guide to
YOUR 2024 BENEFITS AND SERVICES

kaiserpermanente.org

SAMPLE

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

SMALL GROUP EVIDENCE OF COVERAGE

VIRGINIA

SIGNATURE CARE DELIVERY SYSTEM

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

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 Permanente 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 Small 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 Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. or the Bureau of Insurance, have your policy number available.

SAMPLE

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.

SAMPLE

Your Rights and Protections Against Surprise Medical Bills

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

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You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in- network cost-sharing amount (such as 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.

SAMPLE

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate 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.

SAMPLE

HELP IN YOUR LANGUAGE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SAMPLE

TABLE OF CONTENTS

SECTION 1 – INTRODUCTION 1

KAISER PERMANENTE FLEXIBLE CHOICE 1
WHO IS ELIGIBLE 2
Subscribers 2
Dependents 2
Disabled Dependent Certification 3
Genetic Information 4
ENROLLMENT AND EFFECTIVE DATE OF COVERAGE 4
Annual Open Enrollment 4
New Employees and Their Dependents 4
Special Enrollment Due to New Dependents 5
Special Enrollment due to Court or Administrative Order 5
Special Enrollment due to Loss of Other Coverage 6
Special Enrollment due to Reemployment After Military Service 6
Special Enrollment due to Eligibility for Premium Assistance under Medicaid or CHIP 6

SECTION 2 – HOW TO OBTAIN SERVICES 8

YOUR PRIMARY CARE PLAN PHYSICIAN (OPTION 1) 8
CONTINUITY OF CARE (OPTION 1) 9
CONTINUED HEALTH COVERAGE FROM A PRIOR PLAN 9
GETTING A REFERRAL (OPTION 1) 9
STANDING REFERRALS TO SPECIALISTS (OPTION 1) 10
REFERRALS TO NON-PARTICIPATING PROVIDERS (OPTION 1) 11
GETTING EMERGENCY AND URGENT CARE SERVICES (OPTION 1) 12
PRE-CERTIFICATION THROUGH THE MEDICAL REVIEW PROGRAM (OPTIONS 2 AND 3) 13
SECOND OPINIONS (OPTION 1) 18
GETTING THE CARE YOU NEED; EMERGENCY SERVICES, URGENT CARE AND ADVICE NURSES (OPT. 1) 18
GETTING ADVICE FROM OUR ADVICE NURSES (OPTION 1) 18
MAKING APPOINTMENTS (OPTION 1) 19
USING YOUR IDENTIFICATION CARD (OPTION 1) 19
RECEIVING CARE IN ANOTHER KAISER FOUNDATION HEALTH PLAN SERVICE AREA (OPTION 1) 19
MOVING TO ANOTHER KAISER PERMANENTE REGION OR GROUP HEALTH COOPERATIVE SERVICE AREA (OPTION 1) 19
PAYMENT TOWARD YOUR COST SHARE (OPTIONS 1, 2 AND 3) 20

SECTION 3.1 – OPTION 1 (HMO) BENEFITS 21

A. OUTPATIENT CARE 23
B. HOSPITAL INPATIENT CARE 24
C. ACCIDENTAL DENTAL INJURY SERVICES 25
D. ALLERGY SERVICES 25
E. AMBULANCE SERVICES 26
F. ANESTHESIA FOR DENTAL SERVICES 26
G. AUTISM SPECTRUM DISORDER (ASD) 27
H. BLOOD, BLOOD PRODUCTS AND THEIR ADMINISTRATION 28
I. CHIROPRACTIC SERVICES 28
J. CLEFT LIP, CLEFT PALATE OR ECTODERMAL DYSPLASIA 28
K. CLINICAL TRIALS 28
L. DIABETIC SERVICES 29
M. DIALYSIS SERVICES 30
N. DRUGS, SUPPLIES, AND SUPPLEMENTS 31
O. DURABLE MEDICAL EQUIPMENT 32

SAMPLE

P. EARLY INTERVENTION SERVICES 34
Q. EMERGENCY SERVICES 34
R. FAMILY PLANNING SERVICES 37
S. HEARING TESTS 38
T. HOME HEALTH SERVICES 38
U. HOSPICE CARE SERVICES 39
V. INFERTILITY SERVICES 41
W. MATERNITY SERVICES 41
X. MEDICAL FOODS 43
Y. MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER 45
Z. MORBID OBESITY SERVICES 45
AA. ORAL SURGERY 46
BB. DENTAL SERVICES 46
CC. PREVENTIVE HEALTH CARE SERVICES 50
DD. PROSTHETIC AND ORTHOTIC DEVICES 51
EE. PULMONARY REHABILITATION 51
FF. RADIATION THERAPY/CHEMOTHERAPY/INFUSION THERAPY 52
GG. RECONSTRUCTIVE SURGERY 52
HH. SKILLED NURSING FACILITY CARE 53
II. SURGERY 54
JJ. TELEMEDICINE SERVICES 54
KK. THERAPY; HABILITATIVE AND REHABILITATIVE SERVICES 56
LL. TRANSPLANT SERVICES 57
MM. URGENT CARE SERVICES 58
NN. VISION SERVICES 58
OO. X-RAY, LABORATORY, AND SPECIAL PROCEDURES 60

SECTION 3.2 – OPTION 2 (PPO) AND OPTION 3 (INDEMNITY) BENEFITS 62

INSURING CLAUSE 62
PAYMENTS UNDER THIS EVIDENCE OF COVERAGE 62
COVERED SERVICES 62
PEDIATRIC VISION SERVICES 76
PREVENTIVE SERVICES 77
EXTENSION OF BENEFITS 84
BENEFITS FOR INPATIENT MATERNITY CARE 85

SECTION 4 – EXCLUSIONS AND COORDINATION OF BENEFITS 89

EXCLUSIONS 89
OTHER NON-COVERED SERVICES 96
UNUSUAL CIRCUMSTANCES 97
COORDINATION OF BENEFITS 97

SECTION 5 – GETTING ASSISTANCE; CLAIMS AND APPEAL PROCEDURES; AND CUSTOMER SATISFACTION PROCEDURE 102

CLAIMS AND APPEALS INFORMATION FOR OPTION 1 (HMO) 102
CLAIMS AND APPEALS INFORMATION FOR OPTION 2 (PPO) AND OPTION 3 (INDEMNITY) 111
GENERAL PROVISIONS 111
BENEFIT DETERMINATIONS 113
BUREAU OF INSURANCE INDEPENDENT EXTERNAL APPEALS 117
OFFICE OF THE MANAGED CARE OMBUDSMAN 118
THE OFFICE OF LICENSURE AND CERTIFICATION 119
CUSTOMER SATISFACTION PROCEDURE 119

SAMPLE

SECTION 6 – TERMINATION OF MEMBERSHIP 121

TERMINATION DUE TO LOSS OF ELIGIBILITY 121
TERMINATION OF GROUP AGREEMENT 121
TERMINATION FOR CAUSE 121
TERMINATION FOR NONPAYMENT 121
RECISSION FOR FRAUD OR INTENTIONAL MISREPRESENTATION 122
EXTENSION OF BENEFITS 122
DISCONTINUATION OF A PRODUCT OR ALL PRODUCTS 123
CONTINUATION OF GROUP COVERAGE UNDER FEDERAL LAW 123
USERRA 124

SECTION 7 – MISCELLANEOUS PROVISIONS 125

ADMINISTRATION OF AGREEMENT 125
ADVANCE DIRECTIVES 125
AMENDMENT OF AGREEMENT 125
APPLICATIONS AND STATEMENTS 125
ASSIGNMENT 125
ATTORNEY FEES AND EXPENSES 125
CONTRACTS WITH PLAN PROVIDERS 126
GOVERNING LAW 126
GROUPS AND MEMBERS NOT HEALTH PLAN'S AGENTS 126
INCONTESTABILITY 127
LEGAL ACTION 127
MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT 127
MEMBER RIGHTS AND RESPONSIBILITIES 127
MISSTATEMENT OF AGE 130
MONEY PAYABLE 130
NAMED FIDUCIARY 130
NONDISCRIMINATION 130
NOTICE OF NON-GRANDFATHERED COVERAGE 130
NOTICES 130
NO WAIVER 130
OVERPAYMENT RECOVERY 130
PHYSICAL EXAMINATION AND AUTOPSY 131
PRIVACY PRACTICES 131
TIME EFFECTIVE 132

DEFINITIONS 133

SAMPLE

SECTION 1 – INTRODUCTION

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 Evidence of Coverage (EOC).

You have selected the Kaiser Permanente Flexible Choice Plan.

This Evidence of Coverage (EOC) describes health care coverage provided under the agreement between Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS), Kaiser Permanente Insurance Company (KPIC) and your employer Group.

In this EOC, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. is sometimes referred to as "Health Plan." Both Health Plan and KPIC are sometimes referred to as "we," "us" or "our." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this EOC. Please see the "Definitions" section of this EOC for terms you should know.

The term of this EOC is based on your employer Group's Contract Year and your effective date of coverage. Your employer Group's benefits administrator can confirm your eligibility, including that of your covered Dependents (if any).

The Kaiser Permanente Flexible Choice Plan includes three coverage options. You are free to choose the option that best meets your needs each time you plan to receive care. Choose from:

- **Option 1 (HMO**), which gives you access to Plan Providers including Physicians in the highly-regarded Mid-Atlantic Permanente Medical Group. In almost all cases, your Option 1 care is provided in Kaiser Permanente medical centers.
- **Option 2 (PPO**), which gives you access to an extensive network of Participating Providers and Physicians who are part of the PHCS and MultiPlan provider networks for Kaiser Permanente Insurance Company.
- **Option 3 (Indemnity)**, which gives you access to any licensed Provider or Physician who is not in our Option 1 or Option 2 provider networks.

Health Plan underwrites Option 1 coverage, which includes specific covered Services provided, prescribed or directed by Plan Providers. Covered Services also include certain Emergency Services received from non-Plan Providers. Emergency care is covered 24 hours a day, seven days a week, anywhere in the world by Health Plan.

To make your health care easily accessible, Health Plan provides conveniently located Plan Medical Centers and medical offices 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 at our state-of-the-art Plan Medical Centers. In addition, we have added pharmacy, optical, laboratory, and x-ray facilities at most of our Plan Medical Centers.

KPIC underwrites the Option 2 (PPO) and Option 3 (Indemnity) coverage, which includes specific covered Services you may receive from Participating and Non-Participating Providers. You may choose to use a Participating Provider or a Non-Participating Provider when you plan to receive care.

SAMPLE

Your financial responsibility is different for covered Services received under each coverage Option. You should consult the ***Appendix – Summary of Cost Shares*** to determine your financial responsibility under each coverage Option.

You may not have the option to choose among the three Options for all covered Services; you should review this Evidence of Coverage to determine whether medical and hospital services are covered Services, at which Option the covered Service may be accessed and whether any other specific coverage requirements must be met. With the exception of Preventive Benefits, all covered Services must be Medically Necessary.

Your choice of providers will affect the level of benefits you receive.

When you access covered Services, you may be required to pay out-of-pocket costs such as Co-payments, Coinsurance and Deductibles. Your out-of-pocket costs will generally be lowest when receiving care using the Option 1 (HMO) provider network underwritten by KFHP-MAS. Option 2 (PPO) coverage requires out-of-pocket costs that are generally higher than those available under Option 1 (HMO), but generally lower than those available under Option 3 (Indemnity). Finally, Option 3 (Indemnity) coverage generally requires the highest out-of-pocket costs.

It is your choice to receive care from Plan Providers, Participating Providers or Non-Participating Providers. Neither Health Plan nor KPIC is responsible for any Member's decision to receive treatment, services, or supplies under any of the three coverage Options. Neither Health Plan nor KPIC is liable for the qualifications of providers or treatment, services or supplies provided under the other party's coverage.

The three coverage options are treated as one plan; there shall be no coordination of benefits between the benefits provided by Health Plan and those provided by KPIC.

Please note that Health Plan and KPIC are subject to the regulations of the Commonwealth of Virginia by both the State Corporation Commission Bureau of Insurance, as well as the Virginia Department of Health.

SAMPLE

Who is Eligible

To be accepted for enrollment and continuing coverage hereunder, you must meet the requirements set forth here.

Subscribers

You may be eligible if you are employed by a Small Employer Group and that Small Employer offers you coverage under this health benefit plan.

Dependents

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents:

A. Your Spouse or Domestic Partner;

B. Your or your Spouse's or Domestic Partner's children, who are under age 26;

C. Other Dependent persons (including foster children) who meet all of the following requirements:

(1) They are under age 26; and

(2) You or your Spouse or Domestic Partner is the child's court-appointed guardian (or was when the person reached age 18); or

(3) A child for whom you or your Spouse or Domestic Partner have the legal obligation to provide coverage pursuant to a child support order or other court order or court-approved agreement or testamentary appointment.

Dependents who meet the Dependent eligibility requirements, except for the age limit, may be eligible as a disabled Dependent if they meet all of the following requirements:

A. They are incapable of self-sustaining employment because of intellectual disability or physical handicap, or condition that occurred prior to reaching the age limit for Dependents;

B. They receive 50 percent or more of their support and maintenance from you or your Spouse or Domestic Partner;

C. You provide us proof of their incapacity and dependency within 60 days after we request it (see Disabled Dependent Certification section below for additional eligibility requirements).

SAMPLE

Disabled Dependent Certification

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

- If your Dependent is a Member, we will send you a notice of his or her membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. Your Dependent's membership will terminate as described in our notice unless you provide us documentation of his or her incapacity and dependency within 60 days of receipt of our notice and we determine that he or she is eligible as a disabled Dependent. If you provide us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that your Dependent does not meet the eligibility requirements as a disabled Dependent, we will notify you that he or she is not eligible and let you know the membership termination date. If we determine that your Dependent is eligible as a disabled Dependent, there will be no lapse in coverage. Also, beginning two years after the date that your Dependent reached the age limit, you must provide us documentation of his or her incapacity and dependency annually within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled Dependent.
- If your Dependent is not a Member and you are requesting enrollment, you must provide us documentation of his or her incapacity and dependency within 60 days after we request it so that we can determine if he or she is eligible to enroll as a disabled Dependent. If we determine that your Dependent is eligible as a disabled Dependent, you must provide us documentation of his or her incapacity and dependency annually within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled Dependent.

Genetic Information

Note: 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. In addition, genetic information or the request for such information shall not be used to increase the rates of, affect the terms or conditions of, or otherwise affect a Member's coverage.

We will not release identifiable genetic information or the results of a genetic test to any person who is not an employee of Health Plan or a Plan Provider, Participating Provider or Non-Participating Provider who is active in the Member's health care, without prior written authorization from the Member from whom the test results or genetic information was obtained.

Enrollment and Effective Date of Coverage

Annual Open Enrollment

We will provide an annual open enrollment period each year at least 30 days prior to the first day of the Contract Year. The open enrollment period will extend for a minimum of 30 days. 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 us.

Your Group will let you know when the open enrollment period begins and ends. Your membership will be effective at 12:00 a.m. at the location of Health Plan's administrative office at 2101 East Jefferson Street, Rockville, Maryland, 20852 on the first day of your Group's Contract Year.

SAMPLE

New Employees and Their Dependents

Eligible employees who become eligible outside the annual open enrollment period may enroll for themselves and their eligible Dependent within 30 days after the employee first becomes eligible by submitting a Health Plan-approved enrollment application to your Group. (You should check with your Group to see when new employees become eligible).

Group shall notify its employees and their enrolled Dependents of their effective date of membership if such date is different than the effective date of this Evidence of Coverage as specified on the Face Sheet, or is different than the dates specified under "Special Enrollment Due to New Dependents" listed below.

You can only enroll during the annual open enrollment period. If you do not enroll when you are first eligible and later want to enroll, you may only do so if one of the following is true:

A. You become eligible as described in this Special Enrollment section.

B. You 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 in the future. The effective date of an enrollment resulting from this provision is no later than the first 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

Subscribers may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, within 30 days (31 days in the case of birth or

adoption) after marriage, birth, adoption, or placement for adoption as a foster child by submitting to your Group a Health Plan-approved enrollment application.

The effective date of an enrollment resulting from marriage is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber.

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

A. 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 30 days from the date of birth, notification of birth and payment of additional Premium must be provided within 30 days of the date of birth, otherwise coverage for the newborn will terminate 30 days from the date of birth.

B. For newly adopted children, the date of adoptive or parental placement with a Subscriber or Subscriber's Spouse or Domestic Partner, for the purpose of adoption. If a child is placed with the Subscriber within 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 30 days from the date of adoption, notification of adoption and payment of additional Premium must be provided within 30 days of the date of adoption, otherwise coverage for the newly adopted child will terminate 30 days from the date of adoption.

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

C. For children who are newly eligible for coverage as the result of guardianship granted by court, child support order or testamentary appointment, the date of court or testamentary appointment.

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

SAMPLE

Special Enrollment Due to Court or Administrative Order

If a parent eligible for family coverage is required under a court or administrative order requiring a Subscriber to provide health care coverage for a child who meets the eligibility requirements as a Dependent, the Subscriber may add the child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application, regardless of enrollment period restrictions.

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 un-enrolled unless we receive satisfactory written proof that: (a) the court or administrative order is no longer in effect; and (b) 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 (c) 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

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

A. The Subscriber or at least one of the Dependents had other coverage when he or she previously declined all coverage through your Group

B. The loss of the other coverage is due to one of the following:

   (1) Exhaustion of COBRA coverage;

   (2) Termination of employer contributions for non-COBRA coverage;

   (3) Loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (non-group) plan for non-payment. For example, this loss of eligibility may be due to legal separation or divorce, reaching the age limit for Dependent children, or the Subscriber's death, termination of employment, or reduction in hours of employment;

   (4) Loss of coverage because plan does not provide benefits to individuals outside the Service Area.

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

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 30 days after loss of other coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special enrollment Due to Reemployment After Military Service

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

Special Enrollment Due to Eligibility for Premium Assistance under Medicaid or Children's Health Insurance Program (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

SAMPLE

Group within 60 days after the Subscriber or Dependent is determined eligible for premium assistance. The effective date of an enrollment resulting from eligibility for the premium assistance under Medicaid or CHIP is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

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SECTION 2 – HOW TO OBTAIN SERVICES

To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed for any Services we provide at Allowable Charges, and claims for Emergency or Urgent Care Services from non-Plan Providers will be denied.

As a Member, you are selecting our medical care system to provide your health care. To receive benefits under **Option 1 (HMO)**, you must receive all covered Services from Plan Providers inside our Service Area, except as described under the following headings:

- Emergency Services, in the "Benefits" section
- Urgent Care Outside our Service Area, in the "Benefits" section
- Getting a Referral, in this section
- Visiting Other Kaiser Permanente Regions or Group Health Cooperative Service Areas, in this section
- Visiting Member Services, in the "Benefits" section
- Non-emergency surgical and Ancillary Services provided at a Plan Facility and Emergency Services from non-Plan Hospitals, freestanding facilities and Air Ambulance Providers by a non-Plan Provider.

Under **Option 2 (PPO)**, You receive Services from Kaiser Permanente's network of Participating Providers who are part of the PHCS and MultiPlan networks within VA, CA, DC, GA, HI, MD, OR, CO and WA (hereafter referred to as KP states) and the CIGNA PPO Network in all other states. Under **Option 3 (Indemnity)**, you can choose any licensed provider or physician who is not in our Option 1 or Option 2 networks.

NOTE: CIGNA PPO Network providers will obtain any necessary Precertification on Your behalf. For specific Precertification provisions for obtaining certain Services under Option 2 (PPO) and Option 3 (indemnity) of your Kaiser Permanente Flexible Choice Plan, please refer to Pre-certification through the Medical Review Program (Options 2 and 3) in this section.

To verify the current participation status of a Participating Provider (for Option 2), You can call the phone number listed on Your ID card, or You may visit KPIC's Participating Provider network's website at: www.kp.org/flexiblechoice/mas.To request a printed copy at no cost, call the phone number on the back of your card.

Your out-of-pocket costs will generally be lowest when receiving care using the Option 1 (HMO) provider network underwritten by KFHP-MAS. Option 2 (PPO) coverage requires out-of-pocket costs that are generally higher than those available under Option 1 (HMO), but generally lower than those available under Option 3 (indemnity). Finally, Option 3 (Indemnity) coverage generally requires the highest out-of-pocket costs. Both Options 2 and 3 are underwritten by KPIC.

Your Primary Care Plan Physician (Option 1)

Your primary care Plan Physician plays an important role in coordinating your health care needs, including hospital stays and referrals to specialists. We encourage you to choose a primary care Plan Physician when

SAMPLE

you enroll. Each Member of your family should have his or her own 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 any primary care Plan Physician who is available to accept new Members from the following areas: internal medicine, family practice and pediatrics. A listing of all Primary Care Plan Physicians is provided to you on an annual basis.

You may also access our Provider Directory online at the following website address:

www.kp.org

To learn how to choose or change your primary care Plan Physician, please call our Member Services Monday through Friday from 7:30 a.m. until 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or TTY is 711.

Continuity of Care (Option 1)

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

In addition, under the following special situations, the 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.

Continued Health Coverage from a Prior Plan

Continued health coverage will also be provided if: a) The plan replaced a prior benefit plan of your employer or an associated company, and b) a person's continued health coverage under a provision of that prior plan similar to this ended due to the replacement of that prior plan. In such case, that person may obtain continued health coverage under this provision. It will be as though the plan had been in effect when the qualifying event occurred. But no benefits will be paid under the policy for health care expenses incurred before its effective date.

SAMPLE

Getting a Referral (Option 1)

Plan Providers offer primary medical, pediatric, and obstetrics/gynecology care as well as specialty care in areas such as general surgery, orthopedic surgery, dermatology, and other medical specialties. If your primary care Plan Physician decides that you require covered Services from a specialist, you will be referred (as further described in this EOC) to a Plan Provider in your network who is a specialist that can provide the care you need. All referrals will be subject to review and approval (authorization) in accordance with the terms of this EOC. We will notify you when our review is complete.

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 a 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. When utilization management is the responsibility of an in-network provider, any reduction or denial of benefits will not affect the enrollee.

Our facilities include Plan Medical Centers and specialty facilities, such as imaging centers, located within our Service Area. You will receive most of the covered Services that you routinely need at these facilities unless you have an approved referral to another Plan Provider.

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

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

(1) The initial consultation for treatment of mental illness, emotional disorders, drug or alcohol abuse provided by a Plan Provider. The Behavioral Health Access Unit may be reached at 1-866-530-8778.

(2) OB/GYN Services provided by an OB/GYN, or other Plan Provider authorized to provide OB/GYN Services, including the ordering of related, covered OB/GYN Services;

(3) A female Dependent age thirteen (13) years or older can receive direct access to Services from a participating OB/GYN that is authorized to provide Services under this Agreement and is selected by the Dependent.

(4) 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 in accord with this "Getting a Referral" section. When Prior Authorization is the responsibility of an in-network provider, any reduction or denial of benefits will not affect the enrollee.

As a Flexible Choice Member, you may see any Option 2 (Participating Provider) or Option 3 (Non-Participating Provider) without a referral. Services received from Option 2 and Option 3 providers may require Pre-certification. Please refer to *Pre-certification through the Medical Review Program (Options 2 and 3)* in this section for complete details.

SAMPLE

Prior Authorization for Prescription Drugs

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

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

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

Standing Referrals to Specialists (Option 1)

If a Member suffers from a life-threatening, degenerative, chronic or disabling disease or condition that requires specialized care, your primary care Plan Physician may determine, in consultation with the Member and the specialist, that your needs would be best served through the continued care of a specialist. In such instances, your primary care Plan Physician will issue a standing referral to the specialist.

For a Member who is pregnant, after the Member receives a standing referral to an obstetrician, the obstetrician is responsible for the primary management of the Member's pregnancy, including the issuance of referrals in accordance with Health Plan policies and procedures, through postpartum period.

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

With the exception of standing referrals to obstetricians for pregnant women as stated above, standing referrals will be made in accordance with a written treatment plan developed by the primary care Plan Physician, specialist, and the Member. The treatment plan may limit the number of visits to the specialist or the period of time in which visits to the specialist are authorized. We retain the right to require the specialist to provide the primary care Plan Physician with ongoing communication about your treatment and health status.

If you have been diagnosed with cancer, Health Plan will allow your primary care Plan Physician to issue a standing referral to any Health Plan authorized oncologist or board-certified physician in pain management, as you choose.

Referrals to Non-Participating Providers (Option 1)

A Member may request a referral to a Non-Participating Provider in accordance with the requirements listed below:

1. The Member is diagnosed with a condition or disease that requires specialized medical care; and
2. KPIC does not have in its provider network a specialist with the professional training and expertise to treat the condition or disease; and
3. The specialist agrees to accept the same reimbursement as would be provided to a specialist who is part of the carrier's provider network.

Under Virginia law a non-Plan Provider shall not balance bill for:

SAMPLE

1. Emergency Services provided by a non-Plan Provider; or
2. Non-Emergency Services provided at a Plan Facility or a non-Plan Facility if the non-Emergency Services involve surgical or ancillary Services provided by a non-Plan Provider.

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

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.***

Getting Emergency and Urgent Care Services (Option 1)

Emergency Services

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

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department or Independent Freestanding Emergency Department. You do not need Prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services that you receive from Plan Providers or non-Plan Providers anywhere in the world, as long as the Services would be covered under ***Emergency Services in Section 3: Benefits, Exclusions and Limitations*** if you had received them from Plan Providers. Emergency Services are available from Plan Hospital emergency departments twenty-four (24) hours per day, seven (7) days per week.

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

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

Urgent Care Services

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

SAMPLE

Bills for Emergency and Urgent Care Services

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

1. Contact the hospital, physician or other provider to inform them that the bill should be sent to us at the address 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
FAX: 1-866-568-4184

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.

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

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

SAMPLE

Pre-certification through the Medical Review Program (Options 2 and 3)

When using Participating Providers (Option 2) and/or Non-Participating Providers (Option 3), a Member must obtain Pre-certification of all non-emergency Hospital stays and certain other non-Emergency Services and procedures. Request for Pre-certification must be made by the Member, the Member's attending Physician, or the Member's Authorized Representative prior to the commencement of any Service or treatment. If Pre-certification is required, it must be obtained to avoid a reduction in benefits.

Pre-certification/Pre-certified means the required assessment of the Medical Necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program.

Pre-certification will not result in payment of benefits that would not otherwise be covered under this Evidence of Coverage.

