within that time; and

B. Do not agree to be transferred to a Plan Hospital.

VIII. SUBMISSION OF CLAIMS

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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.

When you receive covered Services from a Plan Provider, without a referral from the primary care Plan Physician, there is no need to file a claim with us. Plan Providers have agreed to submit their claims directly to us.

When you receive covered Services from a Non-Plan Provider, you are responsible for submitting itemized bills, a request for payment or reimbursement of the cost of covered Services to us for payment and/or reimbursement. Simply mail or fax a 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 fax your proof to us within one (1) year at the following address:

Kaiser National Claims Administration - Mid-Atlantic States
Attention: Claims Department
P. O. Box 371860
Denver, CO 80237-9998
Fax: 1-866-568-4184

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 request 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 time proof is otherwise required. A Covered Person's legal incapacity shall suspend the time restrictions regarding the submission of proof; however, any suspension period will end when legal capacity is regained.

Benefits payable under the Small Group Evidence of Coverage for any loss will be paid not more than 30 days after receipt of written proof of loss. 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 Small Group Evidence of Coverage and this Amendment.

Each Covered Person claiming reimbursement under this contract 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.

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

This Added Choice: A Point-of-Service Amendment is subject to all the terms and conditions of the Small Group Agreement and Small Group Evidence of Coverage to which this Point of Service Amendment is attached. This Point of Service Amendment does not change any of those terms and conditions, unless specifically stated in this Amendment.

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

By: ____________________________________

Gracelyn McDermott
Vice President, Marketing, Sales & Business Development

SAMPLE

Kaiser Permanente
Your Small Group Agreement and Evidence of Coverage

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

Kaiser Permanente Smile Kids SG Embedded Dental PPO 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 month on which the Member turns 19.

Definitions

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

Coinsurance: The percentage listed on the Schedule of Dental Benefits that the Dental Administrator will pay for Covered Dental Services. The member will be responsible for any remaining percentage. For example, if a procedure is covered at 80 percent, the Dental Administrator will pay 80 percent and the member is responsible for the remaining 20 percent.

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.

Maximum Allowable Charge: A limitation on the billed charge, as determined by the Plan, by geographic area where the expenses are incurred and may not be more than the negotiated fee for the same service when provided by a Participating Dental Provider. Non-Participating Dental Providers will be reimbursed at the rate specified in §19-710.1 of the Health-General Art.

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 includes Out-of-Network benefits. When Covered Dental Services are provided by an Out-of-Network Dentist, the Out-of-Network Dentist can charge you for any amount over the Maximum Allowable Charge for each procedure. Please review the Schedule of Dental Benefits for details on your plan's Out-of-Network benefits.

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.

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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. The Schedule of Dental Benefits will also explain whether your plan includes Out-of-Network benefits in addition to In-Network benefits.

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. When services by a Dental Specialist are needed, you may select any Dental Specialist in our network.

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

Alternate Treatment

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

Dental Administrator

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

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Specialty Care

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, a referral is not required. You may select any Specialist inside or outside 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.

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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. Proof of loss must be submitted by the provider to the Dental Administrator within 180 days after the date of treatment. 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 does not invalidate or reduce Benefits payable if it was not reasonably possible for you to submit the itemized bills and/or proof of payment within the one-year period. If you submit the itemized bill and/or proof of payment as soon as reasonably possible and, except in the absence of legal capacity, no later than two (2) years from the time proof is otherwise required, Benefits will be payable. A Member's legal incapacity shall suspend the time to submit a claim, and the suspension period will end when legal capacity is regained.

Benefits payable under the Small Group 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 Small Group Evidence of Coverage and this Rider.

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Appeals

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

Submit your Appeal to:

LIBERTY Dental Plan
Attn: Grievances and Appeals
Quality Management Department
PO BOX 26110

Santa Ana, CA 92799-6110

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

By: ______________________________________

Gracelyn McDermott
Vice President, Marketing, Sales & Business Development

SAMPLE

Kaiser Permanente
Your Small Group Agreement and Evidence of Coverage

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Kaiser Permanente Smile Kids SG Embedded Dental PPO Plan
2025 Schedule of Dental Benefits (up to 19)

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

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 coinsurance 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 ***Pediatric Dental Plan Appendix*** for a complete description of the terms and conditions of your covered dental benefit.

In-Network Services

You may go to any contracted dental office to utilize In-Network 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/TTY: 1-877-855-8039, Monday through Friday, 8 a.m. to 8 p.m. Eastern Standard Time (EST).

The Dental Administrator will pay a percentage of the Participating Dental Provider's charge for each Covered Dental Service up to the Participating Dental Provider's negotiated fee. The percentage of payment by the Dental Administrator is determined by procedure classification as set forth in the Schedule of Dental Benefits. For example, if a procedure is covered at 80 percent, the Dental Administrator will pay 80 percent and you will pay the remaining balance of 20 percent, up to the Participating Dental Provider's negotiated fee. You may be required to remit payment for the remaining balance at the time of service. Billing arrangements are between you and the Participating Dental Provider.

Out-of-Network Services

To receive Out-of-Network Covered Dental Services, you may go to any Non-Participating Dental Provider. Benefit percentages for Out-of-Network Covered Dental Services are listed in the Schedule of Dental Benefits according to procedure classification.

