guide to

YOUR 2024 BENEFITS AND SERVICES

kaiserpermanente.org

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

GROUP
EVIDENCE OF COVERAGE

VIRGINIA

SELECT CARE DELIVERY SYSTEM

This plan has Excellent accreditation from the NCQA
See 2024 NCQA Guide for more information on accreditation

KAISER PERMANENTE®

Kaiser Foundation Health Plan
of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, Maryland 20852

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

This company is subject to regulation in this Commonwealth by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and by the Virginia Department of Health pursuant to Title 32.1.

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. at the following address and telephone number:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Box 6831
2101 East Jefferson Street
Rockville, MD 20852

(301) 468-6000 or toll-free (800) 777-7902

We recommend that you familiarize yourself with Section 5: Filing Claims, Appeals and Grievances of this Virginia Large Group Agreement and Evidence of Coverage and make use of it before taking any other action.

If you have been unable to contact or obtain satisfaction from the company or your agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

Consumer Services: (804) 371-9741 or toll-free (800) 552-7945

National toll-free (877) 310-6560

Fax: (804) 371-9944

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., or the Bureau of Insurance, have your policy number available.

Notice of Protection Provided by Virginia Life, Accident and Sickness Insurance Guaranty Association

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender and withdrawal values
- Health Insurance
  - $500,000 for health benefit plans
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of accident and sickness insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts is $350,000, except for health benefit plans, for which the limit is increased to $500,000.

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 Virginia law.

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

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://scc.virginia.gov/boi/index.aspx

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network facility, 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 a 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.

"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 in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"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.

Insurers are required to tell you which providers and facilities are in their networks. Providers and facilities must tell you with which provider networks they participate. This information is on the insurer's, provider's or facility's website or on request.

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 deductibles, copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services at the same facility that you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network facility

When you get services from an in-network facility, 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, laboratory, surgeon and assistant surgeon services, and

professional ancillary services such as anesthesia, pathology, radiology, neonatology, hospitalist, or intensivist services. These providers **can't** balance bill you and **can't** ask you to give up your protections not to be balance billed.

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

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

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:

    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (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 out-of-network services toward your in-network deductible and in-network out-of-pocket limit.

If you think you've been wrongly billed, call the federal agencies responsible for enforcing the federal balance billing protection law at: **1-800-985-3059** and/or file a complaint with the Virginia State Corporation Commission Bureau of Insurance at: scc.virginia.gov/pages/File-Complaint-Consumers or call **1-877-310-6560**.

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

Consumers covered under (i) a fully-insured policy issued in Virginia, (ii) the Virginia state employee health benefit plan; or (iii) a self-funded group that opted-in to the Virginia protections are also protected from balance billing under Virginia law. Visit scc.virginia.gov/pages/Balance-Billing-Protection for more information about your rights under Virginia law.

NONDISCRIMINATION NOTICE

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

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

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

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

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

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

HELP IN YOUR LANGUAGE

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

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

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

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

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপদি বাংলা, কথা বলতে পাতেি, েোহতল দিিঃখেচায় ভাষা সহায়ো পদেতষবা উপলব্ধ আতে। ফ াি করুি **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، تسهیالت زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: **711**) تماس بگیرید.

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

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

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

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

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

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

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

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

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

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' 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: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรีโทรที่ **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
Virginia Large Group Agreement and Evidence of Coverage

SECTION 1: Introduction to Your Kaiser Permanente Health Plan

Welcome to Kaiser Permanente

This health benefit Plan is offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (further referred to as "Health Plan," "we," "us," "our" and "Kaiser Permanente." throughout this Agreement). Kaiser Permanente provides you with many resources to support your health and wellbeing. This Membership Agreement and Evidence of Coverage (EOC) is one of them. It provides you with an overview of your Health Plan, including the benefits you are entitled to, how to get care, what services are covered and what part of the costs of your care you will have to pay.

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

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

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

Our Commitment to Diversity and Nondiscrimination

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

We do not discriminate in our employment practices or the delivery of health care Services on the basis of age, race, color, creed, national origin, ancestry, religion, marital status, lawful occupation of the enrollee, sex, sexual orientation, gender identity, status as a transgender individual, or physical, developmental, intellectual disability or because of the frequency of utilization of Services by the enrollee.

About This Group Agreement

Once you are enrolled under this Group Agreement, you become a Member. A Member may be a Subscriber and/or any eligible Dependents, once properly enrolled. Members are sometimes referred to by the terms "you" and "your."

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.

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

Important Terms

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

Entire Contract

This EOC, including the large Group Agreement and any attached applications, riders and amendments, constitutes the entire contract between your Group and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. No portion of the charter or bylaws of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., shall constitute part of this contract unless it is set forth in full in the contract.

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

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

Purpose of this Group Agreement and EOC

This EOC, including the large 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. (see above)
2. Provides evidence of your health care coverage; and
3. Describes the Kaiser Permanente Select[SM] health care coverage provided under this contract.

Administration of this Group Agreement and EOC

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

Group Agreement and EOC Binding on All Members

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

Amendment of Group Agreement and EOC

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

Any changes 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

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.

How Your Health Plan Works

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

Under our contract with your Group, we have assumed the role of a named fiduciary, which is the party responsible for determining whether you are entitled to covered Services under this EOC and provides us

with the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC.

Relations Among Parties Affected By This Group Agreement and EOC

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

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

Additionally:

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

Patient Information Obtained By Affected Parties

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

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

Liability for Amounts Owed By the Health Plan

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

Kaiser Permanente Select℠

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

Eligibility for This Plan

Eligibility of a Member

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

1. Your Group's eligibility requirements that we have approved (your Group is required to inform Subscribers of the Group's eligibility requirements) and meet the Subscriber or Dependent eligibility requirements below.
2. You must work or reside inside our Service Area to be eligible for this Plan. However, you or your Spouse's eligible children who live outside our Service Area may be eligible to enroll if you are required to cover them pursuant to a Qualified Medical Child Support Order (QMCSO). 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. Services received in connection with an approved referral, unless you elect to bring the Dependent within our Service Area to receive covered Services; and
   d. Approved Clinical Trials.
3. **Subscribers**
   You are eligible to enroll if you are employed by a Large Employer and that Large Employer offers you coverage under this Health Plan as an eligible employee, based on your Group's eligibility requirements, which we have previously approved (e.g., you are an employee of your Group who works at least the number of hours specified in those requirements). At the option of the Large Employer, an eligible employee may include:
   a. Only Full-Time Employees; or
   b. Both Full-Time Employees and Part-Time Employees.
4. **Dependents**
   If you are a Subscriber, the following persons may be eligible to enroll as your Dependents:
   a. Your lawful Spouse;
   b. You or your Spouse's Dependent child who is under the age limit specified in the ***Summary of Services and Cost Shares*** 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;
      iv. A child for whom you or your Spouse have been granted legal custody (other than custody as a result of a guardianship); or
      v. A child for whom you or your Spouse 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 age limit specified in the ***Summary of Services and Cost Shares*** 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 an intellectual disability or physical handicap that occurred prior to reaching the age limit for Dependents;

2. They receive 50 percent or more of their support and maintenance from you or your Spouse; and
3. You provide us proof of their intellectual disability or physical handicap and dependency within sixty (60) days after we request it, in accordance with the ***Disabled Dependent Certification*** requirements in this section.

Disabled Dependent Certification

An unmarried child who is covered as a Dependent when they reach the age limit specified in the ***Summary of Services and Cost Shares*** may be eligible for coverage as a disabled Dependent as further described in this section. Proof of intellectual disability or physical handicap and dependency must be provided when requested by the Health Plan as follows:

1. If your Dependent is a Member and reaches the age limit specified in the ***Summary of Services and Cost Shares***, 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 intellectual disability or physical handicap and dependency within sixty (60) days of your Dependent reaching the limiting age. Once proof of intellectual disability or physical handicap 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 intellectual disability or physical handicap 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 intellectual disability or physical handicap 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 intellectual disability or physical handicap and dependency less frequently than once per year; however, proof still must be received within sixty (60) days of our request.

Rights and Responsibilities of Members: Our Commitment to Each Other

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

Rights of Members

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

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

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

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

a. See Plan Providers, get covered health care services and get your prescriptions filled within a reasonable period of time and in an efficient, prompt, caring and professional manner;
b. Have your medical care, medical records and protected health information (PHI) handled confidentially and in a way that respects your privacy;
c. Be treated with respect and dignity;
d. Request that a staff member be present as a chaperone during medical appointments or tests;
e. Receive and exercise your rights and responsibilities without any discrimination based on age, gender, sexual orientation, race, ethnicity, religion, disability, medical condition, national origin, educational background, reading skills, ability to speak or read English, or economic or health status, including any intellectual disability or physical handicap you may have;
f. Request interpreter Services in your primary language at no charge; and
g. Receive health care in facilities that are environmentally safe and accessible to all.

Responsibilities of Members

As a Member of Kaiser Permanente, you are responsible to:

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

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

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

The health care coverage described in this Agreement has been designed to be a High Deductible Health Plan qualified for use with a Health Savings Account. A Health Savings Account is a tax-exempt account established under Section 223(d) of the Internal Revenue Code for the exclusive purpose of paying 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 $1,600 or greater and a family Deductible of $3,200 or greater; and
2. Individual Out-of-Pocket Maximum of no more than $8,050 and a family Out-of-Pocket Maximum of no more than $16,100 in the current contract year.

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

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

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

Payment of Premium

Members are entitled to health care coverage only for the period for which 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. You will be billed for any

Deductible and/or Coinsurance you owe. **Note:** You will not be charged both a Copayment and Coinsurance for the same covered Service.

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

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

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

Open Enrollment

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

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

Enrollment Period and Effective Date of Coverage

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

Your Group will let you know when the open enrollment period begins and ends. Your membership will be effective at 12 a.m. Eastern Time (the time at the location of the administrative office of carrier at 2101 East Jefferson Street, Rockville, Maryland 20852) on the 1st day of the contract year.

New Employees and Their Dependents

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

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

Special Enrollment

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

1. Become eligible for a special enrollment period, as described in this section; or
2. Did not enroll in any coverage through your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions

about enrolling at a later time. The effective date of an enrollment resulting from this provision is no later than the 1st day of the month following the date your Group receives a Health Plan-approved enrollment or change of enrollment application from the Subscriber.

Special Enrollment Due to New Dependents

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

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

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

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

3. **For newly adopted children, the date of adoptive or parental placement with a Subscriber or Subscriber's Spouse, for the purpose of adoption.** If a child is placed with the Subscriber within thirty-one (31) days of birth, such child will be considered a newborn of the Subscriber as of the date of adoptive or parental placement.

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

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

4. **For children who are newly eligible for coverage as the result of foster care placement or guardianship granted by court or testamentary appointment, the date of court or testamentary appointment.** If payment of addition Premium is required to provide coverage for the child, notification of the court or testamentary appointment may be provided at any time but, payment of Premium must be provided within thirty-one (31) days of the enrollment of the child, otherwise, enrollment of the child terminates thirty-one (31) days from the date of court or testamentary appointment.

Special Enrollment Due to Court or Administrative Order

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

approved enrollment or change of enrollment application.

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

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

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

Special Enrollment Due to Loss of Other Coverage

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

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

Note: If you are enrolling yourself as a Subscriber along with at least one (1) eligible Dependent, only one (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-one (31) days after loss of other coverage, except that the timeframe for submitting the application is sixty (60) days if you are requesting enrollment due to loss of eligibility for Medicaid or CHIP coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the 1st day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

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

You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may

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

The effective date of an enrollment resulting from eligibility for the premium assistance under Medicaid or CHIP is no later than the 1st day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special Enrollment Due to Reemployment After Military Service

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

Genetic Testing

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

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

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

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

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

SECTION 2: How to Get the Care You Need

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

When you join the Health Plan, you are selecting our medical care system to provide your medical care. You must receive your care from Plan Providers within our Service Area, except for:

1. Emergency Services, as described in ***Section 3: Benefits, Exclusions and Limitations***;
2. Urgent Care Services outside of our Service Area, as described in ***Section 3: Benefits, Exclusions and Limitations***;
3. ***Continuity of Care***, as described in this section;
4. Approved Referrals, as described in this section under the ***Getting a Referral***, including referrals for Clinical Trials as described in ***Section 3: Benefits, Exclusions and Limitations***;
5. Covered Services received in other Kaiser Permanente regions and Group Health Cooperative service areas; and
6. Non-emergency Surgical or Ancillary Services provided at a Plan Facility by a non-Plan Provider.