If Pre-certification is not obtained when required, or obtained but not followed, benefits otherwise payable for all covered charges incurred in connection with the treatment or Service will be reduced by 30%. However, the reduction will be limited to $5,000 per Policy Year. Any such reduction in benefits will not count toward satisfaction of any Deductible, Co-payment, Coinsurance or Out-of-Pocket Maximum applicable under this EOC.

If this Plan has been designated a Secondary Plan as defined in the Coordination of Benefits section, Pre-

certification is not required when Your Primary Plan has made payment on the Covered Services requiring Pre-certification.

For Pre-certification of covered Services or Utilization Review please call the number listed on Your ID card or 1-888-567-6847.

The Medical Review Program is the organization or program that evaluates proposed treatments and/or Services to determine Medical Necessity and assures that the care received is appropriate and Medically Necessary to the Member's health care needs. If the Medical Review Program determines that the care is not Medically Necessary, Pre-certification will be denied. The Medical Review Program may be contacted 24 hours per day, seven (7) days per week.

Medical Review Program for providers accessed via the CIGNA PPO Network outside KP states will be performed by CIGNA Medical Review. CIGNA PPO Network providers will obtain any necessary Pre-certification on your behalf. Providers may contact them at 888-831-0761.

If Pre-certification is denied, the Adverse Benefit Determination notice will tell You why We denied Your claim and will include information regarding the mandatory internal Appeal process and Your Appeal rights, including external review, that may be available to You.

The following treatment or Services must be Pre-certified by the Medical Review Program:

1. Inpatient admissions
2. Inpatient Rehabilitation Therapy admissions
3. Inpatient Skilled Nursing Facility, long-term care, and sub-acute admissions
4. Inpatient mental health and chemical dependency admissions
5. Inpatient Residential Treatment
6. Non-Emergent (Scheduled) Air or Ground Ambulance
7. Pediatric Medically Necessary contact lenses
8. Low Protein Modified Foods
9. Clinical Trials
10. Medical Foods
11. Bariatric Surgery
12. Dental & Endoscopic Anesthesia
13. Durable Medical Equipment
14. Genetic Testing
15. Home Health & Home Infusion Services
16. Hospice (home, inpatient)
17. Infertility Procedures
18. Imaging Service (Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Computerized Tomography Angiography (CTA),

SAMPLE

Positron Emission Tomography (PET), Electronic Beam Computed Tomography (EBCT), SPECT, not including x-ray or ultrasound)

19. Outpatient Injectable Drugs
20. Outpatient Surgery (performed at hospital, ambulatory surgery center of licensed Facility
21. Orthotics/Prosthetics
22. Implantable prosthetics (includes breast, bone conduction, cochlear)
23. Pain Management Services (radiofrequency ablation, implantable pumps, spinal cord stimulator, injections)
24. Radiation Therapy Services
25. Reconstructive Surgery. Reconstructive Surgery means a surgery performed to significantly improve a physical function; or to correct significant disfigurement resulting from an Injury or covered surgery, such as a covered mastectomy.
26. TMJ/Orthognathic Surgery
27. The following outpatient procedures:

(a) Hyperbaric oxygen
(b) Sclerotherapy
(c) Plasma Pheresis (MS)
(d) Anodyne Therapy
(e) Sleep Studies and Sleep Labs
(f) Vagal Nerve Stimulation
(g) Hemispherectomy
(h) Implants
(i) Pill Endoscopy
(j) Stab phlebectomy
(k) Radiofrequency ablation
(l) Enhanced External Counterpulsation (EECP)
(m) Resection
(n) Corpus Colostomy surgery
(o) Uvulo-palato-pharyngoplasty (UPPP) & laser-assisted UPPP

SAMPLE

IMPORTANT: If Pre-certification is not obtained, benefits will be reduced even if the treatment or Service is deemed Medically Necessary. If the treatment or Service is deemed not to be Medically Necessary, the treatment or Service will not be covered. If a Hospital Confinement or other Confinement is extended beyond the number of days first Pre-certified without further Pre-certification (concurrent review), benefits for the extra days: (1) will similarly be reduced; or (2) will not be covered if deemed not to be Medically Necessary.

Pregnancy Pre-certification: When a Member is admitted to a Hospital for delivery of a child, the Member is authorized to stay in the hospital for a minimum of:

1. Forty-eight (48) hours for a normal vaginal delivery; and
2. Ninety-six (96) hours for a Cesarean section delivery.

A stay longer than the above may be allowed provided the attending provider obtains authorization for an extended confinement through the Medical Review Program. Under no circumstances will KPIC require that a provider reduce the mother's or child's Hospital Confinement below the allowable minimums cited

above.

Treatment for Complications of Pregnancy is subject to the same Pre-certification requirements as any other Sickness.

Complications of Pregnancy means 1) conditions requiring hospital confinement when the pregnancy is not terminated and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, pre-eclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity; 2) ectopic pregnancy which is terminated; or 3) an act of rape of an insured.

Complications of Pregnancy will not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Hysterectomy Pre-certification: When a Member is admitted to a Hospital for a hysterectomy, either a laparoscopy-assisted vaginal hysterectomy or a vaginal hysterectomy, the minimum authorized Hospital stay will be:

1. twenty-three (23) hours for laparoscopy-assisted vaginal hysterectomy; or
2. forty-eight (48) hours for vaginal hysterectomy.

A stay longer than the above noted minimums may be allowed provided the attending provider obtains authorization for an extended confinement through the Medical Review Program.

Pre-certification Procedures

The Member, or provider acting on behalf of the Member, must notify the Medical Review Program as follows:

1. Planned Hospital Confinement - as soon as reasonably possible after Member learns of a Hospital Confinement, but at least three days prior to admission for such Hospital Confinement.
2. Extension of a Hospital Confinement - as soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond the number of days originally Pre-certified.
3. Other treatments or procedures requiring Pre-certification - as soon as reasonably possible after the Member learns of the need for any other treatment or Service requiring Pre-certification but at least three days prior to performance of any other treatment or Service requiring Pre-certification.

A Member, or provider acting on behalf of the Member, must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Member, or provider acting on behalf of the Member, may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Member is required to obtain a second opinion, it will be provided at no charge to the Member;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long-term case management programs; and/or

SAMPLE

3. Obtain from the attending Physician information required by the Medical Review Program relating to the Member's medical condition and the requested treatment or Service. If the Member or the Member's provider does not provide the necessary information or will not release necessary information, Pre-certification will be denied.

Pre-Service Reviews: Within two days of receiving all necessary information, the Medical Review Program will make its determination. Necessary information includes, but is not necessarily limited to, the results of any face-to-face clinical evaluation or any second opinion that may be required. If an admission, procedure or Service is Pre-certified, KPIC will:

1. Notify the provider by telephone within one working day of Pre-certification; and
2. Confirm the Pre-certification with the Member and provider in writing or electronically within two working days of the initial Pre-certification.

If Pre-certification is denied or an alternate treatment or Service recommended, KPIC will:

1. Notify the provider by telephone within one working day of making the denial or alternate treatment or Service recommendation; and
2. Confirm the adverse decision with the Member and provider in writing or electronically within one working day of making the denial or alternate treatment or Service recommendation.

Concurrent Reviews: The Medical Review Program will make concurrent review determinations within one working day of obtaining all the necessary information. If the Medical Review Program certifies an extended stay or additional Services under the concurrent review, KPIC will:

1. Notify the provider by telephone within one working day of the certification;
2. Confirm the certification in writing or electronically with the Member and provider within one working day after the telephone notification. The written notification will include the number of extended days or next review date, the new total number of days or Services approved, and the date of admission or initiation of Services.

If the request for extended stay or additional Services is denied, KPIC will:

1. Notify the provider of the denial by telephone within one working day of making the adverse determination;
2. Confirm the denial in writing or electronically with the Member and provider within one working day of the telephone notification. Coverage will continue for covered Services until the Member and provider rendering the Service have been notified of the adverse determination.

Post-Service Reviews: The Medical Review Program will make its determination on post-Service reviews within thirty (30) working days of receiving all necessary information. If the treatment or Service is certified, KPIC may notify the Member and provider of the certification. If the treatment or Service is not certified, KPIC will notify the Member, and the provider acting on behalf of the Member, of the adverse determination in writing within five working days of making the adverse determination.

Written Denial Notices and the Internal Review (Appeal) Process

A written notification of an adverse determination will include:

1. The principal reasons for the determination;

SAMPLE

2. Instructions for initiating an Appeal or reconsideration of the determination; and
3. Instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make that determination.

If a request for Pre-certification is denied, in whole or in part, the Member, or provider acting on behalf of the Member, that received notice of the adverse determination, will be given an opportunity for review. Requests for review will not be granted unless proper procedures are followed in making the request.

Upon receipt of a request for review, the Medical Review Program will reconsider a denied request for Pre-certification within three working days of receiving the request for review and notify the Member or provider of its decision. Unresolved denials may be appealed, as follows:

1. Standard Appeals initiated by a Member, or provider acting on behalf of the Member. Written request will be entered into a complaint record. Evaluation will be by a Physician and/or clinical peer. The Member and provider will be notified within thirty (30) working days following the Appeal request. The written decision will include:
   i) The name of the decision maker(s), and their qualifications to make this decision;
   ii) The reviewer's decision in clear terms, with supporting medical detail;
   iii) The reference sources on which the decision was based, including clinical criteria and instructions for requesting the criteria; and
   iv) In the case of an unresolved difference of opinion, instructions to be used by the Member or provider for submitting a written Appeal requesting a further review, unless state or federal law prohibits the provider from making such a request.
2. Expedited Appeals for adverse determinations will be provided if completing the standard review procedure would seriously jeopardize the life, health or ability of the Member to regain maximum function. The review procedure will apply to all requests regarding an admission, availability of health care and continued stay for a Member who had received Emergency Care but has not yet been released from a Facility. The review will occur within twenty-four (24) hours of receiving the request and will:
   i) Be conducted by clinical peers in the same specialty who were not involved in the initial determination.
   ii) Allow all necessary information, including the decision, to be transmitted between the parties involved by telephone, facsimile or a similarly available method.
   iii) Render a decision and notify the Member and provider within twenty-four (24) hours of the start of the review process. The decisions must also be provided in writing within seventy-two (72) hours of the initial notification.
   iv) Include, in the case of an unresolved difference of opinion, instructions to be used by the Member or provider for submitting a written request for further review, unless law prohibits the provider from making such a request.
   v) Not include reviews for retrospective adverse determinations.

Second Opinions (Option 1)

You may receive a second medical opinion from a Plan Physician upon request.

SAMPLE

Getting the Care You Need; Emergency Services, Urgent Care and Advice Nurses (Option 1)

If you think you are experiencing an Emergency Medical Condition, call 911 (where available) or go to the nearest emergency department.

Getting Advice from Our Advice Nurses (Option 1)

If you are not sure you are experiencing a medical emergency, or may require Urgent Care Services (for example, a sudden rash, high fever, severe vomiting, ear infection, or a sprain), you may call our advice nurses at:

Inside the Washington, D.C. Metropolitan Area

(703) 359-7878

TTY 711

Outside the Washington, D.C. Metropolitan Area

1-800-777-7902

TTY 711

After office hours, call: 1-800-677-1112. You can call this number from anywhere in the United States, Canada, Puerto Rico, or the Virgin Islands.

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

Making Appointments (Option 1)

When scheduling appointments it is important to have your identification card handy. If your primary care Plan Physician is located in a Plan Medical Center, please call:

Inside the Washington, D.C. Metropolitan Area

(703) 359-7878

TTY 711

Outside the Washington, D.C. Metropolitan Area

1-800-777-7902

TTY 711

If your primary care Plan Physician is not located in a Plan Medical Center, please call his or her office directly. You will find his or her telephone number on the front of your identification card.

Using Your Identification Card (Option 1)

Your ID card is for identification only. You will be issued a Health Plan identification (ID) card that will serve as evidence of your Membership status. In addition to your Health Plan ID card, you may be asked to show a valid photo ID at your medical appointments. Allowing another person to use your Membership card will result in forfeiture of your card and may result in termination of your membership.

Each Member has a Health Plan ID card with a medical record number on it to use when you call for advice,

SAMPLE

make an appointment, or go to a Plan Provider for care. The medical record number is used to identify your medical records and membership information. You should always have the same medical record number. If you need to replace your card, or if we ever inadvertently issue you more than one medical record number, please let us know by calling Member Services Monday through Friday from 7:30 a.m. until 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or TTY is 711.

Receiving Care in Another Kaiser Foundation Health Plan Service Area (Option 1)

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 Co-payments, Coinsurance and/or Deductibles shown in the ***Appendix – Summary of Cost Shares***, and the exclusions, limitations and reductions described in this EOC.

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

Moving to Another Kaiser Permanente Health Plan Region or Group Health Cooperative Service Area (Option 1)

If you move to another Kaiser Permanente Health Plan Region or Group Health Cooperative Service area, you may be able to transfer your Group membership if there is an arrangement with your Group in the new Service area. However, eligibility requirements, benefits, Premiums, Co-payments, Coinsurance and Deductibles may not be the same in the other Service area. You should contact your Group's employee benefits coordinator before you move.

Payment toward your Cost Share (and when you may be billed) (Options 1, 2 and 3)

When receiving Services under Option 1, you will generally be asked to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services (such as primary care treatment and laboratory tests), you may be required to pay separate Cost Shares for each of those Services. When receiving Services under Options 2 and 3, 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 by your provider. When receiving Services under Option 3, your provider may require you to pay for the Services at the time the Services are provided. In such case, you must file a claim with us for reimbursement.

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:

- **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.
- **You receive diagnostic Services during a treatment Visit**. For example, you go in for

SAMPLE

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;

- **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;
- **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; or
- **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.

SAMPLE

SECTION 3.1 – OPTION 1 (HMO) BENEFITS

The Services described in this "Option 1 (HMO) Benefits" section is covered only if all of the following conditions are satisfied:

- You are a Member on the date the Services are rendered;
- You have not met the maximum benefit for the Service, if any. A maximum benefit applies per Member per Contract Year;
- The Services are provided by a Plan Provider (unless the Service is to be provided by a non-Plan Provider subject to an approved referral as described in Section 2) in accordance with the terms and conditions of this EOC including but not limited to the requirements, if any, for prior approval (authorization);
- The Services are Medically Necessary; and
- You receive the Services from a Plan Provider except as specifically described in this EOC.

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

- Emergency Services
- Urgent Care outside our Service Area
- Authorized referrals to non-Plan Providers (as described in Section 2)
- Visiting Member Services (as described in Section 2)
- Non-emergency surgical and Ancillary Services provided at a Plan Facility by a non-Plan Provider.

Limitations: Limitations that apply only to a particular benefit are described in this section. Exclusions and coordination of benefits that generally affect benefits are described in Section 4 of this EOC, ***Exclusions and Coordination of Benefits***.

Note: The ***Appendix – Summary of Cost Shares*** lists the Co-payments, Coinsurances and Deductibles that apply to the following covered Services. Your Cost Share will be determined by the type and place of Service.

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 ***Appendix – Summary of Cost Shares***.

If you are balance billed by a hospital, urgent care center, physician or ancillary provider for covered Services that were provided to you, simply mail a copy of the bill 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

SAMPLE

terms and conditions set forth herein. To view your benefits, see **Section 3.1 – Option 1 (HMO) Benefits** in this section.

A. Outpatient Care

We cover the following outpatient care:

- Primary care visits, including those provided in your home or online via webcam, chat, or voice, for internal medicine, family practice, pediatrics, routine preventive obstetrics and gynecology Services, and routine care and common illnesses (refer to ***Preventive Health Care Services*** for coverage of preventive care Services);
- Walk-in Services available from any Health Plan Medical Facility. These Services are available 24 hours a day in certain Plan Medical Centers, including Services provided by nurse practitioners, advanced practice registered nurse (APRN), and physician assistants. Call Member Services for location and hours of operation of all of our Plan Medical Facilities.
- Specialty care visits (refer to ***Section 2 How to Obtain Services*** for information about referrals to Plan specialists);
- Consultations and immunizations for foreign travel;
- 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:
- Diagnostic examinations, including digital rectal exams and prostate antigen (PSA) tests provided in accordance with American Cancer Society guidelines to:
    - persons age 50 and over and
    - persons age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society;
    - 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.
- 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 estrogen deficient individual at clinical risk for osteoporosis;
    - an individual 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;
    - an individual receiving long-term gluco-corticoid (steroid) therapy;

SAMPLE

  - an individual with primary hyperparathyroidism; or
  - an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy (Refer to ***Preventive Health Services*** for coverage of preventive care tests and screening Services);

- Outpatient surgery received at an outpatient or ambulatory surgery Facility, or doctor's office for the following services:.
- Physician Services;
- Anesthesia, including services of an anesthesiologist;
- Chemotherapy and radiation therapy;
- Respiratory therapy;
- Sleep treatment;
- Medical social Services;
- House calls when care can best be provided in your home as determined by a Plan Provider;
- After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to the Urgent Care provision for covered Services; and
- Equipment, supplies, splints, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care professional legally authorized to prescribe or provide such items under law.

Additional outpatient Services are covered, but only as specifically described in this **Section 3.1 – Option 1 (HMO) Benefits**, and subject to all the limits and exclusions for that Service.

B. Hospital Inpatient Care

We cover inpatient Services in a Plan Hospital, or a non-Plan Hospital in an emergency, when you are an inpatient because of illness, injury, or pregnancy (see Maternity below for additional pregnancy benefits). We cover Services that are generally and customarily provided by an acute care general hospital in our Service Area for:

- Room and board in a semi-private room or a private room when deemed Medically Necessary. Room and board includes your bed, meals, and special diets;
- Specialized care and critical care units;
- General and special nursing care;
- Medically Necessary Services and supplies provided by the hospital;
- Operating and recovery room;
- Plan Physicians' and surgeons' Services, including consultation and treatment by specialists;
- Anesthesia, including services of an anesthesiologist;
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider;

SAMPLE

- Medical and surgical supplies, including hypodermic needles and syringes;
- Drugs, injectable drugs, blood, and oxygen;
- Nuclear medicine;
- Chemotherapy and radiation therapy;
- Respiratory therapy; and
- Medical social Services and discharge planning.

We cover necessary Services and Supplies, including medication dispensed while confined in a Hospital to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Additional inpatient Services are covered, but only as specifically described in this **Section 3.1 – Option 1 (HMO) Benefits**, and subject to all the limits and exclusions for that Service.

Minimum Hospital Stay

We cover inpatient hospitalization Services for you and your newborn child for a minimum stay of at least 48 hours following an uncomplicated vaginal delivery; and at least 96 hours following an uncomplicated cesarean section.

We also cover postpartum home health visits upon release. 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 24 hours after discharge, and an additional home visit.

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

We cover a minimum hospital stay of no less than 48 hours following a radical or modified radical mastectomy and no less than 24 hours following a total or partial mastectomy with lymph node dissection.

We cover a minimum hospital stay of no less than 23 hours for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy.

SAMPLE

C. 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.

Accidental Dental Injury Services Exclusions:

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

D. Allergy Services

We cover the following allergy Services:

- Evaluations and treatment
- Allergy testing
- Injections and serum

E. Ambulance Services

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

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

A licensed ambulance is a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation. Coverage is also provided for Medically Necessary transportation or Services including Medically Necessary air ambulance transport to the nearest hospital able to provide needed Services, provided during an encounter with an ambulance Service, as a result of a 911 call or when ground or water transportation is not appropriate.

Coverage is included when you are taken from the home, the scene of an accident or medical emergency to a Hospital. Coverage is also included for Medically Necessary treatment of a Sickness or Injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

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

We cover ambulance and medically appropriate non-emergent transportation Services only inside our Service Area, except as related to out of area Services covered under the ***Emergency Services*** provision in this section of the EOC. Your cost share will apply to each encounter whether or not transport was required.

Bills for Emergency Air Ambulance Services
You will incur no additional cost sharing than what is set forth in your ***Appendix – Summary of Cost Shares*** for emergency Air Ambulance Services, and you do not have to pay any amount billed in excess of what we pay. If you are billed for emergency Air Ambulance Services, 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 bill to us at the following address:

Kaiser Permanente National Claims Administration - Mid-Atlantic States
P.O. 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***.

F. Anesthesia for Dental Services

We cover general anesthesia and hospitalization Services for:

- Members who are children under the age of five;
- Members who are severely disabled; and

SAMPLE

- Members who have a medical condition that requires admission to a hospital or outpatient surgery Facility. These services are only provided when it is determined by a licensed dentist, in consultation with the Member's treating physician that such Services are required to effectively and safely provide dental care.

G. 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.

Medically Necessary defined in this section 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:

(i) prevent the onset of an illness, condition, injury, or disability;
(ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or
(iii) 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.

SAMPLE

Note: Physical, Occupational, and Speech Therapy for the treatment of autism is not subject to any visit limits.

H. Blood, Blood Products and Their Administration

We cover blood, blood products, both derivatives and components, including the collection and storage of autologous blood, 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, we cover the purchase of blood products and blood infusion equipment, and the administration of the blood products and Services 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. We cover surgical dressings and splints for treatment of blood disorders.

I. Chiropractic Services

For musculoskeletal illness or injury only, we cover spinal manipulations and other manual medical interventions for a maximum of 30 visits per calendar year. These limits apply separately for habilitative and rehabilitative services.

J. 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.

K. 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:

- The cost of an investigational drug or device, except as provided below for off-label use of an FDA approved drug or device;
- The cost of non-health care Services that may be required as a result of treatment in the clinical trial; or
- 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:

- The Services would be covered if they were not related to a clinical trial.
- The Member is eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition or disease (a condition or disease from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
    i. A Plan Provider makes this determination.

SAMPLE

ii. The Subscriber or Member provides us with medical and scientific information establishing this determination.

- If any Plan Providers participate in the clinical trial and will accept the Member as a participant in the clinical trial, the Member must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where the Member lives.
- 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 or disease and it meets one of the following requirements:

i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.

ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.

iii. The study or investigation is approved or funded by at least one of the following:

a. The National Institutes of Health.

b. The Centers for Disease Control and Prevention.

c. The Agency for Health Care Research and Quality.

d. The Centers for Medicare & Medicaid Services.

e. A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.

f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

g. The Department of Veterans Affairs or the 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 U.S. Secretary of Health and Human Services determines meets all of the following requirements:

h. It is comparable to the National Institutes of Health system of peer review of studies and investigations.

i. It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

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.

L. Diabetic Services

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

- Insulin-using diabetes;

SAMPLE

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

Covered treatment for diabetic foot care include the following:

- Corns;
- Calluses; and
- Care of toenails

Covered medical supplies and equipment include the following:

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

Pursuant to IRS Notice 2019-45, coverage for glucose monitoring equipment is not subject to the Deductible. Refer to the ***Appendix – Summary of Cost Shares*** for Cost Sharing requirements.

Note: Insulin is covered under the "Outpatient Prescription Drug Benefit."

Diabetic Equipment and Supplies Limitation:

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) (a) there is no equivalent preferred equipment or supply available, or (b) an equivalent preferred equipment or supply, (i) has been ineffective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member. "Health Plan preferred equipment and supplies" are those purchased from a Plan preferred vendor.

SAMPLE

M. Dialysis Services

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

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

We cover the following renal dialysis Services:

- Outpatient maintenance dialysis treatments in a Plan dialysis Facility or doctor's office. Coverage includes the cost of laboratory tests, equipment, supplies and other Services associated with your treatment.

- Inpatient maintenance dialysis if you are admitted to a Plan Hospital because your medical condition requires specialized hospital Services on an inpatient basis.
- Plan Provider Services related to inpatient and outpatient dialysis.

We cover the following self-dialysis Services:

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

We cover home dialysis, which includes:

- Equipment and supplies;
- Hemodialysis;
- Home intermittent peritoneal dialysis (IPD);
- Home continuous cycling peritoneal dialysis (CCPD); and
- 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 Contract Year. Prior Authorization is required.

N. Drugs, Supplies, and Supplements

SAMPLE

We cover the following during a covered stay in a Plan Hospital, outpatient Facility, or Skilled Nursing Facility, or if they require administration or observation by medical personnel and are administered to you in a Plan Medical Center as part of a doctor's Visit or during home visits:

- 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;
- Injectable devices;
- The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
- Medical and surgical supplies that serve only a medical purpose, are used once and are purchased (not rented). Covered supplies including dressings casts, splints, hypodermic needles, syringes, or any other Medically Necessary supplies provided at the time of treatment; and
- Vaccines and immunizations approved for use by the federal Food and Drug Administration (FDA) that are not considered part of routine preventive care.

Note: Additional Services that require administration or observation by medical personnel are covered. Refer to the ***Outpatient Prescription Drug Benefit*** appendix for coverage of self-administered outpatient prescription drugs, ***Preventive Health 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.

Coverage will not be denied:

- For any drug approved by the United States Food and Drug Administration (FDA) for treatment of cancer because the drug has not been approved by FDA for treatment of the specific type of cancer for which it has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the Standard Reference Compendia.
- For any drug prescribed to treat a covered indication if the drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-Reviewed Medical Literature.
- For any drug approved by FDA for treatment of cancer pain because the dosage is in excess of the recommended dosage of the pain–relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with §§ 54.1-2971.01, 54.1-3303 and 54.1-3408.1 for a patient with intractable cancer pain.

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

O. Durable Medical Equipment

Durable Medical Equipment is defined as equipment that: (a) is intended for repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) is generally not useful to a person in the absence of illness or injury; and (d) meets Health Plan criteria for medical necessity. Refer to “Prosthetic Devices” for coverage of internal and external prosthetic 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 cover maintenance needed for use of the equipment. 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.

We cover the following types of equipment:

- Hospital type beds;
- Wheelchairs;
- Traction equipment;
- International Normalized Ratio (INR) home testing machines;
- Walkers; and
- Crutches.

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. We will also cover the supplies and equipment needed for use of the equipment or device, such as a battery for a powered wheelchair. You must return the equipment to us or pay us the fair market price

SAMPLE

of the equipment when we are no longer covering it.

Note: Diabetes equipment and supplies are not covered under this section (refer to "Diabetic Services.")

Supplemental Durable Medical Equipment

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

1. Oxygen and Equipment

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

2. Positive Airway Pressure Equipment

We cover continuous automatically-adjusting positive airway pressure (APAP), positive airway pressure (CPAP), automatic positive airway pressure (APAP) and bi-level positive airway pressure (BIPAP) equipment when prescribed by a Plan Provider and your medical condition meets Health Plan's criteria for medical necessity. Health Plan covers devices and supplies for sleep treatment, such as APAP, CPAP, BPAP and oral devices for sleep treatment. These Services are subject to medical necessity reviews by us. A Plan Provider must certify the continued medical for positive airway pressure equipment. A Plan Provider must certify the continued medical need for oxygen and equipment. Benefits include purchase-only equipment and devices and purchase or rent-to-purchase equipment and devices such as continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

SAMPLE

3. Apnea Monitors

We cover apnea monitors for a period not to exceed six months.