Benefits are calculated using a Maximum Allowable Charge. You are responsible for any amount charged which exceeds the Maximum Allowable Charge per procedure. Billing arrangements are between you and the Non-Participating Dental Provider. If you receive treatment from a Non-Participating Dental Provider, you may be required to make payment in full at the time of Service. You may then submit a claim to the Dental Administrator for Benefit payment. For information on how to submit a claim, please see "Submission of Claims" in this Rider.

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Pre-Determination of Benefits

If the charge for treatment is expected to exceed $300, it is strongly advised that the treating dentist submit a treatment plan prior to initiating Services. The Dental Administrator may request X-rays, periodontal charting or other dental records prior to issuing the pre-determination. The proposed Services will be reviewed, and a pre-determination will be issued to you or the treating dentist specifying coverage. The pre-determination is not a guarantee of coverage and is considered valid for 180 days.

Covered Dental Services	In-Network	Out-of-Network
WAITING PERIODS	None	None
TYPE I, DIAGNOSTIC & PREVENTIVE SERVICES Oral Exams, Cleanings, Fluoride, X-rays, Space Maintainers, Teledentistry	100% Not subject to deductible	80% Not subject to deductible
TYPE II, BASIC BENEFITS Fillings (Amalgam, Composite), Periodontal Services, Surgical Extractions, Palliative Treatment	80% Not subject to deductible	60% Not subject to deductible
TYPE III, MAJOR BENEFITS Inlays, Onlays, Crowns, Repair/Relines, Endodontic Services, Dentures, Implants, Oral Surgery, Sedation/Anesthesia, Occlusal Guard Services	50% Not subject to deductible	40% Not subject to deductible
TYPE IV, ORTHODONTIA Medically Necessary Orthodontia **Note:** Refer to your Ortho Plus Plan, if applicable, for details about your cosmetic orthodontia benefits.	50% Not subject to deductible	40% Not subject to deductible

CDT Code	Description	Limitations
TYPE I - DIAGNOSTIC & PREVENTIVE SERVICES		
D0120	Periodic oral evaluation	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	
D0145	Oral evaluation under age 3	2 of (D0120, D0145, D0150) every 12 months, per provider or location.
D0150	Comprehensive oral evaluation	2 of (D0120, D0145, D0150) every 12 months, per provider or location
D0160	Oral evaluation, problem focused	
D0170	Re-evaluation, limited, problem focused	
D0171	Re-evaluation, post operative office visit	
D0180	Comprehensive periodontal evaluation	
D0210	Intraoral, comprehensive series of radiographic images	1 of (D0210, D0330, D0701, D0709) every 36 months, per provider or location
D0220	Intraoral, periapical, first radiographic image	

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CDT Code	Description	Limitations
D0230	Intraoral, periapical, each add 'l radiographic image	
D0240	Intraoral, occlusal radiographic image	
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	
D0270	Bitewing, single radiographic image	
D0272	Bitewings, two radiographic images	2 of (D0272-D0274, D0277) every 12 months, per provider
D0273	Bitewings, three radiographic images	2 of (D0272-D0274, D0277) every 12 months, per provider
D0274	Bitewings, four radiographic images	2 of (D0272-D0274, D0277) every 12 months, per provider
D0277	Vertical bitewings, 7 to 8 radiographic images	2 of (D0272-D0274, D0277) every 12 months, per provider
D0310	Sialography	
D0320	TMJ arthrogram, including injection	
D0321	Other TMJ radiographic images, by report	
D0330	Panoramic radiographic image	1 of (D0210, D0330, D0701, D0709) every 36 months, per provider or location
D0340	2D cephalometric radiographic image, measurement and analysis	
D0350	2D oral/facial photographic image, intra-orally/extra-orally	
D0391	Interpretation, diagnostic image by a practitioner, not associated with image, including report	
D0460	Pulp vitality tests	
D0470	Diagnostic casts	
D0486	Accession of transepithelial cytologic sample, prep, written report	
D0601	Caries risk assessment and documentation, low risk	2 of (D0601-D0603) every 12 months
D0602	Caries risk assessment and documentation, moderate risk	2 of (D0601-D0603) every 12 months
D0603	Caries risk assessment and documentation, high risk	2 of (D0601-D0603) every 12 months
D0701	Panoramic radiographic image, image capture only	1 of (D0701, D0709, D0210, D0330) every 36 months, per provider or location
D0702	2-D cephalometric radiographic image, image capture only	
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally, image capture only	
D0705	Extra-oral posterior dental radiographic image, image capture only	
D0706	Intraoral, occlusal radiographic image, image capture only	
D0707	Intraoral, periapical radiographic image, image capture only	