When a non-Plan Provider provides Ancillary Services at a Plan Hospital or Plan Facility, Your Cost Share will be the same cost sharing amount for the same Service(s) from a Plan Provider. Such Cost Share shall count toward your Deductible and Out-of-Pocket Maximum. You will not be liable for any additional payment other than your Cost Share for Ancillary Services.

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 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 offices. You may also ask your Primary Care Plan Physician or other health care professionals about problems you may have.

Advance Directives to Direct Your Care While Incapacitated

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

1. Durable Power of Attorney for Health Care, which lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your views on life support and other treatments; and
2. Living Will and the Natural Death Act Declaration to Physicians 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 Member will also receive a physical Kaiser Permanente identification card.

Using Your Kaiser Permanente Identification Card

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

Your medical record number is used to identify your medical records and status as a Member. 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 Member.

Choosing Your Primary Care Plan Physician

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

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

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 twice each month. A listing of all Primary Care Plan Physicians is also provided to you on an annual basis.

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

Getting a Referral

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

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

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

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

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

Copayments, Coinsurance and/or Deductibles for approved referral Services provided by a non-Plan Provider are the same as those required for Services provided by a Plan Provider. **Note:** You will not be charged both a Copayment and Coinsurance for the same covered Service. When Prior Authorization is the responsibility of an in-network provider, any reduction or denial of benefits will not affect the enrollee.

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

Services that Do Not Require a Referral

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

1. An initial consultation for treatment of mental illness, emotional disorders, and drug or alcohol misuse when provided by a Plan Provider. For continued treatment, you or your Plan Provider must contact the Behavioral Health Access Unit for assistance to arrange and schedule these covered Services. The Behavioral Health Access Unit may be reached at 1-866-530-8778;
2. OB/GYN Services provided by an OB/GYN, a certified nurse-midwife or any other Plan Provider authorized to provide OB/GYN Services, including routine care and the ordering of related, covered obstetrical and gynecological Services. A female Dependent age thirteen (13) years or older can receive direct access to Services from a participating obstetrician-gynecologist that is authorized to provide Services under this Agreement and is selected by the Dependent; and

3. Optometry Services.

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

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

Standing Referrals to Specialists

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

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

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

Referrals to Non-Plan Specialists and Non-Physician Specialists

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

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

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

Under Virginia law, a non-Plan Provider shall not balance bill for (i) Emergency Services or (ii) non-emergency Services provided at a Plan Facility if the non-emergency Services involve Surgical or Ancillary Services provided by a non-Plan Provider. If you are balance billed by a non-Plan physician or other non-Plan provider for authorized Services that were provided to you, simply mail a copy of the bill to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. Please mail your proof to us within one (1) year at the following

address:

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

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

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 from your Plan Provider.

Prior Authorization for Prescription Drugs

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

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

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

Continuity of Care

Members may request to continue to receive health care services for a period of at least ninety (90) days from the date of the termination of a Plan Provider from the Health Plan's provider panel, except when terminated for cause.

Under the following special situations, Health Plan will continue to provide benefits for Plan Provider's care for the time periods specified:

1. When the Member has been medically confirmed to be pregnant at the time of the provider's termination, except when terminated for cause. Such treatment may continue, at the Member's option, through the provision of postpartum care directly related to the delivery;

2. When the Member is determined to be terminally ill at the time of the Plan Provider's termination, except when terminated for cause. Such treatment may continue, at the Member's option, for the remainder of their life for care directly related to the treatment of the terminal illness;
3. When the Member has been determined by a medical professional to have a life-threatening condition at that time of the provider's termination of participating such treatment may continue, at the Member's option, for up to 180 days for care directly related to the life-threatening condition; or
4. When the Member is admitted to and receiving treatment in any inpatient facility at the time of a provider's termination, the provider may continue care until the Member is discharged from the inpatient facility.

The terminated Provider will be reimbursed in accordance with Health Plan's agreement with the Provider existing immediately before the Provider's termination of participation.

Getting Emergency and Urgent Care Services

Emergency Services

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

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

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

If Emergency Services are provided by a Non-Plan Provider, Health Plan will make payment for the covered Emergency Services directly to the Non-Plan Provider. The payment amount will be equal to the amount by which the Allowable Charge exceeds your cost sharing amount for the Services.

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

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

1. A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a Hospital, including Surgical or Ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and,

2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under the Emergency Medical Treatment and Active Labor Act.

Urgent Care Services

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

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

Bills for Emergency Services You should not receive a bill for Emergency Services directly from a Plan Provider or non-Plan Provider when the federal No Surprises Act applies. When you do receive a bill from a Hospital, , Independent Freestanding Emergency Department, physician or Surgical or Ancillary provider for Emergency Services that were provided to you, you should either (1) contact the Hospital, physician or other provider to inform them that the bill should be sent to us at the address listed below, or (2) simply mail the bill to us with your medical record number written on it. (Your medical record number can be found on the front of your Kaiser Permanente identification card.) You do not have to pay the bill until we determine what amount you owe, if any, for the Emergency Services. A bill from either the provider or you can be mailed to us at the following address:

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

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

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

Hospital Admissions

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

Getting Assistance from Our Advice Nurses

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

If you are not sure you are experiencing a medical emergency, or for Urgent Care Services for symptoms such as a sudden rash, high fever, severe vomiting, ear infection or sprain, you may call our advice nurses at 1-800-777-7904 or 711 (TTY).

You may also call 1-800-677-1112 from anywhere in the United States, Canada, Puerto Rico or the Virgin Islands.

Getting a Second Opinion

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

Receiving Care in Another Kaiser Foundation Health Plan Service Area

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

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

Payment Toward Your Cost Share and When You May Be Billed

In most cases, you will be asked to make a payment toward your Cost Share at the time you receive Services. Cost share payments made by you or on your behalf, (including manufacturer coupons, when accepted) will apply to your Out-of-Pocket Maximum.

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

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

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

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

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

SECTION 3: Benefits, Exclusions and Limitations

Your Benefits

The benefits described in this section are covered only when:

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

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

1. Emergency Services, as described in this section;
2. Urgent Care Services outside of our Service Area, as described in this section;
3. Continuity of Care for New Members, as described in ***Section 2: How to Get the Care You Need***;
4. Approved referrals, as described under ***Getting a Referral*** in ***Section 2: How to Get the Care You Need***, including referrals for clinical trials as described in this section; and
5. Non-emergency Surgical or Ancillary Services provided at a Plan Facility by a non-Plan Provider.

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

For authorized Services provided within our Service Area by a Plan Provider or a non-Plan Provider, 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, Independent Freestanding Emergency Department, urgent care center, physician or ancillary provider for covered Services that were provided to you, simply mail a copy of the bill to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. Please mail your proof to us within one (1) year at the following address:

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

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

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

List of Benefits

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

Accidental Dental Injury Services

We cover Medically necessary dental services to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. Dental appliances required to diagnose or treat an accidental injury to the teeth, and the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face, are also covered.

Coverage is provided when all of the following conditions have been satisfied:

1. A Plan Provider provides the restorative dental Services;
2. The injury occurred as the result of an external force that is defined as violent contact with an external object; and

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

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

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

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

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

Benefit-Specific Exclusion:

1. Services provided by non-Plan Providers.

Allergy Services

We cover the following allergy Services:

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

Ambulance Services

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

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

2. The ambulance transportation has been ordered by a Plan Provider.

Coverage is also provided for Medically Necessary transportation or Services including Medically Necessary air ambulance transport to the nearest Hospital able to provide needed Services, rendered as the result of a 911 call. Your Cost Share will apply to each encounter, whether or not transport was required. Cost Shares for Air Ambulance Services provided by a non-Plan Provider will not exceed that of the Cost Shares for Air Ambulance Services provided by a Plan Provider, and will apply toward your Deductible, if any, and Out-of-Pocket Maximum.

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

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

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

Note: Any person providing Services by an Emergency medical Services vehicle will receive reimbursement for such Services, when an assignment of benefits is presented by the person providing such Services.

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

Benefit-Specific Exclusions:

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

Anesthesia for Dental Services

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

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

General anesthesia and associated Hospital and ambulatory facility charges will be covered only for

dental care that is provided by a fully accredited Specialist for whom hospital privileges have been granted.

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

Benefit-Specific Exclusions:

1. The dentist or Specialist's dental Services.

Autism Spectrum Disorder (ASD)

We cover Services for the diagnosis and treatment of Autism Spectrum Disorder (ASD) for Members of any age. Autism Spectrum Disorder (ASD) means any pervasive developmental disorder, or Autism Spectrum Disorder as defined in the most recent edition, or the most recent edition at the time of diagnosis, of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. For the purposes of this benefit, diagnosis of ASD means Medically Necessary assessments, evaluations, or tests to diagnose whether an individual has ASD. The diagnosis of ASD shall be made by a Plan Provider or a licensed psychologist who determines the care, including behavioral health treatments and therapeutic care, to be Medically Necessary.

For the purposes of this benefit, Medically Necessary means in accordance with the generally accepted standards of mental disorder or condition care and clinically appropriate in terms of type, frequency, site and duration based upon evidence and reasonably expected to do any of the following:

1. Prevent the onset of illness, condition, injury, or disability;
2. Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury; or disability; or
3. Assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

Treatment for ASD shall be identified in a treatment plan and include the following care prescribed or ordered for an individual diagnosed with ASD by a Plan Provider who determines the care to be Medically Necessary:

1. Behavioral health treatment;
2. Pharmacy care;
3. Psychiatric care;
4. Psychological care;
5. Therapeutic care; and
6. Applied Behavior Analysis (ABA), when provided or supervised by a board-certified behavior analyst licensed by the Virginia Board of Medicine.

Applied Behavior Analysis (ABA) is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior; including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The prescribing practitioner shall be independent of the provider of applied behavior analysis.

A treatment plan means a plan for the treatment of ASD developed by a Plan Provider pursuant to a

comprehensive evaluation or re-evaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

Blood, Blood Products and their Administration

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

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

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

Benefit-Specific Limitation:

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

Benefit-Specific Exclusion:

1. Directed blood donations.

Chemical Dependency and Mental Health Services

We cover the treatment of mental illnesses including, but not limited to, emotional disorders, and Drug and Alcohol Misuse. Coverage includes mobile crisis response services and support and stabilization Services provided in a residential crisis stabilization unit to the extent that such Services are covered in other settings or modalities.

For the purposes of this benefit provision:

1. Drug and Alcohol Misuse means a disease that is characterized by a pattern of pathological use of a drug and/or alcohol with repeated attempts to control its use and with significant negative consequences in at least one the following areas of life: medical, legal, financial or psycho-social.
2. Mobile crisis response Services means Services delivered to provide for rapid response to, assessment of, and early intervention for individuals experiencing an acute mental health crisis that are deployed at the location of the individual.

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

1. Individual therapy;
2. Group therapy;
3. Electroconvulsive Therapy (ECT);
4. Drug therapy;
5. Education;
6. Psychiatric nursing care; and
7. Appropriate Hospital Services.

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

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

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

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

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

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

Benefit-Specific Exclusions:

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

Cleft Lip, Cleft Palate or Ectodermal Dysplasia

We cover inpatient and outpatient Services when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia. Coverage includes orthodontics, oral surgery, otologic, audiological and speech/language treatment, and dental Services and dental appliances furnished to a newborn child.

Clinical Trials

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

1. The cost of an investigational drug or device, except as provided below for off-label use of an United States Food and Drug Administration (FDA) approved drug or device;

2. The cost of non-health care Services that may be required as a result of treatment in the clinical trial; or
3. Costs associated with managing the research for the clinical trial.

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

1. The Services would be covered if they were not related to a clinical trial;
2. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   a. A Plan Provider makes this determination;
   b. You provide us with medical and scientific information establishing this determination;
3. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside of the state in which you live;
4. The clinical trial is a phase I, phase II, phase III or phase IV clinical trial related to the prevention, detection or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
   a. The study or investigation is conducted under an investigational new drug application reviewed by the FDA;
   b. The study or investigation is a drug trial that is exempt from having an investigational new drug application;
   c. An institutional review board of an institution in the state which has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the National Institutes of Health; or
   d. The study or investigation is approved or funded 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; or
   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.