4. Asthma Equipment

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

- Spacers
- Peak-flow meters
- Nebulizers

5. Bilirubin Lights

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

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

P. Early Intervention Services

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

- speech and language therapy;
- occupational therapy;
- physical therapy; and
- 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 will not apply if you get that care as part of the Early Intervention.

Q. Emergency Services

As described below, you are covered for Emergency Services if you experience an Emergency Medical Condition anywhere in the world.

If an emergency room visit is made for a condition that is not a true emergency then assessment and stabilization received are also covered for Option 1 and Option 2 will be at the in-network benefit level.

If you think you are experiencing an Emergency Medical Condition as defined in the section ***Important Terms You Should Know***, you should call 911 immediately. If you are not sure whether you are experiencing an Emergency Medical Condition, please contact us at the number listed on the reverse side of your ID card for immediate medical advice. You or your representative must notify the Health Plan as soon as possible, not to exceed forty-eight (48) hours or the next business day, whichever is later, if you receive care at a hospital emergency room (ER) to ensure coverage. If you are incapacitated and unable to notify us within 48 hours, you or your representative must notify us as soon as reasonably possible.

We cover Emergency Services as follows:

Inside our Service Area

We cover emergency room surgical or ancillary Services, including diagnostic x-ray, laboratory Services, medical supplies, and advanced diagnostic imaging such as magnetic resonance imaging (MRI) and computed tomography (CT) scans, 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 ***Appendix – Summary of 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. Coverage for Emergency Services will be provided without need for prior authorization and regardless of the final diagnosis rendered to the Member.

SAMPLE

Outside our Service Area

If you are injured or become ill while temporarily outside the Service Area, but within the United States, we will cover charges for Emergency Services as defined in this section. We cover emergency room surgical or ancillary Services, including diagnostic x-ray, laboratory Services, medical supplies, and advanced diagnostic imaging such as magnetic resonance imaging (MRI) and computed tomography (CT) scans, when received from a Plan Provider or a non-Plan Provider at a Plan Facility or a non-Plan Facility. You will incur no additional cost sharing for Emergency Services beyond that which is indicated in your ***Appendix – Summary of Cost Shares*** for in-network Services. We will cover Services received outside of the Service Area until you can, without medically harmful consequences, be transported to a Plan Hospital or primary care Plan Physician's office. Coverage for Emergency Services will be provided without need for prior authorization and regardless of the final diagnosis rendered to the Member.

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 ***Appendix – Summary of Cost Shares***.

SAMPLE

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 our Service Area:

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

Transport to a Service Area

If you obtain prior approval from us, or from the nearest Kaiser Foundation Health Plan Region, we will cover necessary ambulance Services or other special transportation arrangements medically required to transport you to a Plan Hospital or Medical Office in our Service Area, or in the nearest Kaiser Foundation Health Plan Region, for continuing or follow-up treatment. **Note**: All ambulance transportation is covered under the "Ambulatory Services" benefit in this section.

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 48 hours of any hospital admission, or on the first working day following the admission, unless it was

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

Post-Stabilization Care

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

When you receive Emergency Services in Virginia, and federal law does not require that we consider the Post-Stabilization Care as Emergency Services, we cover Post-Stabilization Care only if we provide Prior Authorization for the Post-Stabilization Care. Therefore, it is very important that you, your provider, including your non-Plan Provider, or someone else acting on your behalf, call us to notify us that you need Post-Stabilization Care and to get Prior Authorization from us before you receive the Post-Stabilization Care.

To request Prior Authorization, you, your provider, including your non-Plan Provider, or someone else acting on your behalf, must call 1-800-225-8883 or the notification telephone number on the reverse side of your ID card before you receive the care. We will discuss your condition with the non-Plan Provider. If we determine that you require Post-Stabilization Care, we will authorize your care from the non-Plan Provider or arrange to have a Plan Provider, or other designated provider, provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated non-Plan Provider provide your care, we may authorize special transportation Services that are non-Plan Providers. If you receive care from a non-Plan Provider that we have not authorized, you may have to pay the full cost of that care.

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

Non-Plan Providers may provide notice and seek your consent to provide Post-Stabilization Care Services or other covered Services. Such Services will not be covered when you do not obtain Prior Authorization as described herein. If you, or your Authorized Representative, consent to the furnishing of Services by non-Plan Providers, then you will be responsible for paying for such Services in the absence of any Prior Authorization. The cost of such Services will not accumulate to your Deductible, if any, or your Out-of-Pocket Maximum costs.

Filing Claims for Non-Plan Emergency Services

Keep all your receipts for Emergency Services provided by non-Plan Providers and verify that the non-Plan Provider has submitted the claims. All claims must be filed with us within six months of the date of the

SAMPLE

Service, or as soon as reasonably possible in order to assure payment.

Bills for Emergency Services

If you are balance billed by a hospital, freestanding emergency department, or physician or ancillary provider for Emergency Services that were provided to you, simply mail a copy of the bill to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. Please mail your proof to us within one (1) year at the following address:

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

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

Emergency Services Limitations:

- **Notification**: If you receive care at a hospital emergency room or are admitted to a non-Plan Hospital, you, or someone on your behalf, must notify us as soon as possible, but not later than 48 hours 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.
- **Continuing or Follow-up Treatment**: Except as provided for under "Continuing Treatment Following Emergency Surgery," we do not cover continuing or follow-up treatment after Emergency Services unless authorized by Health Plan. We cover only the Out-of-Plan Emergency Services that are required before you could, without medically harmful results, have been moved to a Facility we designate either inside or outside our Service Area or in another Kaiser Foundation Health Plan or allied plan service area.
- **Hospital Observation**: Transfer to an observation bed or observation status does not qualify as an admission to a hospital. Your emergency room Visit Co-payment, if applicable, will not be waived.

R. Family Planning Services

Coverage is provided for family planning Services, including:

- Women's Preventive Services (WPS), including:
  - Patient education and contraceptive method counseling for all women of reproductive capacity;
  - 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
  - Female sterilization.

SAMPLE

Note: WPS are preventive care and are covered at no charge.

- Family planning counseling, including pre-abortion and post-abortion counseling;

  Note: Counseling does not include instruction for fertility awareness based methods;

- Male sterilization;
- Elective and therapeutic termination of pregnancy, as permitted under state law.

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

Note: We cover therapeutic termination of pregnancy as permitted under state law:

- o 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
- o 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
- o When the pregnancy is the result of an alleged act of rape or incest.

S. Hearing Services

Hearing Exams

We cover hearing tests to determine the need for hearing correction, when ordered by a Plan Provider. See "Preventive Health Care Services" for coverage of newborn hearing screenings.

Hearing Aids

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 maximum the Health Plan will pay toward the cost of a covered hearing aid.

Coverage for hearing aids is 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, including 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.

Hearing Aids Limitations:

- We cover one (1) hearing aid for each hearing-impaired ear every twenty-four (24) months.
- Coverage is provided for one (1) hearing aid for each hearing-impaired ear, up to the hearing aid benefit allowance of $1,500 for each hearing aid.

T. Home Health Services

We cover treatment provided in your home on a part-time or intermittent basis. This coverage allows for an alternative to repeated hospitalizations that will provide the quality and appropriate level of care to treat your condition. Services provided as a part of home care are not subject to separate Visit limits for therapy

SAMPLE

services. This home health care limit does not apply to home infusion therapy or home dialysis. To ensure benefits, your Plan Provider must provide a description of the treatment you will receive at home. Your coverage includes the following home health services:

- Visits by a licensed health care professional, including a nurse, therapist, or home health aide; and
- Physical therapy, speech therapy, and occupational therapy;
- Medical social Services;
- Nutritional guidance;
- Training of the patient and/or family/caregiver;
- Medical supplies;
- Durable medical equipment;
- Diagnostic services; and
- Remote patient monitoring.

These services are only covered when your condition confines you to your home at all times except for brief absences.

Note: Coverage for home health Services will not be less than one hundred (100) Visits per Contract Year.

Home Private Duty Nurse's Services

We also cover the cost of medically skilled Services of a currently licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in your home when the nurse is not a relative or member of your family. Your Plan Provider must certify to us that private duty nursing services are Medically Necessary for your condition and not merely custodial in nature.

Except as provided for Visiting Member Services, we cover the home health care Services only within our Service Area.

We also cover any other outpatient Services, as described in this "Benefits" 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 48 hours of inpatient hospitalization following the surgery, are entitled to the following:

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

Home Health Care Limitations:

- Home private duty nurses Services are limited to 16 hours per calendar year.

U. 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 6 months or less, you can choose Hospice Care Services

SAMPLE

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:

- Skilled nursing care, including IV therapy Services;
- Physical, occupational, speech, and respiratory therapy;
- Medical social Services;
- Home health aide Services;
- Homemaker Services;
- Medical supplies and appliances;
- Palliative drugs in accord with our drug formulary guidelines;
- Physician care;
- Nutritional counseling;
- General hospice inpatient Services for acute symptom management including pain management;
- Respite Care that may be limited to five consecutive days for any one inpatient stay up to four times in any Contract Year;
- 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 year after the Member’s death; and
- Services of hospice volunteers;
- Custodial care.

Note: No therapy Visit maximum applies to occupational, physical, or speech therapy services received under this benefit.

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Definitions:

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

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.

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

Caregiver means an individual primarily responsible for the day to day care of the Member during the

period in which the Member receives Hospice Services.

V. Infertility Diagnostic Services

Covered infertility services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Infertility benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis and hormone deficiency).

Fertility treatments such as artificial insemination and in vitro fertilization are not a covered Service. Nor are the medications for the treatment of infertility a covered benefit.

Infertility Exclusions:

- Artificial insemination, in vitro fertilization (IVF), ovum transplants and gamete intrafallopian tube transfer (GIFT), zygote intrafallopian transfer (ZIFT), or cryogenic or other preservation techniques used in these or similar procedures.
- Infertility drugs used in assisted reproductive technology (ART) procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
- Any services or supplies provided to a person not covered under your Health Plan in connection with a surrogate/gestational carrier pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- Services to reverse voluntary, surgically induced infertility; or fallopian scar revision surgery.

W. Maternity Services

Pregnancy and Maternity Services

Coverage is provided for the Member and Dependents who become pregnant. Health plan covers prenatal and postnatal Services, which includes pregnancy testing, routine and non-routine office Visits, inpatient care, home Visits, telemedicine Visits, x-ray, laboratory and specialty test. Health Plan covers birthing classes and breastfeeding support, supplies, and counseling from trained providers during pregnancy and/or in the postpartum period.

Coverage for postpartum Services include benefits for inpatient care and a home visit, or Visits, which shall be in accordance with the medical criteria outlined in the most current version of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Pregnancy Testing

We cover tests to determine if a Member is pregnant.

Prenatal and Newborn Care

If a Member becomes pregnant, Health Plan provides coverage for maternity care, maternity-related checkups, and delivery of the baby in the hospital.

We cover the following:

- Use of the delivery room and care for deliveries;
- Home setting covered with nurse midwives; If there are no midwives in your network, the actuarial equivalent of such Service, such as delivery at a birthing center, will be covered;

SAMPLE

- Anesthesia services to provide partial or complete loss of sensation before delivery;
- Hospital services for routine nursery care for the newborn during the mother's normal hospital stay;
- Prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary;
- Screenings for pregnant women for anemia, gestational diabetes, Hepatitis B, Rh incompatibility, asymptomatic bacteriuria, and urinary tract or other infections;
- Screenings for newborns for blood pressure, hearing, Hemoglobinopathies, gonorrhea prophylactic medication, Hypothyroidism, and Phenylketonuria (PKU);
- Folic acid supplements;
- Breastfeeding support, equipment and supplies, including one (1) breast pump per pregnancy;
- Behavioral assessments and measurements for children;
- Screenings for blood pressure and hearing in newborn children;
- Hemoglobinopathies screening for newborn children;
- Gonorrhea prophylactic medication for newborn children;
- Hypothyroidism screening for newborn children;
- PKU screening for newborn children;
- Dental Services and dental appliances furnished to a newborn child when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Expanded tobacco intervention and counseling for pregnant users;
- Initial examination of a newborn and circumcision of a covered male Dependent; and
- Fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies.

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

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.

X. Medical Food

We cover Medically Necessary medical foods, formulas, infusion of special medical formulas, supplements, enteral nutrition, and low protein food products for Members with inborn errors of amino acid or organic acid metabolism, inherited metabolic disorder, metabolic abnormality or severe protein or soy allergies when they are 1) prescribed for therapeutic treatment; 2) required to maintain adequate nutritional

status; and 3) are administered under the direction of a Plan Provider.

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 are administered under the direction of a Plan Provider.

Low protein modified foods are food products that are:
(a) Specially formulated to have less than one (1) gram of protein per serving; and
(b) 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 formula and enteral products.

We do not cover nutritional counseling and related services, except when received as part of a covered wellness service Visit or screening, diabetes education, or for hospice with respect to person's care.

Y. Mental Health Services and Substance Use Disorder

Mental Health Services means planned individualized interventions intended to reduce or improve mental illness or the effects of mental illness through care, treatment, counseling, rehabilitation, medical or psychiatric care, or other supports provided to individuals with mental illness.

Substance Use Disorder 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.

We cover inpatient and outpatient Mental Health Services, which includes partial day Mental Health Services and Substance Use Disorder services, and intensive outpatient programs for treatment of alcohol or drug dependence. We cover individualized and intensive treatment in a residential treatment Facility which includes observation and assessment by a psychiatrist at least weekly and rehabilitation, therapy, education and recreational or social activities.

Inpatient Services

While you are an inpatient in a Hospital, Plan Facility or program that we must cover per state law, we cover all medical Services of physicians and other health professionals as performed, prescribed or directed by a Plan Physician including:

- Individual psychotherapy;
- Group psychotherapy;
- Psychological testing;
- Convulsive therapy;
- Electroconvulsive therapy;
- Detoxification
- Drug therapy;
- Education;

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- Treatment for psychiatric conditions;
- Psychiatric nursing Services;
- Appropriate Hospital Services;
- Structured program of treatment and rehabilitation, including 24 hour-a-day nursing care;
- Counseling with family members to assist with patient's diagnosis and treatment;
- Medical Services for detoxification.

Residential Treatment

We provide coverage for inpatient Services for substance abuse and eating disorders provided in a hospital or treatment Facility that is licensed to provide a continuous, structured program of treatment, and rehabilitation, including twenty-four (24) hour-a-day nursing care.

Residential treatment means specialized 24-hour treatment in a licensed Residential Treatment center or intermediate care Facility. It offers individualized and intensive treatment and includes:

- Observation and assessment by a psychiatrist weekly or more often; and
- Rehabilitation, therapy, education, and recreational or social activities.

You can receive Covered Services from the following Plan Providers:

- Psychiatrist
- Psychologist
- Neuropsychologist
- Licensed clinical social worker (L.C.S.W)
- Clinical nurse specialist
- Licensed marriage and family therapist (L.M.F.T)
- Licensed professional counselor (L.P.C)
- Any agency licensed by the state to provide these services

Note: Inpatient Services for the treatment of disorders such as substance use disorder and eating disorders cannot be merely custodial, residential, or domiciliary in nature and must be provided in a hospital or residential treatment Facility that is licensed to provide a continuous, structured program of drug or alcohol treatment and rehabilitation including 24-hour-a-day nursing care.

Partial Hospitalization

We cover partial hospitalization in a Plan Facility. Partial hospitalization is defined as a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such

SAMPLE

term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

Outpatient Services

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

- Evaluation and diagnosis;
- Crisis intervention;
- Individual psychotherapy;
- Group psychotherapy;
- Psychological and neuropsychological testing;
- Medical treatment for withdrawal symptoms;
- Treatment for psychiatric conditions
- Visits for the purpose of monitoring drug therapy.

Visit limits do not apply to outpatient rehabilitative and habilitative therapy Services and home health Services for mental health Services and substance use disorder.

Z. Morbid Obesity Services

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

Morbid obesity is defined as:

- A weight that is at least 100 pounds over or twice the ideal weight for a patients frame, age, height, and gender, as specified in the 1983 Metropolitan Life Insurance tables; or
- A body mass index (BMI) that is equal to or greater than 35 kilograms per meter squared with a comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary condition, sleep apnea, or diabetes; or
- A BMI of 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.

AA. Oral Surgery

We cover diagnosis, oral surgery, and related medical care for:

- surgical treatment of tumors in the oral cavity, where a biopsy is needed for evaluation of pathology;

SAMPLE

- maxillary or mandibular frenectomy when not related to a dental procedure;
- alveolectomy when related to tooth extraction;
- orthognathic surgery, including surgery to correct temporomandibular joint (TMJ) pain dysfunction syndrome and Craniomandibular joint disorders that are required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part;
- surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures; and
- the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia (see also "Cleft Lip, Cleft Palate, or Ectodermal Dysplasia" in this Section);
- removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services;
- anesthesia to prepare mouth for medical treatments, such as radiation therapy to treat cancer and prepare for transplants;
- Incision and drainage of infection of soft tissue;
- Treatment of non-dental lesions, such as removal of tumors and biopsies;
- Medically Necessary pre-operative and post-operative care;
- Oral and/or surgical correction of accidental injuries as described in Accidental Dental Injury Services; and
- Medically Necessary oral restoration after major reconstructive surgery.

BB. Dental Services

Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

SAMPLE

CC. Preventive Health Care Services

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

- 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. Examples include screenings for BRCA genetic testing, Type 2 Diabetes, cholesterol, cervical cancer, counseling for breast cancer genetic testing or breast cancer chemoprevention. You may see a list of the most recent services described in this provision at: www.healthcare.gov;

- Immunizations, including flu shots and their administration, for children, adolescents, and adults 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;
- 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; and
- With respect to women, such additional preventive care and screenings, not described in paragraph (a) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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

Health Plan also covers medically appropriate preventive health care Services based on your age, sex, and 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:

- Preventive care exams, including:
  - Routine physical examinations and health screening tests appropriate to your age and sex;
  - Well-woman examinations; and
- Well child care examinations, including child health supervision services for the periodic review of a child's physical and emotional status and immunizations offered at the following age intervals: birth, two (2) months, four (4) months, six (6) months, nine (9) months, twelve (12) months, fifteen (15) months, eighteen (18) months, two (2) years, three (3) years, four (4)years, five (5) years, and six (6) years;
- Sterilization services and services to reverse a non-elective sterilization resulting from an illness or injury. Female sterilization must be covered;
- Hemoglobinopathies screening for newborn children;
- Gonorrhea prophylactic medication and screening for newborn children;
- Hypothyroidism screening for newborn children;
- PKU screening for newborn children;
- Rh incompatibility screening;
- Abdominal aortic aneurysm screening;

SAMPLE

- Depression screening;
- Lung cancer screening;
- Colorectal screening;
- Routine and Medically Necessary immunizations (travel immunizations are not preventive and are covered under Outpatient Services in this section) for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;
- An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
- High-risk human papillomavirus (HPV) DNA testing every three (3) years for women age thirty (30) years and over whether or not they have normal Pap test results;
- Screening for gestational (pregnancy-related) diabetes in pregnant women between 24-28 weeks of gestation and at the first prenatal Visit for pregnant women identified to be at high risk for diabetes;
- Comprehensive lactation (breastfeeding) education and counseling, by trained clinicians during pregnancy and/or in the postpartum period in connection with each birth;
- Breastfeeding support equipment and supplies issued, including breast pumps per pregnancy and in accordance with Health Plan coverage guidelines;
- Annual screening and counseling for sexually transmitted infections for all sexually active women;
- Annual screening and counseling for human immune-deficiency virus (HIV) infection for all sexually active women;
- Annual screening and counseling for interpersonal and domestic violence;
- Patient education and contraceptive counseling for all women with reproductive capacity;
- We cover all FDA approved contraceptive methods and sterilization treatments for women, including drugs, injectables, patches, rings and devices such as diaphragms, IUDs, and implants. This includes all related counseling. A prescription for a twelve (12)-month supply of hormonal contraceptives is covered when dispensed or furnished at one time;
- Low dose screening mammograms to determine the presence of breast cancer are covered as follows: (i) one mammogram for persons ages thirty-five (35) through thirty-nine (39); (ii) one (1) mammogram biennially for persons ages forty (40) through forty-nine (49); and (iii) one (1) mammogram annually for persons fifty (50) and over;
- Medical History assessments for children;
- Behavioral and oral health risk assessments for children;
- Bone mass index measurement to determine risk for osteoporosis;

SAMPLE

- Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate-specific antigen (PSA) tests provided to men who are age fifty (50) and over and for persons age forty (40) and over who are at high risk;
- Colorectal cancer screening in accordance with screening guidelines issued by the American Cancer Society including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy and follow-up colonoscopies following a positive non-invasive stool-based screening test including polyp removal and anesthesia provided in connection with a preventive colonoscopy screening;
- Cholesterol test (lipid profile);
- Diabetes screening (fasting blood glucose test);
- Screenings for children for autism (18 and 24 months), anxiety, blood pressure, cervical dysplasia, depression, development, dyslipidemia, hematocrit or hemoglobin, Hepatitis B, HIV, lead, tuberculin, and vision;
- Sexually Transmitted Disease (STD) and Sexually Transmitted Infection (STI) testing (including chlamydia, gonorrhea, syphilis and HPV) and counseling for STI prevention, subject to the following:
- Annual chlamydia screening is covered for (1) women under the age of twenty (20), if they are sexually active; and (2) women twenty (20) years of age or older, and men of any age, who have multiple risk factors, which include: (i) a prior history of sexually transmitted diseases; (ii) new or multiple sex partners; (iii) inconsistent use of barrier contraceptives; or (iv) cervical ectopy;
- Human Papillomavirus (HPV) screening as recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;
- HIV tests;
- Hepatitis B and C screening;
- Syphilis screening;
- TB tests;
- Alcohol and drugs screening, assessments and counseling;
- Nutritional counseling when received as part of plans that provide outpatient prescription drug covered wellness service screening, diabetes education, and for hospice with respect to person's care and death.
- Obesity screening and counseling for children;
- Body mass index (BMI) measurements for children;
- Supplements for fluoride chemoprevention and iron for children;
- Smoking, screening, and tobacco cessation counseling;
- Nicotine patches and gum when obtained by a prescription;

SAMPLE

- 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;
- Screening for alcohol and drug use for children;
- Screening for blood pressure for children;
- Screening for high blood pressure and obesity, and counseling for obesity for adults; and
- Associated preventive care radiological and laboratory tests not listed above.

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

- Retinopathy screening for diabetics
- HbA1C for diabetics
- Low density Lipoprotein laboratory test for people with heart disease
- INR laboratory test for liver failure and bleeding disorders

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

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

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

DD. Prosthetic and Orthotic Devices

We cover the following when prescribed by your Plan Provider for activities of daily living:

- Artificial limbs, eyes and components;
- Orthopedic braces;
- Leg braces, including attached or built-up shoes attached to a leg brace;
- Orthotics (braces, boots, splints) other than foot orthotics. Covered Services include the initial purchase, fitting, adjustment, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part;
- Medically Necessary molded, therapeutic shoes and inserts;
- Arm, back, and neck braces;
- Head halters;
- Catheters and related supplies;
- Restoration prosthesis (composite facial prosthesis); and
- One (1) Medically Necessary hair prosthesis.

SAMPLE

A prosthetic device is an artificial substitute to replace, in whole or in part, a limb or body part, such as an arm, hand, leg, foot, or eye, or any portion of an arm, a hand, a leg, or a foot. Coverage is also included for the repair, fitting, adjustments, and replacement of a prosthetic device. In addition, components for artificial limbs are covered. Components are the materials and equipment needed to ensure the comfort and functioning of the prosthetic device.

Orthotic devices such as leg, arm, back and neck braces and boots 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 are covered when prescribed by a Plan Provider. This coverage also includes Medically Necessary molded therapeutic shoes and inserts.

Internally Implanted Devices

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

Colostomy, Ostomy and Urological Supplies

We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets Health Plan's criteria for medical necessity. We cover colostomy and other ostomy supplies directly related to ostomy care.

Breast Prosthetics

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.

Breast Prosthetics Limitation:

- Coverage for mastectomy bras is limited to a maximum of four (4) per Contract Year.

Wigs

We cover one (1) Medically Necessary hair prosthesis.

Hair Prosthesis Limitation:

- Coverage for wigs are limited to one (1) per Contract Year.

EE. Pulmonary Rehabilitation

Includes outpatient short-term respiratory care to restore your health after an illness or injury.

FF. Radiation Therapy/Chemotherapy/Infusion Therapy

Radiation Therapy

We cover treatment of an illness by x-ray, or radioactive isotopes, including the treatment of disease by radium, cobalt, or high energy particle sources. Coverage includes the rental or cost of radioactive materials, treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), the rental or cost of radioactive materials, administration, treatment planning, the supplies needed, and

SAMPLE

certain other covered services. We also cover the dental Services needed to prepare the mouth for radiation therapy.

Chemotherapy

We cover treatment of an illness by chemical or biological antineoplastic agents. Administered as a part of a doctor's Visit, home care visit, or at an outpatient Facility for treatment of an illness.

Infusion Therapy

We cover infused medical formulas for the treatment of internal metabolic disorders when prescribed by a Plan Provider. Coverage is also provided for Services for drug infusion therapy and infusion therapy, which is treatment by placing therapeutic agents into the vein, including therapeutic nuclear medicine and parenteral administration of medication and nutrients. Infusion therapy includes nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. by a Plan Provider as part of a doctor's Visit, home care visit or at an outpatient Facility. Infusion Services also include Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care, blood products, blood infusion equipment and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). These services include coverage of all medications administered intravenously and/or parenterally. Medically Necessary injectables that are not self-administered are covered. Infusion services may be received at multiple sites of service, including facilities, professional provider offices, ambulatory infusion centers and from home infusion providers. The Cost Share amount will apply based on the place and type of Service provided.

GG. Reconstructive Surgery

We cover reconstructive surgery. This shall include plastic, cosmetic and related procedures required to: (a) correct significant disfigurement resulting from an injury or Medically Necessary surgery; (b) correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function; and (c) treat congenital hemangioma known as port wine stains on the face.