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CDT Code	Description	Limitations
D0708	Intraoral, bitewing radiographic image, image capture only	
D0709	Intraoral, comprehensive series of radiographic images, image capture only	1 of (D0701, D0709, D0210, D0330) every 36 months, per provider or location
D1110	Prophylaxis, adult	2 of (D1110, D1120, D4346) every 12 months
D1120	Prophylaxis, child	2 of (D1110, D1120, D4346) every 12 months
D1206	Topical application of fluoride varnish	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	2(D1208) every 12 months
D1310	Nutritional counseling for control of dental disease	
D1320	Tobacco counseling, control/prevention oral disease	
D1321	Counseling for the control and prevention of adverse oral, behavioral, health effects associated with high-risk substance use	
D1330	Oral hygiene instruction	
D1351	Sealant, per tooth	1 (D1351) per tooth every 36 months, limited to unrestored posterior permanent teeth
D1352	Preventive resin restoration, permanent tooth	
D1354	Application of caries arresting medicament, per tooth	1 (D1354) per tooth every 6 months, no more than twice per tooth in a lifetime
D1355	Caries preventive medicament application, per tooth	
D1510	Space maintainer, fixed, unilateral, per quadrant	1 of (D1510, D1520, D1575) per quadrant every 2 years
D1516	Space maintainer, fixed, bilateral, maxillary	1 of (D1516, D1517, D1526, D1527) per arch every 2 years
D1517	Space maintainer, fixed, bilateral, mandibular	1 of (D1516, D1517, D1526, D1527) per arch every 2 years
D1520	Space maintainer, removable, unilateral, per quadrant	1 of (D1510, D1520, D1575) per quadrant every 2 years
D1526	Space maintainer, removable, bilateral, maxillary	1 of (D1516, D1517, D1526, D1527) per arch every 2 years
D1527	Space maintainer, removable, bilateral, mandibular	1 of (D1516, D1517, D1526, D1527) per arch every 2 years
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	

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CDT Code	Description	Limitations
D1556	Removal of fixed unilateral space maintainer, per quadrant	
D1557	Removal of fixed bilateral space maintainer, maxillary	
D1558	Removal of fixed bilateral space maintainer, mandibular	
D1575	Distal shoe space maintainer, fixed, per quadrant	1 of (D1510, D1520, D1575) per quadrant every 2 years
D9995	Teledentistry, synchronous; real-time encounter	Must be accompanied by a covered procedure
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review	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	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2150	Amalgam, two surfaces, primary or permanent	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2160	Amalgam, three surfaces, primary or permanent	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2161	Amalgam, four or more surfaces, primary or permanent	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2330	Resin-based composite, one surface, anterior	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2331	Resin-based composite, two surfaces, anterior	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2332	Resin-based composite, three surfaces, anterior	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2335	Resin-based composite, four or more surfaces	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2390	Resin-based composite crown, anterior	
D2391	Resin-based composite, one surface, posterior	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2392	Resin-based composite, two surfaces, posterior	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2393	Resin-based composite, three surfaces, posterior	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2394	Resin-based composite, four or more surfaces, posterior	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	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	1 of (D4210, D4211, D4212, D4230, D4231 D4240, D4241, D4260, D4261) per site/quadrant every 24 months

SAMPLE

CDT Code	Description	Limitations
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	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	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	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	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	1 of (D4210, D4211, D4212, D4230, D4231 D4240, D4241, D4260, D4261) per site/quadrant every 24 months
D4249	Clinical crown lengthening, hard tissue	Prior Authorization Required
D4260	Osseous surgery, four or more teeth per quadrant	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	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	
D4264	Bone replacement graft, retained natural tooth, each additional site	
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	
D4268	Surgical revision procedure, per tooth	
D4270	Pedicle soft tissue graft procedure	
D4273	Autogenous connective tissue graft procedure, first tooth	
D4274	Mesial/distal wedge procedure, single tooth	
D4275	Non-autogenous connective tissue graft, first tooth	
D4276	Combined connective tissue and pedicle graft	
D4277	Free soft tissue graft, first tooth	
D4278	Free soft tissue graft, each additional tooth	
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	
D4322	Splint, intra-coronal; natural teeth or prosthetic crowns	
D4323	Splint, extra-coronal; natural teeth or prosthetic crowns	
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	1 of (D4341, D4342) per site/ quadrant, every 24 months;

SAMPLE

CDT Code	Description	Limitations
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	1 of (D4341, D4342) per site/ quadrant, every 24 months;
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	2 of (D1110, D1120, D4346) every 12 months
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit	1 (D4355) every 12 months
D4910	Periodontal maintenance	2 (D4910) every 12 months
D4920	Unscheduled dressing change (other than treating dentist or staff)	
D4921	Gingival irrigation with a medicinal agent, per quadrant	1 per quadrant every 36 months, not payable within 4 weeks of periodontal scaling and root planing
D7111	Extraction, coronal remnants, primary tooth	
D7140	Extraction, erupted tooth or exposed root	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	
D7220	Removal of impacted tooth, soft tissue	
D7230	Removal of impacted tooth, partially bony	
D7240	Removal of impacted tooth, completely bony	
D7241	Removal impacted tooth, complete bony, complication	
D7250	Removal of residual tooth roots (cutting procedure)	
D9110	Palliative treatment of dental pain, per visit	
D9410	House/extended care facility call	
D9420	Hospital or ambulatory surgical center call	Prior Authorization Required
D9440	Office visit, after regularly scheduled hours	
TYPE III - MAJOR SERVICES		
Guideline: Single Crowns - Payable at the least expensive covered material.		
D2510	Inlay, metallic, one surface	1 of (D2510-D2794) per tooth every 60 months
D2520	Inlay, metallic, two surfaces	1 of (D2510-D2794) per tooth every 60 months
D2530	Inlay, metallic, three or more surfaces	1 of (D2510-D2794) per tooth every 60 months
D2542	Onlay, metallic, two surfaces	1 of (D2510-D2794) per tooth every 60 months
D2543	Onlay, metallic, three surfaces	1 of (D2510-D2794) per tooth every 60 months
D2544	Onlay, metallic, four or more surfaces	1 of (D2510-D2794) per tooth every 60 months
D2610	Inlay, porcelain/ceramic, one surface	1 of (D2510-D2794) per tooth every 60 months
D2620	Inlay, porcelain/ceramic, two surfaces	1 of (D2510-D2794) per tooth every 60 months
D2630	Inlay, porcelain/ceramic, three or more surfaces	1 of (D2510-D2794) per tooth every 60 months