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

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

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

Benefit-Specific Exclusions:

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

Diabetic Equipment, Supplies, and Self-Management Training

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

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

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

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

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

Benefit-Specific Limitations:

Diabetic equipment and supplies are limited to Health Plan preferred equipment and supplies unless the equipment or supply:

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

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

Dialysis

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

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

We cover the following renal dialysis Services:

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

We cover the following self-dialysis Services:

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

We cover home dialysis, which includes:

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

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

Drugs, Supplies and Supplements

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

1. Oral, infused or injected drugs and radioactive materials used for therapeutic purposes including chemotherapy. This includes off-label use of a drug when the drug is recognized in Standard Reference Compendia or certain medical literature as appropriate in the treatment of the diagnosed condition. Standard Reference Compendia means American Hospital Formulary Service Drug Information, National Comprehensive Cancer Network's Drugs & Biologics Compendium, or Elsevier Gold Standard's Clinical Pharmacology;
2. Injectable devices;
3. The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
4. Medical and surgical supplies including dressing, splints, casts, hypodermic needles, syringes or any other Medically Necessary supplies provided at the time of treatment;
5. Vaccines and immunizations approved for use by the FDA that are not considered part of routine preventive care;

6. Any drug prescribed to treat a covered condition, even those typically used as a customary treatment for another condition, so long as the drug has been approved by the FDA and is recognized for treatment of the covered condition in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature;
7. Any drug approved by the FDA for use in the treatment of cancer, even if that drug has not been approved by the FDA for treatment of the specific type of cancer for which the drug has been prescribed, as long as the drug has been recognized as safe and effective for treatment of the member's type of cancer; and
8. Any drug approved by the FDA for cancer pain in excess of the recommended dosage when the excess dosage is determined to be Medically Necessary by a Plan Provider for a patient with intractable cancer pain.

Note: Dispensing limitations for FDA-approved prescription drugs used in the treatment of cancer pain management for patients with intractable cancer pain will be waived.

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

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

Prior authorization or step-therapy may be required for covered prescription drugs or supplies, and supplements administered by medical personnel in an office Visit. A list of drugs subject to utilization management is available to you upon request. You may contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

For more information, see ***Getting a Referral*** in ***Section 2: How to Get the Care You Need***.

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

Benefit-Specific Exclusions:

1. Drugs, supplies, and supplements which can be self-administered or do not require administration or observation by medical personnel.
2. Drugs for which a prescription is not required by law.
3. Drugs for the treatment of sexual dysfunction disorders.
4. Drugs for the treatment of infertility.
5. Contraceptive drugs, unless otherwise covered under an ***Outpatient Prescription Drug Rider*** attached to this EOC.

Durable Medical Equipment

Durable Medical Equipment is defined as equipment that:

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

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

Basic Durable Medical Equipment

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

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

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

Supplemental Durable Medical Equipment

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

Oxygen and Equipment

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

Positive Airway Pressure Equipment

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

Apnea Monitors

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

Asthma Equipment

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

1. Spacers
2. Peak-flow meters

3. Nebulizers

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

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

International Normalized Ratio (INR) Home Testing Machines
INR home testing machines when deemed Medically Necessary by a Plan Physician.

Lymphedema Equipment & Supplies
We cover diagnosis, evaluation and treatment of lymphedema, including:

1. Equipment;
2. Supplies;
3. Complex decongestive therapy;
4. Gradient compression garments, and
5. Self–management training and education.

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

Benefit-Specific Exclusions:

1. Comfort, convenience, or luxury equipment or features.
2. Exercise or hygiene equipment.
3. Non-medical items such as sauna baths or elevators.
4. Modifications to your home or car.
5. Devices for testing blood or other body substances, except as covered under the ***Diabetes Equipment, Supplies and Self-Management Training*** benefit.
6. Electronic monitors of the heart or lungs, except infant apnea monitors, and oximetry monitors for patients on home ventilation.
7. Services not preauthorized by the Health Plan.

Early Intervention Services

We cover Medically Necessary early intervention Services for Dependents from birth to age 3 who are certified by the Department of Behavioral Health and Developmental Services ("the Department") as eligible for Services under Part C of Individuals with Disabilities Education Act. These Services consist of:

1. Speech and language therapy;
2. Occupational therapy;
3. Physical therapy; and
4. Assistive technology Services and devices.

Early intervention Services for the population certified by the Department are those Services listed above which are determined to be Medically Necessary by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include services which enhance functional ability without effecting a cure. Benefits for Services listed shall not

be limited by the exclusion of Services that are not Medically Necessary. The benefit maximums for physical, occupational, and speech therapy listed in ***Therapy and Multidisciplinary Rehabilitation Services*** will not apply if you get that care as part of the early intervention benefit.

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

Benefit-Specific Exclusion:

1. Care which has been provided under federal, state or local early intervention programs, including school programs, at no cost to the member.

Emergency Services

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

If you think you are experiencing an Emergency Medical Condition you should call 911 immediately. If you are not sure whether you are experiencing an Emergency Medical Condition, please contact us at the number listed on the reverse side of your ID card for immediate medical advice.

We cover Emergency Services as follows:

Inside our Service Area

We cover emergency room Surgical or Ancillary Services for Emergency Services provided within our Service Area by a Plan Provider or a non-Plan Provider. You will not incur any additional Cost Sharing for Emergency Services beyond that which is indicated in your ***Summary of Services and Cost Shares***. Coverage provided by a non-Plan Provider is limited to Emergency Services required before you can, without medically harmful consequences, be transported to a Plan Hospital or your Primary Care Plan Physician's office.

Outside of our Service Area

We cover charges for Emergency Services if you are injured or become ill while temporarily outside of our Service Area but within the United States. We cover emergency room Surgical or Ancillary Services when received by a non-Plan Provider at a Plan Facility. You will not incur any additional Cost Sharing for Emergency Services beyond that which is indicated in your ***Summary of Services and Cost Shares***.

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

Note: Surgical or Ancillary Services are professional Services including surgery, anesthesiology, pathology, radiology, or hospitalist Services and laboratory Services.

Outside the United States

If you are injured or become ill while temporarily outside the United States, we will cover charges for Emergency Services as defined in this section; subject to the same Cost Shares that would apply if the Service was provided inside our Service Area. You will not incur any additional Cost Sharing for Emergency Services beyond that which is indicated in your Summary of Cost Shares.

Continuing Treatment Following Emergency Services

Inside our Service Area

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

Inside another Kaiser Permanente Region

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

Outside of our Service Area

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

Transport to a Service Area

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

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

Continued Care in Non-Plan Facility Limitation

If you are admitted to a non-Plan Hospital, you or someone on your behalf must notify us within the later of forty-eight (48) hours of any hospital admission, or on the 1st business day following the admission, unless it was not reasonably possible to notify us within that time. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us, of if you choose not to be transferred, we will not cover any Services you receive after transfer would have been possible.

Post-Stabilization Care

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

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

within a reasonable travel distance taking into account your medical condition.

Filing Claims for Non-Plan Emergency Services

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

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

Bills for Emergency Services

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

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

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

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

Benefit-Specific Limitations:

1. **Notification:** If you receive care at a Hospital emergency room or are admitted to a non-Plan Hospital, you, or someone on your behalf, must notify us as soon as possible, but not later than forty-eight (48) hours after the emergency room Visit or Hospital admission, or the next business day, whichever is later, unless it was not reasonably possible to notify us. If you are admitted to a Hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. Once your emergency condition has been Stabilized, all continuing, and follow-up treatment must be authorized by us. If you do not notify us and obtain authorization for a continued hospital stay once your condition has Stabilized, we will not cover the inpatient Hospital charges you incur after transfer would have been possible.
2. **Continuing or Follow-up Treatment:** We do not cover continuing or follow-up treatment after Emergency Services unless authorized by the Health Plan. We cover only the out-of-Plan Emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside of our Service Area or in another Kaiser Foundation Health Plan or allied plan Service area.
3. **Hospital Observation:** Transfer to an observation bed or observation status does not qualify as an admission to a Hospital. Your emergency room visit copayment, if applicable, will not be waived.

Family Planning Services

We cover the following:

1. Women's Preventive Services (WPS), including:
   a. Patient education and contraceptive method counseling for all women of reproductive capacity;
   b. Coverage for FDA-approved contraceptive devices, 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; and
2. Family planning counseling, including pre-abortion and post-abortion counseling; and
3. Male sterilization (i.e., vasectomies); and
4. Voluntary termination of pregnancy, elective and therapeutic termination of pregnancy as permitted under state law.

Note: We cover therapeutic termination of pregnancy as permitted under state law (1) if the fetus is believed to have an incapacitating chromosomal, metabolic or anatomic defect or deformity that has been certified by a Plan Provider; or (2) when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself; or (3) when the pregnancy is the result of an alleged act of rape or incest.

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

Gender Affirming Care

We cover Medically necessary transition-related care which includes:

1. outpatient psychotherapy and mental health Services for gender dysphoria and associated comorbid psychiatric diagnoses;
2. continuous hormone replacement therapy;
3. outpatient laboratory testing to monitor continuous hormone therapy; and
4. gender reassignment surgeries.

Hearing Services

Hearing Exams

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

Hearing Aids and Related Services (for children eighteen (18) years of age or younger

A hearing aid is defined as any wearable, non-disposable instrument or device designed or offered to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including earmolds. The hearing aid benefit allowance is the maximum the Health Plan will pay toward the cost of a covered hearing aid.

Coverage for hearing aids are provided for children eighteen (18) years of age or younger when Services and equipment are recommended, provided, or dispensed by an otolaryngologist, licensed audiologist, or licensed hearing aid specialist.

Related services include earmolds, initial batteries, and other necessary equipment, maintenance, and adaptation training.

Note*: A Member may apply the hearing aid benefit allowance towards a hearing aid upgrade, however, the Member must pay the difference in the hearing aid benefit allowance and the cost of the hearing aid upgrade.*

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

Benefit-Specific Limitations:

1. Your hearing aid Benefit Allowance is $1500 per hearing aid.
2. Coverage is provided for one Hearing Aid for each hearing-impaired ear every twenty-four (24) months. Two Hearing Aids are covered every twenty-four (24) months only if both are required to provide significant improvement that is not obtainable with only one Hearing Aid, as determined by your Plan Provider.
3. You are not required to obtain Hearing Aids for both ears at the same time. The twenty-four (24) month benefit period extends separately for each ear, and commences at the initial point of sale for each ear.
4. The hearing aid Benefit Allowance must be used at the initial point of sale for each hearing aid. Any part of the hearing aid Benefit Allowance that is not exhausted at the initial point of sale may not be used at a later time.
5. The type of Hearing Aid is limited to the models provided by Kaiser Permanente or the Kaiser Permanente-designated Hearing Aid vendor.

Note: You may apply the hearing aid Benefit Allowance toward a hearing aid upgrade. However, you must pay the difference in the hearing aid Benefit Allowance and the cost of the hearing aid upgrade.

Benefit-Specific Exclusions:

1. Tests to determine an appropriate hearing aid.
2. Hearing tests to determine hearing aid efficacy; except as specifically provided in this section, or as provided under a ***Hearing Services Rider***, if applicable.
3. Replacement of parts including cords and batteries.
4. Replacement of lost or broken hearing aid.
5. Repair of hearing aid beyond one year.
6. Comfort, convenience, or luxury equipment or features.
7. Hearing aids prescribed and ordered prior to coverage or after termination of coverage.

Home Health Care

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

1. Skilled nursing Services;
2. Home health aide Services;
3. Medical social Services and
4. Remote patient monitoring

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

Remote Patient Monitoring is the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

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

Home Health Visits Following Mastectomy or Removal of Testicle

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

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

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

Benefit-Specific Limitation:

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

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

Visit limits do not apply to home health Services for Chemical Dependency and Mental Health Services.

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

Benefit-Specific Exclusions:

1. Custodial care (see the definition under ***Exclusions*** in this section).

2. Routine administration of oral medications, eye drops and/or ointments.
3. General maintenance care of colostomy, ileostomy and ureterostomy.
4. Medical supplies or dressings applied by a Member or family caregiver.
5. Corrective appliances, artificial aids and orthopedic devices.
6. Homemaker Services.
7. Services not preauthorized by the Health Plan.
8. Care that a Plan Provider determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, and we provide or offer to provide that care in one of these facilities.
9. Transportation and delivery Service costs of Durable Medical Equipment, medications, drugs, medical supplies and supplements to the home.