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

We also cover the following Services:

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

HH. Skilled Nursing Facility Care

We cover skilled inpatient Services, a private room if Medically Necessary and related services for

SAMPLE

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

We cover the following Services:

- Room and board;
- Physician and nursing care;
- Medical social Services;
- Drugs, biological and medical supplies; and
- Respiratory therapy;
- Rehabilitative therapy.

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

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

Coverage is provided for Medically Necessary routine foot care.

Benefit-Specific Limitation:
Coverage is limited to Medically Necessary routine foot care.

Benefit-Specific Exclusions:
Routine foot care is not provided to Members who do not meet the requirements of the limitations of this benefit.

Skilled Nursing Facility Care Limitation:

- We cover up to 100 days of skilled nursing inpatient Services per stay.

II. Surgery

Plan cover surgical services on an inpatient or outpatient basis, including office surgeries, blood and blood products, hypodermic needles, syringes, surgical dressings, and services rendered by an anesthesiologist. Covered Surgeries include:

- Accepted operative and cutting procedures;
- Surgeries and procedures to correct congenital abnormalities that cause functional impairment and congenital abnormalities in newborn children;
- Other invasive procedures, such an angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy,

SAMPLE

- Treatment of fractures and dislocations, including splints;
- Anesthesia and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

JJ. Telemedicine Services

We cover interactive telemedicine Visits with a Plan Provider regardless of the originating site and whether the patient is accompanied by a health care provider at the time such services are provided. Telemedicine is the real-time, two-way transfer of medical data and information. Telemedicine Services include the interactive use of audio, video, or other electronic media, such as internet communication between Plan Provider and patient by webcam, chat or voice, 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. Such webcam, chat and voice medical Visits are covered in place of an office Visit. Equipment utilized for interactive telemedicine should be of sufficient audio quality and visual clarity as to be functionally equivalent to a face-to-face Visit for professional medical Services.

Telemedicine Exclusion:

Non-interactive telemedicine Services include electronic mail message, or facsimile transmission.

KK. Therapy; Habilitative and Rehabilitative Services

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

These Services may include physical and occupational therapy, speech-language pathology and other Services for people with disabilities in a variety of inpatient and/or outpatient settings.

Rehabilitative Services includes coverage for health care Services, devices, and therapies to restore and in some cases, maintain capabilities lost due to disease, illness, injury, or in the case of speech therapy, loss additionally due to congenital anomaly or prior medical treatment. To be a covered service, rehabilitative services must involve goals you can reach in a reasonable period of time. Benefits will end once treatment is no longer Medically Necessary and you stop progressing toward those goals.

We provide coverage for the following habilitative and rehabilitative Services including the professional services, when Medically Necessary and provided by a licensed or certified therapist. The Visit limits listed for each Service apply separately for habilitative and rehabilitative Services. The Visit limits do not apply to outpatient rehabilitative and habilitative therapy Services, and home health care Services for mental health conditions and substance use disorders. We cover medical supplies that are purchased and used once, such as syringes, needles, dressings, splints, etc.

Cardiac Rehabilitation Services

We cover medical evaluation, training, supervised exercise, and psychosocial support Services following coronary surgery or a myocardial infarction when approved by Health Plan. Cardiac rehabilitation Services must be provided or coordinated by a Facility approved by Health Plan, and that offers the process of diagnosing, restoring, maintaining, teaching, or improving physiological, psychological, social and vocational capabilities of patients with heart disease. Cardiac rehabilitation is the medical evaluation,

SAMPLE

training, supervised exercise, and psychosocial support to care for a person after a cardiac event (heart problem). Benefits do not include home programs (other than home health care Services), on-going conditioning, or maintenance care.

Chiropractic / Osteopathic / Manipulation Therapy
We cover therapy to treat problems of the bones, joints, and the back. We cover these therapies for a maximum of 30 Visits per Contract Year for rehabilitative chiropractic, osteopathic, manipulation therapy; and a maximum of 30 Visits; and a maximum of 30 Visits per Contract Year for habilitative chiropractic, osteopathic, manipulation therapy.

Multidisciplinary Rehabilitation
We cover multidisciplinary rehabilitation Services in a Plan Hospital, Plan Medical Center, Plan Provider's medical office, or a Skilled Nursing Facility. Multidisciplinary rehabilitation Service programs are inpatient or outpatient day programs that incorporate more than one therapy at a time in the rehabilitation treatment.

Multidisciplinary Rehabilitation Limitations:
The limitations listed below for physical, occupational and speech therapy also apply to those Services when provided within a multidisciplinary program.

Physical, Occupational, and Speech Therapy
The Visit limits listed below for physical, occupational and speech therapy apply separately to habilitative and rehabilitative Services. For each of the following Services, you receive a maximum of thirty (30) combined video and face-to-face Visits for both rehabilitative therapy and habilitative therapy per Contract Year:

- Physical therapy;
- Occupational therapy; and
- Speech therapy.

The limits do not apply to therapy provided while you are an inpatient in a hospital or to early intervention Services, home health Services, autism spectrum disorder (ASD) Services, and hospice care.

Physical Therapy
We cover physical therapy, which is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb. Physical therapy services include hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. Your coverage includes benefits for physical therapy to treat lymphedema.

Occupational Therapy
We cover inpatient and outpatient occupational therapy, which is treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, bathing and job-related activities.

Speech Therapy
We cover inpatient and outpatient speech therapy. Speech therapy is the identification assessment and treatment for the correction of a speech impairment, swallowing disorders, or Services necessary to improve or teach speech, which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment and will treat communication or swallowing difficulties and swallowing disorders to correct a speech impairment and set rehabilitative speech therapy goals attainable in a reasonable period of

SAMPLE

time for adults and children. Therapy is also covered for a child in order to keep, learn or improve skills needed for daily living, such as therapy for a child who is not talking at the expected age.

Respiratory Services

We cover respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury. This coverage includes: the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; bronchopulmonary drainage and breathing exercises.

LL. Transplant Services

We cover any Medically Necessary stem cell rescue, bone marrow, infusions, organ and tissue transplants and transfusions, including autologous bone marrow transplants for breast cancer, if the following criteria are met:

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

Coverage also includes necessary acquisition procedures, mobilization, and harvest and storage. It also includes Medically Necessary and preparatory myeloablative therapy or reduced intensity preparative chemotherapy, radiation therapy or a combination of these therapies.

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

- Unless otherwise authorized by Medical Group, transplants are covered only in our Service Area.
- 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.
- 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.
- When a human organ or tissue transplant is provided from a living donor to a Member, both the recipient and the donor may receive the benefits of the Health Plan. We may cover expenses for medical, hospital, transportation, and lodging, that we pre-authorize in accordance with our travel and lodging guidelines, as long as Services 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. Coverage is provided for the donor for complications from the donor procedure for up to six (6) weeks from the date of procurement.

We will not deny transplant Services based on physical, intellectual, developmental or other disability.

SAMPLE

Travel and Lodging Expenses
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 Obtain Services***, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines. For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code. We will reimburse for reasonable and necessary transportation and lodging costs for the recipient and donor when both are covered by the Health Plan; however, reimbursement may be limited if only the recipient is covered by the Health Plan.

Non-Covered benefits for transportation and lodging include, but are not limited to:

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Return Visits for the donor for a treatment of an illness found during the evaluation.
- Meal

SAMPLE

If Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions for benefits related to transplant surgery.

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

MM. Urgent Care Services

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

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 ***Appendix – 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 call:

- Inside the Washington, D.C. Metropolitan Area

  (703) 359-7878
  TTY 711
- Outside the Washington, D.C. Metropolitan Area

  1-800-777-7902
  TTY 711

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

Outside the Service Area
If you are injured or become ill while temporarily outside 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 ***Appendix – 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 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.

NN. Vision Services

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

Vision Correction after Surgery or Accident
We cover prescription glasses or contact lenses required as a result of surgery or for treatment of accidental injury. Includes cost of materials and fitting, exams, and replacement of eyeglasses or contact lenses if related to the surgery or injury. Eyeglass or contact lens purchase and fitting are covered under this benefit if:

- Prescribed to replace the human lens lost due to surgery or injury;

SAMPLE

- "Pinhole" glasses are prescribed after surgery for a detached retina; or
- Lenses are prescribed instead of surgery due to:
    - Contact lenses used for treatment of infantile glaucoma;
    - Corneal or sclera lenses prescribed in connection with keratoconus;
    - Scleral lenses prescribed to retain moisture when normal tearing is not possible or inadequate; or
    - Corneal or sclera lenses are required to reduce a corneal irregularity other than astigmatism.

In addition, we cover the following Services:

Eye Exams
We cover routine and necessary eye exams for adults and children (for adults age 19 or older), including:

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

Exams performed in an Ophthalmology Department will be subject to the Specialty Care Co-payment, if different.

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. Children are provided one pair of standard eyeglass lenses per calendar year from a select group of lenses at no charge. Coverage is included for bifocal, trifocal, and progressive eyeglass lenses.

Frames
We provide a discount on the purchase of eyeglass frames, when purchased at a Kaiser Permanente Optical Shop. The discount includes the mounting of eyeglass lenses in the frame, original fitting of the frames, and subsequent adjustment. Children are provided one pair of frames per calendar year from a select group of frames at no charge.

SAMPLE

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

- Fitting of contact lenses;
- Initial pair of diagnostic lenses (to assure proper fit);
- Insertion and removal of contact lens training; and
- 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. Children may select contact lenses in lieu of lenses/frames on initial purchases at no charge.

Low Vision Services

Low vision services are provided for Members up until the end of the month that they turn age 19. Low vision services include: one comprehensive low vision evaluation every five (5) years, four (4) follow-up Visits in any five-year period, and prescribed optical devices such as high-power spectacles, magnifiers and telescopes.

We also cover Pediatric Vision Services for Members up until the end of the month that they turn to age 19, including: (1) one routine eye examination each Contract Year, including dilation if professionally indicated.

OO. X-ray, Laboratory, and Special Procedures

We cover the following Services only when prescribed as part of care covered in other parts of this Benefits 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***):

- Diagnostic EKGs, EEGs;
- Echocardiograms;
- Diagnostic imaging and interventional diagnostic tests;
- Laboratory and pathology services or tests, including tests for specific genetic disorders for which genetic counseling is available;
- Hearing and vision tests for medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission;
- Special procedures, such as electrocardiograms and electroencephalograms;
- Sleep testing; including sleep laboratory and sleep studies;
- Specialty imaging: including CT, MRI, PET scans, CT/PET Fusion scans, and diagnostic Nuclear Medicine studies; and
- Radiology including x-rays, mammograms, and ultrasounds.

We cover the following outpatient diagnostic imaging tools:

- Magnetic resonance angiography (MRA);
- Magnetic resonance imaging (MRI);
- Magnetic resonance spectroscopy (MRS);
- Computed tomographic angiography (CTA);
- Positron emission tomography (PET) scans and PET Fusion scans;
- Computed tomography (CT) scans and CT Fusion scans;

SAMPLE

- QCT Bone Densitomerty;
- Diagnostic CT Colongraphy;
- Single photon emission computed tomography (SPECT) scans; and
- Nuclear cardiology.

Coverage includes professional Services for test interpretation, x-ray reading, laboratory interpretation and scan reading.

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

SAMPLE

SECTION 3.2 – OPTION 2 (PPO) AND OPTION 3 (INDEMNITY) BENEFITS

This section describes the general benefits under this Evidence of Coverage. Exclusions are listed in Section 4 - Exclusions and Coordination of Benefits. Please refer to the ***Appendix – Summary of Cost Shares*** to determine which, if any, optional benefits your employer elected.

Insuring Clause:

If KPIC receives satisfactory notice of claim and Proof of Loss, KPIC will pay the Percentage Payable (shown in the ***Appendix – Summary of Cost Shares***) of the covered charges up to the Maximum Allowable Charge for the treatment of a covered Injury or Sickness, provided:

- The expense is incurred while the Member is insured for this benefit;
- The expense is for a covered Service that is Medically Necessary;
- The expense is for a covered Service prescribed or ordered by an attending Physician or by a provider duly licensed to provide medical services without the referral of a Physician;
- The Member has satisfied the applicable Deductibles, Co-payments, and other amounts payable; and
- The Member has not exceeded the Maximum Benefit While Insured or any other maximum shown in the ***Appendix – Summary of Cost Shares***, subject to the Reinstatement of Your Maximum Benefit While Insured provision.

Payments under this Evidence of Coverage:

- Will be subject to the limitations shown in the ***Appendix – Summary of Cost Shares***;
- Will be subject to the General Limitations and Exclusions and all terms of this Evidence of Coverage;
- May be subject to Pre-certification; and
- Does not duplicate any other benefits paid or payable by KPIC.

Covered Services:

- Room and Board in a Hospital.
- Room and Board in a Hospital Intensive Care Unit. **Intensive Care Unit** means a section, ward or wing within the Hospital which:
    1. Is separated from other Hospital facilities;
    2. Is operated exclusively for the purpose of providing professional care and treatment for critically-ill patients;
    3. Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use;
    4. Provides Room and Board; and

SAMPLE

5. Provides constant observation and care by Registered Nurses or other specially trained Hospital personnel.

- Room and Board and other Skilled Nursing services in a Skilled Nursing Facility or other licensed medical facility. Care in a Skilled Nursing Facility must be in lieu of Hospital Confinement, and is limited to: a) the maximum number of covered days shown in the ***Appendix – Summary of Cost Shares***; b) care in a licensed Skilled Nursing Facility; c) care under the active medical supervision of a Physician; and d) services and supplies consistent with medical needs. Covered Services will include Durable Medical Equipment furnished during a Confinement in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish such Durable Medical Equipment. A Benefit Period specific to care in a Skilled Nursing Facility begins when a Physician admits a Member to a Hospital or Skilled Nursing Facility and ends when the Member has not been a patient in either a Hospital or Skilled Nursing Facility for sixty (60) consecutive days. A private room will be covered only if Medically Necessary. Coverage will include but is not limited to: rehabilitative services, medications, and biologicals. **Confinement** means being registered as an inpatient in a licensed medical facility as ordered by a Physician. **Hospital Confinement** means being registered as an inpatient in a Hospital upon the order of a Physician. **Skilled Nursing Care Services** means skilled inpatient services that are: 1) ordered by a Physician; 2) customarily provided by Skilled Nursing Facilities; and 3) above the level of custodial or intermediate care.
- Necessary Services and Supplies, including medication dispensed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. Coverage will not be denied for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia. Coverage shall not be denied for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer pain on the basis that the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with §§ 54.1-2971.01, 54.1-3303 and 54.1-3408.1 for a patient with intractable cancer pain.
- Emergency Services for medical emergencies are covered as an In-Plan (Option 1) benefit. Please see Section 3.1, Benefits (Option 1).
- Physicians' services, including office Visits, covered home visits, and online visits by a webcam, chat or voice. Includes walk-in services, where available for routine care and common illnesses.
- Ambulance service of a licensed ground, water, or air ambulance by fixed wing or rotary wing if, in the judgment of a physician, transportation to an acute care hospital is Medically Necessary and ground or water transportation is not appropriate, or your medical condition requires either the basic life support, advance life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer and the ambulance transportation has been ordered by a physician.

SAMPLE

Includes coverage for professional ambulance services to or from the nearest facility or provider adequate to treat condition.

- Coverage for medically skilled Services of a licensed Registered Nurse (RN), or Licensed Practical Nurse (LPN), in your home when the nurse is not a relative or member of your family. Private duty nursing will only be covered for the period for which KPIC validates a Physician's certification that states the services are Medically Necessary for your condition and not merely custodial in nature.
- Services by a Certified Nurse Practitioner; Advanced Practice Registered Nurse (APRN); Clinical Nurse Specialist; Licensed Midwife; Physician's Assistant or Certified Nurse-Midwife. This care must be within the individual's area of professional competence.
- Radiation Therapy. Coverage of treatment of an illness is limited to: a) radiation therapy when used in lieu of generally accepted surgical procedures or for the treatment of malignancy; or b) the use of x-ray, or radioactive isotopes, including radium. Coverage includes materials and supplies, administration, treatment planning, and certain other covered Services.
- Chemotherapy. Coverage includes Medically Necessary treatment of an illness by chemical or biological antineoplastic agents. Administered as a part of a doctor's Visit, home care visit, or at an outpatient facility for treatment of an illness.
- Infusion Therapy. Coverage is provided for Services for drug infusion therapy and infusion therapy, which is treatment by placing therapeutic agents into the vein, including therapeutic nuclear medicine and parenteral administration of medication and nutrients. Infusion therapy includes blood products and injectables that are not self-administered, antibiotic therapy, chemotherapy, pain care, nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. by a Provider as part of a doctor's Visit, home care visit or at an outpatient facility. Services for infusion therapy also include Total Parenteral Nutrition (TPN) and enteral nutrition therapy.
- One (1) Medically Necessary Hair Prosthesis for hair loss.
- One (1) hearing aid for each hearing-impaired ear every twenty-four (24) months. Coverage is provided for one (1) hearing aid for each hearing-impaired ear, up to the hearing aid benefit allowance of $1,500 for each hearing aid. Coverage for hearing aids is 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, including maintenance and adaptation training 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. This paragraph applies only to Option 2. Please refer to the ***Appendix – Summary of Cost Shares.***
- Emergency medical transportation provided through the 911 emergency response system is covered as an In-Plan (Option 1) benefit. Please see Section 3.1, Benefits (Option 1).
- Urgent Care Services.
- Diagnostic x-ray, laboratory tests and other diagnostic services. Coverage includes, but is not limited to: diagnostic laboratory and pathology services; diagnostic hearing and vision tests; diagnostic EKGs, EEG, and echocardiograms, advanced diagnostic

SAMPLE

imaging including, MRA, MRI, MRS, CTA, PET scans, CT scans, PET/CT Fusion scans, SPECT scans, QCT bone densitometry, diagnostic CT colonography, mammography, nuclear cardiology, nuclear medicine studies, and ultrasounds.

- Anesthesia and its administration when provided by a licensed anesthesiologist or licensed nurse anesthetist.
- Home Health Care, including intermittent care and remote patient monitoring services, provided in a Member's home when:

  The institutionalization of the Member in a hospital or related institution or Skilled Nursing Facility would otherwise have been required if Home Health Care were not provided; and

  - The plan of treatment covering the Home Health Care service is established and approved in writing by the health care practitioner; and
  - As an alternative to otherwise covered Services in a hospital or related institution; or for Members who receive less than 48 hours of inpatient hospitalization following a Mastectomy or removal of a testicle on an outpatient basis:
    1. One home visit scheduled to occur 24 hours after discharge from the hospital or outpatient health care facility, and
    2. An additional home visit if prescribed by the Member's attending physician.

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

  Remote patient monitoring services means 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.

  Note: Home Health Care includes Visits by licensed health care professional (includes nurse, therapist, or home health aide) and physical, speech, and occupational therapy (services provided as a part of home care are not subject to separate Visit limits for therapy services). Also includes diagnostic and social services, nutritional guidance, training, medical supplies and durable medical equipment. For Options 2 and 3, coverage for Home Health Care services is limited to a combined Benefit Maximum of one hundred (100) Visits per Contract Year.

- Outpatient surgery in a Free-Standing Surgical Facility, other licensed medical facility or in a doctor's office. Includes Medically Necessary pre-operative, post-operative care, surgical supplies, coverage for blood and blood products, and coverage for Services rendered by an anesthesiologist. A **Free-Standing Surgical Facility** means a legally operated institution which is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO) or other similar organization approved by KPIC that:
  - Has permanent operating rooms;
  - Has at least one recovery room;
  - Has all necessary equipment for use before, during and after surgery;

SAMPLE

- Is supervised by an organized medical staff, including Registered Nurses, available for care in an operating or recovery room;
- Has a contract with at least one nearby Hospital for immediate acceptance of patients requiring Hospital care following care in the Free-Standing Surgical Facility;
- Is other than: a) a private office or clinic of one or more Physicians; or b) part of a Hospital; and
- Requires that admission and discharge take place within the same working day.

- Hospital charges for use of a surgical room on an outpatient basis.
- Medically Necessary invasive procedures on an inpatient or outpatient basis, such as an angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.
- Treatment of fractures, and dislocation.
- Pre-admission testing, limited to diagnostic, x-ray, and laboratory exams made during a Hospital outpatient visit. The exams must be made prior to a Hospital Confinement for which a Room and Board charge is made.
- Maternity Services including those performed in a Birth Center and hospital delivery room. Services are available to You or a covered Dependent who becomes pregnant. **Maternity Services** means prenatal or antepartum (before labor); intrapartum (during labor); and postpartum (after birth) care in accordance with medical criteria outlined by the American College of Obstetricians and Gynecologists. Coverage includes inpatient services, postpartum care, and anesthesia services in a Birth Center and hospital delivery room. This care is given with respect to: 1) uncomplicated pregnancy and labor and delivery; and 2) spontaneous vaginal delivery. Benefits payable for the treatment of Complications of Pregnancy will be covered on the same basis as a Sickness. **Birth Center** means a free-standing health care facility that:
  - Complies with licensing and other legal requirements in the jurisdiction where it is located;
  - Is engaged mainly in providing a comprehensive Maternity Services program to pregnant individuals who are considered normal to low risk patients;
  - Has organized facilities for Maternity Services on its premises;
  - Has Maternity Services performed by a Physician specializing in obstetrics and gynecology; and
  - Has 24-hour-a-day Registered Nurse services.
- Hospital services for routine nursery care for the newborn during the mother's normal hospital stay. Benefits include coverage for circumcision of a covered Dependent.
- Birthing classes, one course per pregnancy.
- Services for diagnosis and treatment of involuntary infertility for females and males, including reversal of non-elective sterilization.
- Rental of Durable Medical Equipment, limited to after the following:
  - A Hospital Confinement;

SAMPLE

- A Confinement in a sub-acute facility;
- A Confinement in a specialized rehabilitation facility; or
- An outpatient surgical procedure.

Durable Medical Equipment means medical equipment that is:

- Designed for repeated use;
- Mainly and customarily used for medical purposes;
- Not generally of use to a person in the absence of a Sickness or Injury;
- Not primarily and customarily for the convenience of the Member; and
- Appropriate for use in the home.

Durable Medical Equipment will not include:

- Equipment generally used for comfort or convenience that is not primarily medical in nature (e.g., bed boards, bathtub lifts, adjust-a-beds, telephone arms, air conditioners, and humidifiers);
- Deluxe equipment such as motor driven wheelchairs and beds, except when such deluxe features are necessary for the effective treatment of a Member's condition and in order for the Member to operate the equipment;
- Disposable supplies, exercise and hygiene equipment, experimental or research equipment, and devises not medical in nature such as sauna baths, elevators, or modifications to the home or automobile. This exclusion does not apply to disposable diabetic supplies;
- Devices for testing blood or other body substances, except diabetic testing equipment and supplies;
- Electronic monitors of bodily functions, except infant apnea monitors;
- Replacement of lost equipment;
- Repair, adjustments or replacements necessitated by misuse;
- More than one piece of Durable Medical Equipment serving essentially the same function; except for replacements other than those necessitated by misuse or loss; and
- Spare or alternate use equipment.

SAMPLE

Expense(s) Incurred means expenses a Member incurs for covered Services. An expense is deemed incurred as of the date of the service, treatment or purchase.

The following items of Durable Medical Equipment do not require prior Confinement or receipt of an outpatient surgical procedure:

- Apnea Monitors for infants up to age 3 for a period not to exceed 6 months;
- Asthma Equipment for pediatric and adult asthmatics limited to the following: spacers, peak-flow meters, or nebulizers;
- Bilirubin Lights for infants up to age 3 for a period not to exceed 6 months;

- Oxygen and Equipment (including oxygen concentrator and ventilators) when your medical condition meets Medicare guidelines and is prescribed by a Participating Provider. A Participating Provider must certify the continued medical need for oxygen and equipment.
- Continuous Positive Airway Pressure Equipment when your medical condition meets Medicare's guidelines and is prescribed by a Participating Provider. A Participating Provider must certify the medical necessity of the continued medical need.

Purchase of such equipment may be made if, in the judgment of KPIC: a) purchase of the equipment would be less expensive than rental; or b) such equipment is not available for rental.

We decide whether to rent or purchase the equipment, and we select the vendor. We will repair the equipment without charge, unless the repair is due to loss or misuse. You must return the equipment to us or pay us the fair market price of the equipment when it is no longer prescribed. Durable Medical Equipment coverage will also include (when Medically Necessary) negative pressure wound therapy devices hospital-type beds, wheelchairs, traction equipment walkers, crutches, maintenance, and supplies needed for use of the equipment, and devices and supplies for sleep treatment, such as APAP, CPAP, BPAP and oral devices for sleep treatment.

- Equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes when prescribed by a health care professional legally authorized to prescribe such items. For benefits to be payable, diabetes in-person outpatient self-management training and education must be provided by a certified, registered or licensed health care professional. Coverage includes insulin pumps, home blood glucose monitors, lancets, syringes, hypodermic needles and blood glucose test strips.
- Routine diabetic foot care which includes coverage of treatment of corns, calluses, and care of toenails.
- Services for acute and chronic (end-stage) renal disease, including home dialysis equipment and supplies, hemodialysis, home intermittent peritoneal dialysis, home continuous cycling peritoneal dialysis, and home continuous ambulatory peritoneal dialysis; dialysis treatments in an outpatient dialysis facility or doctor's office.
- Multidisciplinary Rehabilitative Services. **Multidisciplinary Rehabilitative Services** means occupational therapy, speech therapy, and physical therapy, in a prescribed, organized, multidisciplinary rehabilitation program in a Hospital, Physician's office, or a Skilled Nursing Facility, or other appropriately licensed medical facility. Such services must be rendered for a condition that the attending Physician determines is subject to significant improvement in function within a two-month period. Multidisciplinary Rehabilitative Services does not include long-term rehabilitative therapy or cardiac rehabilitation.
- Cardiac Rehabilitation. Coverage is provided for medical evaluation, training, supervised exercise, and psychosocial support Services following coronary surgery or a myocardial infarction when approved by KPIC. Benefits do not include home programs (other than provided under Home Health Care services), on-going conditioning, or maintenance care.