SAMPLE

CDT Code	Description	Limitations
D2642	Onlay, porcelain/ceramic, two surfaces	1 of (D2510-D2794) per tooth every 60 months
D2643	Onlay, porcelain/ceramic, three surfaces	1 of (D2510-D2794) per tooth every 60 months
D2644	Onlay, porcelain/ceramic, four or more surfaces	1 of (D2510-D2794) per tooth every 60 months
D2650	Inlay, resin-based composite, one surface	1 of (D2510-D2794) per tooth every 60 months
D2651	Inlay, resin-based composite, two surfaces	1 of (D2510-D2794) per tooth every 60 months
D2652	Inlay, resin-based composite, three or more surfaces	1 of (D2510-D2794) per tooth every 60 months
D2662	Onlay, resin-based composite, two surfaces	1 of (D2510-D2794) per tooth every 60 months
D2663	Onlay, resin-based composite, three surfaces	1 of (D2510-D2794) per tooth every 60 months
D2664	Onlay, resin-based composite, four or more surfaces	1 of (D2510-D2794) per tooth every 60 months
D2710	Crown, resin-based composite (indirect)	1 of (D2510-D2794) per tooth every 60 months
D2712	Crown, ¾ resin-based composite (indirect)	1 of (D2510-D2794) per tooth every 60 months
D2720	Crown, resin with high noble metal	1 of (D2510-D2794) per tooth every 60 months
D2721	Crown, resin with predominantly base metal	1 of (D2510-D2794) per tooth every 60 months
D2722	Crown, resin with noble metal	1 of (D2510-D2794) per tooth every 60 months
D2740	Crown, porcelain/ceramic	1 of (D2510-D2794) per tooth every 60 months
D2750	Crown, porcelain fused to high noble metal	1 of (D2510-D2794) per tooth every 60 months
D2751	Crown, porcelain fused to predominantly base metal	1 of (D2510-D2794) per tooth every 60 months
D2752	Crown, porcelain fused to noble metal	1 of (D2510-D2794) per tooth every 60 months
D2753	Crown, porcelain fused to titanium and titanium alloys	1 of (D2510-D2794) per tooth every 60 months
D2780	Crown, ¾ cast high noble metal	1 of (D2510-D2794) per tooth every 60 months
D2781	Crown, ¾ cast predominantly base metal	1 of (D2510-D2794) per tooth every 60 months
D2782	Crown, ¾ cast noble metal	1 of (D2510-D2794) per tooth every 60 months
D2783	Crown, ¾ porcelain/ceramic	1 of (D2510-D2794) per tooth every 60 months
D2790	Crown, full cast high noble metal	1 of (D2510-D2794) per tooth every 60 months

SAMPLE

CDT Code	Description	Limitations
D2791	Crown, full cast predominantly base metal	1 of (D2510-D2794) per tooth every 60 months
D2792	Crown, full cast noble metal	1 of (D2510-D2794) per tooth every 60 months
D2794	Crown, titanium and titanium alloys	1 of (D2510-D2794) per tooth every 60 months
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	
D2920	Re-cement or re-bond crown	
D2928	Prefabricated porcelain/ceramic crown, permanent tooth	
D2929	Prefabricated porcelain/ceramic crown, primary tooth	
D2930	Prefabricated stainless steel crown, primary tooth	
D2931	Prefabricated stainless steel crown, permanent tooth	
D2932	Prefabricated resin crown	
D2933	Prefabricated stainless steel crown with resin window	
D2934	Prefabricated esthetic coated stainless steel crown, primary tooth	
D2940	Protective restoration	
D2941	Interim therapeutic restoration, primary dentition	
D2950	Core buildup, including any pins when required	
D2951	Pin retention, per tooth, in addition to restoration	
D2952	Post and core in addition to crown, indirectly fabricated	
D2954	Prefabricated post and core in addition to crown	
D2955	Post removal	
D2960	Labial veneer (resin laminate), direct	1 of (D2960, D2961, D2962) per tooth every 60 months
D2961	Labial veneer (resin laminate), indirect	1 of (D2960, D2961, D2962) per tooth every 60 months
D2962	Labial veneer (porcelain laminate), indirect	1 (D2962) per tooth every 60 months
D2980	Crown repair necessitated by restorative material failure	
D2981	Inlay repair necessitated by restorative material failure	
D2982	Onlay repair necessitated by restorative material failure	
D2983	Veneer repair necessitated by restorative material failure	
D2990	Resin infiltration of incipient smooth surface lesions	
D3110	Pulp cap, direct (excluding final restoration)	
D3120	Pulp cap, indirect (excluding final restoration)	