Hospice Care Services

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

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

Hospice Care Services include the following:

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

Definitions:

1. **Family Member** means a relative by blood, marriage or adoption who lives with or regularly participates in the care of the terminally ill Member.
2. **Hospice Care** means a coordinated, interdisciplinary program of hospice care Services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other

health Services through home or inpatient care during the illness and bereavement counseling following the death of the Member.

3. **Respite Care** means temporary care provided to the terminally ill Member to relieve the Member's Caregiver from the daily care of the Member.
4. **Caregiver** means an individual primarily responsible for the day to day care of the Member during the period in which the Member receives Hospice Services.

Hospital Inpatient Care

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

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

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

Minimum Stay for Hysterectomy

We cover a minimum stay in a Hospital of not less than 23 hours laparoscopy-assisted vaginal hysterectomy; and a minimum stay in a Hospital of not less than 48 hours coverage for a vaginal hysterectomy including as provided in this section. A shorter period of Hospital stay may be determined appropriate between you and your physician.

Minimum Stay for Mastectomy

We cover a minimum hospital stay of no less than forty-eight (48) hours following a radical or modified radical mastectomy and no less than twenty-four (24) hours following a total or partial mastectomy with lymph node dissection.

Infertility Services

We cover the following:

1. Services for diagnosis and treatment of involuntary infertility for females and males. ; and
2. Artificial insemination.

Notes:

1. Involuntary infertility means the inability to conceive after one (1) year of unprotected vaginal intercourse.

2. Diagnostic procedures and any covered drugs administered by or under the direct supervision of a Plan Provider are covered under this provision. Refer to the ***Outpatient Prescription Drug Rider***, if applicable, for coverage of outpatient infertility drugs.

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

Benefit-Specific Exclusions:

1. Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member's eggs and/or male Member's sperm for future attempts.
2. With the exception of those seeking artificial insemination, assisted reproductive procedures and any related testing or Service that includes the use of donor sperm, donor eggs or donor embryos.
3. Any charges associated with obtaining donor eggs, donor sperm or donor embryos.
4. Infertility Services when the Member does not meet medical guidelines established by the American Society of Reproductive Medicine and the American Society for Reproductive Endocrinology.
5. Services not preauthorized by the Health Plan.
6. Services to reverse voluntary, surgically induced infertility.
7. Infertility Services when the infertility is the result of an elective male or female surgical procedure.
8. Assisted reproductive technologies and procedures, including, but not limited to: in vitro fertilization (IVF); gamete intrafallopian transfers (GIFT); zygote intrafallopian transfers (ZIFT); assisted hatching; and prescription drugs related to such procedures.

Maternity Services

We cover pre-and post-natal Services, which includes routine and non-routine office Visits, telemedicine Visits, x-ray, laboratory and specialty tests. The Health Plan covers birthing classes and breastfeeding support, supplies, and counseling from trained providers during pregnancy and/or in the postpartum period.

Services for non-routine obstetrical care are covered subject to applicable cost share for specialty, diagnostic and/or treatment Services. "Non-routine obstetrical care" includes:

1. Services provided for a condition not usually associated with pregnancy;
2. Services provided for conditions existing prior to pregnancy;
3. Services related to the development of a high-risk condition(s) during pregnancy; and
4. Services provided for the medical complications of pregnancy.

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

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

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

Note: Prior authorization is not required for the interhospital transfer of a newborn infant experiencing a life-threatening emergency condition or for the hospitalized mother of such newborn infant to accompany that infant.

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

Benefit-Specific Exclusions:

1. Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.
2. Services for newborn deliveries performed at home.

Medical Foods

We cover Medically Necessary medical foods, formulas, enteral nutrition, and low protein modified food products for the therapeutic treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry including a disease for which the State screens newborn babies. Medically Necessary formula and enteral nutrition products are classified as medicine. Coverage is provided if the medical foods, formulas, enteral nutrition and low protein food products are administered under medical supervision, which may include a home setting.

Medical foods are intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and are formulated to be consumed under the direction of a Plan Provider.

Low protein modified foods are food products that are:

1. Specially formulated to have less than one (1) gram of protein per serving; and
2. Intended to be used under the direction of a Plan Provider for the dietary treatment of an inherited metabolic disorder.

We cover medical equipment and supplies and Services that are required to administer the covered formulas or enteral products.

Amino Acid-based Elemental Formula (Drugs, Supplies and Supplements)

We cover amino acid-based elemental formula, regardless of delivery method, for the diagnosis and treatment of:

1. Immunoglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins;
2. Severe food protein induced enterocolitis syndrome;
3. Eosinophilic disorders, as evidenced by the results of a biopsy; and
4. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Coverage shall be provided if the ordering physician has issued a written order stating that amino acid-based elemental formula is Medically Necessary for the treatment of a disease or disorder listed above. The Health Plan, or a private review agent acting on behalf of the Health Plan, may review the ordering physician's determination of the Medical Necessity of the amino acid-based elemental formula for the

treatment of a disease or disorders listed above.

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

Benefit-Specific Exclusions:

1. Medical food for treatment of any conditions other than an inherited metabolic disease.
2. Amino-acid based elemental formula for treatment of any condition other than those listed above.

Medical Nutrition Therapy and Counseling

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

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

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

Morbid Obesity Services

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

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

Morbid obesity is defined as:

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

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

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

Benefit-Specific Exclusion:

1. Services not preauthorized by the Health Plan.

Oral Surgery

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

We also cover treatment of significant congenital defects, causing functional impairment, found in the oral cavity or jaw area which are similar to disease or which occur in other parts of the body, including

Medically Necessary medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses.

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

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

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

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

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

Temporomandibular Joint Services

Coverage is provided for:

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

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

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

Benefit-Specific Exclusions:

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

Outpatient Care

We cover the following outpatient care:

1. Primary Care Visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics/gynecology (OB/GYN) Services. (Refer to ***Preventive Health Care Services*** for coverage of preventive care Services);

2. Specialty care Visits (Refer to ***Section 2: How to Get the Care You Need*** for information about referrals to Plan Specialists);
3. Consultations and immunizations for foreign travel;
4. Diagnostic testing for care or treatment of an illness, or to screen for a disease for which you have been determined to be at high risk for contracting, including, but not limited to:
    a. Diagnostic examinations, including digital rectal exams and prostate antigen (PSA) tests provided in accordance with American Cancer Society guidelines to:
        i. Persons age 50 or older and
        ii. Persons age 40 or older who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society;
    b. Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations. Your initial screening colonoscopy will be preventive;
    c. Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A "qualified individual" means an individual:
        i. Who is estrogen deficient individual at clinical risk for osteoporosis;
        ii. With a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
        iii. Receiving long-term glucocorticoid (steroid) therapy;
        iv. With primary hyperparathyroidism; or
        v. Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;
8. Outpatient surgery;
9. Anesthesia, including Services of an anesthesiologist;
10. Chemotherapy and radiation therapy;
11. Respiratory therapy;
12. Medical social Services;
13. House calls when care can best be provided in your home as determined by a Plan Provider;
14. After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to ***Urgent Care*** for covered Services.

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

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

Preventive Health Care Services

In addition to any other preventive benefits described in the group contract or certificate, the Health

Plan shall cover the following preventive Services and shall not impose any cost-sharing requirements, such as Deductibles, Copayment amounts or Coinsurance amounts to any Member receiving any of the following benefits for Services from Plan Providers:

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

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

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

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

1. Preventive care exams, including:
   a. Routine physical examinations and health screening tests appropriate to your age and sex;
   b. Well-woman examinations; and
   c. Well childcare examinations;
2. Routine and necessary immunizations (travel immunizations are not preventive and are covered under ***Outpatient Care***) for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;
3. An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
4. Low dose screening mammograms to determine the presence of breast disease is covered as follows:
   a. One mammogram for persons age 35 through 39;
   b. One mammogram biennially for persons age 40 through 49; and
   c. One mammogram annually for person 50 or older;

5. Bone mass measurement to determine risk for osteoporosis;
6. Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to men who are age 40 or older;
7. Colorectal cancer screening in accordance with screening guidelines issued by the American Cancer Society including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy;
8. Cholesterol test (lipid profile);
9. Diabetes screening (fasting blood glucose test);
10. Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis and Human Papillomavirus (HPV)), subject to the following:
    a. Annual chlamydia screening is covered for:
        i. Women under age 20 if they are sexually active; and
        ii. Women age 20 or older, and men of any age, who have multiple risk factors, which include:
            a) Prior history of sexually transmitted diseases;
            b) New or multiple sex partners;
            c) Inconsistent use of barrier contraceptives; or
            d) Cervical ectopy;
    b. Human Papillomavirus Screening (HPV) as recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;
11. Human immunodeficiency virus (HIV) tests and counseling;
12. TB tests;
13. Newborn hearing screenings that include follow up audiological examinations, as recommended by a physician or audiologist, and performed by a licensed audiologist to confirm the existence or absence of hearing loss when ordered by a Plan Provider;
14. Associated preventive care radiological and laboratory tests not listed above;
15. BRCA counseling and genetic testing is covered at no Cost Share. Any follow up Medically Necessary treatment is covered at the applicable Cost Share based upon type and place of Service.

Note: Colorectal cancer screening also includes polyp removal and anesthesia provided in connection with a preventive colonoscopy screening at no cost sharing to the Member. Follow-up colonoscopies following a positive non-invasive stool-based screening test are also covered at no charge to the Member.

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

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

Note: Refer to ***Diabetic Equipment, Supplies, and Self-Management Training*** for coverage of glucose

monitoring equipment.

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

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

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

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

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

Prosthetic and Orthotic Devices

We cover the devices listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or injured. Coverage includes fitting and adjustment of these devices, repair or replacement (unless due to loss, misuse or theft), and Services to determine whether you need the Prosthetic Device. If we do not cover the Prosthetic Device, we will try to help you find facilities where you may obtain what you need at a reasonable price. Coverage is limited to the standard device that adequately meets your medical needs.

Internal Prosthetics
We cover Medically Necessary internal devices implanted during surgery, such as pacemakers, monofocal intraocular lens implants, artificial hips and joints, breast implants (see ***Reconstructive Surgery***) and cochlear implants, that are approved by the federal Food and Drug Administration for general use.

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

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

Artificial Limbs and Eyes
We cover Medically Necessary Prosthetic Devices to replace, in whole or in part, a limb or eye, their repair, fitting, replacement and components.

As used in this provision:
Medically necessary prosthetic device includes any myoelectric, biomechanical, or microprocessor-controlled prosthetic device that peer-reviewed medical literature has determined to be medically appropriate on the basis of the clinical assessment of the enrollee's rehabilitation potential.

"Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

"Component" means the materials and equipment needed to ensure the comfort and functioning of a Prosthetic Device.

Ostomy and Urological Supplies and Equipment

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

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

Breast Prosthetics and Hair Prosthesis

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

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

In addition, we cover one Medically Necessary hair prosthesis.

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

Benefit-Specific Limitations:

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

Benefit-Specific Exclusions:

1. Internally implanted breast prosthesis for cosmetic purposes.
2. Repair or replacement of prosthetic devices due to loss, misuse or theft.

3. Myoelectric, biomechanical or microprocessor and robotic-controlled external prosthetics that dos not meet the Health Plan criteria as Medically Necessary.
4. Multifocal intraocular lens implants.
5. More than one piece of equipment or device for the same part of the body, except for replacements, spare devices or alternate use devices.
6. Dental prostheses, devices and appliances, except as specifically provided in this section, or the Oral Surgery section, or as provided under an ***Adult Dental Plan Rider*** or a ***Pediatric Dental Plan Rider***, if applicable.
7. Hearing aids, except as specifically provided in this section, as provided under Hearing Services/Hearing Aids and Related Services, or as provided under a ***Hearing Services Rider***, if applicable.
8. Corrective lenses and eyeglasses, except as specifically provided in this section.
9. Orthopedic shoes or other supportive devices, unless the shoe is an integral part of a leg brace; or unless indicated above.
10. Non-rigid appliances and supplies, including but not limited to: jobst stockings; elastic garments and stockings; and garter belts.
11. Comfort, convenience, or luxury equipment or features.

Reconstructive Surgery

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

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

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

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

Benefit-Specific Exclusions:

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

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

Routine Foot Care

Coverage is provided for Medically Necessary routine foot care.