SAMPLE

- Pulmonary Rehabilitation Program. **Pulmonary Rehabilitation Program** means pulmonary rehabilitation program sessions limited to a maximum of two 1-hour sessions per day for up to 36 sessions, with the option for an additional 36 sessions if Medically Necessary. Pulmonary Rehabilitation Program includes outpatient short-term respiratory care to restore your health after an illness or injury. The care must be rendered according to an individualized treatment plan. As used in this definition, individualized treatment plan means a written plan established, reviewed, and signed by a Physician every 30 days, that describes all of the following: (i) The individual's diagnosis; (ii) The type, amount, frequency, and duration of the items and services under the plan; (iii) The goals set for the individual under the plan. The pulmonary rehabilitation team may include doctors, nurses, and specialists. Examples of specialists include respiratory therapists, physical and occupational therapists, dietitians or nutritionists, and psychologists or social workers.
- Early Intervention Services for Dependents from birth to age three. **Early Intervention Services** means speech and language therapy, occupational therapy, physical therapy and assistive technology Services and devices for Dependents who are certified by the Department of Mental Health, Mental Retardation and Substance Use Disorder as eligible for Services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).
- Physical therapy rendered by a certified physical therapist ease pain, restore health, and avoid disability after an illness, injury, or loss of an arm or a leg, including hydrotherapy, heat, physical agents, bio-mechanical and neurophysiological principles and devices. Includes the treatment of lymphedema. To be eligible for coverage rehabilitative services must be: 1) progressive therapy (not maintenance therapy); 2) Rendered according to the attending Physician's written treatment plan; 3) rehabilitative Services must involve goals you can reach in a reasonable period of time. Benefits for rehabilitative Services will end once treatment is no longer Medically Necessary and you stop progressing toward those goals; and 4) completed by the Member as prescribed. As used in this provision "maintenance therapy" means ongoing rehabilitative therapy after the Member has 1) reached maximum rehabilitation potential or functional level; or 2) shown no significant improvement.
- Speech therapy rendered by a certified speech therapist or certified speech pathologist. Speech therapy (habilitative and rehabilitative) is the identification assessment and treatment for the correction of a speech impairment, swallowing disorders, or Services necessary to improve or teach speech, which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment and will treat communication or swallowing difficulties and swallowing disorders to correct a speech impairment. Rehabilitative speech therapy services must involve goals that are attainable in a reasonable period of time for adults and children. Benefits for rehabilitative Services will end once treatment is no longer Medically Necessary and you stop progressing toward those goals. Habilitative speech therapy is also covered for a child in order to keep, learn or improve skills needed for daily living, such as therapy for a child who is not talking at the expected age.
- Habilitative Services for Medically Necessary speech therapy, occupational therapy, and physical therapy that help a person keep, learn or improve skills and functioning for daily living. Examples include habilitative physical and occupational therapy for a child who is not walking at the expected age.

SAMPLE

- Occupational therapy rendered by a certified occupational therapist. Occupational therapy is limited to Services to achieve and maintain improved self-care and other customary activities of daily living including treatment to restore activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, bathing, and job-related activities. To be eligible for coverage rehabilitative Services must be progressive therapy (not maintenance therapy); and 2) rendered according to a written treatment plan and involve goals you can reach in a reasonable period of time. Benefits for rehabilitative Services will end once treatment is no longer Medically Necessary, and you stop progressing toward those goals. As used in this provision "maintenance therapy" is defined as ongoing rehabilitative therapy after the Member has: 1) reached maximum rehabilitation potential or functional level; or 2) shown no significant improvement.
- Coverage for outpatient physical therapy, occupational therapy and speech therapy is limited to thirty (30) Visits per Contract Year. The Visit limits apply separately to habilitative and rehabilitative Services. The Visit limits do not apply to outpatient rehabilitative and habilitative therapy Services, and home health care Services for mental health conditions and substance use disorders.
- Respiratory therapy rendered by a certified respiratory therapist. This coverage includes: the use of dry or moist gases in the lungs, non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; bronchopulmonary drainage and breathing exercises.
- Rehabilitation Services includes coverage for therapies to restore and in some cases, maintain capabilities lost due to disease, illness, injury, or in the case of speech therapy, loss additionally due to congenital anomaly or prior medical treatment.
- Medically Necessary early intervention services related to speech and language therapy, occupational therapy, physical therapy, and assistive technology services and devices for Dependents, from birth to age three, who are certified as disabled by the Department of Behavioral Health and Developmental Services in accordance with applicable federal requirements. Early intervention services are Medically Necessary when such services are designed to help a Dependent attain or retain the capability to function age-appropriately within his or her environment, and shall include services that enhance functional ability without effecting a cure, except school services. Treatment, services, or supplies covered under this Evidence of Coverage if received as an inpatient or outpatient in a Hospital or other licensed medical facility in connection with Mental Illness.
- Treatment in connection with Mental Health Services or Substance Use Disorder Services. For purposes hereof, "treatment" means services including diagnostic evaluation, medical, group and individual psychotherapy, psychiatric care, psychological care and testing, and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence, eating disorders, rendered by a Hospital or in an office Visit, alcohol or drug rehabilitation facility, Intermediate Care Facility, Mental Health Treatment Center, residential treatment facility, a Physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed substance use disorder treatment practitioner, marriage and family therapist or clinical

SAMPLE

nurse specialist. Includes coverage for counseling with family members to assist with patient's diagnosis and treatment and convulsive therapy. Coverage will be provided for Medically Necessary hospital and inpatient professional charges in any hospital or facility required by state law. Coverage in a resident treatment facility includes 24 hour-a-day nursing care, individualized and intensive treatment including observation and assessment by a psychiatrist at least weekly and rehabilitation, therapy, education, and recreational or social activities. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified alcoholism, drug, or substance use disorder counselor or substance use disorder counseling assistant, operating within the scope of his/her license, employed by a facility or program licensed to provide such treatment. Medication Management Visits will be covered in the same manner as a medication management Visit for the treatment of a Sickness and will not be counted as an Outpatient Treatment Visit. Medical complications of alcoholism, which include, but are not limited to: a) cirrhosis of the liver; b) gastrointestinal bleeding; c) pneumonia; and d) delirium tremens are otherwise covered under the plan. **Substance Use Disorder** 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. **Intermediate Care Facility** means a licensed, residential public or private facility that is not a Hospital and that is operated primarily for the purpose of providing a continuous, structured 24-hour-per-day, state-approved program of inpatient Substance Use Disorder Services. **Medication Management Visit** means a visit no more than twenty minutes in length with a licensed Physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance use disorder treatment.

SAMPLE

- Partial hospitalization services. Partial hospitalization is defined as a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.
- Detoxification services, in a hospital or related institution, will be limited to the removal of the toxic substance or substances from the system.
- Coverage for the diagnosis and treatment of Autism Spectrum Disorder 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 . **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 Physician or a licensed psychologist who determines the care, including behavioral health

treatments and therapeutic care, to be Medically Necessary. Medically Necessary defined in this section 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: (i) prevent the onset of an illness, condition, injury, or disability; (ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (iii) 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 of ASD** shall be identified in a treatment plan and include the following care prescribed or ordered for an individual diagnosed with ASD by a Physician or a licensed psychologist who determines the care to be Medically Necessary: behavioral health treatment; pharmacy care; psychiatric care; psychological care; therapeutic care; and Applied Behavioral Analysis (ABA), when provided or supervised by a board-certified analyst licensed by the Virginia Board of Medicine. A **treatment plan** means a plan for the treatment of ASD developed by a Physician or a licensed psychologist 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. **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. Physical, Occupational, and Speech Therapy for the treatment of autism is not subject to any Visit limits.

- Blood, blood products, and its derivatives and components, the collection and storage of autologous blood, and as well as cord blood procurement and storage. In addition, benefits will be payable 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. Covered Services will not include directed blood donations.
- Medical and surgical supplies that serve only a medical purpose, are used once and are purchased (not rented). Covered supplies including surgical dressings; hypodermic needles, syringes, splints or any other Medically Necessary supplies provided at the time of treatment.
- Coverage for inpatient care following a mastectomy or lymph node dissection until the completion of the appropriate period of stay for such inpatient care as determined by the attending physician in consultation with the patient. If the period of stay is less than forty-eight (48) hours, then coverage will include:
    - One home visit scheduled to occur within 24 hours after discharge from the hospital or outpatient health care facility; and
    - An additional home visit if prescribed by the patient's attending physician.

SAMPLE

- Laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy. The minimum authorized Hospital stay when undergoing either procedure will be twenty-three (23) hours for laparoscopy-assisted vaginal hysterectomy, or forty-eight (48) hours for vaginal hysterectomy.

  Hospital stays beyond the minimums noted above will be subject to the normal Pre-certification procedures as outlined in the "Getting Assistance; Claims and Appeal Procedures; and Customer Satisfaction Procedure" section of this EOC.

- Endoscopic exams, such as arthroscopy, bronchoscopy, and laparoscopy.
- Transplants are covered on an In-Plan (Option 1) basis only (See Section 3.1).
- Allergy testing and treatment (including shots), services, material and serums.
- Professional Services for Test Interpretation, X-ray Reading, Lab.
- Coverage for surgical services on an inpatient or outpatient basis to correct congenital abnormalities that cause functional impairment, newborn congenital abnormalities, or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery.
- Coverage for reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast. The minimum authorized Hospital stay is forty-eight (48) hours for radical and no less than twenty-four (24) hours for total or partial mastectomy with lymph node dissection.
- Vision services, including routine exams, eye refractions, orthoptics, glasses, contact lenses or the fitting of glasses or contact lenses. Coverage includes prescription glasses or contact lenses required as a result of surgery or for treatment of accidental injury. Includes cost of materials and fitting, exams, and replacement of eyeglasses or contact lenses if related to the surgery or injury. Eyeglass or contact lens purchase and fitting are covered under this benefit if:
  - Prescribed to replace the human lens lost due to surgery or injury;
  - "Pinhole" glasses are prescribed after surgery for a detached retina; or
  - Lenses are prescribed instead of surgery due to:
    - Contact lenses used for treatment of infantile glaucoma;
    - Corneal or sclera lenses prescribed in connection with keratoconus;
    - Scleral lenses prescribed to retain moisture when normal tearing is not possible or inadequate; or
    - Corneal or sclera lenses are required to reduce a corneal irregularity other than astigmatism.
- Prosthetic and Orthotic devices and expense incurred for components to a prosthetic and orthotic device and repair of a prosthetic and orthotic device. Covered Services will be limited to coverage for Medically Necessary prosthetic and orthotic devices, their repair, fitting, replacement, and components. Coverage will not include repair or replacement due to neglect, misuse, or abuse nor

SAMPLE

will it include devices designed primarily for an athletic purpose. Prosthetic Device means an artificial device to replace, in whole or in part, a limb or a body part, such as an arm, a hand, a leg, a foot, or an eye, or any portion of an arm, a hand, a leg, or a foot. Orthotic Device means braces, boots and other than foot orthotics.

- Prosthetics: Coverage will include fitting and adjustment of these devices, repair or replacement, and services and supplies to determine whether you need the prosthetic. Covered Services will be limited to the standard device that adequately meets your medical needs. This includes, but is not limited to, colostomy, ostomy, cochlear implants, and composite facial prosthetics. Coverage will include internally implanted and external Breast Prosthetics following a mastectomy. Breast Prosthetics will also be provided for the non-diseased breast to achieve symmetry with the diseased breast.

- Coverage for participation in an approved clinical trial and coverage for routine patient cost for items and services furnished in connection with participation in such clinical trial.

  "Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and the study or investigation is (i) a federally funded or approved trial, (ii) conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration, or (iii) a drug trial that is exempt from having an investigational new drug application.

  "Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of disease or condition is interrupted.

  "Qualified individual" means a Member who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to treatment of cancer or other life-threatening disease or condition, and the referring health care professional has concluded that the individual's participation in such trial is appropriate to treat the disease or condition, or the individual's participation is based on medical and scientific information.

  "Routine patient costs" means all items and services consistent with the coverage provided under the health benefit plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include the investigational item, device, or service itself; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

- Chiropractic services rendered by a licensed Chiropractor. Coverage is provided for musculoskeletal illness or injury only, we cover spinal manipulations and other manual medical interventions for a maximum of 30 Visits per calendar year. Coverage includes therapy to treat problems of the bones, joints, and back. These limits apply separately for habilitative and rehabilitative services. Habilitative chiropractic services include services that help keep or improve skills and functioning for daily living and services for people with disabilities in an inpatient or outpatient setting.

- Other services or treatment approved through the Medical Review Program, including second opinions.

SAMPLE

- Diagnostic and surgical treatment involving any bone or joint of the skeletal structure if the treatment is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part. Includes treatment of temporomandibular (TMJ) and craniomandibular disorders. Coverage includes removable appliances for TMJ repositioning and related medical care.
- Treatment of morbid obesity. Morbid obesity means a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes or a BMI of 40 kilograms per meter squared without such comorbidity. BMI equals weight in kilograms divided by height in meters squared.
- Medical foods, formula, enteral nutrition, and low protein modified food products for the treatment of severe protein and soy allergies and inherited metabolic disorders caused by an inherited abnormality of body chemistry including a disease for which the State screens newborn babies. Coverage is provided if the medical foods formula, enteral nutrition, and low protein food products are prescribed as Medically Necessary for the therapeutic treatment of inherited metabolic disorders or for Members with inborn errors of amino acid or organic acid metabolism, and when administered under the direction of a Physician. With regard to Medically Necessary formula and enteral nutrition products, **inherited metabolic disorders** means an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, or fatty acids. Coverage includes medical equipment, supplies, and Services that are required to administer the covered formula or enteral nutrition products.
- Hospice Care. **Hospice Care** means a coordinated program of home and inpatient care provided directly or under the direction of a hospice licensed and/or accredited within the jurisdiction within which the care is provided. Hospice Care is limited to individuals with a terminal illness whose condition has been diagnosed as terminal by a Physician, whose medical prognosis is death within six months, and who elect to receive palliative rather than curative care. Hospice Care will include Palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medically directed interdisciplinary team. No therapy Visit maximum applies to occupational, physical, or speech therapy services received under this benefit.
- Anesthesia for dental services, limited to general anesthesia and Hospital or outpatient surgery facility charges for outpatient surgical procedures for dental care provided to a Member who is determined by a licensed dentist, in consultation with the Member's treating Physician, to require general anesthesia and admission to a Hospital or outpatient surgery facility to effectively and safely provide dental care. For the purpose of this Covered Service, a determination of medical necessity will include but not be limited to a consideration of whether the age, physical condition or mental condition of the Member or mental condition of the Member requires the utilization of general anesthesia and the admission to a Hospital or outpatient surgery facility to safely provide the underlying dental care. This provision does not provide coverage for any dental procedure or the professional fees or services of the dentist. At a minimum coverage will be provided for a person who is: 1) under the age of 5; 2) is severely disabled; or 3) admitted to an ambulatory surgery facility for dental care.

SAMPLE

- Covered Services related to oral surgery for the surgical treatment of tumors in the oral cavity, where a biopsy is needed for evaluation of pathology; maxillary or mandibular frenectomy when not related to a dental procedure; alveolectomy when related to tooth extraction; orthognathic surgery, including surgery to correct temporomandibular joint (TMJ) pain dysfunction syndrome and Craniomandibular joint disorders that are required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part; and surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures, including the treatment of non-dental lesions. Coverage is also provided for the incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
- Covered Services for the Medically Necessary treatment of cleft lip, cleft palate, or ectodermal dysplasia, including orthodontics, oral surgery and otologic, audiological and speech/language treatment.
- Medically Necessary dental services as a result of accidental injury. For injuries occurring after the effective date of coverage, the covered Services must be requested within 60 days of the injury. Coverage does not include injuries from biting or chewing. Coverage includes repair of dental appliances damaged in an accidental injury to jaw, mouth or face and dental appliances need to treat an accidental injury. X-rays, extractions, and anesthesia to prepare the mouth for medical treatments are also covered.
- Coverage for health care services provided through Telemedicine Services. **Telemedicine Services,** as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment, 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" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.
- Coverage for lymphedema. Coverage shall include benefits for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care professional legally authorized to prescribe or provide such items.
- Diagnostic sleep testing.

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Pediatric Vision (children up to age 19)

Unless otherwise stated, the requirement that Medically Necessary covered Services be incurred as a result of Injury or Sickness will not apply to the following covered Services. Please refer to your ***Appendix – Summary of Cost Shares*** regarding each benefit in this section:

Exams

Routine eye exams including refractive exams to determine the need for vision correction and to provide a prescription for eyeglasses or contact lenses. This exam includes dilation if medically indicated.

Eyewear

The following eyewear is covered:

- Lenses
  - Single vision;
  - Conventional (Lined) Bifocal;
  - Trifocal;
  - Progressive.

Note: Lenses include choice of glass or plastic lenses; all lens powers (single vision, bifocal). Polycarbonate lenses are covered in full. All lenses include scratch resistant coating.

- Eyeglass frames (non-deluxe/designer) frames
- Contact lenses including evaluation, fitting, or follow-up care relating to contact lenses (in lieu of eyeglasses)
- Medically Necessary contact lenses in lieu of other eyewear for the following conditions:
  - Keratoconus;
  - Pathological Myopia;
  - Aphakia;
  - Anisometropia;
  - Aniseikonia;
  - Aniridia;
  - Corneal Disorders;
  - Post-traumatic Disorders; and
  - Irregular Astigmatism.

Note: Contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

Preventive Services

Unless otherwise stated, the requirement that Medically Necessary covered Services be incurred as a result of Injury or Sickness will not apply to the following covered Services. Please refer to your ***Appendix – Summary of Cost Shares*** regarding each benefit in this section:

The following preventive services are covered under this Group Agreement as required by the Patient Protection Affordable Care Act (PPACA) and may be subject to Deductibles, Co-payments or Coinsurance as described in the ***Appendix – Summary of Cost Shares.*** Preventive Services means medical services rendered to prevent diseases.

Consult with your physician to determine what preventive services are appropriate for you.

Exams

SAMPLE

- Well-Baby, Child, Adolescent Exam according to the Health Resources and Services Administration (HRSA) guidelines
- Well-woman exam Visits including preconception counseling, routine prenatal and postpartum office Visits. Routine prenatal office Visits include the initial and subsequent histories, physical examinations, recording of weight, blood pressure, fetal heart tones, and routine chemical urinalysis.

Screenings

- Abdominal aortic aneurysm screening
- Anxiety screening in adolescent and adult women, including those who are pregnant or postpartum
- Anatomical, biochemical, or biophysical tests to better define likelihood of genetic and/or chromosomal anomalies.
- Asymptomatic bacteriuria screening
- Autism Screening (18 and 24 months)
- Behavioral/Social/Emotional Screening for children newborn to age twenty-one (21)
- Breast cancer mammography screening
- Cervical cancer and dysplasia screening including HPV screening. Cervical dysplasia screening will also be provided for children.
- Colorectal cancer screening using fecal occult blood tests, flexible sigmoidoscopy, or colonoscopy. Follow-up colonoscopies after a positive non-invasive stool-based screening test or direct visualization screening test. This includes polyp removal and anesthesia provided in connection with a preventive colonoscopy screening, pathology for biopsies resulting from a screening colonoscopy, over the counter and prescription drugs necessary to prepare the bowel for the procedure, and a specialist consultation Visit prior to the procedure. Your initial screening colonoscopy will be preventive.
- Depression screening for children and adults including suicide risk as an element of universal depression screening for children ages twelve to twenty-one (12-21).
- Diabetes screening for non-pregnant women with a history of gestational diabetes who have not previously been diagnosed with type 2 diabetes mellitus
- Dyslipidemia screening for children
- Fetal screenings for genetic and/or chromosomal status of fetus.
- Gestational and postpartum diabetes screening
- Hepatitis B virus infection screening for pregnant women and children
- Hepatitis B and Hepatitis C virus infection screening for adults.
- Hematocrit or Hemoglobin screening in children

SAMPLE

- Hypertension (High blood pressure) screening
- Lead Screening for children and adults.
- Lipid disorders screening
- Lung cancer screening with low-dose computed tomography including a counseling Visit to discuss the screening in adults who have a 20 pack-year smoking history and currently smoke or have quit within the past fifteen (15) years. One pack year is equal to smoking one pack per day for one year, or two packs per day for half a year.
- Newborn congenital hypothyroidism screening
- Newborn hearing loss screening
- Newborn behavioral assessments and measurements
- Newborn and children blood pressure screening
- Newborn metabolic/hemoglobinopathies screening
- Newborn sickle cell disease screening
- Newborn Phenylketonuria (PKU) screening
- Obesity screening (Body Mass Index) for children and adults, and counseling for obesity for adults
- Osteoporosis screening
- Pre-eclampsia screening with blood pressure measurements throughout pregnancy
- Rh (D) incompatibility screening for pregnant women
- Sexually transmitted infection (STI) screening such as chlamydia, gonorrhea, syphilis, and HIV screening for children and adults
- Sudden cardiac arrest and sudden cardiac death risk assessment in children ages twelve to twenty-one (12-21).
- Type 2 diabetes mellitus screening
- Tuberculin (TB) Testing for children and adults
- Urinary incontinence screening in women. Includes screening for urinary tract and other infections.
- Visual impairment in children screening

SAMPLE

Health Promotion

- Screening by asking questions about unhealthy drug use in adults ages eighteen (18) years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.
- Unhealthy alcohol and drug use assessment and behavioral counseling interventions in a primary

care setting to reduce alcohol use for children and adults.

- Behavioral counseling interventions to promote healthy diet and physical activity for persons with cardiovascular disease.
- Offer Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults and children.
- Counseling for midlife women with normal or overweight body mass index to maintain weight or limit weight gain to prevent obesity.
- Offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.
- Tobacco use screening and tobacco-caused disease counseling and interventions. FDA- approved tobacco cessation prescription or over-the-counter medications prescribed by a licensed health care professional authorized to prescribe drugs for women who are not pregnant and men. Expanded tobacco intervention and counseling for pregnant users.
- Referral for testing for breast and ovarian cancer susceptibility, referral for genetic risk assessment and BRCA mutation testing.
- Sexually transmitted infections counseling.
- Discuss use of risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, with women who are at increased risk for breast cancer and at low risk for adverse medication effects.
- When prescribed by a licensed health care professional authorized to prescribe drugs:
  - Aspirin in the prevention of preeclampsia in pregnant women.
  - Oral fluoride supplementation at currently recommended doses to preschool children older than six (6) months of age whose primary water source is deficient in fluoride.
  - Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.
  - Folic acid supplementation for women planning or capable of pregnancy for the prevention of neural tube defects.
  - Vitamin D to prevent falls in community-dwelling adults aged sixty-five (65) years or older who are at increased risk for falls
- Interventions to promote breastfeeding. The following additional services are covered: breastfeeding support and counseling by a provider acting within the scope of his or her license or certified under applicable state law during pregnancy and/or in the postpartum period; breast milk storage supplies; any equipment and supplies as clinically indicated to support women and babies with breast feeding difficulties; and the purchase of a manual breast pump. A manual breast pump is one that does not require a power source to operate. In lieu of purchase of a manual breast

SAMPLE

pump, rental of a hospital-grade electric breast pump, including any equipment that is required for pump functionality is covered when Medically Necessary and prescribed by a physician. KPIC may decide to purchase the hospital-grade electric breast pump if purchase would be less expensive than rental or rental equipment is not available.

- All prescribed FDA-approved contraceptive methods for women with reproductive capacity, including but not limited to drugs, cervical caps, vaginal rings, continuous extended oral contraceptives and patches. This includes all FDA-approved cleared or granted contraceptive products that are determined by an individual's medical Provider to be medically appropriate. Also included are contraceptives which require medical administration in Your doctor's office, implanted devices and professional services to implant them, female sterilization procedures, follow-up and management of side effects; counseling for continued adherence, device removal and patient education and counseling. Items and services that are integral to the furnishing of a recommended preventive service such as a pregnancy test needed before provision of certain contraceptives is included in contraceptive coverage. Over the counter FDA approved female contraceptive methods are covered only when prescribed by a licensed health care professional authorized to prescribe drugs. In addition, fertility awareness-based methods, including the lactation amenorrhea method, although less effective, is covered for women desiring an alternative method. A prescription for a 12-month supply of hormonal contraceptives must be covered when dispensed or furnished at one time.
- Screening, counseling, and other interventions such as education, harm reduction strategies, and referral to appropriate supportive services for interpersonal and domestic violence.
- Physical therapy to prevent falls in community-dwelling adults who are at increased risk for falls. Community dwelling adults means those adults not living in assisted living, nursing homes or other institutions.
- Counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged six (6) months to twenty-four (24) years with fair skin types to reduce their risk for skin cancer.
- Counseling intervention for pregnant and postpartum persons who are at increased risk of perinatal depression.
- Oral health risk assessment and Medical history for children BMI measurements for children.
- Counseling for children for obesity and STI Supplements for fluoride chemoprevention for children.

SAMPLE

Disease Prevention

- Immunizations (including flu shots) as recommended by the Centers for Disease Control and HRSA.
- Prophylactic gonorrhea medication: for newborns to protect against gonococcal ophthalmia neonatorum.
- Low to moderate dose statin drugs for the prevention of cardiovascular disease events and mortality when all the following criteria are met: 1) individuals are aged forty to seventy-five (40-75) years;

2) they have 1 or more cardiovascular risk factors; and 3) they have a calculated 10-year risk of a cardiovascular event of ten percent (10%) or greater.

- Pre exposure prophylaxis (PrEP) with at least one drug providing effective antiretroviral therapy to persons who are at high risk of HIV acquisition as well as the following baseline and monitoring services:
    - HIV testing – to confirm the absence of HIV infection before PrEP is started and testing for HIV every 3 months while PrEP is being taken
    - Hepatitis B testing before PrEP is started.
    - Hepatitis C testing before PrEP is started and periodically during treatment according to CDC guidelines.
    - Creatinine testing and calculated estimated creatine clearance (eCrCl) or glomerular filtration rate (eGFR) is covered as follows:
        - eCrCl or eGFR testing before starting PrEP to assess kidney function.
        - Creatinine and eCrCL or eGFR testing periodically consistent with CDC guidelines during treatment.
    - Pregnancy testing for persons of childbearing potential before PrEP is started and periodically during treatment consistent with CDC guidelines.
    - Sexually transmitted infection screening and counseling before PrEP is started and periodically during treatment consistent with CDC guidelines.
    - Adherence counseling for assessment of behavior consistent with CDC guidelines.

SAMPLE

The following services are not covered as Preventive Care:

- Personal and convenience supplies associated with breast-feeding equipment such as pads, bottles, and carrier cases unless clinically indicated.
- Upgrades of breast-feeding equipment, unless determined to be Medically Necessary and prescribed by Your physician.

Preventive services may change upon Policy renewal according to federal guidelines in effect as of January 1 of each year in the Policy Year in which this Group Agreement renews. You will be notified at least sixty (60) days in advance, if any item or service is removed from the list of covered services.