SAMPLE

CDT Code	Description	Limitations
D3220	Therapeutic pulpotomy (excluding final restoration)	
D3221	Pulpal debridement, primary and permanent teeth	
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	1 of (D3310-D3330) in a lifetime, per tooth
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	1 of (D3310-D3330) in a lifetime, per tooth
D3330	Endodontic therapy, molar tooth (excluding final restoration)	1 of (D3310-D3330) in a lifetime, per tooth
D3333	Internal root repair of perforation defects	
D3346	Retreatment of previous root canal therapy, anterior	1 of (D3346-D3348) in a lifetime, per tooth
D3347	Retreatment of previous root canal therapy, premolar	1 of (D3346-D3348) in a lifetime, per tooth
D3348	Retreatment of previous root canal therapy, molar	1 of (D3346-D3348) in a lifetime, per tooth
D3351	Apexification/recalcification, initial visit	
D3352	Apexification/recalcification, interim medication replacement	
D3353	Apexification/recalcification, final visit	
D3355	Pulpal regeneration, initial visit	
D3356	Pulpal regeneration, interim medication replacement	
D3357	Pulpal regeneration, completion of treatment	
D3410	Apicoectomy, anterior	
D3421	Apicoectomy, premolar (first root)	
D3425	Apicoectomy, molar (first root)	
D3426	Apicoectomy (each additional root)	
D3430	Retrograde filling, per root	
D3450	Root amputation, per root	
D3470	Intentional reimplantation (including necessary splinting)	
D3471	Surgical repair of root resorption, anterior	
D3472	Surgical repair of root resorption, premolar	
D3473	Surgical repair of root resorption, molar	
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption, anterior	
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption, premolar	
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption, molar	
D3920	Hemisection, not including root canal therapy	

SAMPLE

CDT Code	Description	Limitations
D3921	Decoronation or submergence of an erupted tooth	
D3950	Canal preparation and fitting of preformed dowel or post	
D5110	Complete denture, maxillary	1 of (D5110-D5120) per arch every 60 months
D5120	Complete denture, mandibular	1 of (D5110-D5120) per arch every 60 months
D5130	Immediate denture, maxillary	
D5140	Immediate denture, mandibular	
D5211	Maxillary partial denture, resin base	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5212	Mandibular partial denture, resin base	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5213	Maxillary partial denture, cast metal, resin base	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5214	Mandibular partial denture, cast metal, resin base	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5221	Immediate maxillary partial denture, resin base	
D5222	Immediate mandibular partial denture, resin base	
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	
D5225	Maxillary partial denture, flexible base	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5226	Mandibular partial denture, flexible base	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	1 of (D5284, D5286) per quad every 60 months
D5286	Removable unilateral partial denture, one piece resin, per quadrant	1 of (D5284, D5286) per quad every 60 months
D5410	Adjust complete denture, maxillary	Not payable within first 6 months of initial placement by same provider
D5411	Adjust complete denture, mandibular	Not payable within first 6 months of initial placement by same provider
D5421	Adjust partial denture, maxillary	Not payable within first 6 months of initial placement by same provider
D5422	Adjust partial denture, mandibular	Not payable within first 6 months of initial placement by same provider
D5511	Repair broken complete denture base, mandibular	Member not responsible for cost share during the first 6 months of initial placement by same provider

SAMPLE

CDT Code	Description	Limitations
D5512	Repair broken complete denture base, maxillary	Member not responsible for cost share during the first 6 months of initial placement by same provider
D5520	Replace missing or broken teeth, complete denture	Member not responsible for cost share during the first 6 months of initial placement by same provider
D5611	Repair resin partial denture base, mandibular	Member not responsible for cost share during the first 6 months of initial placement by same provider
D5612	Repair resin partial denture base, maxillary	Member not responsible for cost share during the first 6 months of initial placement by same provider
D5621	Repair cast partial framework, mandibular	Member not responsible for cost share during the first 6 months of initial placement by same provider
D5622	Repair cast partial framework, maxillary	Member not responsible for cost share during the first 6 months of initial placement by same provider
D5630	Repair or replace broken retentive clasping materials, per tooth	Member not responsible for cost share during the first 6 months of initial placement by same provider
D5640	Replace broken teeth, per tooth	Member not responsible for cost share during the first 6 months of initial placement by same provider
D5650	Add tooth to existing partial denture	Member not responsible for cost share during the first 6 months of initial placement by same provider
D5660	Add clasp to existing partial denture, per tooth	Member not responsible for cost share during the first 6 months of initial placement by same provider
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	Member not responsible for cost share during the first 6 months of initial placement by same provider
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	Member not responsible for cost share during the first 6 months of initial placement by same provider
D5710	Rebase complete maxillary denture	Member not responsible for cost share during the first 6 months of initial placement by same provider
D5711	Rebase complete mandibular denture	Member not responsible for cost share during the first 6 months of initial placement by same provider
D5720	Rebase maxillary partial denture	Member not responsible for cost share during the first 6 months of initial placement by same provider
D5721	Rebase mandibular partial denture	Member not responsible for cost share during the first 6 months of initial placement by same provider