Benefit-Specific Exclusion:

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

Skilled Nursing Facility Care

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

We cover the following Services:

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

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

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

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

Benefit-Specific Exclusions:

1. Custodial care (see the definition under ***Exclusions*** in this section).
2. Domiciliary Care

Telemedicine Services

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

Regardless of the originating site and whether the patient is accompanied by a health care provider at the time such Services are provided, telemedicine Services is the delivery of healthcare Services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, treatment or providing remote patient monitoring Services as it pertains to the delivery of covered health care Services including mental health and substance use disorder Services.

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

Benefit-Specific Exclusion:

1. Services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions.

Therapy and Rehabilitation Services

Physical, Occupational, and Speech Therapy Services

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

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

Refer to the ***Summary of Services and Cost Shares*** for Visit limitations for Physical, Occupational, and Speech Therapy Services. The limits do not apply to necessary treatment of cleft lip or cleft palate, early intervention Services, home health Services, autism spectrum disorder (ASD) Services, hospice care and mental health conditions or while you are an inpatient in a Hospital.

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

Multidisciplinary Rehabilitation Services

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

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

Cardiac Rehabilitation Services

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

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

Pulmonary Rehabilitation Services

We cover pulmonary rehabilitation Services that are Medically Necessary.

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

Benefit-Specific Limitations:

1. Physical therapy is limited to treatment to restore physical function that was lost due to injury or illness. It is not covered to develop physical function, except as provided for under ***Early Intervention Services*** in this ***List of Benefits***.
2. Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.

3. The limitations listed above for physical, occupational and speech therapy also apply to those Services when provided within a multidisciplinary program.

Benefit-Specific Exclusion:

1. Long-term rehabilitative therapy.

Therapy: Radiation, Chemotherapy and Infusion Therapy

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

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

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

We will not hold proton radiation therapy to a higher standard of clinical evidence for decisions regarding coverage under this Agreement than is applied for decisions regarding coverage of other types of radiation therapy treatment.

Transplants

We will not deny transplant Services based on physical, intellectual, developmental or other disability.
If the following criteria are met, we cover stem cell rescue and transplants of organs, tissue or bone marrow:

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

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

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

We also provide coverage for Medically Necessary routine dental Services recommended prior to transplant. See the benefit-specific exclusion immediately below for additional information.

Benefit-Specific Exclusion:

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

Urgent Care

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

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

Inside our Service Area

We will cover charges for Urgent Care Services received from Plan Providers and Plan Facilities within the Service Area. You will not incur any additional Cost Sharing for Urgent Care Services beyond that which is indicated in your Summary of Cost Shares.

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

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

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

Outside of our Service Area

If you are injured or become ill while temporarily outside of the Service Area, we will cover charges for Urgent Care Services as defined in this section. You will not incur any additional Cost Sharing for Urgent Care Services beyond that which is indicated in your Summary of Cost Shares. All follow-up care must be provided by a Plan Provider or Plan Facility.

Bills for Urgent Care Services

If you are balance billed by an urgent care center for Urgent Care Services that were provided to you, simply mail a copy of the bill to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. Please mail your proof to us within one (1) year at the following address:

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

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

If you obtain prior approval from the Health Plan, covered benefits include the cost of necessary ambulance or other special transportation Services medically required to transport you to a Plan Hospital

or Plan Medical Center in the Service Area, or in the nearest Kaiser Foundation Health Plan region for continuing or follow-up treatment.

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

Benefit-Specific Limitation:

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

Benefit-Specific Exclusion:

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

Vision Exam Services

Medical Treatment

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

Eye Exams

We cover routine and necessary eye exams, including:

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

Pediatric Eye Exams

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

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

Pediatric Lenses and Frames

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

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

In addition, we cover the following Services:

Eyeglass Lenses

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

Frames

We provide a discount on the purchase of eyeglass frames, when purchased at a Kaiser Permanente Optical Shop. You will receive a discount on the purchase of eyeglass lenses and frames combined in lieu of the purchase of contact lenses. The discount includes the mounting of eyeglass lenses in the frame, original fitting of the frames, and subsequent adjustment.

Contact Lenses

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

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

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

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

Benefit-Specific Exclusions:

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

X-Ray, Laboratory and Special Procedures

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

the extent the outpatient Services are covered under ***Outpatient Care***):

1. Diagnostic imaging, including x-ray, diagnostic mammograms and ultrasounds;
2. Laboratory tests, including tests for specific genetic disorders such as preimplantation genetic testing (PGT), for Monogenic/single gene defects (PGT-M) or inherited structural chromosome rearrangements (PGT-SR) for which genetic counseling is available;
3. Special procedures, such as:
   a Electrocardiograms, and
   b Electroencephalograms.
   c Sleep lab and sleep studies; and
4. Specialty imaging: including CT, MRI, PET Scans, and Nuclear Medicine studies; and interventional radiology.

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

Exclusions

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

These exclusions apply to all Services that would otherwise be covered under this Agreement. Benefit-specific exclusions that apply only to a particular Service are noted in the ***List of Benefits*** in this section.

When a Service is not covered, all Services, drugs, or supplies related to the non-covered Service are excluded from coverage, except services we would otherwise cover to treat direct complications of the non-covered Service. For example, if you have a non-covered cosmetic surgery, we will not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication, such as a serious infection, this exclusion will not apply, and we would cover any Services that we would otherwise cover to treat that complication.

The following Services are excluded from coverage:

1. **Alternative Medical Services:** Chiropractic and acupuncture Services and any other Services of a Chiropractor, Acupuncturist, Naturopath and/or Massage Therapist, unless otherwise covered under a Rider attached to this EOC.

2. **Certain Exams and Services:** Physical examinations and other Services:
   a. Required for obtaining or maintaining employment or participation in employee programs;
   b. Required for insurance, licensing, or;
   c. On court-order or required for parole or probation, except for Medically Necessary Services covered in the ***List of Benefits*** in this section.

3. **Cosmetic Services:** Cosmetic Services, including surgery or related Services and other Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies. Examples of cosmetic Services include but are not limited to cosmetic dermatology, cosmetic surgical Services and cosmetic dental Services.

4. **Custodial Care:** Custodial care means assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

5. **Dental Care:** Dental care and dental X-rays, including dental appliances, dental implants, orthodontia, shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any dental treatment involved in temporomandibular joint (TMJ) pain dysfunction syndrome, unless otherwise covered under a Rider attached to this EOC. This exclusion does not apply to Medically Necessary dental care covered under ***Accidental Dental Injury Services***, ***Cleft Lip, Cleft Palate or Ectodermal Dysplasia*** or ***Oral Surgery*** in the ***List of Benefits*** in this section.

6. **Disposable Supplies:** Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices, not specifically listed as covered in the ***List of Benefits*** in this section.

7. **Durable Medical Equipment:** Except for Services covered under ***Durable Medical Equipment*** in the ***List of Benefits*** in this section.

8. **Employer or Government Responsibility:** Financial responsibility for Services that an employer or government agency is required by law to provide.

9. **Experimental or Investigational Services:** Except as covered under ***Clinical Trials*** in the ***List of Benefits*** in this section, a Service is experimental or investigational for your condition if any of the following statements apply to it as of the time the Service is, or will be, provided to you:
   a. It cannot be legally marketed in the United States without the approval of the United States Food and Drug Administration (FDA), and such approval has not been granted; or
   b. It is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or
   c. It is subject to the approval or review of an Institutional Review Board (IRB) of the treating facility that approves or reviews research concerning the safety, toxicity or efficacy of services; or
   d. It is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

   In making determinations whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:
   a. Your medical records;
   b. Written protocols or other documents pursuant to which the Service has been or will be provided;
   c. Any consent documents you or your representative has executed or will be asked to execute, to receive the Service;

d. Files and records of the IRB or a similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;
e. Published authoritative medical or scientific literature regarding the Service, as applied to your illness or injury; and
f. Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

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

10. **Prohibited Referrals:** Payment of any claim, bill or other demand or request for payment for covered Services determined to be furnished as the result of a referral prohibited by law.
11. **Services for Members in the Custody of Law Enforcement Officers:** Non-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as Out-of-Plan Emergency Services.
12. **Travel and Lodging Expenses:** Travel and lodging expenses. , except that in some situations, if a Plan Physician refers you to a non-Plan Provider outside our Service Area as described under ***Getting a Referral*** in ***Section 2: How to Get the Care You Need***, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines.
13. **Vision Services:** Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia or astigmatism (for example: radial keratotomy, photo-refractive keratectomy and similar procedures.
14. **Worker's Compensation or Employer's Liability:** Charges made for the following are not covered by the Health Plan: Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, Services during a jail or prison sentence, Services you get from workers' compensation, and Services from free clinics. If workers' compensation benefits are not available to you, this exclusion does not apply. This exclusion will apply if you get the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

Limitations

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

1. A major disaster;
2. An epidemic;
3. War;
4. Riot;
5. Civil insurrection;

6. Disability of a large share of personnel of a Plan Hospital or Plan Medical Center; and/or
7. Complete or partial destruction of facilities.

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

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

SECTION 4: Coordination of Benefits

This section provides information on how your benefits may be coordinated with other types of coverage.

Coordination of Benefits

Coordination of Benefits Overview

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

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

Right to Obtain and Release Needed Information

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

Primary and Secondary Plan Determination

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

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

Coordination of Benefits Rules

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

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

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

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

about your eligibility.

Assistance with Questions about the Coordination of Your Benefits

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

Order of Benefit Determination Rules

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

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

Rules for a Non-Dependent and Dependents

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

Rules for a Dependent Child/Parent

1. **Dependent child with parents who are not separated or divorced:** When the Health Plan and another plan cover the same child as a Dependent of different persons, called "parents," who are married or are living together, whether or not they have ever been married, then the plan of the parent whose birthday falls earlier in the year is primary to the plan of the parent whose birthday falls later in the year. When both parents have the same birthday, the plan that covered a parent longer is primary - this is known as the "Birthday Rule". If the "Birthday Rules" does not apply by the terms of the other plan, then the applicable rule in the other plan will be used to determine the order of benefits.
2. **Dependent child with separated or divorced parents:** If two (2) or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   a. First, the plan of the parent with custody of the child;
   b. Then, the plan of the spouse of the parent with custody of the child; and
   c. Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the plan obligated to pay or provide the benefits of that parent has actual knowledge of those terms, that plan is primary. This paragraph does not apply with respect to any Claim

Determination Period or plan year during which any benefits are actually paid or provided before the payer has that actual knowledge.

Active/Inactive Employee Coverage

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

Longer/Shorter Length of Coverage

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

Effect of Coordination of Benefits on the Benefits of this Plan

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

Coordination with the Health Plan's Benefits

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

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

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

Facility of Payment

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

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

Right of Recovery of Payments Made Under Coordination of Benefits

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

Military Service

For any Services for conditions arising from military service that the law requires the Department of

Veterans Affairs to provide, we will not pay the Department of Veterans Affairs. When we cover any such Services, we may recover the value of the Services from the Department of Veterans Affairs.

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

Medicare and TRICARE Benefits

The value of your benefits is coordinated with any benefits to which you are entitled under Medicare, except for Members whose Medicare benefits are secondary by law. TRICARE benefits are usually secondary benefits by law.

Workers' Compensation or Employer's Liability

If you have an active workers' 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
2101 East Jefferson Street, 4 East
Rockville, Maryland 20852

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

SECTION 5: Filing Claims, Appeals and Grievances

Getting Assistance

Member Services representatives are available to assist you at most of our Plan Medical Centers and by phone 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 will answer any questions you have about your benefits, available services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace your Kaiser Permanente identification card. These representatives can also help you file a claim for Emergency Services and Urgent Care Services outside of our Service Area (see ***Post-Service Claims***) or to initiate an Appeal for any unresolved problem.

We want you to be satisfied with your health care. Please discuss any problems with your Primary Care Plan Provider or other health care professionals treating you. If you are not satisfied with your Primary Care Plan Provider, you can request a different Plan Provider by visiting our website **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).

Who to Contact

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

To contact us in writing, mail or fax your correspondence to:

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

When you must file a claim (request for payment/reimbursement) for services inside or outside of the Plan's service area, please submit paper claims to the following address:

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

Paper forms can be obtained by visiting kp.org or by calling the Member Services Contact Center. You may also file a claim electronically by visiting kp.org.