For a complete list of current preventive services required under the Patient Protection Affordable Care Act for which Cost Share does not apply, please call: 1-888-225-7202 (TTY 711). You may also visit: www.healthcare.gov/center/regulations/prevention.html. Please note, however, for recommendations that have been in effect for less than one year, KPIC will have one year from the effective date to comply.

Note: The following services are not covered Services under this Preventive Exams and Services benefit, but may be covered Services elsewhere in this section:

- Laboratory, Imaging, and other ancillary services associated with prenatal care not inclusive to routine prenatal care
- Non-routine prenatal care Visits

- Non-preventive services performed in conjunction with sterilization
- Laboratory, Imaging, and other ancillary services associated with sterilizations
- Treatment for complications that arise after a sterilization procedure

Other Preventive Care

This Benefit section contains preventive care not required by the Patient Protection and Affordable Care Act. These preventive care services are not subject to the Medical Necessity requirement but are subject to the Deductible and Coinsurance requirements unless otherwise stated below or in the ***Appendix – Summary of Cost Shares***. In the event of a duplication of benefits, duplicate benefits will not be paid but the higher of the applicable benefits will apply.

- Adult routine physical examination. Covered Services at each examination are limited to: a) examination; and b) history. Any X-rays or laboratory tests ordered in connection with the examination will be subject to your plan's Deductible, Co-payments, and/or Coinsurance requirements as set forth in the ***Appendix – Summary of Cost Shares***
- Double contrast barium enema as an alternative to colonoscopy
- Iron deficiency anemia screening for pregnant women
- Iron supplementation for children from 6 months to 12 months of age
- Aspirin when prescribed by a licensed health care professional authorized to prescribe for the prevention of cardiovascular disease and colorectal cancer screening.
- Screening prostate-specific antigen test (PSA)
- The following services and items are covered as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition as described below, and only when prescribed for the purpose of preventing the chronic condition from becoming worse or preventing the development of a secondary condition:
    a. Hemoglobin A1C testing for individuals with diagnosed with diabetes.
    b. Retinopathy Screening for individuals with diagnosed with diabetes.
    c. Low Density Lipo-Protein testing for individuals diagnosed with heart disease.
    d. International Normalized Ratio (INR) testing for individuals diagnosed with liver disease or bleeding disorders.
    e. DME items:
        i. Peak flow meters for individuals diagnosed with Asthma.

        Glucometers including lancets, strips, control solution and batteries for individuals diagnosed with Diabetes
- Family planning limited to:
    - The charge of a Physician for consultation concerning the family planning alternatives available to a male Member, including any related diagnostic tests;
    - Vasectomies;

SAMPLE

  - Services and supplies for diagnosis and treatment of involuntary infertility (including reversal of non-elective sterilization) for females and males, unless otherwise excluded; and
  - Voluntary termination of pregnancy.
- Diagnostic examination which shall include a digital rectal exam and a blood test called the prostate-specific antigen (PSA) test:
  - For men who are between forty (40) and seventy-five (75) years of age;
  - When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;
  - When used for staging in determining the need for a bone scan in patients with prostate cancer; or
  - When used for male patients who are at high risk for prostate cancer.

  This coverage does not cover the surgical and other procedures known as radical prostatectomy, external beam radiation therapy, radiation seed implants, or combined hormonal therapy.
- Venipuncture for ACA preventive laboratory screenings. If a venipuncture is for the purpose of drawing blood for both ACA preventive and Non-ACA preventive labs, a Cost Share may apply.
- Behavioral counseling interventions to promote a healthy diet and physical activity for cardiovascular disease (CVD) prevention in adults with CVD risk factors and type 2 diabetes mellitus.

Benefits payable for diagnostic procedures will be covered on the same basis as a Sickness. Additional family planning benefits under PPACA are listed under Preventive Services.

Family planning charges do not include any charges for the following:

- The cost of donor semen and donor eggs including retrieval of eggs;
- Storage and freezing of eggs and/or sperm;
- Services to reverse voluntary, surgically induced infertility;
- Services related to conception by artificial means, including, but not limited to, artificial insemination, in vitro fertilization, gamete intrafallopian tube transfer; ovum transplants; zygote intrafallopian transfer, and prescription drugs related to such services.

Extension of Benefits

Except with regard to any Optional Outpatient Drug Benefit that may be provided under this Evidence of Coverage, the benefits for the disabling condition of a Member will be extended if:

- The Member becomes Totally Disabled while insured for that insurance under the plan; and
- The Member is still Totally Disabled on the date this Plan terminates.

The extended benefits will be paid only for treatment of the Injury or Sickness that causes the Total

SAMPLE

Disability. The extension will start on the day that follows the last day for which Premiums are paid for the insurance of the Member. It will end on the first of these dates that occur:

- The date on which the Total Disability ends;
- The last day of the 12-month period that follows the date the Total Disability starts; or
- The date on which the Member becomes covered under any plan that: a) replaces this insurance; and b) covers the disabling condition so that benefits are not limited due to the Total Disability having started before that plan was in effect.
- This Evidence of Coverage Terminates.

A Member other than a Dependent minor is Totally Disabled only if, in the judgment of a Physician, a Sickness or Injury: a) is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months; and b) makes the person unable, even with training, education and experience, to engage in any employment or occupation.

A Member, who is a Dependent minor, is Totally Disabled only if, in the judgment of a Physician, a Sickness or Injury: a) is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months; and b) makes the person unable to engage in most of the normal activities of persons in good health of like age.

Benefits for Inpatient Maternity Care

Hospital Confinements in connection with childbirth for the mother or newborn child will not be limited to less than 48 hours following normal vaginal delivery and not less than 96 hours following a Caesarean section, unless, after consultation with the mother, the attending provider discharges the mother or newborn earlier.

A stay longer than the above may be allowed provided the attending provider obtains authorization for an extended confinement through KPIC's Medical Review Program.

For stays shorter than 48 hours following normal vaginal delivery and 96 hours following a Caesarean section, one home visit within 24 hours of hospital discharge will be scheduled, and an additional home visit if prescribed by the attending physician.

Coverage for additional hospitalization, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, will be provided for the newborn up to four days.

Note: Prior authorization is not required for the interhospital transfer of (i) a newborn infant experiencing a life- threatening emergency condition or (ii) the hospitalized mother of such newborn infant to accompany the infant in compliance with § 38.2-3407.11:4.

Emergency Services

Emergency Services are covered twenty-four (24) hours per day, seven (7) days per week, anywhere in the world. If You have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department or Independent Freestanding Emergency Department. When You have an Emergency Medical Condition, We cover Emergency Services that You receive from Participating Providers or Non-Participating Providers anywhere in the world, as long as the Services would be covered

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under the **SECTION 3.2 – OPTION 2 (PPO) AND OPTION 3 (INDEMNITY) BENEFITS** of the Group Policy (subject to the **SECTION 4 – EXCLUSIONS AND COORDINATION OF BENEFIT** of the Group Policy) if You had received them from Participating Providers. Emergency Services are covered:

1. Without the need for any prior authorization determination, even if the Emergency Services are provided on an out-of-network basis;
2. Without regard to whether the health care provider furnishing the Emergency Services is a Participating Provider or a Participating Emergency Facility, as applicable, with respect to the Services;
3. If the Emergency Services are provided by a Non-Participating Provider or Non-Participating Emergency Facility, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency Services received from Participating Providers;
4. Without limiting what constitutes an Emergency Medical Condition solely on the basis of diagnosis codes; and
5. Without regard to any other term or condition of the coverage, other than:
   a. Applicable Cost-sharing; and
   b. For Emergency Services provided for a condition that is not an Emergency Medical Condition, the exclusion or coordination of benefits.

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Cost-sharing Requirements, Payment, and Balance Billing Protections for Emergency Services

1. The Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility is the same as the Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement listed under the Group Policy for Emergency Services provided by a Participating Provider or Participating Emergency Facility;
2. Any Cost-sharing payments made with respect to Emergency Services provided by a Non-Participating Provider or a Non-Participating Emergency Facility will be counted toward any applicable in-network Deductible and in-network Out-of-Pocket Maximum;
3. If Emergency Services are provided by a Non-Participating Provider or Non-Participating Emergency Facility, any Cost-sharing requirement will be calculated based on the Recognized Amount;
4. If Emergency Services are provided by a Non-Participating Provider or Non-Participating Emergency Facility, We will make payment for the covered Emergency Services directly to the Non-Participating Provider or Non-Participating Emergency Facility. The payment amount will be equal to the amount by which the Out-of-Network Rate exceeds the Cost-sharing amount for the services; and
5. For Emergency Services furnished by Non-Participating Providers or Non-Participating Emergency Facilities, the member will not be liable for an amount that exceeds the member's Cost-sharing requirement.

Cost-sharing Requirements, Payment, and Balance Billing Protections for Non-Emergency, Surgical or Ancillary Services Performed by Non-Participating Providers at Participating Facilities

Cost-sharing Requirements, Payment, and Balance Billing Protections for Non-Emergency, Surgical or

Ancillary Services Performed by Non-Participating Providers at Participating Facilities.

The Group Policy covers items and Surgical or Ancillary Services furnished by a Non-Participating Provider with respect to a covered visit at a Participating Facility in the following manner:

1. The Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement for items and Surgical or Ancillary Services furnished by a Non-Participating Provider with respect to a visit in a Participating Facility is the same as the Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement listed in the Group Policy for the items and Surgical or Ancillary Services when provided by a Participating Provider;
2. Any Cost-sharing requirement for the items and Surgical or Ancillary Services will be calculated based on the Recognized Amount;
3. Any Cost-sharing payments made with respect to the items and Surgical or Ancillary Services will be counted toward any applicable in-network Deductible and in-network Out-of-Pocket Maximum;
4. We will make payment for the items and Surgical or Ancillary Services directly to the Non-Participating Provider. The payment amount will be equal to the amount by which the out-of-network rate exceeds the Cost-sharing amount for the items and services; and
5. For charges for such items or Surgical or Ancillary Services that exceed Our payment, the member will not be liable for an amount that exceeds the member's Cost-sharing requirement.

Cost-sharing Requirements, Payment, and Balance Billing Protections for Non-Participating Providers Air Ambulance Services

When services are received from a Non-Participating Provider of Air Ambulance Services:

1. The Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement for the Air Ambulance Service is the same as the Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement listed in the Group Policy for Air Ambulance Services when provided by a Participating Provider of ambulance services;
2. Any Cost-sharing requirement will be calculated based on the lesser of the Qualifying Payment Amount or the billed amount for the Services;
3. Any Cost-sharing payments made with respect to the Air Ambulance Service will be counted toward any applicable in-network Deductible and in-network Out-of-Pocket Maximum;
4. We will make payment for the Air Ambulance Services directly to the Non-Participating Provider of ambulance services. The payment amount will be equal to the amount by which the Out-of-Network Rate exceeds the Cost-sharing amount for Air Ambulance Services; and
5. The member will not be liable for an amount that exceeds the member's Cost-sharing requirement.

Continuity of Care (Options 2 and 3)

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

In addition, under the following special situations, KPIC will continue to provide benefits for Participating Provider's care for the time periods specified:

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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 Participating 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 one-hundred eighty (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 KPIC's agreement with the Provider existing immediately before the Provider's termination of participation.

SAMPLE

SECTION 4 – EXCLUSIONS AND COORDINATION OF BENEFITS

Exclusions

The Services listed below ***are excluded*** from coverage, except as covered under Section 3.1 (Option 1-HMO Benefits) and Section 3.2 (Option 2-PPO Benefits and Option 3-Indemnity Benefits) of this EOC. These exclusions apply to all Services that would otherwise be covered under this EOC. When a Service is not covered, all Services, drugs, or supplies directly related to the non-covered Service are also excluded, even if they would otherwise be covered under this EOC. Services that are not Medically Necessary are also excluded.

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

Alternative Medical Services

- Acupuncture Services and the Services of an Acupuncturist
- Naturopath or Massage Therapist Services

Ambulance Services

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

Biofeedback or Hypnotherapy (Excluded for Options 2 and 3 only)

Biotechnology Drugs and Diagnostic Agents (Excluded for Options 2 and 3 only) The following biotechnology drugs are excepted from this exclusion: Human insulin, vaccines, biotechnology drugs administered for the treatment or diagnosis of cancer, and Dornase for the treatment of cystic fibrosis, human growth hormones prescribed or administered for the treatment of documented human growth hormone deficiency such as Turner's Syndrome.

Clinical Trials

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

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.

SAMPLE

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.

Dental Care

- Dental care and dental x-rays, including dental appliances, dental implants, orthodontia, shortening of the mandible or maxillae for cosmetic purposes, and correction of malocclusion, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any non-removable dental appliance involved in temporomandibular joint (TMJ) pain dysfunction syndrome.

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 ***Section 3: Benefits, Exclusions and Limitations*** or under Dental Plans.

Disposable Supplies

- Disposable supplies for home use such as bandages, gauze, tape, antiseptics, Ace-type bandages, and any other supplies, appliances, or devices, not specifically listed as covered in the "Benefits" section.

Drugs, Supplies and Supplements

- Drugs for which a prescription is not required by law.
- Drugs for the treatment of sexual dysfunction disorders.

Durable Medical Equipment

Except as covered under "Durable Medical Equipment" in Section 3, the following items and Services are excluded:

- Comfort, convenience, or luxury equipment or features;
- Exercise or hygiene equipment;
- Non-medical items such as sauna baths or elevators;
- Modifications to your home or car;
- Electronic monitors of the heart or lungs, except infant apnea monitors and oximetry monitors for patients on home ventilation;
- Purchases of Durable Medical Equipment. Purchase of such equipment may be made if, in the judgment of KPIC: a) purchase of the equipment would be less expensive than rental; or b) such equipment is not available for rental. (For Options 2 and 3 only).

Emergency Care (Excluded for Options 2 and 3 only)

- Charges for non-Emergency services in an Emergency care setting, except for non-Emergency surgical or Ancillary Services provided at a Participating Provider facility by a Non-Participating

SAMPLE

Provider, to the extent that such charges exceed charges that would have been incurred for the same treatment in a non-Emergency care setting. Final determination as to whether non-Emergency Services were rendered appropriately in an Emergency care setting will rest solely with KPIC. Charges for the screening and treatment necessary for stabilization will be processed at the in-network (Option 1) benefit level.

- Weekend admission charges for non-Emergency Care Hospital services. This exclusion applies only to such admission charges for Friday through Sunday, inclusive.

Employer or Government Responsibility

- Financial responsibility for Services that an employer or government agency is required by law to provide.

Experimental or Investigational Services

Except as covered under "Clinical Trials" section of the "Benefits" 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:

- It cannot not be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or
- 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
- 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
- It is the subject of a written protocol used by the treating facility for research, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself.

SAMPLE

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

- Your medical records,
- The written protocols or other documents pursuant to which the Service has been or will be provided,
- Any consent documents you or your representative has executed or will be asked to execute, to receive the Service,
- The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
- The published authoritative medical or scientific literature regarding the service, as applied to your illness or injury, and
- 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 Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

External Prosthetic and Orthotic Devices

- Services and supplies for external prosthetic and orthotic devices, except as specifically covered under the "Benefits" section of this EOC.

Health Education (Excluded for Options 2 and 3 only)

- Health education, including but not limited to: a) stress reduction; b) weight reduction; or d) the services of a dietitian. This exclusion will not apply to treatment of Morbid Obesity.

Hearing Services

- Batteries, except for those received initially, and cords.
- This exclusion does not apply to newborn hearing screenings.

Home Health Services

- Custodial care (see definition under "Exclusions" in the "Exclusions, Limitations, and Coordination of Benefits" section of this EOC);
- Services given by a member of the Member's immediate family;
- Homemaker Services;
- Maintenance therapy; or
- Food and home delivered meals.

Infertility Services

- Services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;
- Any services or supplies provided to a person not covered under your Health Plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple);
- Drugs used to treat infertility; or
- Services to reverse voluntarily induced sterility.

Intermediate Care (Excluded for Options 2 and 3 only)

- Care in an intermediate care facility. This is a level of care for which a Physician determines the facilities and services of a Hospital are not Medically Necessary.

Morbid Obesity Services (Excluded for Option 1 only)

SAMPLE

- Services not preauthorized by Health Plan.

Oral Surgery

- Oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures.
- Orthodontic care, except as required in the treatment of cleft lip, cleft palate, or ectodermal Dysplasia.

Preventive Health Care Services

While treatment may be provided in the following situations, the following Services are not considered Preventive Health Care Services. Applicable Cost Share will apply:

- Monitoring chronic disease.
- Follow-up Services after you have been diagnosed with a disease.
- Services provided when you show signs or symptoms of a specific disease or disease process.
- Non-routine gynecological Visits.
- Lab, imaging, and other ancillary Services not included in routine prenatal care.
- Non-preventive Services performed in conjunction with a sterilization.
- Lab, imaging, and other ancillary Services associated with sterilizations.
- Complications that arise after a sterilization procedure.
- Over-the-counter contraceptive pills, supplies, and devices.
- Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.
- Replacement or upgrades for breastfeeding equipment that is not rented Durable Medical Equipment.
- Prescription contraceptives that do not require clinical administration for certain group health coverage that includes FDA-approved contraception that is separate from Health Plan coverage and furnished through another prescription drug provider.

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

Prosthetic Devices

- Internally implanted breast prosthetics for cosmetic purposes.

Reconstructive Surgery

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:

- Removal of moles or other benign skin growths for appearance only

SAMPLE

- Chemical peels
- Pierced earlobe repairs, except for the repair of an acute bleeding laceration

Routine Foot Care Services

Except when Medically Necessary, the following foot care Services (palliative or cosmetic) are excluded:

- Flat foot conditions;
- Support devices and arch supports;
- Foot inserts;
- Orthopedic and corrective shoes not part of a leg brace and fitting;
- Castings and other services related to devices of the feet;
- Foot orthotics;
- Subluxations of the foot;
- Corns, calluses and care of toenails;
- Bunions except for capsular or bone surgery;
- Fallen arches;
- Weak feet; and
- Chronic foot strain or symptomatic complaints of the feet.

Services Outside the United States (Excluded for Options 2 and 3 only)

Confinement, treatment, Services, or supplies received outside the United States, if such confinement, treatment, Services, or supplies are of the type and nature that are not available in the United States.

Sexual Dysfunction Treatment (Excluded for Options 2 and 3 only)

Any drug, procedure, or treatment for sexual dysfunction regardless of cause, including but not limited to Inhibited Sexual Desire, Female Sexual Arousal Disorder, Female Orgasmic Disorder, Vaginismus, Male Arousal Disorder, Erectile Dysfunction and Premature Ejaculation.

Skilled Nursing Facility Care

- Custodial care (see definition under "Exclusions" in the "Exclusions, Limitations, and Coordination of Benefits" section of this EOC).
- Domiciliary care.

See "Therapy; Habilitative and Rehabilitative Services" for coverage of therapy during an inpatient stay.

Surrogacy Arrangements Services (Option 2 and 3)

Services in connection with a Surrogacy Arrangement, except for otherwise-Covered Services provided to a Member who is a surrogate.

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Telemedicine Services

Non-interactive Telemedicine Services include an audio-only telephone conversation, electronic mail message, or facsimile transmission.

Therapy; Habilitative and Rehabilitative Services

Long-term rehabilitation therapy, except as provided for cardiac rehabilitation Services

Refer to the following benefits in this section for the Habilitative and Rehabilitative devices that are also covered under this Agreement:

- Diabetic Equipment, Supplies, and Self- Management
- Durable Medical Equipment
- Prosthetic Devices, including orthotics
- Vision Services, including lenses prescribed following surgery or for the treatment of accidental injury

Transplant Services

- Services related to non-human or artificial organs and their implantation (Excluded for Option 1 only).

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 the "How to Obtain Services" section, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines. Travel and Lodging Expenses are allowed for the transportation benefit related to transplant surgery.

Vein Treatment

Treatment of varicose veins or telangiectatic dermal veins, also known as spider veins, by any method including sclerotherapy or other surgeries for cosmetic purposes.

Vision Services

- Industrial and athletic safety frames.
- Eyeglass lenses and contact lenses with no refractive value.
- Sunglasses without corrective lenses unless Medically Necessary.
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), farsightedness (hyperopia), and astigmatism (for example, radial keratotomy, photorefractive keratectomy, and similar procedures).
- Eye exercises.
- Non-corrective contact lenses;

SAMPLE

- Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section.
- Replacement of lost, broken, or damaged lenses frames and contact lenses.
- Plano lenses.
- Lens adornment, such as engraving, faceting, or jewelling.
- Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits.
- Orthoptic (eye training) therapy.

Visiting Member Services (Excluded for Option 1 only)

All the terms and conditions, exclusions and limitations that apply to covered Services in our Service Area, will apply to Services received as a visiting Member in different Kaiser regional health plan or Group Health Cooperative service area.

Workers' Compensation or Employer's Liability

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.

Other Non-Covered Services

- Inpatient stays for environmental changes;
- Cognitive rehabilitation therapy;
- Educational therapy;
- Coma stimulation therapy;
- Services, surgeries and drugs to treat sexual deviation and dysfunction;
- Treatment of social maladjustment without signs of a psychiatric disorder; or
- Remedial or special education services.

Special education and related counseling or therapy; or learning deficiencies. This applies whether or not the services are associated with manifest Mental Illness or other disturbances. (Excluded for Options 2 and 3 only)

Unusual Circumstances

We will use our best efforts to provide or arrange for covered Services in the event of unusual circumstances that delay or render impractical the provision of Services, such as major disaster, epidemic, war, riot, terrorist activity, civil insurrection, disability of a large share of personnel of a Plan Facility, complete or partial destruction of facilities, and labor disputes not involving Health Plan, Kaiser Foundation Hospitals, or Medical Group. However, in these circumstances Health Plan, Kaiser Foundation Hospitals, Medical

SAMPLE

Group, and Medical Group Physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying care is safe and will not result in harmful health consequences.

Coordination of Benefits (COB)

Note: The three coverage options in your Kaiser Permanente Flexible Choice plan are treated as one plan; there shall be no coordination of benefits between benefits provided by Health Plan (Option 1) and those provided by KPIC (Options 2 and 3).

Coordination of Benefits means the way benefits are payable under more than one medical or dental plan. Under Coordination of Benefits, the Member will not receive more than the Allowable Expenses for a loss.

If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage. The Plan that pays first (Primary Plan) is determined by using National Association of Insurance Commissioners (NAIC) and Medicare Secondary Payer (MSP) Order of Benefits Guidelines.

- The Primary Plan then provides benefits as it would in the absence of any other coverage.
- The Plan that pays benefits second (Secondary Plan) coordinates with the Primary Plan, and pays the difference between what the Primary Plan paid, or the value of any benefit or service provided, and the maximum liability of the Secondary Plan, not to exceed 100 percent of total Allowable Expenses. The Secondary Plan is never liable for more expenses than it would cover if it had been Primary.

For Health Plan (Option 1), if you have any questions about COB, please call our Member Services Monday through Friday from 7:30 a.m. until 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or TTY is 711.

For KPIC (Options 2 and 3), if you have any questions about COB, please call our Customer Service Center.

- Nationwide 1-888-225-7202 (TTY 711), 9 a.m. to 9 p.m. Eastern Standard Time (EST)

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Definitions

Allowable Expense: A health care service or expense, including Deductibles, Coinsurance or Co-payments, 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 health care service that is not covered by any of the Plans is not an allowable expense. For example, if a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room usually is not an Allowable Expense. “Allowable Expense” does not include coverage for dental care except as provided under "Accidental Dental Injuries" in the "benefits" section.

Closed Panel Plan means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other plan that provides health benefits to Members primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in the cases of emergency or referral by a panel Member.

- If the primary plan is a closed panel plan with no Out-of-Network benefits and the secondary plan is not a closed panel plan, the secondary plan must pay or provide benefits as if it were primary when no benefits are available from the primary plan because the Member used a non-panel provider, except for Emergency Services that are paid or provided by the primary plan
- If, however, the two plans are closed panels, the two plans will coordinate benefits for services that are Covered Services for both plans, including Emergency Services, authorized referrals, or Services from providers that are participating in both plans. There is no COB if there is no covered benefit under either plan.

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

Primary Plan/Secondary Plan means that when This Plan is primary, its benefits are determined before those of the other Plan; the benefits of the other Plan are not considered. When This Plan is secondary, its benefits are determined after those of the other Plan; its benefits will coordinate with the other Plan's benefits. When there are more than two Plans, This Plan may be primary as to one and may be secondary as to another.

Plan: Any of the following that provides benefits or services for, or because of, medical care or treatment: Individual or Group insurance or Group-type coverage, whether insured or uninsured. This includes prepaid Group practice or individual practice coverage. "Plan" does not include an individually underwritten and issued, guaranteed renewable, specified disease policy or intensive care policy, that does not provide benefits on an expense-incurred basis. "Plan" also does not include the medical benefits under an automobile policy, including benefits for personal injury protection. "Plan" also does not include:

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

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Order of Benefit Determination Rules

Coordination of Benefits ("COB") applies when a Member has health care coverage under more than one Plan. "Plan" and "Health Plan" are defined below.

- The Order of Benefit Determination Rules will be used to determine which Plan is the Primary Plan. The other Plans will be Secondary Plan(s).
- If the Health Plan is the Primary Plan, it will provide or pay its benefits without considering

the other Plan(s) benefits.

- If the Health Plan is a 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 Expenses.
- If another Plan does not have a COB provision, that Plan is the Primary Plan.
- If another Plan has a COB provision, the first of the following rules that apply will determine which Plan is the Primary Plan:
  - o Non-Dependent/Dependent. 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.
  - o Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph (b)(iii) below, when Health Plan and another Plan cover the same child as a Dependent of different persons, called "parents":
    - i. 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; but
    - ii. When both parents have the same birthday, the Plan that covered a parent longer is Primary – this is known as the “Birthday Rule”; or
    - iii. 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.
  - o Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
    - i. First, the Plan of the parent with custody of the child;
    - ii. Then, the Plan of the Spouse or Domestic Partner of the parent with custody of the child; and
    - iii. Finally, the Plan of the parent not having custody of the child.
    - iv. 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 (iv) 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.
    - v. Active/Inactive Employee. A Plan that covers a person as an employee who is neither laid off nor retired (or as such an employee's Dependent) is Primary to a Plan which covers that person as a laid off or retired employee (or as such an employee's Dependent).
    - vi. Longer/Shorter Length of Coverage. If none of the above rules determines the order

SAMPLE

of benefits, the Plan that has covered a Subscriber longer is Primary to the Plan which has covered the Subscriber for the shorter time.