SAMPLE

CDT Code	Description	Limitations
D5730	Reline complete maxillary denture, direct	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by same provider
D5731	Reline complete mandibular denture, direct	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by same provider
D5740	Reline maxillary partial denture, direct	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by same provider
D5741	Reline mandibular partial denture, direct	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by same provider
D5750	Reline complete maxillary denture, indirect	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by same provider
D5751	Reline complete mandibular denture, indirect	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by same provider
D5760	Reline maxillary partial denture, indirect	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by same provider
D5761	Reline mandibular partial denture, indirect	1 of (D5730-D5761) per arch every 24 months. Member not responsible for cost share during the first 6 months of initial placement by same provider
D5810	Interim complete denture, maxillary	
D5811	Interim complete denture, mandibular	
D5820	Interim partial denture, maxillary	
D5821	Interim partial denture, mandibular	
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
D5863	Overdenture, complete, maxillary	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5864	Overdenture, partial, maxillary	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5865	Overdenture, complete, mandibular	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5866	Overdenture, partial, mandibular	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5951	Feeding aid	Prior Authorization Required

SAMPLE

CDT Code	Description	Limitations
D5992	Adjust maxillofacial prosthetic appliance, by report	1 (D5992) per arch every 6 months
D5993	Maintenance & cleaning, maxillofacial prosthesis, other than required adjustments, by report	1 (D5993) per arch every 6 months
Guideline: Implants and Implant Related Services - Payable at the least expensive covered material.		
D6010	Surgical placement of implant body, endosteal	Prior Authorization Required
D6012	Surgical placement of interim implant body, transitional prosthesis: endosteal implant	Prior Authorization Required
D6040	Surgical placement: eposteal implant	Prior Authorization Required
D6050	Surgical placement: transosteal implant	Prior Authorization Required
D6055	Connecting bar, implant supported or abutment supported	Prior Authorization Required
D6056	Prefabricated abutment, includes modification and placement	Prior Authorization Required
D6057	Custom fabricated abutment, includes placement	Prior Authorization Required
D6058	Abutment supported porcelain/ceramic crown	Prior Authorization Required
D6059	Abutment supported porcelain fused to high noble crown	Prior Authorization Required
D6060	Abutment supported porcelain fused to base metal crown	Prior Authorization Required
D6061	Abutment supported porcelain fused to noble metal crown	Prior Authorization Required
D6062	Abutment supported cast metal crown, high noble	Prior Authorization Required
D6063	Abutment supported cast metal crown, base metal	Prior Authorization Required
D6064	Abutment supported cast metal crown, noble metal	Prior Authorization Required
D6065	Implant supported porcelain/ceramic crown	Prior Authorization Required
D6066	Implant supported crown, porcelain fused to high noble alloys	Prior Authorization Required
D6067	Implant supported crown, high noble alloys	Prior Authorization Required
D6068	Abutment supported retainer, porcelain/ceramic FPD	Prior Authorization Required
D6069	Abutment supported retainer, metal FPD, high noble	Prior Authorization Required
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	Prior Authorization Required
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	Prior Authorization Required
D6072	Abutment supported retainer, cast metal FPD, high noble	Prior Authorization Required
D6073	Abutment supported retainer, cast metal FPD, base metal	Prior Authorization Required
D6074	Abutment supported retainer, cast metal FPD, noble	Prior Authorization Required
D6075	Implant supported retainer for ceramic FPD	Prior Authorization Required
D6076	Implant supported retainer for FPD, porcelain fused to high noble alloys	Prior Authorization Required

SAMPLE

CDT Code	Description	Limitations
D6077	Implant supported retainer for metal FPD, high noble alloys	Prior Authorization Required
D6080	Implant maintenance procedures, prosthesis removed/reinserted, including cleansing	Prior Authorization Required
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	Prior Authorization Required
D6087	Implant supported crown, noble alloys	Prior Authorization Required
D6090	Repair implant supported prosthesis, by report	
D6091	Replacement of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	Prior Authorization Required
D6095	Repair implant abutment, by report	
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	Prior Authorization Required
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	Prior Authorization Required
D6100	Surgical removal of implant body	
D6110	Implant/abutment supported removable denture, maxillary	Prior Authorization Required
D6111	Implant/abutment supported removable denture, mandibular	Prior Authorization Required
D6112	Implant/abutment supported removable denture, partial, maxillary	Prior Authorization Required
D6113	Implant/abutment supported removable denture, partial, mandibular	Prior Authorization Required
D6114	Implant/abutment supported fixed denture, maxillary	Prior Authorization Required
D6115	Implant/abutment supported fixed denture, mandibular	Prior Authorization Required
D6116	Implant/abutment supported fixed denture for partial, maxillary	Prior Authorization Required
D6117	Implant/abutment supported fixed denture for partial, mandibular	Prior Authorization Required
D6121	Implant supported retainer for metal FPD, predominantly base alloys	Prior Authorization Required
D6122	Implant supported retainer for metal FPD, noble alloys	Prior Authorization Required
Guideline: Bridge Services - Payable at the least expensive covered material.		
D6205	Pontic, indirect resin based composite	Prior Authorization Required
D6210	Pontic, cast high noble metal	Prior Authorization Required
D6211	Pontic, cast predominantly base metal	Prior Authorization Required
D6212	Pontic, cast noble metal	Prior Authorization Required
D6214	Pontic, titanium, and titanium alloys	Prior Authorization Required
D6240	Pontic, porcelain fused to high noble metal	Prior Authorization Required
D6241	Pontic, porcelain fused to predominantly base metal	Prior Authorization Required
D6242	Pontic, porcelain fused to noble metal	Prior Authorization Required