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

- Member/Patient Name and Medical/Health Record Number

- The date you received the Services
- Where you received the Services
- The Physician or other health care provider who provided the Services
- Why you think we should pay for the Services
- A copy of the bill, your medical record(s) for these Services, and your receipt if you paid for the Services.

Procedure for Filing a Claim and Initial Claim Decisions

When receiving services outside of a Plan Medical Center, you will receive an Explanation of Benefits (EOB) within twenty-one (21) days of Proof of Loss. The EOB will describe the Services provided, whether the claim was paid or denied, the amount paid by Health Plan, your Cost Share, and the amounts accumulated toward meeting your Deductible (if applicable) and Out-of-Pocket Maximum. For Services furnished by Kaiser Permanente staff clinicians within a Plan Medical Center, EOBs will not be issued unless the Services provided are subject to a Deductible and/or Coinsurance.

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

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

The initial response of the Health Plan may be to request additional information from the prescribing provider in order to make a determination. The Health Plan will make its utilization review decision no later than two (2) business days following receipt of all the information necessary to complete the review.

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

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

We do not charge you for filing claims or Appeals, but you must bear the cost of anyone you hire to represent or help you. You may also contact the Office of the Managed Care Ombudsman, for which contact information is contained within this section, to obtain assistance.

Pre-Service Claims

Pre-Service Claims are requests that the Health Plan provide or pay for a Service that you have not yet received. Our clinical peer will decide if your claim involves an Urgent Medical Condition or not. If you receive any of the Services you are requesting before we make our decision, your claim or Appeal will

become a Post-Service Claim with respect to those Services. If you have any questions about Pre-Service Claims, please contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Procedure for Making a Non-Urgent Pre-Service Claim

1. Tell Member Services that you want to make a claim for the Health Plan to provide or pay for a Service you have not yet received. Your written or oral request and any related documents you give us constitutes your claim. You may write or call us at the address and number listed above.
2. We will review your claim, and if we have all the information we need, we will communicate our decision within two (2) working days after we receive your claim. If we cannot make a determination because we do not have all the information we need, we will ask you for more information within fifteen (15) days of receipt of your claim. We encourage you to send all the requested information at one time so that we will be able to consider all of it when we make our decision. If we do not receive any of the requested information (including documents) within days, we will then make a decision within fifteen (15) days of the due date or the receipt date, whichever is earlier, based on the information we have.
3. We will make a good faith attempt to obtain information from the treating provider before we make any Adverse Decision. At any time before we make our decision, the provider shall be entitled to review the issue of medical necessity with a physician advisor or peer of the treating provider. A physician reviewer will review the issue of medical necessity with the provider prior to making any Adverse Decision relating to cancer pain medication.
4. If we make an Adverse Decision regarding your claim, we will notify the treating provider:
   a. In writing within two (2) working days of the decision; or
   b. Orally by telephone within twenty-four (24) hours of the decision if the claim is for cancer pain medication.

   Note: The notice will include instructions for the provider to seek a reconsideration of the Adverse Decision, on behalf of the Member, including the name, address and telephone number of the person responsible for making the Adverse Decision.

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

Expedited Procedure for an Urgent Medical Condition

1. If you or your treating provider feels that you have an Urgent Medical Condition, you may request an expedited review of your Pre-Service Claim.
2. If our clinical peer determines your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Pre-Service Claim.
3. We will review your claim, and if we have all the information we need we will notify you of our decision as soon as possible taking into account your medical condition(s) but no later than seventy-two (72) hours after receiving your claim. We will send a written or electronic confirmation within three (3) days after making our decision. If we cannot make a decision because we do not have all the information we need, we will ask you for more information within twenty-four (24) hours of receipt of your claim. You will have forty-eight (48) hours from the time of notification by us to

provide the missing information. We will make a decision forty-eight (48) hours after the earlier of:

a. Our receipt of the requested information; or
b. The end of the forty-eight (48)-hour period we have given you to provide the specified additional information.

4. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can Appeal.
5. When you or your Authorized Representative sends an Appeal, you or your Authorized Representative may also request simultaneous external review of our initial Adverse Decision. If you or your Authorized Representative wants simultaneous external review, your or your Authorized Representative's Appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service Appeal qualifies as urgent. If you do not request simultaneous external review in your Appeal, then you or your Authorized Representative may be able to request external review after we make our decision regarding the Appeal. See ***Bureau of Insurance Independent External Appeals*** in this section for additional information about filing an external Appeal.

Concurrent Care Claims

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

1. Expire; or
2. Be shortened.

Determinations regarding a Concurrent Care Claim request will be made, and notice provided to the Member's provider, by telephone and in writing, within one (1) business day of receipt of all information necessary to make a decision, but no later than fifteen (15) calendar days of receipt of the request.

1. If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date of onset of services and the date of the next scheduled concurrent review of the case.
2. If we reduce or terminate coverage for an ongoing course of treatment that we already approved, we will notify the Member sufficiently in advance of the reduction or termination to allow the member to Appeal the decision as described below.

Concurrent Care Claims for an Urgent Medical Condition

If your Concurrent Care Claim involves an Urgent Medical Condition, and the claim is submitted within twenty-four (24) hours before the end of the initially approved period, we will decide the claim within twenty-four (24) hours of receipt.

If you filed a request for additional services at least twenty-four (24) hours before the end of an approved course of treatment, you may continue to receive those services during the time your claim is under consideration. If your claim is 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 your claim was received.

1. If our clinical peer determines your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Concurrent Care Claim.
2. We will notify you of our decision orally or in writing within twenty-four (24) hours after we receive your claim. If we notify you orally, we will send you a written decision within three (3) days after that.
3. If we deny your claim or if we do not agree to continue approval of all the Services you requested, we will tell you in writing why we denied your claim and how you can Appeal.
4. When you or your Authorized Representative sends the Appeal, you or your Authorized Representative may also request simultaneous external review of our Adverse Decision. If you want simultaneous external review, you or your Authorized Representative's Appeal must tell us this. You or your Authorized Representative will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you or your Authorized Representative do not request simultaneous external review in the Appeal, then you or your Authorized Representative may be able to request external review after we make our decision regarding the Appeal. See ***Bureau of Insurance Independent External Appeals*** in this section for additional information about filing an external Appeal.

Post-Service Claims

Post-Service Claims are requests for payment for Services you already received, including claims for Emergency Services and Urgent Care Services rendered outside of our Service Area. If you have any questions about Post-Service Claims or Appeals, please contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Procedure for Making a Post-Service Claim

Claims for Emergency Services or Urgent Care Services rendered outside of our Service Area or other Services received from non-Plan Providers must be filed on forms provided by the Health Plan; such forms may be obtained on our website, **www.kp.org** or 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).

1. You must send the completed claim form to us at the address listed on the claim form within one-hundred eighty (180) days, or as soon as reasonably possible after the Services are rendered. You should attach itemized bills along with receipts if you have paid the bills. Incomplete claim forms will be returned to you. This will delay any payments that may be owed to you. Also, you must complete and submit to us any documents that we may reasonably need for processing your claim or obtaining payment from insurance companies or other payors.
2. We will review your claim, and if we have all the information we need we will send you a written decision within thirty (30) days after we receive your claim. If we tell you we need more time because of circumstances beyond our control, we may take an additional fifteen (15) days to send you our written decision. If we tell you we need more time and ask you for more information, you will have days to provide the requested information. We encourage you to send all the requested information at one time, so that we will be able to consider all of it when we make our decision. If we do not receive any of the requested information (including documents) within days, we will

make a decision based on the information we have. We will issue our decision within fifteen (15) days of the deadline for receiving the information.

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

Reconsideration of an Adverse Decision

Reconsideration of an Adverse Decision is available only to the treating health care provider, to request the review of an Adverse Decision by the Health Plan, on behalf of a Member. A request for reconsideration is optional. The treating provider may choose to skip this step, and you or your Authorized Representative may file an Appeal, as described below. If the provider does request reconsideration, the Member still has a right to Appeal.

The Health Plan will render its decision regarding the reconsideration request and provide the decision to the treating provider and the Member, in writing, within ten (10) working days of the date of receipt of the request. If we deny the claim, the notice will include the criteria used and the clinical reason for the Adverse Decision, the alternate length of treatment of any alternate treatment recommended, and the Member's right to Appeal the decision as described below.

Appeals of Claim Decisions

The Appeal Procedures are designed by the Health Plan to assure that Member concerns are fairly and properly heard and resolved. By following the steps outlined below, Member concerns can be quickly and responsively addressed.

Standard Appeal

This procedure applies to decisions regarding non-urgent Pre-Service Claims and Concurrent Claims as well as for Post-Service Claims. Please note that the time frame for our response differs for Post-Service Claims (it is longer).

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

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

You or your Authorized Representative may request a standard Appeal by contacting the Member Services Department. In addition, 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.

Wherever the term "Member" or "you" or "your" is used in this section, it shall include the Member's Authorized Representative.

The Appeal must be filed in writing within one-hundred eighty (180) days from the date of receipt of the original denial notice**.** If the Appeal is filed after the one-hundred eighty (180) days, the Health Plan will

send a letter denying any further review due to lack of timely filing.

If within five (5) working days after a Member files an Appeal, the Health Plan does not have sufficient information to initiate its internal Appeal process, the Health Plan shall:

1. Notify the Member that it cannot proceed with reviewing the Appeal unless additional information is provided; and
2. Assist in gathering the necessary information without further delay.

Standard Appeals will either be acknowledged within five (5) working days of the filing date of the written Appeal request. An acknowledgement letter will be sent as described immediately below.

Appeal of a Non-Urgent Pre-Service or Non-Urgent Concurrent Care Claim

If the Appeal is for a Service that the Member is requesting, the acknowledgment letter will:

1. Request additional information, if necessary;
2. Inform the Member when there will be a decision on their Appeal; and
3. State that written notice of the Appeal decision will be sent within thirty (30) days of the date the Appeal was received.

Appeal of a Post-Service Claim

If the Appeal is asking for payment for completed services, an acknowledgment letter is sent:

1. Requesting additional information, if necessary;
2. Informing the Member when a decision will be made;
3. That the Member will be notified of the decision within sixty (60) days of the date the Appeal was received.

If there will be a delay in concluding the Appeal process in the designated time, the Member will be sent a letter requesting an extension of time during the original time frame for a decision. If the Member does not agree to this extension, the Appeal will move forward to be completed by end of the original time frame. Any agreement to extend the Appeal decision shall be documented in writing.

If the Appeal is approved, a letter will be sent to the Member stating the approval. If the Appeal is by an Authorized Representative, the letter will be sent to both the Member and the Authorized Representative.

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

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

If the Health Plan asked for additional information before and you or your Authorized Representative did not provide it, you or your Authorized Representative may still submit the additional information with the

Appeal. In addition, you or your Authorized Representative may also provide testimony by writing or by telephone. Written testimony may be sent along with the Appeal to the address above. To arrange to give testimony by telephone, you or your Authorized Representative may contact the Appeals and Complaints Resolution Department. The Health Plan will add all additional information to the claim file and review all new information without regard to whether this information was submitted or considered in the initial decision.

Prior to the Health Plan rendering its final decision, it must provide you or your Authorized Representative, without charge, any new or additional evidence considered, relied upon, or generated (or at the direction of) by the Health Plan in connection with the informal Appeal.

If during the Health Plan's review of the standard Appeal, it determines that an Adverse Decision can be made based on a new or additional rationale, the Health Plan must provide you or your Authorized Representative with this new information prior to issuing its final Adverse Decision. The additional information must be provided to you or your Authorized Representative as soon as possible and sufficiently before the deadline to give you or your Authorized Representative a reasonable opportunity to respond to the new information.

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

1. The specific factual basis for the decision in clear understandable language;
2. References to any specific criteria or standards on including interpretive guidelines, on which the Appeal Decision was based (including reference to the specific plan provisions on which determination was based);
3. A statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request. In addition, you or your Authorized representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of your or your Authorized representative's claim.
4. A description of the right of the Member to file an external Appeal with the Bureau of Insurance, along with the forms for filing and a detailed explanation of how to file such an Appeal. An external Appeal must be filed within one-hundred twenty (120) days after the date of receipt of a notice of the right to an external review of a final Adverse Decision or an Adverse Decision if the internal Appeal process has been deemed to be exhausted or waived, a Member or their Authorized Representative may file a request for an external review in writing with the Commission of the date of the Health Plan's final Adverse Decision, as described below; and
5. A statement of your rights under section 502(a) of ERISA.