Effect of COB on the Benefits of this Plan

When Health Plan is the Primary Plan, COB has no effect on the benefits or services provided under this Agreement. When Health Plan is a Secondary Plan as to one or more other Plans, its benefits may be coordinated with the Primary Plan carrier using the guidelines below. COB shall in no way restrict or impede the rendering of Services covered by Health Plan. At the Member's request, Health Plan will provide or arrange for covered services and then seek coordination with a Primary Plan.

Coordination with This Plan's Benefits: Health Plan may coordinate benefits payable or may recover the reasonable cash value of services it has provided when the sum of:

- The benefits that would be payable for, or the reasonable cash value of, the services provided as Allowable Expenses by Health Plan in the absence of this COB provision; and
- The benefits that would be payable for Allowable Expenses under one or more of the other Plans, in the absence of provisions with a purpose like that of this COB 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 Health Plan may be recovered, from the Primary Plan, so that they and the benefits payable under the other Plans do not total more than the Allowable Expenses.

Right to Reserve and Release Needed Information (Option 1): Certain information is needed to apply these COB rules. Health Plan will decide the information it needs, and may get that information from, or give it to, any other organization or person. Health Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under Health Plan must give Health Plan any information it needs.

Right to Reserve and Release Needed Information (Options 2 and 3): Certain facts are needed to coordinate benefits. KPIC has the right to decide which facts it needs. KPIC may get needed facts from or give them to any other organization or person. KPIC need not tell, or get the consent of any person to do this. Each person claiming benefits under This Plan must give KPIC any facts it needs to pay the claim.

Facility of Payment (Option 1): If a payment made or service provided under another Plan includes an amount that should have been paid or provided by or through Health Plan, Health Plan may pay that amount to the organization which made that payment. The amount paid will be treated as if it was a benefit paid by Health Plan.

Facility of Payment (Options 2 and 3): A payment made under another Plan may have included an amount, which should have been paid under This Plan. If it does, KPIC may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. KPIC will not pay that amount again. The term "payment made" includes providing benefits in the form of services. In this case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery (Option 1): If the amount of payments by Health Plan is more than it should have paid under this COB provision, or if it has provided Services that should have been paid by the Primary Plan, Health Plan may recover the excess or the reasonable cash value of the Services, as applicable, from one

SAMPLE

or more of:

- The persons it has paid or for whom it has paid;
- Insurance companies; or
- Other organizations

Right of Recovery (Options 2 and 3): If the amount of the payments made by KPIC is more than it should have paid, KPIC may recover the excess if related to payments made under any workers' compensation laws or federal or state programs. The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

Military Services

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, and when we cover any such Services we may recover the value of the of the Services from the Department of Veterans Affairs.

Effect of Medicare

This Plan will be primary to Medicare for an active employee and Dependent Spouse or Domestic Partner of such active employee. The value of your benefits is coordinated with any benefits to which you are entitled under Medicare. Medicare is primary for an insured retiree or the Dependent Spouse or Domestic Partner of a retiree age 65 or over; this applies whether or not the retiree or Spouse or Domestic Partner is enrolled in Medicare.

TRICARE Benefits

The value of your benefits are coordinated with any benefits to which you are entitled under TRICARE.. TRICARE benefits are usually secondary benefits by law.

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SECTION 5 – GETTING ASSISTANCE; CLAIMS AND APPEAL PROCEDURES; AND CUSTOMER SATISFACTION PROCEDURE

The following provisions under this Evidence of Coverage explain both claims procedures and your Appeal rights for Adverse Benefit Determinations made under your Kaiser Permanente Flexible Choice Plan. Claims and Appeal procedures for decisions made regarding Services under Option 1 (HMO) benefits are different from those under Option 2 (PPO) benefits and Option 3 (Indemnity) benefits.

Claims and Appeals Information for Option 1 (HMO)

General Provisions

When receiving services outside of a Plan Medical Center, you will receive an Explanation of Benefits (EOB) within 21 days of Proof of Loss. An Explanation of Benefits is any form provided by an insurer, health services plan or health maintenance organizations which explains the amounts covered under a policy or Plan or shows the amounts payable by a Member to a health care provider. 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.

Proof of Loss means all necessary documentation reasonably required by the Health Plan to make a determination of benefit coverage.

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 above.

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

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

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

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represent or help you. You may also contact the Office of the Managed Care Ombudsman (contact information is set forth below) to obtain assistance.

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
1-404-949-5001(FAX)

When you must file a claim (request for payment or 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

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

If you are unable to access the electronic form or obtain the paper form, you may also file your claim by mailing the minimum amount of information we need to process claim:

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

The Claims Process

Pre-Service Claims

Pre-Service claims are requests that Health Plan provide or pay for a Service that you have not yet received. We 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 our

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Member Services Department at the numbers listed above.

Procedure for Making a Non-Urgent Pre-Service Claim

- Tell the Member Services Department that you want to make a claim for Health Plan to provide or pay for a Service you have not yet received. Your written or oral request and any related documents you give us constitute your claim. You may write or call us at the address and number listed above.
- We will review your claim, and if we have all the information we need we will communicate our decision within two 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 15 days of receipt of your claim. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days, we will then make a decision within 15 days of the due date or the receipt date, whichever is earlier, based on the information we have.
- 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.
- If we make an Adverse Decision regarding your claim, we will notify the Treating Provider:
    1. in writing within two working days of the decision; or
    2. orally by telephone within 24 hours of the decision if the claim is for cancer pain medication. 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.

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

- 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.
- If we determine your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Pre-Service Claim.
- We will review your claim, and if we have all the information we need we will notify you of our decision as soon as possible taking into account your medical condition(s) but no later than 72 hours after receiving your claim. We will send a written or electronic confirmation within three 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 24 hours of receipt of your claim. You will have 48 hours from the time of notification by us to provide the missing

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information. We will make a decision 48 hours after the earlier of (a) our receipt of the requested information, or (b) the end of the 48-hour period we have given you to provide the specified additional information.

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

Concurrent Care Claims

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

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

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

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

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Concurrent Care Claims for an Urgent Medical Condition

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

If you filed a request for additional services at least 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, Health Plan will decide your request for review within a reasonable period of time appropriate to the circumstances but in no event later than 30 calendar days from the date on which your claim was received.

- If we determine your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Concurrent Care Claim.
- We will notify you of our decision orally or in writing within 24 hours after we receive your claim. If we notify you orally, we will send you a written decision within three days after that.

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

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

<u>Post-Service Claims</u>

Post-service claims are requests for payment for Services you already received, including claims for Emergency Services and Urgent Care Services rendered outside our Service Area. If you have any questions about post-service claims or Appeals, please call the Member Services Department at the address and telephone numbers listed below.

Procedure for Making a Post-Service Claim

Claims for Emergency Services or Urgent Care Services rendered outside our Service Area or other Services received from non-Plan Providers must be filed on forms provided by Health Plan; such forms may be obtained by calling or writing to the Member Services Department.

- You must send the completed claim form to us at the address listed on the claim form within 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 which may be owed to you. Also, you must complete and submit to us any documents that we may reasonably need for processing your claim or obtaining payment from insurance companies or other payers.
- We will review your claim, and if we have all the information we need we will send you a written decision within 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 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 45 days to provide the requested information. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days, we will make a decision based on the information we have. We will issue our decision within 15 days of the deadline for receiving the information.
- 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 a review, on behalf of a Member, of an Adverse Decision by Health Plan. A request for reconsideration is optional. The Treating Provider may choose to skip this step and the Member or the Authorized

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Representative may file an Appeal as described below. If the provider does request reconsideration, the Member still has a right to Appeal.

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 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 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
1-404-949-5001 (FAX)

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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.

Member Service Representatives are available by telephone each day during business hours to describe to Members how Appeals are processed and resolved and to assist the Member with filing an Appeal. The Member Service Representative can be contacted Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

The Appeal must be filed in writing within 180 days from the date of receipt of the original denial notice**.** If the Appeal is filed after the 180 days, Health Plan will send a letter denying any further review due to lack of timely filing.

If within five 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:

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

Standard Appeals will either be acknowledged within 5 working days of the filing date of the written Appeal

request. An acknowledgement letter will be sent as follows:

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: i) request additional information, if necessary; ii) inform the Member when there will be a decision on their Appeal; and iii) state that written notice of the Appeal decision will be sent within 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: i) requesting additional information, if necessary; ii) informing the Member when a decision will be made; and iii) that the Member will be notified of the decision within 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 on which 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
1-404-949-5001 (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 Member Services Appeals Unit. 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 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 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

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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, Health Plan will notify the Member or the member's Authorized Representative. The notification shall include:

- The specific factual basis for the decision in clear understandable language;
- 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);
- 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;
- 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 30 days of the date of Health Plan's final Adverse Decision, as described below; and
- 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.

If Health Plan fails to make an Appeal decision for a non-urgent Pre-Service Appeal within 30 days or within 60 days for a Post-Service Appeal, the Member may file a complaint with the Bureau of Insurance.

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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. at 1-800-777-7902 or 711 (TTY) 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, clinical review 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, Health Plan will verbally notify the Member within 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, 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 72 hours after receipt of the claim, if we have all of the necessary information; or if the claim is for cancer pain medication, no later than 24 hours after receipt of the claim.

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

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

- 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
- Within 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.

SAMPLE

The notification shall also include:

- The specific factual basis for the decision in clear understandable language;
- 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);
- 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

- 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 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.

Claims and Appeals Information for Option 2 (PPO) and Option 3 (indemnity)

General Provisions

All claims under Options 2 (PPO) and 3 (Indemnity) of the Kaiser Permanente Flexible Choice Plan will be administered by:

Kaiser Permanente Claims Administration
PO Box 371860
Denver, CO 80237-9998

Questions about claims

For assistance with questions regarding claims filed with KPIC, please have Your ID Card available when you call 1-888-225-7202 (TTY 711) or you may write to the address listed above. Claim forms are available from your employer.

Participating Provider claims

If you receive services from a Participating Provider, that provider will file the claims on your behalf. Benefits will be paid to the provider. You need pay only your Deductible and Coinsurance or Co-payment.

Non-Participating Provider claims

If you receive services from a Non-Participating Provider, that provider may file the claims on your behalf. For Emergency Services and non-emergency surgical or ancillary Services provided by a Non-Participating Provider at a Participating Provider facility, benefits will be paid directly to the Non-Participating Provider. In all other instances; if you do not assign benefits, benefits will be paid to you. Under those instances, it is your responsibility to apply the plan payment to the claim from such Non-Participating Provider.

Notice of Claims

You must give us written notice of claim within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon as reasonably possible. You may give notice or may have someone do it for you. The notice should give your name and your account number shown in Your ***Appendix – Summary of Cost Shares.*** The notice should be mailed to us at our mailing address or to our Administrator.

Kaiser Permanente Claims Administration
PO Box 371860
Denver, CO 80237-9998

Claim Forms

When we receive your notice of claim, we will furnish you forms for filing Proof of Loss. If we do not

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furnish these forms to you within fifteen (15) days after receipt of your notice of claim, you shall be deemed to have complied with the Proof of Loss requirements by submitting written proof covering the occurrence, character and extent of the loss, within the time limit stated in the Proof of Loss section.

Proof of Loss

Written Proof of Loss must be sent to us at the address shown on the preceding page or our Administrator within ninety (90) days after the date of the loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible, but in no event, later than one year from the time proof is otherwise required, except in the absence of legal capacity.

"Proof of Loss" means sufficient information to allow KPIC to decide if a claim is payable under the terms of the Evidence of Coverage. The information needed to make this determination may include but is not limited to: reports of investigations concerning fraud and misrepresentation, necessary consent forms, releases and assignments, medical records, information regarding provider services, information regarding medical necessity or other necessary information requested by KPIC.

Time for Payment of Benefits

In accordance with the terms of your coverage, benefits will be paid immediately upon receipt of proper written Proof of Loss.

Unless the Member has asked us not to do so, KPIC may pay all or any part of the benefits provided by the Evidence of Coverage directly to the service provider. Any such payment made by KPIC in good faith will fully discharge KPIC's obligation to the extent of the payment.

Any benefits for health expenses for covered medical transportation services are payable to the provider of these services. No benefits are payable to the Member to the extent benefits for the same expenses are paid to the provider.

Contested Claims

If KPIC is unable to pay your claim after receiving proper Proof of Loss, KPIC will notify you of any contest to or denial of the claim within thirty (30) working days of the date the Proof of Loss was received by KPIC. The written notice will specify:

- The parts of the claim that are being contested or denied;
- The reasons the claim is being contested or denied; and
- The pertinent provisions of the Evidence of Coverage on which the contest or denial is based.

If the Member is dissatisfied with the result of the review, the Member may request reconsideration. The request must be in writing and filed with KPIC's Administrator at the address specified above.

The request for reconsideration shall be filed in writing within sixty (60) days after the notice of denial is received. A written decision on reconsideration will be issued within sixty (60) days after KPIC's Administrator receives the request for reconsideration, unless the Member is notified that additional time is required, but in no event later than one hundred twenty (120) days from the time KPIC's Administrator receives the request.

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Rights of a Custodial Parent

If the parents of a covered Dependent child are:

- Divorced or legally separated; and
- Subject to the same Order,

The custodial parent will have the rights stated below without the approval of the non-custodial parent. However, for this provision to apply the non-custodial parent must be a Member approved for family health coverage under the Policy, and KPIC must receive:

- A request from the custodial parent who is not a Member under the policy; and
- A copy of the Order.

If all of these conditions have been met, KPIC will:

- Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the Policy;
- Accept claim forms and requests for claim payment from the custodial parent; and
- Make claim payments directly to the custodial parent for claims submitted by the custodial parent, subject to all the provisions stated in the Policy. Payment of claims to the custodial parent, which are made in good faith under this provision, will fully discharge KPIC's obligations under the Policy to the extent of the payment.

KPIC will continue to comply with the terms of the Order until we determine that:

- The Order is no longer valid;
- The Dependent child has become covered under other health insurance or health coverage;
- In the case of employer-provided coverage, the employer has stopped providing family coverage for all employees; or
- The Dependent child is no longer a Member under the Policy.

"Order" means a valid court or administrative order that:

- Determines custody of a minor child; and
- Requires a non-custodial parent to provide the child's medical insurance coverage or to pay any portion of the medical expenses resulting from medical treatment of the child.

Time Limitations

If any time limitation provided in the plan for giving notice of claims, or for bringing any action at law or in equity, is less than that permitted by the applicable law, the time limitation provided in the plan is extended to agree with the minimum permitted by the applicable law.

Benefit Determinations

A Benefit Determination will be made in accordance with the following rules:

SAMPLE

Urgent Claims

We will notify you within twenty-four (24) hours of our decision. We will also notify you within twenty-four (24) hours if we need additional information to determine such claims, or if you or your representative failed to follow proper procedures that would result in a claim Denial. If additional information is requested, you will be allowed forty-eight (48) hours in which to provide such information. We will make a final determination for this type of claim within twenty-four (24) hours following the earlier of: a) receipt of the requested information from you; or b) the end of the period allowed for providing the information. Decisions regarding Urgent Care Claims will be communicated to you by telephone within twenty-four (24) hours. They will be confirmed in writing within three calendar days of the initial decision.

Concurrent Care Claims for Ongoing Course of Treatment

We will make decisions involving an approved ongoing course of treatment, provided over a period of time, sufficiently in advance of limiting or ending treatment, when a course of treatment will be limited or ended early as a result of a concurrent claim review.

Concurrent Care Claims for Additional Treatment

We will make decisions involving a request for additional treatment, when a previously approved course of treatment is about to end, within twenty-four (24) hours following receipt of such a request, provided that you make this type of request at least twenty-four (24) hours prior to the time that treatment is scheduled to end. If the request for concurrent care review is urgent, such request will be handled like any other Urgent Claim.

Non-Urgent Pre-Service Care Claims

We will make decisions within a maximum of fifteen (15) calendar days after receipt of the Pre-certification request. This time period may be extended one time by us, for up to fifteen (15) calendar days, if we determine that an extension is necessary due to matters beyond our control and notify you of the extension within the initial 15-day period. Any such notice will detail the circumstances requiring the extension and the date upon which we expect to render a decision on your Claim for Benefits. If such an extension is necessary due to your failure to submit any necessary information, the notice of extension will describe the required information.

Post-Service Claims

We will adjudicate such claims within an initial period of thirty (30) calendar days. This time period may be extended one time by us, for up to fifteen (15) calendar days, if we determine that an extension is necessary due to matters beyond our control and notify you of the extension within the initial 30-day period. Any such notice will detail the circumstances requiring the extension and the date upon which we expect to render a decision on your Claim for Benefits. If such an extension is necessary due to your failure to submit any necessary information, the notice of extension will describe the required information.

You must respond to requests for additional information within forty-five (45) calendar days or we will make our decision on your Claim for Benefits based upon the information we have available to us at that time. In the case of an Urgent Care Claim, You must respond to our request for information within forty-eight (48) hours.

We will allow you to review the claim file and to present evidence and testimony in support of your claims request.

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We will notify you when we approve or deny a Claim for Benefits. If we deny your Claim for Benefits the notification will include the following information:

- Information sufficient to identify the claims being denied including but not limited to:
    1. The date of service;
    2. The name of the provider; and/or
    3. Claim amount, if applicable.
- The specific reason or reasons for the Denial;
- Reference to the specific provisions in your EOC on which the Denial is based;
- A description of any additional material or information needed for us to reevaluate your Claim for Benefits;
- An explanation of why such material or information is necessary in order for us to reevaluate your Claim;
- A description of the review (appeal) procedures and the time limits applicable to such procedures;
- A statement of your rights under section 502(a) of ERISA following a Denial on your appeal.
- If any internal rule, guideline, protocol or other similar criterion was relied upon in making the Denial, an offer to provide the rule;
- If the Denial was based upon Medical Necessity, experimental treatment or similar exclusions or limitations, an offer to provide the specific basis for the Denial;
- In the case of a Denial, a description of the available appeals process.

The Appeals Process

In order to afford you the opportunity for a full and fair review of a Denial, the Policyholder has designated KPIC as the "named fiduciary" for appeals arising under the EOC. You may appeal an Adverse Benefit Determination (Denial) to us. Such appeals will be subject to the following:

- You may appeal a Denial any time, up to one hundred eighty (180) days following the date you receive a notification of Denial;
- Our review of your appeal will not afford deference to the initial Denial;
- In deciding an appeal of any Denial that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither the person who made the initial Denial that is the subject of the appeal, nor the subordinate of such person.
- In the case of an Urgent Claim, we will provide for an expedited review process. You may request an expedited appeal of a Denial orally or in writing. All necessary information, including our

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approval or Denial of the appeal, will be transmitted by telephone, facsimile, or other available and similarly expeditious method.

As part of the appeals process, we will allow you to review the claim file and to present evidence and testimony in support of your claim.

Pending the outcome of an Appeal, you will continue to receive benefits. Any ongoing course of treatment during the appeals process will not be reduced or terminated without providing you an advance notice and an opportunity for advance review and an opportunity to respond prior to the mailing of such notice.

You must either mail your Appeal to us, or fax your Appeal to us at:

For Pre-Service, Concurrent and Expedited Medical Review Appeals

Permanente Advantage Appeals
8954 Rio San Diego Dr., 4th Floor, Ste 406
San Diego, CA 92108
Telephone number: 1-888-567-6847
Fax number: 1-866-338-0266

For Post Service Appeals

Kaiser Foundation Health Plan
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305-1736
Phone: 1-888-225-7202
Fax: 1-404-949-5001

We will generally notify you of our decision on your appeal within the following time frames:

- For Urgent Claims, we will provide you with our decision within seventy-two (72) hours after we receive your request for an appeal of a Denial.
- For Pre-service Claims, we will provide you with our decision within thirty (30) days after we receive your request for an appeal of a Denial.

  For Post-service Claims, we will provide you with our decision within sixty (60) days after we receive an appeal of a Denial.

Prior to the mailing of any notice required of final internal Adverse Benefit Determination, we will provide you with any new additional evidence considered, relied upon or generated by us and the rationale of our decision. This notice will be sent to you as soon as possible to give you sufficient time and the opportunity to respond prior to the mailing of such notice.

We will notify you when we approve or deny your appeal of Our Denial. If we deny Your appeal, the notification will include the following information:

- Information sufficient to identify the claims being denied including but not limited to:
    1. The date of service;
    2. The name of the provider; and/or

SAMPLE

3. Claim amount if applicable.

- The specific reason or reasons for the Denial;
- Reference to the specific provisions in the EOC on which the Denial was based;
- Your right to obtain reasonable access to, and copies of, all documents, records and other information relevant to your Claim for Benefits;
- An explanation of any procedures for you to follow to request a voluntary level of appeal, if applicable;
- A statement of your rights under section 502(a) of ERISA following a Denial on your appeal;
- If any internal rule, guideline, protocol or other similar criterion was relied upon in making the Denial, an offer to provide the rule, guideline, protocol or similar criterion;
- If the Denial was based upon Medical Necessity, experimental treatment or similar exclusions or limitations, an offer to provide the specific basis for the Denial.

If you are not satisfied with our decision after you have exhausted the appeals process, your remaining remedies may include:

- A voluntary review of your Claim for Benefits by us;
- The right to bring suit in Federal Court under Section 502(a) of ERISA;
- Additional rights under state law, including the right to pursue independent external review when the following has occurred;
    1. Member has completed standard internal appeals process;
    2. Member has not received timely decision from KPIC;
    3. Expedited internal appeals of Adverse Determination has been requested; or
    4. KPIC waives exhaustion requirement.
- Voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency;

If you believe that health care services have been improperly denied, modified, or delayed, you may have the right to an independent medical review. For more information about how to obtain this review, please call KPIC at 1-888-225-7202 (TTY 711) or see below.

The following applies to Options 1, 2 and 3 of your Kaiser Permanente Flexible Choice Plan.

Bureau of Insurance Independent External Appeals

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

- All of the Health Plan's appeal procedures described above have been exhausted;

SAMPLE

- 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
- The Member requested an Expedited Appeal and the Health Plan determined that the standard appeal timeframes should apply; or
- When an Expedited Appeal is reviewed and is denied.

However, a member may request an ER prior to exhausting our internal appeal process if:

- An Adverse Decision 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;
- An Expedited emergency review (ER) for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness denials may be requested simultaneously with an expedited internal review; the Independent Review Organization (IRO) will review and determine if internal appeal should be completed prior to ER;
- 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 the Health Plan waives the exhaustion requirement.

The forms and instructions for filing an ER 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 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
Phone: 1-804 371-9691
Fax: 804-371-9944
Website: www.scc.virginia.gov

The decision resulting from the external review will be binding on both the member and 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 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.

SAMPLE

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
Local: 1-804-371-9032
Toll Free: 1-877-310-6560
Fax: 804-371-9944
E-Mail: ombudsman@scc.virginia.gov

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:
Local: 1-804-367-2106
Toll Free: 1-800-955-1819
Fax No.: 1-804-527-4503

Customer Satisfaction Procedure

In addition, 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 Membership Services Representative located at a Medical Office or by sending a letter to our Member Services Department at the following address:

Kaiser Permanente
Attention: Member Services Department Appeals and Correspondence
2101 East Jefferson St.
Rockville, MD 20852

You or your Authorized Representative will receive a written response to your complaints within 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 (Bureau) at any time.

For information visit the Bureau's website at www.scc.virginia.gov or call the Life and Health Consumer Services Section at (804) 371-9691 or toll- free (877) 310-6560, to discuss your complaint or receive

SAMPLE

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
Fax: (804) 371-9944

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SECTION 6 – TERMINATION OF MEMBERSHIP

Your Group is required to inform the Subscriber of the date your coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. Eastern Standard Time (EST) on the termination date. In addition, Dependents' membership end at the same time as the Subscriber's membership ends.

You will be billed at Non-Member Rates for any Services you receive after your membership terminates. Health Plan, Plan Providers and Participating Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Extension of Benefits" in this "Termination of Membership" section.

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

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who is Eligible" section on the first 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 Health Plan and KPIC to terminate at a time other than the last day of the month. Please check with your Group's benefits administrator to confirm your termination date.

Termination of Group Agreement

If Your Group Agreement with Health Plan and KPIC terminates for any reason, your membership ends on the same date.

Termination for Cause

- By sending written notice to the Subscriber at least thirty-one (31) days before the termination date we may terminate your or your Dependent's membership for cause if You or your Dependent(s) knowingly perform an act or practice that constitutes fraud, which under certain circumstances may include, but is not limited to, presenting a fraudulent prescription or physician order, selling your prescription, or allowing someone else to obtain covered Services using your health plan ID card;
- You or your Dependent(s) make an intentional misrepresentation of material fact in connection with your coverage.

If the fraud or intentional misrepresentation was committed by the Subscriber, we may terminate the memberships of the Subscriber and all Dependents in the Family Unit.

If the fraud or intentional misrepresentation was committed by a Dependent, we may terminate the membership of only that Dependent. We may report any Member fraud to the authorities for prosecution.

Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Premium from your Group. If your Group fails to pay us the appropriate Premium for your Family Unit after a grace period of thirty-one (31) days, we will terminate the memberships of everyone in your Family Unit.

SAMPLE

Rescission for Fraud or Intentional Misrepresentation

A rescission of coverage means that coverage may be legally voided all the way back to the day Health Plan and KPIC began to provide coverage, just as if the coverage never existed. Subject to any applicable state or federal law, if Health Plan and/or KPIC make a determination that a Member performed an act, practice or omission that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Evidence of Coverage, Health Plan and/or KPIC may rescind coverage under this Evidence of Coverage by giving no less than thirty (30) days advance written notice. The notice will contain:

- Clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;
- An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;
- Notice that the Member or the Member's Authorized Representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission;
- A description of the health carrier's internal appeal process for rescissions, including any time limits applicable to those procedures; and
- The date when the advance notice ends and the date back to which the coverage will be rescinded.

The rescission will be effective, on:

- The effective date of coverage, if we relied upon such information to provide coverage; or
- The date the act of fraud or intentional misrepresentation of a material fact occurred, if the fraud or intentional misrepresentation of a material fact was committed after the Effective Date of Your coverage.

Your Premium will be refunded from date of coverage being rescinded.

You or Your Dependent have the right to request an appeal from us for the rescission of coverage. Please refer to Section 5 (Getting Assistance: Claims and Appeal Procedures; and Customer Satisfaction Procedure) section for a detailed discussion of the claims and appeals process.

SAMPLE

Extension of Benefits

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

- If you 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 no longer qualify as being Totally Disabled, or until such time as a succeeding health plan elects to provide coverage to you without limitations as to the disabling condition, whichever comes first.