SAMPLE

CDT Code	Description	Limitations
D6243	Pontic, porcelain fused to titanium and titanium alloys	Prior Authorization Required
D6245	Pontic, porcelain/ceramic	Prior Authorization Required
D6250	Pontic, resin with high noble metal	Prior Authorization Required
D6251	Pontic, resin with predominantly base metal	Prior Authorization Required
D6252	Pontic, resin with noble metal	Prior Authorization Required
D6545	Retainer, cast metal for resin bonded fixed prosthesis	Prior Authorization Required
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis	Prior Authorization Required
D6549	Resin retainer, for resin bonded fixed prosthesis	Prior Authorization Required
D6600	Retainer inlay, porcelain/ceramic, two surfaces	Prior Authorization Required
D6601	Retainer inlay, porcelain/ceramic, three or more surfaces	Prior Authorization Required
D6602	Retainer inlay, cast high noble metal, two surfaces	Prior Authorization Required
D6603	Retainer inlay, cast high noble metal, three or more surfaces	Prior Authorization Required
D6604	Retainer inlay, cast base metal, two surfaces	Prior Authorization Required
D6605	Retainer inlay, cast base metal, three or more surfaces	Prior Authorization Required
D6606	Retainer inlay, cast noble metal, two surfaces	Prior Authorization Required
D6607	Retainer inlay, cast noble metal, three or more surfaces	Prior Authorization Required
D6608	Retainer onlay, porcelain/ceramic, two surfaces	Prior Authorization Required
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	Prior Authorization Required
D6610	Retainer onlay, cast high noble metal, two surfaces	Prior Authorization Required
D6611	Retainer onlay, cast high noble metal, three or more surfaces	Prior Authorization Required
D6612	Retainer onlay, cast base metal, two surfaces	Prior Authorization Required
D6613	Retainer onlay, cast base metal, three or more surfaces	Prior Authorization Required
D6614	Retainer onlay, cast noble metal, two surfaces	Prior Authorization Required
D6615	Retainer onlay, cast noble metal three or more surfaces	Prior Authorization Required
D6634	Retainer onlay, titanium	Prior Authorization Required
D6710	Retainer crown, indirect resin based composite	Prior Authorization Required
D6720	Retainer crown, resin with high noble metal	Prior Authorization Required
D6721	Retainer crown, resin with predominantly base metal	Prior Authorization Required
D6722	Retainer crown, resin with noble metal	Prior Authorization Required
D6740	Retainer crown, porcelain/ceramic	Prior Authorization Required
D6750	Retainer crown, porcelain fused to high noble metal	Prior Authorization Required
D6751	Retainer crown, porcelain fused to predominantly base metal	Prior Authorization Required
D6752	Retainer crown, porcelain fused to noble metal	Prior Authorization Required

SAMPLE

CDT Code	Description	Limitations
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	Prior Authorization Required
D6780	Retainer crown, ¾ cast high noble metal	Prior Authorization Required
D6781	Retainer crown, ¾ cast predominantly base metal	Prior Authorization Required
D6782	Retainer crown, ¾ cast noble metal	Prior Authorization Required
D6783	Retainer crown, ¾ porcelain/ceramic	Prior Authorization Required
D6784	Retainer crown ¾, titanium and titanium alloys	Prior Authorization Required
D6790	Retainer crown, full cast high noble metal	Prior Authorization Required
D6791	Retainer crown, full cast predominantly base metal	Prior Authorization Required
D6792	Retainer crown, full cast noble metal	Prior Authorization Required
D6794	Retainer crown, titanium and titanium alloys	Prior Authorization Required
D6930	Re-cement or re-bond fixed partial denture	
D6980	Fixed partial denture repair, restorative material failure	
D6999	Unspecified fixed prosthodontic procedure, by report	Prior Authorization Required
D7251	Coronectomy, intentional partial tooth removal	
D7260	Oroantral fistula closure	
D7261	Primary closure of a sinus perforation	
D7270	Tooth reimplantation and/or stabilization, accident	
D7272	Tooth transplantation	
D7280	Exposure of an unerupted tooth	
D7282	Mobilization of erupted/malpositioned tooth	
D7283	Placement, device to facilitate eruption, impaction	
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	
D7286	Incisional biopsy of oral tissue, soft	
D7288	Brush biopsy, transepithelial sample collection	
D7290	Surgical repositioning of teeth	1 (D7290) in a lifetime, per tooth
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	
D7350	Vestibuloplasty, ridge extension	
D7410	Excision of benign lesion, up to 1.25 cm	
D7411	Excision of benign lesion, greater than 1.25 cm	
D7413	Excision of malignant lesion, up to 1.25 cm	
D7414	Excision of malignant lesion, greater than 1.25 cm	
D7440	Excision of malignant tumor, up to 1.25 cm	
D7441	Excision of malignant tumor, greater than 1.25 cm	