If we send you a notice of an Adverse Decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least 10 percent

of the population is literate only in the same federally mandated non-English language. You or your Authorized Representative may request translation of the notice by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

If the Health Plan fails to make an Appeal Decision for a non-urgent pre-service Appeal within thirty (30) days or within sixty (60) days for a post-service Appeal, the Member may file a complaint with the Bureau of Insurance.

Expedited Appeal

When an Adverse Decision or adverse reconsideration is made, and you, your Authorized Representative, or treating health care provider believes that such Adverse Decision or adverse reconsideration warrants an immediate Expedited Appeal, you, your Authorized Representative, or your treating health care provider shall have the opportunity to Appeal the Adverse Decision or adverse reconsideration by telephone on an expedited basis.

An Expedited Appeal may be requested only when the regular reconsideration and Appeal process will delay the rendering of covered Services in a manner that would be detrimental to the Member's health.

You, your Authorized Representative, or your treating health care provider may initiate an Expedited 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/TDD) or faxing the request to (404) 949-5001 during regular business hours. During non-business hours, please contact the Advice and Appointment Line at 703-359-7878.

Once an Expedited Appeal is initiated, our clinical peer will determine if the Appeal involves an urgent Pre-Service or Concurrent Care Claim. If the Appeal does not meet the criteria for an expedited Appeal, the request will be managed as a standard Appeal, as described above. If such a decision is made, the Health Plan will verbally notify the Member within twenty-four (24) hours.

If the request for Appeal meets the criteria for an expedited Appeal, the Appeal will be reviewed by a Plan physician who is board certified or eligible in the same specialty as the treatment under review, and who is not the individual (or the individual's subordinate) who made the initial Adverse Decision.

If additional information is needed to proceed with the expedited review, the Health Plan and the provider shall attempt to share the maximum information by telephone, facsimile, or otherwise to resolve the expedited Appeal in a satisfactory manner.

A decision with respect to such Expedited Appeal shall be rendered no later than:

1. Seventy-two (72) hours after receipt of the claim, if we have all of the necessary information; or
2. If the claim is for cancer pain medication, no later than twenty-four (24) hours after receipt of the claim.

If approval is recommended, the Health Plan will immediately provide assistance in arranging the authorized treatment or benefit.

If the Health Plan declines to review an Appeal as an Expedited Appeal; or if the Expedited Appeal results in a denial, the Health Plan shall immediately take the following actions:

1. Notify you, your Authorized Representative, or the provider who requested the expedited review, by telephone, fax, or electronic mail that the Member is eligible for an Expedited Appeal to the Bureau of Insurance without the necessity of providing the justification required for a standard Appeal; and
2. Within twenty-four (24) hours after the initial notice, provide a written notice to the provider and the Member clearly informing them of the right to Appeal this decision to the Bureau of Insurance. The written notice will include the appropriate forms and instructions to file an Appeal with the Bureau of Insurance, as described below.

The notification shall also include:

1. The specific factual basis for the decision in clear understandable language;
2. References to any specific criteria or standards, including interpretive guidelines, on which the decision was based (including reference to the specific plan provisions on which determination was based);
3. A statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request; and
4. A statement of your rights under section 502(a) of ERISA.

An Expedited Appeal may be further Appealed through the standard Appeal process described above unless all material information was reasonably available to the provider and to the Health Plan at the time of the expedited Appeal, and the physician advisor reviewing the Expedited Appeal was a peer of the treating health care provider, was board certified or board eligible, and specialized in a discipline related to the issues of the Expedited Appeal.

Bureau of Insurance Independent External Appeals

A Member may file for an Independent External Appeal with the State Corporation Commission's Bureau of Insurance:

1. If all of the Health Plan's Appeal procedures described above have been exhausted; or
2. If the Member's Adverse Decision involves cancer treatment or a medical condition where the timeframe for completion of an expedited internal appeal of an Adverse Decision would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function; or
3. If the Member requested an Expedited Appeal and the Health Plan determined that the standard Appeal time frames should apply; or
4. When an Expedited Appeal is reviewed and is denied.

A Member may request an expedited emergency review prior to exhausting our internal Appeal process if:

1. An Adverse Decision that was based on a determination that services are experimental/investigational may be expedited with written certification by the treating physician that services would be less effective if not initiated promptly;
2. The Health Plan fails to render a standard internal Appeal determination within thirty (30) or sixty (60) days and you, your Authorized Representative or Health Care Provider has not requested or agreed to a delay; or
3. The Health Plan waives the exhaustion requirement.

An expedited emergency review for denials due to medical necessity, appropriateness, health care setting, level of care or effectiveness may be requested simultaneously with an expedited internal review. The Independent Review Organization will review and determine if internal Appeal should be completed prior to expedited emergency review.

The forms and instructions for filing an emergency review are provided to the Member along with the notice of a final Adverse Decision.

To file an Appeal with the Bureau it must be filed in writing within one-hundred twenty (120) days from the date of receipt of your Health Plan decision letter using the forms required by the Bureau. The request is mailed to the following address:

Virginia State Corporation Commission
Bureau of Insurance
Life and Health Consumer Services Division
P. O. Box 1157
Richmond, VA 23218
804-371-9691 (Phone)
www.scc.virginia.gov (Website)

The decision resulting from the external review will be binding on both the member and the Health Plan to the same extent to which we would have been bound by a judgment entered in an action of law or in equity, with respect to those issues which the external review entity may review regarding a final Adverse Decision of the Health Plan.

Office of the Managed Care Ombudsman

The Office of the Managed Care Ombudsman is available to assist Health Plan Members to file an Appeal.

If a Member has questions regarding an Appeal or grievance concerning the health care Services that he or she has been provided which have not been satisfactorily addressed by the Health Plan, he or she may contact the Office of the Managed Care Ombudsman for assistance at:

Bureau of Insurance
Attention: Office of the Managed Care Ombudsman
P.O. Box 1157
Richmond, VA 23218
804-371-9032 (Phone)
1-877-310-6560 (Toll-free)
ombudsman@scc.virginia.gov (Email)

The Office of Licensure and Certification

If a Member has concerns regarding the quality of care he or she has received, he or she may contact The Office of Licensure and Certification at:

Complaint Intake
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Richmond, VA 23233-1463

Complaint Hotline:
804-367-2106 (Phone)
1-800-955-1819 (Toll-free)
804-527-4503 (FAX)

www.vdh.virginia.gov (Website)
mchip@vdh.Virginia.gov (Email)

Customer Satisfaction Procedure

In addition, the Health Plan has established a procedure for hearing and resolving Complaints by Members. An oral Complaint may be made to any Health Plan employee or to any person who regularly provides health care Services to Members. A written Complaint must be given or sent to a Members Services representative located at a Medical Office or by sending a letter to the following address:

Kaiser Permanente
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Rd NE
Atlanta, GA 30305

You or your Authorized Representative will receive a written response to your Complaint within thirty (30) days unless you or your Authorized Representative is notified that additional time is required.

If you are dissatisfied with our response, you may file a complaint with the Bureau of Insurance at any time.

For information visit the Bureau of Insurance's website at www.scc.virginia.gov or call the Life and Health Consumer Services Section at 804-371-9691 or toll-free at 1-877-310-6560, to discuss your complaint or receive assistance on how to file a complaint. Written complaints may be mailed to:

Bureau of Insurance
Attention: State Corporation Commission
P.O. Box 1157
Richmond, VA 23218
804-371-9944 (FAX)

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 2101 East Jefferson Street, Rockville, Maryland 20852) 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 of Membership

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

Termination Due to Loss of Eligibility

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 of Group Agreement

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

Termination Due to Change of Residence

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

Termination for Cause

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

1. You knowingly:
    a. Misrepresent membership status;
    b. Present an invalid prescription or physician order;
    c. Misuse (or let someone else misuse) a Member ID card; or
    d. Commit other types of fraud in connection with your membership;

2. You knowingly furnish incorrect or incomplete information to us or fail to notify us of changes in your family status that may affect your eligibility or benefits;
3. You no longer live or work within the Health Plan's Service Area; or
4. Your behavior with respect to the Health Plan staff or Medical Group providers is:
   a. Disruptive;
   b. Unruly;
   c. Abusive; or
   d. Uncooperative, to the extent that your continued enrollment under this EOC seriously impairs the Health Plan's ability to furnish Services to you or to other Health Plan members.

Termination for Nonpayment

Nonpayment of Premium
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.

Nonpayment of any other charges
We may terminate the memberships of a Subscriber and all Dependents in your Family Unit if any one of you fails to pay any amount he or she owes to the Health Plan or Medical Group, or fails to pay the applicable Cost Share to any Plan Provider. We will send written notice of the termination to the Subscriber at least thirty-one (31) days before the termination date.

Extension of Benefits

In those instances when coverage with us has terminated for you and/or your covered Dependent(s), we will extend benefits for covered Services, subject to Premium payment, in the following instance:

1. If you and/or your covered Dependent(s) become Totally Disabled while enrolled under this Agreement and remain so at the time your coverage ends, we will continue to provide benefits for covered Services. Coverage will continue for one-hundred eighty (180) days from the date of termination or until you and/or your covered Dependent(s) no longer qualify as being Totally Disabled, or until such time as a succeeding health plan elects to provide coverage to you and/or your covered Dependent(s) without limitations as to the disabling condition, whichever comes first.

To assist us, if you believe you and/or your covered Dependent(s) qualify under this provision, you must notify us in writing.

Upon termination of the Extension of Benefits, the Member will have the right to convert his or her coverage as described below.

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

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

Continuation of Coverage

A member whose eligibility for coverage terminates under this group contract has the opportunity to continue coverage at their own expense under the group contract for a period no shorter than twelve (12)

months. The continuation coverage period begins immediately after the member's termination date of eligibility for coverage under this group contract.

1. Continuation coverage is to be provided without additional evidence of insurability, and is subject to the following requirements:
   a. The application and payment for continued coverage is made to the group contract holder within thirty-one (31) days following issuance of the written notice required in number 3 of this section (below), but not beyond the sixty (60)-day period following the member's termination date, as indicated in the written notice provided by the group contract holder;
   b. Each premium payment for continued coverage is paid timely to the group contract holder on a monthly basis during the twelve (12)-month continuation coverage period (or longer, if offered by the group); and
   c. The premium for continuation coverage shall be at the Health Plan's current rate, as applicable to similarly situated individuals under the group contract, plus any applicable administrative fee not to exceed 2 percent of the current rate.
2. Continuation coverage is not required to be made available by the group when the enrollee:
   a. Is covered by or eligible for Medicare;
   b. Is covered by substantially the same level of benefits under any policy, contract or plan for individuals in a group;
   c. Has not been continuously covered during the three (3)-month period immediately preceding the enrollee's termination of coverage;
   d. Was terminated by the Health Plan or coverage was rescinded for:
      i. Failure to pay the premium required by the contract as shown in the contract or EOC; and/or
      ii. The policyholder or contract holder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage.
   e. Was terminated from a plan administered by the Department of Medical Assistance Services that provided benefits pursuant to Title XIX or XXI of the Social Security Act (42 USC § 1396 et seq. or § 1397aa et seq.).
3. The group contract holder shall provide each enrollee or other person covered under the group contract with written notice of the procedures and timeframes for obtaining continuation of coverage under the group contract. This notice shall be provided within fourteen (14) days of the group contract holder's knowledge of the enrollee's or other covered person's loss of eligibility under the group contract.

Note: This continuation coverage provision is not applicable when a group contract holder is required by federal law to provide Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits under its group health plan.

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. Members are eligible for COBRA continuation coverage even if they live in another Kaiser Foundation Health Plan or allied plan service area. Please contact your Group if you want

to know whether you or your Dependents are eligible for COBRA coverage, how to elect COBRA coverage, or how much you will have to pay your Group for it.

USERRA

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

Coverage Available on Termination

For information about non-group plans available through us with no waiting period or pre-existing condition limitations, contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at Eastern Standard Time (EST) 1-800-777-7902 or 711 (TTY) or online at **www.kp.org**.

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 rights, interests, claims for money due, benefits or obligations hereunder without our prior written consent.

Attorney Fees and Expenses

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

Certificates

A certificate is a statement that summarizes the benefits and rights that pertain to each Member 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

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

Contracts with Plan Providers

Plan Provider Relationship and Compensation

The 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).