SAMPLE

CDT Code	Description	Limitations
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	
D7471	Removal of lateral exostosis, maxilla or mandible	
D7472	Removal of torus palatinus	
D7473	Removal of torus mandibularis	
D7485	Reduction of osseous tuberosity	
D7510	Incision & drainage of abscess, intraoral soft tissue	
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	
D7520	Incision & drainage of abscess, extraoral soft tissue	
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	
D7880	Occlusal orthotic device, by report	
D7910	Suture of recent small wounds up to 5 cm	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot, stabilization, per site	
D7961	Buccal/labial frenectomy (frenulectomy)	1 (D7961) in a lifetime, per arch
D7962	Lingual frenectomy (frenulectomy)	1 (D7962) in a lifetime
D7963	Frenuloplasty	1 (D7963) In a lifetime, per arch
D7970	Excision of hyperplastic tissue, per arch	
D7971	Excision of pericoronal gingiva	
D7972	Surgical reduction of fibrous tuberosity	
D7979	Non – surgical sialolithotomy	
D7999	Unspecified oral surgery procedure, by report	
D9210	Local anesthesia not in conjunction, operative or surgical procedures	
D9211	Regional block anesthesia	
D9212	Trigeminal division block anesthesia	
D9215	Local anesthesia in conjunction with operative or surgical procedures	Not payable as separate service
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	
D9222	Deep sedation/general anesthesia, first 15 minute increment	Prior Authorization Required
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	Prior Authorization Required

SAMPLE

CDT Code	Description	Limitations
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	Not allowed on same date of service as D9248
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	Prior Authorization Required
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	Prior Authorization Required
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	Not allowed on same date of service as D9230
D9310	Consultation, other than requesting dentist	
D9311	Consultation with a medical health care professional	
D9610	Therapeutic parenteral drug, single administration	Prior Authorization Required
D9612	Therapeutic parenteral drugs, two or more administrations, different meds.	Prior Authorization Required
D9630	Drugs or medicaments dispensed in the office for home use	Prior Authorization Required
D9910	Application of desensitizing medicament	
D9920	Behavior management, by report	
D9930	Treatment of complications, post surgical, unusual, by report	
D9941	Fabrication of athletic mouthguard	1 (D9941) every 12 months
D9944	Occlusal guard, hard appliance, full arch	
D9945	Occlusal guard, soft appliance, full arch	
D9946	Occlusal guard, hard appliance, partial arch	
D9950	Occlusion analysis, mounted case	
D9951	Occlusal adjustment, limited	
D9952	Occlusal adjustment, complete	
D9986	Missed appointment	
TYPE IV - MEDICALLY NECESSARY ORTHODONTIC SERVICES - Prior Authorization required for Orthodontic Services		
Guideline: Medically Necessary Orthodontic Services Orthodontic needs are limited to 1 course of treatment per lifetime and must meet medically necessary requirements as determined by a verified score of 26 or higher (or other qualify conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.		
D8010	Limited orthodontic treatment of the primary dentition	Prior Authorization Required for medically necessary benefits
D8020	Limited orthodontic treatment of the transitional dentition	Prior Authorization Required for medically necessary benefits
D8030	Limited orthodontic treatment of the adolescent dentition	Prior Authorization Required for medically necessary benefits
D8040	Limited orthodontic treatment of the adult dentition	Prior Authorization Required for medically necessary benefits
D8070	Comprehensive orthodontic treatment of the transitional dentition	Prior Authorization Required for medically necessary benefits
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Prior Authorization Required for medically necessary benefits

SAMPLE

CDT Code	Description	Limitations
D8090	Comprehensive orthodontic treatment of the adult dentition	Prior Authorization Required for medically necessary benefits
D8210	Removable appliance therapy	Prior Authorization Required for medically necessary benefits, for thumb sucking and tongue thrusting
D8220	Fixed appliance therapy	Prior Authorization Required for medically necessary benefits, for thumb sucking and tongue thrusting
D8660	Pre-orthodontic treatment examination to monitor growth and development	Prior Authorization Required for medically necessary benefits
D8670	Periodic orthodontic treatment visit	Prior Authorization Required for medically necessary benefits
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Prior Authorization Required for medically necessary benefits
D8681	Removable orthodontic retainer adjustment	Prior Authorization Required for medically necessary benefits
D8698	Re-cement or re-bond fixed retainer, maxillary	Prior Authorization Required for medically necessary benefits
D8699	Re-cement or re-bond fixed retainer, mandibular	Prior Authorization Required for medically necessary benefits
D8701	Repair of fixed retainer, includes reattachment, maxillary	Prior Authorization Required for medically necessary benefits
D8702	Repair of fixed retainer, includes reattachment, mandibular	Prior Authorization Required for medically necessary benefits
D8703	Replacement of lost or broken retainer, maxillary	Prior Authorization Required for medically necessary benefits
D8704	Replacement of lost or broken retainer, mandibular	Prior Authorization Required for medically necessary benefits
D8999	Unspecified orthodontic procedure, by report	Prior Authorization Required for medically necessary benefits

SAMPLE

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

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

SAMPLE