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.

Governing Law

Except as preempted by federal law, this EOC will be covered in accordance with the law of the Commonwealth of Virginia. Any provision that is required to be in this EOC by state or federal law shall bind Members and the Health Plan whether or not it is set forth in this EOC.

Legal Action

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

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

Mailed Notices

Our notices to you will be sent to the most recent address we have on file for the Subscriber. The Subscriber is 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.
P.O. Box 6831
2101 East Jefferson Street
Rockville, MD 20852-4908

Notice of Non-Grandfathered Group Plan

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. believes that your Plan is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when PPACA was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the PPACA that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the PPACA. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause your Plan to change from grandfathered health plan status can be directed to your plan administrator. If your Plan is governed by ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or **www.dol.gov/ebsa/healthreform**. You may also contact the U.S. Department of Health and Human Services at **www.healthcare.gov**.

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**.

Important Terms You Should Know

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

A

Adverse Decision: Any determination by Health Plan that:

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

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

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

Allowable Charges: means:

1. Services provided by the Health Plan or Medical Group: The amount in the Health Plan's schedule of Medical Group and the Health Plan charges for Services provided to Members;
2. Items obtained at a Plan Pharmacy: For items covered under "Pharmacy Services" and

a. Obtained at a pharmacy owned and operated by Health Plan, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item. This amount is an estimate of: the cost of acquiring, storing and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente Pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan.

b. Obtained at a Plan Pharmacy other than a pharmacy owned and operated by Health Plan, the cost of the item calculated on a discounted wholesale price plus a dispensing fee ;

3. Emergency Services from a Non-Plan Provider (including Post-Stabilization Care that constitutes Emergency Services under federal law): the out-of-network rate.
4. For Services received from Plan Providers, the amount the Plan Provider has agreed to accept as payment.
5. All other Services: The amount that:
   a. The provider has contracted or otherwise agreed to accept;
   b. The provider has negotiated with the Health Plan;
   c. Health Plan must pay the non-Plan Provider pursuant to state law, when it is applicable, or federal law, including the out-of-network rate, or in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the provider and us;

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

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

Allowable Expense: A health care Service or expense, including Deductibles, Copayments or Coinsurance, that is covered in full or in part by any of the Plans covering the Member. This means that an expense or healthcare Service or a portion of an expense or healthcare Service that is not covered by any of the Plans is not an Allowable Expense. For example, if a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room usually is not an Allowable Expense. Allowable Expense does not include coverage for dental care except as provided under ***Accidental Dental Injury Services*** in ***Section 3: Benefits, Exclusions and Limitations***.

Ancillary Service: Services that are:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner
- Items and services provided by assistant surgeons, hospitalists, and intensivists
- Diagnostic services, including radiology and laboratory Services
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-Plan Provider satisfies the notice and consent requirements under federal law.

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

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

Appellant: An appellant is a person eligible to file an Independent External Appeal. The Member or the following persons may be considered an Appellant:

1. An Authorized Representative; or
2. The member's spouse, parent, committee, legal guardian or other individual authorized by law to act on the Member's behalf if the Member is not a minor but is incompetent or incapacitated.

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

Authorized Representative: An individual authorized by the Member in writing or otherwise authorized by state law to act on the Member's behalf to file claims and to submit Appeals or Grievances to the Health Plan. A Health Care Provider (as defined below) may act on behalf of a Member with the Member's express

consent, or without such consent in an Emergency Case.

C

Caregiver: An individual primarily responsible for the day-to-day care of the Member during the period in which the Member receives Hospice Care Services.

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 a Coordination of Benefits provision or a similar provision takes effect.

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

Complaint: A Complaint is an inquiry to the Member Services Department about Services, Member rights or other issues; or the communication of dissatisfaction about the quality of service or other issue which is not an Adverse Decision. Complaints do not involve utilization review decisions.

Complex or Chronic Medical Condition: A physical, behavioral, or developmental condition that:

1. May have no known cure;
2. Is progressive; or
3. Can be debilitating or fatal if left untreated or undertreated.

Complex or Chronic Medical Conditions include, but are not limited to: Multiple Sclerosis, Hepatitis C, and Rheumatoid Arthritis.

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

1. Is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;
2. Is undergoing a course of institutional or inpatient care from the provider or facility;
3. Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
4. Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

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

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

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

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

D

Deductible: The Deductible is an amount of Allowable Charges you must incur during a calendar 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.

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

E

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

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

Emergency Medical Condition: Regardless of the final diagnosis rendered to a Member, 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. Serious jeopardy to the mental or physical health of the individual or, with respect to a pregnant person, the health of the pregnant person or their unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

1. An appropriate medical screening examination (as required federal Emergency Medical Treatment and Active Labor Act (section 1867 of the Social Security Act) ("EMTALA")) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department, to evaluate such Emergency Medical Condition;
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment required under EMTALA (or would be required under EMTALA if EMTALA applied to an Independent Freestanding Emergency Department) to Stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and
3. Except as further described in this paragraph 3, covered Services (also referred to as Post-Stabilization Care) that are furnished by a Non-Plan Provider after you are Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Visit in which the Emergency Services are furnished:

a. When, under applicable federal law, the covered Services described in this paragraph 3 are not included as Emergency Services if all of the following conditions are met:
    i. The attending emergency physician or Treating Provider determines that the Member is able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Hospital or Plan Facility located within a reasonable travel distance, taking into account the Member's medical condition;
    ii. The provider or facility furnishing such additional covered Services satisfies the notice and consent requirements set forth in federal regulation (45 C.F.R § 149.420(c) through (g)) with respect to such covered Services, provided that the written notice additionally (1) identifies Plan Providers to whom you can be referred when a non-Plan Provider proposes to furnish covered Services at a Plan Hospital or Plan Facility when a non-Plan Provider proposes to provide such covered Services and (2) includes a good faith estimate of the charges for covered Services to be furnished at a non-Plan Hospital or non-Plan Facility by non-Plan Providers during the Visit; and
    iii. The Member, or an Authorized Representative of such Member, is in a condition to receive the information in the consent as described in this paragraph 3, as determined by the attending emergency physician or Treating Provider using appropriate medical judgment, and to provide informed consent in accordance with applicable State law; or

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

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

Expedited (Urgent Care) Appeal: An appeal that must be reviewed under an expedited process because the application of non-expedited appeal time frames could seriously jeopardize a Member's life or health or the Member's ability to regain maximum function. In determining whether an appeal involves Urgent Care, Health Plan must apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine. An Expedited Appeal is also an appeal involving:

1. Care that the treating physician deems urgent in nature;
2. The treating physician determines that a delay in the care would subject the Member to severe pain that could not adequately be managed without the care or treatment that is being requested; or
3. When Health Plan covers prescription drugs and the requested services is a prescription for the alleviation of cancer pain, the Member is a cancer patient and the delay would subject the Member to pain that could not adequately be managed without the care or treatment that is being requested.

Explanation of Benefits (EOB): Any form provided by an insurer, health services plan or health maintenance organization which explains the amounts covered under a policy or Plan or shows the amounts payable by a Member to a health care provider.

F

Facility: An institution providing health care related Services or a health care setting, including Hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, Skilled Nursing Facilities, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

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

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

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

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

G

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

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

Group: The entity with which we have entered into the Agreement that includes this Evidence of Coverage.

H

Health Care Provider:

1. An individual who is: licensed or otherwise authorized in this State to provide health care services in the ordinary course of business or practice of a profession and is the treating provider of the Member; or
2. A hospital.

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

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

Health Plan: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., providing Services or benefits for health care. This EOC sometimes refers to the Health Plan as “we” or “us”.

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

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

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

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

Hospital: Any hospital:

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

I

Independent External Appeal: If the Member receives an Adverse Decision of an appeal, the Member or the Member's Authorized Representative, which may include the treating provider, may appeal the Adverse Decision to the Bureau of Insurance for an Independent External Appeal.

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

K

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

M

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

Medically Necessary/Medical Necessity: Medically Necessary means that the Service is all of the following:

1. Medically required to prevent, diagnose or treat the Member's condition or clinical symptoms;
2. In accordance with generally accepted standards of medical practice;

3. Not solely for the convenience of the Member, the Member's family and/or the Member's provider; and
4. The most appropriate level of Service which can safely be provided to the Member. For purposes of this definition, "generally accepted standards of medical practice" means:
   a. Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
   b. Physician specialty society recommendations; and/or
   c. The view of physicians practicing in the Kaiser Permanente Medical Care Program.

Note: Unless otherwise required by law, we decide if a Service (described in ***Section 3: Benefits, Exclusions and Limitations***) is Medically Necessary and our decision is final and conclusive subject to the Member's right to Appeal, or go to court, as set forth in ***Section 5: Filing Claims, Appeals and Grievances*****.**

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

Member: A person who is eligible and enrolled under this Agreement as a Subscriber or a Dependent, and for whom we have received applicable Premium. Members are sometimes referred to as "you" within this Agreement.

N

Non-Physician Specialist: A health care provider who:

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

O

Orthotic Device: An appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of movable parts of the body.

Out-of-Pocket Maximum: The maximum amount of Deductibles, Copayments and Coinsurance that an individual or family is obligated to pay for covered Services per calendar year.

P

Plan: The health benefit Plan described in this Agreement.

Plan: (For use in relation to ***Coordination of Benefits*** provisions only, which are located in ***Section 4: Coordination of Benefits***): Any of the following that provides benefits or services for, or because of, medical care or treatment: Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepaid group practice or individual practice coverage. "Plan" does not include an individually underwritten and issued, guaranteed renewable, specified disease policy or intensive care policy, that does not provide benefits on an expense-incurred basis. "Plan" also does not include the medical benefits under an automobile policy, including benefits for personal injury protection. "Plan" also does not include:

1. Accident only coverage;

2. Hospital indemnity coverage benefits or other fixed indemnity coverage;
3. Specified disease or specified accident coverage;
4. Limited benefit health coverage, as provided for by Virginia state law;
5. School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four (24)-hour basis or on a "to and from school" basis;
6. Benefits provided in long-term insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
7. Personal injury protection under a motor vehicle insurance policy;
8. Medicare supplement policies;
9. A state plan under Medicaid; or
10. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

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

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

Plan Medical Center: Medical office and specialty care facilities such as imaging centers operated by us in which Medical Group and other health care providers including Non-Physician Specialists employed by us provide primary care, specialty care, and ancillary care Services to Members.

Plan Pharmacy: Any pharmacy that:

1. Is located at a Plan Medical Office; or
2. Contracts, directly or indirectly, to provide Services to Members.

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

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

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

Post Stabilization Care: Medically Necessary Services related to Your Emergency Medical Condition that You receive after Your attending emergency physician or Treating Provider determines that Your Emergency Medical Condition is Stabilized. 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).

Pre-Service Claim: A request that the Health Plan provide or pay for a Service that you have not yet received.

Premium: Periodic membership charges paid by Group.

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

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

Proof of Loss: All necessary documentation reasonably required by the Health Plan to make a determination of benefit or coverage.

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

R

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

S

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

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

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

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

Specialist: A licensed health care professional that includes physicians and non-physicians who is trained to treat or provide health care Services for a specified condition or disease in a manner that is within the scope of their license or certification. Specialist physicians shall be board-eligible or board-certified.

Spouse: Your legal husband or wife. The person to whom you are legally married under applicable law.

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

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

Surgical or Ancillary Service: Any professional Service including surgery, anesthesiology, pathology, radiology, or hospitalist Services and laboratory Services.

T

Totally Disabled:

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

For Dependent Children: In the judgment of a Medical Group Physician, an illness or injury which makes the child unable to substantially engage in any of the normal activities of children in good health and like age.

Treating Provider: A physician or other health care provider who has evaluated the Member's Emergency Medical Condition.

U

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

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

1. A medical condition, including a physical, mental health or dental condition, where the absence of medical attention within seventy-two (72) hours could reasonably be expected by an individual, acting on behalf of the Health Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
   a. Placing the Member's life or health in serious jeopardy;
   b. The inability of the Member to regain maximum function;
   c. Serious impairment to bodily function;
   d. Serious dysfunction of any bodily organ or part; or

e. The Member remaining seriously mentally ill with symptoms that cause the Member to be a danger to self or others.

A medical condition, including a physical, mental health or dental condition, where the absence of medical attention within seventy-two (72) hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Coverage Decision.

V

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