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

Upon termination of the Extension of Benefits, the Member will have the right to continue his or her

c overage as described below.

Limitation(s):

The "Extension of Benefits" section listed above does not apply to Members' whose coverage ends because of failure to pay Premium; or Members' whose coverage ends because of fraud or material misrepresentation by the Member.

For the continued health coverage of disabled Members that exceeds eighteen (18) months, Health Plan and KPIC may increase the Premium it charges by as much as fifty percent (50%). The employer may require the disabled Members to pay all or part of that total increased Premium.

In no event will continued health coverage extend beyond the first month to begin more than thirty (30) days after Social Security determines that the Member is no longer disabled. The Member must notify the employer within thirty (30) days of the date of such a Social Security determination.

Discontinuation of a Product or All Products

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

Continuation of Group Coverage under Federal Law (COBRA)

You and/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 Region 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.

If your Group is not eligible for COBRA, you and/or your Dependents may be eligible for continuation of coverage under the existing Group coverage for a period of at least twelve (12) months immediately following the date of termination of your eligibility for coverage under this Evidence of Coverage. Continuation of coverage for twelve (12) months is not applicable if the Group is required by federal law to provide for continuation of coverage under COBRA. If applicable, this coverage shall be provided without additional evidence of insurability subject to the following requirements:

- The application and payment for the extended coverage are made to the Group within thirty-one (31) days after issuance of notification of your continued rights, but in no event beyond the 60 day period following the date of termination of eligibility;
- Each Premium for the extended coverage is timely paid to the Group on a monthly basis for the 12-month period; and
- The Premium for continuing the coverage shall be at the Health Plan's current rate applicable to this Evidence of Coverage plus any applicable administrative fee not to exceed two percent (2%) percent of the current rate.

The Group Administrator shall provide you or other persons covered under this Evidence of Coverage written notice of the availability of the option chosen and the procedures and timeframes for obtaining continuation of continued of this Evidence of Coverage. This notice shall be provided within fourteen (14)

SAMPLE

days of the Group Administrator's knowledge of your or other your Dependent's loss of eligibility under this Evidence of Coverage.

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 Region 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.

SAMPLE

SECTION 7 – MISCELLANEOUS PROVISIONS

Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this EOC. For purposes of this EOC, KPIC has designated Health Plan as its administrator.

Advance Directives

The following legal forms help you control the kind of health care you will receive if you become very ill or unconscious:

- *Durable Power of Attorney for Health Care* 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.
- *A 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).

Amendment of Agreement

Your Group's Agreement with Health Plan and KPIC will change periodically. If these changes affect this EOC, a revised EOC will be issued to you.

No agent or other person except an officer of Health Plan or an officer of KPIC has authority to do any of the following: (1) waive any condition or restriction of this Agreement; (2) extend the time for making Premium; or (3) bind Health Plan and/or KPIC by making any promises or representations or by giving or receiving any information.

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

Assignment

Except as provided below for ambulance Services, 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.

For ambulance Services, any person providing such Services to a Member under this EOC may receive reimbursement for such Services directly from us upon submission of Assignment of benefits within six months from the date of Service.

If you receive a payment for covered Services received from a Non-Participating Provider for which you have not already made payment, you are responsible for applying that Plan payment to the claim from that Non-Participating Provider.

Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers or Participating Providers, each party

SAMPLE

will bear its own attorneys' fees and other expenses.

Contracts with Plan Providers

Health Plan and Plan Providers are independent contractors. Your Plan Providers are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee for service, and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please refer to your Provider Directory or call our Member Services Call Center Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from non-Plan Providers, except for Emergency Services or authorized referrals.

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 Co-payments, Coinsurance or Deductibles for a period at least 90 days from the date we have notified you of the Plan Provider's termination.

Cost-sharing and Balance Billing Protections for Services Provided Based on Reliance on Incorrect Provider Network Information

If a Member is furnished, by a Non-Participating Provider, an item or service that would otherwise be covered if provided by a Participating Provider, and the Member relied on a database, provider directory, or information regarding the provider's network status provided by Us through a telephone call or electronic, web-based, or Internet-based means which incorrectly indicated that the provider was a Participating Provider for the furnishing of such item or service, then the following apply:

1. The Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement for such item or service furnished by a Non-Participating Provider is the same as the Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement listed in the Group Policy for the item or service when provided by a Participating Provider; and
2. Any Cost-sharing payments made with respect to the item or service will be counted toward any applicable in-network Deductible and in-network Out-of-Pocket Maximum.
3. The member will not be liable for an amount that exceeds the Cost-sharing that would have applied to the member if the provider was a Participating Provider.

Governing Law

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

Groups and Members not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan or KPIC.

SAMPLE

Incontestability

Any statement made by the Policyholder or a Member in applying for insurance under This Plan will be considered a representation and not a warranty. After This Plan has been in force for two years, its validity cannot be contested except for nonpayment of Premiums. No statement made by any person insured under the policy relating to his insurability or the insurability of his insured Dependents shall be used in contesting the validity of the insurance with respect to which such statement was made: 1) after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and 2) unless the statement is contained in a writing and signed by the Member.

Legal Action

No legal action may be brought to recover on this policy before 60 days from the date written Proof of Loss has been given to us as required under the Proof of Loss section. No such action may be brought more than three (3) years after the date Proof of Loss is given to us.

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or Visit limits) on mental health and substance use disorder benefits with day or Visit limits on medical and surgical benefits. In general, Group health plans offering mental health and substance use disorder benefits cannot set day/Visit limits on mental health or substance use disorder benefits that are lower than any such day or Visit limits for medical and surgical benefits. A plan that does not impose day or Visit limits on medical and surgical benefits may not impose such day or Visit limits on mental health and substance use disorder benefits offered under the Plan. Also, the Plan may not impose Deductibles, Co-payment, Coinsurance, and out of pocket expenses on mental health and substance use disorder benefits that are more restrictive than Deductibles, Co-payment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Member Rights and Responsibilities

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.

MEMBER RIGHTS

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 your 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

SAMPLE

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, 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.

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 HIPAA criteria 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 your records are released, unless otherwise permitted by law.

2. Receive information about Kaiser Permanente and your plan. This includes your 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.

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 your 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.

SAMPLE

b. Have your medical care, medical records and protected health information 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, gender identification, 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 or physical disability you may have.

f. Request interpreter services in your primary language at no charge.

g. Receive health care in facilities that are environmentally safe and accessible to all.

MEMBER RESPONSIBILITIES

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

1. **Promote your own good health:**

   a. Be active in your health care and engage in healthy habits.

   b. Select a Primary Care Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics, or Family Practice as your Primary Care 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 physician or health care professional recommends.

   g. Schedule the health care appointments your physician or health care professional recommends.

   h. Keep scheduled appointments or cancel appointments with as much notice as possible.

2. **Know and understand your plan and benefits:**

   a. Read about your health care benefits in this EOC and become familiar with them. Call us when you have questions or concerns.

   b. Pay your plan Premiums and bring payment with you when your Visit requires a Co-payment, Coinsurance or Deductible.

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

   a. Extend the same courtesy and respect to others that you expect when seeking health care Services.

SAMPLE

b. Assure a safe environment for other Members, staff, and physicians by not threatening or harming others.

c. Let us know if you have any questions, concerns, problems or suggestions.

Misstatement of Age

If the age of any person insured under This Plan has been misstated: 1) Premiums shall be adjusted to correspond to his or her true age; and 2) if benefits are affected by a change in age, benefits will be corrected accordingly (in which case the Premium adjustment will take the correction into account).

Money Payable

All sums payable by or to Health Plan, KPIC or its Administrator must be paid in the lawful currency of the United States.

Named Fiduciary

Under our Agreement with your Group, we have assumed the role of a "named fiduciary," a party responsible for determining whether you are entitled to benefits under this EOC. Also, as a named fiduciary, we have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC.

Nondiscrimination

We do not discriminate in our employment practices on the basis of age, race, color, national origin, religion, sex, sexual orientation, gender identification, status as a transgender individual, or physical, development or intellectual disability.

Notice of Non-Grandfathered Coverage

Health Plan and KPIC believe this coverage is a "non-grandfathered health plan'' under the Patient Protection and Affordable Care Act (PPACA).

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 call our Member Services Call Center Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1800-777-7902 or 711 (TTY) as soon as possible to give us their new address.

No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Overpayment Recovery (Option 1)

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services, to the extent that if we have made payment to a health care provider, we may only retroactively deny reimbursement to the health care provider during the 6-month period after the date we paid the claim submitted by the health care provider.

SAMPLE

Overpayment Recovery (Options 2 and 3)

KPIC will not withhold any portion of a claim payment on the basis that the sum withheld is an adjustment or correction for an overpayment made on a prior claim unless:

- KPIC's files contain clear, documented evidence of an overpayment and written authorization from the claimant or assignee, if applicable, permitting such withholding procedure; or
- KPIC's files contain clear, documented evidence of all of the following:
    1. The overpayment was erroneous under the provisions of the Policy;
    2. The error which resulted in the payment is not a mistake of the law;
    3. KPIC notifies the claimant within 6 months of the date of the error, except that in instances of errors prompted by representations or nondisclosure of claimants or third parties, KPIC notifies the claimant within 15 calendar days after the date of discovery of such error. For the purpose of this provision, the date of the error is the day on which the draft for benefits is issued; and
    4. Such notice states clearly the cause of the error and the amount of the overpayment; however,
    5. The procedure set forth above will not be used if the overpayment is the subject of a reasonable dispute as to facts.

The overpayment will only be recovered from the person or entity that was overpaid.

With each payment, KPIC will provide to the claimant and assignee, if any, an explanation of benefits which shall include, if applicable, the provider's name or Service covered, dates of Service, and a clear explanation of the computation of benefits.

Physical Examination and Autopsy

Health Plan and/or KPIC, at their own expense, shall have the right and opportunity to examine the person of any individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

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 care Services you receive, or payment for your health care. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting 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 your (or your representative's) written authorization, except as described in our Notice of Privacy Practices (see below). 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

SAMPLE

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 on our Web site at www.kp.org.

Time Effective

The effective time for any dates used is 12:01 AM at the address of the Policyholder.

SAMPLE

DEFINITIONS

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

Administrator: For Options 2 and 3, means Kaiser Permanente Claims Administration, PO Box 371860, Denver CO, 80237-9998 and refers to the administrator for KPIC for this Evidence of Coverage only. KPIC reserves the right to change the Administrator at any time during the term of this Evidence of Coverage without prior notice. Neither KPIC nor Health Plan is the administrator of your employee benefit plan as that term is defined under Title I of the l Employee Retirement Income Security Act of 1974 (ERISA), as then constituted or later amended**.**

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 (AC): means either:

- Services provided by Health Plan or Medical Group: The amount in the Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members;
- Items obtained at a Plan Pharmacy. For items covered under the Outpatient Prescription Drug Benefit appendix and:
  - 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.
  - 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;
- Emergency Services from a Non-Plan Provider, including Post-Stabilization Care that constitutes Emergency Services under federal law, the Out-of-Network Rate.
- For Services received from Plan Providers, the amount the Plan Provider has agreed to accept as payment;
- For all other Services: The amount:
  - The provider has contracted or otherwise agreed to accept;
  - The provider has negotiated with the Health Plan;
  - 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;
  - The Fee Schedule, that providers have agreed to accept as determining payment for Services, states; or
  - Health Plan pays for those Services.
- Emergency Services performed by a non-Plan provider in a non-Plan Facility and for non-emergency Surgical or Ancillary Services provided by a non-Plan provider at a Plan Facility:
  - The allowed and median billed charge amounts shall base payments for the same or similar Services provided in a similar geographic area.
  - Under Virginia Law, a non-Plan Provider shall not balance bill for (i) Emergency Services provided by a non-Plan Provider or (ii) non-Emergency Services provided at a Plan Facility or a

SAMPLE

non-Plan Facility if the non-Emergency Services involve Surgical or Ancillary Services provided by a non-Plan Provider.

Assignment: You may assign benefits, in writing, to a Non-Participating Provider from whom you receive covered Services. A copy of this written assignment must accompany a claim for payment submitted by the Non-Participating Provider. The claim for payment must be submitted to the Health Plan within six months from the date of service.

If you receive a payment for covered Services received from a Non-Participating Provider for which you have not already made payment, you are responsible for applying that Plan payment to the claim from that Non-Participating Provider.

For ambulance Services, any person providing such Services to a Member under this Agreement may receive reimbursement for such Services directly from us upon submission of Assignment of benefits within six months from the date of Service.

Authorized Representative: An individual authorized under State law to provide consent on behalf of a patient, provided that the individual is not a provider affiliated with the facility or employee of the Facility, unless such provider or employee is a family member of the patient.

Benefit Maximum (for Options 2 and 3): means a total amount of benefits that will be paid by KPIC for a specified type of covered charges incurred during a given period of time. Applicable Benefit Maximums are contained within the text of this EOC and/or are shown in the ***Appendix – Summary of Cost Shares***. When a Benefit Maximum is reached, additional Expenses Incurred for the specific benefit, or class of benefits, do not qualify as covered charges and will not count toward satisfaction of any Deductible or Out-of-Pocket Maximum.

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

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

- Is in active course of treatment with the terminated provider prior to the notice of termination.
- Is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;
- Is undergoing a course of institutional or inpatient care from the provider or facility;
- 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;
- Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- Is in active course of treatment with the terminated provider prior to the notice of termination except for when the provider is terminated for cause; 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.

Contract Year: A consecutive 12-month period during which Health Plan and/or KPIC provides coverage for benefits.

Co-payment: The predetermined dollar amount that you or a Dependent must pay when you receive a covered Service from Plan Providers or Participating Providers. Co-payments are applied on a per Visit or per Service basis. Co-payment amounts are shown in the ***Appendix – Summary of Cost Shares*** section. Co-payments do not count toward satisfaction of Individual or Family Deductibles if applicable.

SAMPLE

Cost Shares: The Deductible (including any benefit-specific Deductible), Co-payment or Coinsurance a Member is required to pay for covered Services, as shown in the ***Appendix – Summary of Cost Shares***.

Cost Sharing: Any expenditure required by or on behalf of a Member with respect to Essential Health Benefits. Such term includes Deductibles, Coinsurance, Co-payments, 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.

Deductible: The amount of Allowable Charges that must be incurred by an individual or a family per year before benefits become payable. Please refer to the ***Appendix – of Summary of Cost Shares*** section for the Services that are subject to Deductible and the amount of the Deductible. Benefits are not covered until the Deductible has been met.
For Options 2 and 3 only: Charges in excess of the Allowable Charge, and additional expenses a Member must pay because Pre-certification was not obtained, will not be applied toward satisfying 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 "Who Is Eligible".)

Emergency Facility (for Options 2 and 3): means an emergency department of a hospital, or an Independent Freestanding Emergency Department where Emergency Services are provided. Emergency Facility includes a hospital, regardless of the department of the hospital, in which items or Services with respect to Emergency Services are provided by a Non-Participating Provider or non-participating Emergency Facility: after the individual is Stabilized; and as part of outpatient observation or an inpatient or outpatient stay with respect to the Visit in which other Emergency Services are furnished.

Emergency Medical Condition: means, regardless of the final diagnosis rendered to a Member, a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so 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 Member;
2. Danger of serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

1. An appropriate medical screening examination, as required federal under the Emergency Medical Treatment and Active Labor Act (EMTALA), section 1867 of the Social Security Act, that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Surgical or 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

SAMPLE

3. Except as further described in this paragraph 3, covered Services, also referred to as Post-Stabilization Care, that are furnished by a Non-Plan Provider after you are Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Visit in which the Emergency Services are furnished:
    a. When, under applicable federal law, the covered Services described in item #3 are not included as Emergency Services if all of the following conditions are met:
        i. The attending emergency physician or Treating Provider determines that the Member is able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Hospital or Plan Facility located within a reasonable travel distance, taking into account the Member's medical condition; and
        ii. The Member, or an Authorized Representative of such Member, is in a condition to receive the information in the consent as described in item #3, as determined by the attending emergency physician or Treating Provider using appropriate medical judgment, and to provide informed consent in accordance with applicable State law; or
    b. When the covered Services are rendered by a Health Care Provider who is subject to state law prohibiting balance billing (§19-710(p) of the Health-General Article).

Encounter (for Option 1): An ambulance encounter begins at the point of origin where the Member is picked up, ending at the point of destination where the Member is dropped off.

Essential Health Benefits: Services that are defined by federal law and further defined by the Secretary of the United States Department of Health and Human Services that 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.

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.

SAMPLE

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

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

Group: A specific organization such as an employer or an association including a labor union, which shall have a constitution and bylaws and which has been organized and maintained in good faith for purposes other than that of obtaining insurance. The specific organization has entered into a contractual arrangement with Health Plan and KPIC to provide benefits for eligible persons.

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

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

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.

Injury: An accidental bodily injury sustained by a Member.

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

Maximum Allowable Charge (for Options 2 and 3): means the lesser of:

1. The Usual, Customary and Reasonable Charge (UCR):

   The UCR is the charge generally made by a Physician or other provider of covered Services. The charge cannot exceed the general level of charge made by other providers within an area in which the charge is incurred for Injury or Sickness comparable in severity and nature to the Injury or Sickness being treated. The general level of charges is determined in accord with schedules on file with the authorized Administrator. For charges not listed in the schedules, KPIC will establish the UCR. KPIC reserves the right to periodically adjust the charges listed in the schedules.

   The term "area" as it would apply to any particular Service, medicine or supply means a city or such greater area as is necessary to obtain a representative cross section of a particular level of charges.

   If the Maximum Allowable Charge is the UCR, the Member will be responsible for payment to the provider of any amount in excess of the UCR when the UCR is less than the actual billed charges. Such difference will not apply towards satisfaction of the Out-of-Pocket Maximum nor any Deductible under this Evidence of Coverage.

2. The Negotiated Rate:

   KPIC or its authorized Administrator may have an arrangement with the provider or supplier of covered Services under which discounts have been negotiated for certain services or supplies. Any such discount is referred to as the Negotiated Rate.

   If there is a Negotiated Rate, the provider will accept the Negotiated Rate as payment in full for Covered Services, subject to payment of Deductibles and Coinsurance by the Member.

3. The Actual Billed Charge for the covered Service:

   The charges actually billed by the provider for covered Services.

SAMPLE

IMPORTANT: Notwithstanding the foregoing, the Maximum Allowable Charge for a Hospital or other licensed medical facility Confinement may not exceed:

Hospital Routine Care	
Daily Limit:	the Hospital's average semi-private room rate
Intensive Care	
Daily Limit:	the Hospital's average Intensive Care Unit room rate
Other licensed medical facility	

Daily Limit:	the facility's average semi-private room rate

Exception for Emergency Services rendered by a Non-Participating Provider and non-Emergency surgical or Ancillary Services rendered at a Participating Provider facility by a Non-Participating Provider:

Charges for Emergency Services are processed under the in-network (Option 1) benefit level. For non-Emergency surgical or Ancillary Services, the Maximum Allowable Charge will be a commercially reasonable amount based on payments for the same or similar services provided in a similar geographic area. Under Virginia law a Non-Participating Provider shall not balance bill you for: (i) Emergency Services provided by a Non-Participating Provider; or (ii) non-Emergency Services provided at a Participating Facility by a Non-Participating Provider if the non-Emergency Services involve surgical or Ancillary Services.

KPIC may deduct from its payment: (1) any Participating Provider Co-payment and/or Coinsurance amounts that would have been paid had the non-Emergency surgical or Ancillary Service been rendered by a Participating Provider; and/or (2) any Non-Participating Provider Deductible amounts.

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

Medically Necessary: Services that are all of the following: (i) medically required to prevent, diagnose or treat your condition or clinical symptoms; (ii) in accordance with generally accepted standards of medical practice; (iii) not solely for the convenience of you, your family and /or you provider; and (iv) the most appropriate level of Service that can safely be provided to you. 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. Unless otherwise required by law, we decide if a Service (described in this Section 3) is Medically Necessary and our decision is final and conclusive subject to your right to appeal as set forth in Section 5.

Medicare: The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended. It is a federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

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

Month: A period of time: 1) beginning with the date stated in this Evidence of Coverage; and 2) terminating on the same date of the succeeding calendar month. If the succeeding calendar month has no such date, the last day of the month will be used.

Non-Participating Emergency Facility (for Options 2 and 3): means an Emergency Facility that has not contracted directly with Us or indirectly, such as through an entity contracting on behalf of us to provide health care services to our members.

Non-Participating Provider (for Options 2 and 3): means a physician or Other Health Care Provider that has not contracted directly with us or an entity contracting on behalf of Us to provide health care services to our members.

SAMPLE

Other Health Care Provider (for Options 2 and 3): means any person who is licensed or certified under applicable State law to provide health care services, and is acting within the scope of practice of that provider's license or certification, but does not include a provider of Air Ambulance Services.

Out-of-Network Rate (for Options 2 and 3): means with respect to an item or service furnished by a Non-Participating Provider, Non-Participating Emergency Facility, or Non-Participating Provider of Air Ambulance Services:

1. In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to the plan/carrier, Non-Participating Provider/Non-Participating Emergency Facility, and item/service, the amount that the State approves under the All-Payer Model Agreement for the item or service.
2. If there is no such All-Payer Model Agreement applicable to the item or service, but a specified State law is in effect and applicable, the amount for the item or service determined in accordance with such specified State law.
3. If there is no such All-Payer Model Agreement or specified State law applicable to the item or service, an amount agreed upon by us and the Non-Participating Provider or Non-Participating Emergency Facility.
4. If none of the three conditions above apply, an amount determined by a certified independent dispute resolution (IDR) entity under the IDR process described in section 2799A–1(c) or 2799A–2(b) of the federal Public Health Service Act, as applicable.

Out-of-Plan: Those benefits underwritten by KPIC and set forth in this Evidence of Coverage. Unless specifically stated otherwise in this Evidence of Coverage, KPIC will not pay for services arranged, provided or reimbursed under Health Plan's In-Plan coverage.

Participating Emergency Facility (for Options 2 and 3): means any Emergency Facility that has contracted directly with us or an entity contracting on behalf of us to provide health care services to our members. A single case agreement between an Emergency Facility and us that is used to address unique situations in which a Member requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition and is limited to the parties to the agreement.

Participating Facility (for Options 2 and 3): means a health care facility that has contracted directly with us or an entity contracting on behalf of us to provide health care services to our members. A single case agreement between a health care facility and us that is used to address unique situations in which a Member requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition and is limited to the parties to the agreement. Additionally, for purposes of this definition and in the context of non-Emergency Services, "health care facility" includes a hospital (as defined in section 1861(e) of the Social Security Act); a hospital outpatient department; a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act; and 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 centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

SAMPLE

Participating Provider: Health care providers including Primary Care Physicians, Specialty Care, Hospital, Participating Pharmacy, laboratory, or other similar entities operating under a written contract with a Participating Provider Organization (PPO), KPIC or its Administrator to deliver medical services to Members. Please consult your Group administrator for a list of Participating Providers or Visit MultiPlan/PHCS' website at www.multiplan.com/kpmas. You may also contact Member Services at the number shown on Your ID card.

Participating Provider Organization (PPO): An organization under a written contract with KPIC or its Administrator in which Members have access to a network of Participating Providers. Please refer to your ***Appendix – Summary of Cost Shares*** to determine if a PPO is applicable to your plan.

Patient Protection and Affordable Care Act (PPACA): Title XXVII of the Public Health Service Act (PHS), as then constituted or later amended.

Percentage Payable (Options 2 and 3): That percentage of covered charges payable by KPIC. The Percentage Payable and the covered Service to which it applies is set forth in the ***Appendix – Summary of Cost Shares.*** The Percentage Payable is applied against the Maximum Allowable Charge for covered Services to calculate the benefit payable under this Evidence of Coverage.

Physician: A health practitioner who is duly licensed as such in the state in which the treatment is rendered. He or she must be practicing within the scope of that license. The term does not include a practitioner who is defined elsewhere in this Definitions section.

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

Plan Facility: A Plan Medical Center, a Plan Hospital or another freestanding Facility including licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings that are (i) operated by us or contracts, directly or indirectly, to provide Services and supplies to Members, and (ii) included in your Signature care delivery system.

Plan Hospital: A hospital that (i) contracts, directly or indirectly, to provide inpatient and/or outpatient Services to Members and (ii) is included in your Signature care delivery system.

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 nurse practitioners, advanced practice registered nurse (APRN); and physician assistants employed by us to provide primary care, specialty care, and ancillary care Services to Members.

Plan Pharmacy: Any pharmacy that:

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

Plan Physician: Any licensed physician who is an employee of Medical Group, or any licensed physician (except for those physicians who contract only, directly or indirectly, to provide Services upon referral) who (1) contracts, directly or indirectly, to provide Services and supplies to Members and (ii) is included in your Signature care delivery system.

Plan Provider: A Plan Physician, or Other Health Care Provider including but not limited to a non-physician specialist, and Plan Facility that (i) is employed by or operated by an entity that participates in

SAMPLE

the Kaiser Permanente Medical Care Program, or (ii) contracts, directly or indirectly, with an entity that participates in the Kaiser Permanente Medical Care Program.

Policy Year: A period of time: 1) beginning with this Evidence of Coverage's Effective Date of any year; and 2) terminating, unless otherwise noted on this Evidence of Coverage, on the same date shown on this Evidence of Coverage. If this Evidence of Coverage's Effective Date is February 29, such date will be considered to be February 28 in any year having no such date.

Post-Stabilization Care (for Option 1): 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.

Premium: Periodic membership charges paid by Group.

Prior Authorization (for Option 1): 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.

Qualifying Payment Amount (for Option 1): The amount calculated using the methodology described in federal regulation (45 C.F.R. § 149.140(c)), which is based on the median contracted rate for all individual plans issued by Health Plan for the same or similar Service that is:

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

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

Qualifying Payment Amount (for Options 2 and 3): means the amount calculated using the methodology described in 45 C.F.R. § 149.140(c), which is based on the median contracted rate for all plans offered by the carrier in the same insurance market for the same or similar item or service that is: provided by a provider in the same or similar specialty or facility of the same or similar facility type; and provided in the geographic region in which the item or service is furnished. The median contracted rate is subject to additional adjustments specified in federal regulations.

Recognized Amount (for Options 2 and 3): means with respect to an item or service furnished by a Non-Participating Provider or Non-Participating Emergency Facility, an amount that is determined as follows:

1. In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to the plan/carrier, Non-Participating Provider/Non-Participating Emergency Facility, and item/service, the amount that the State approves under the All-Payer Model Agreement for the item or service. .

2. If there is no such All-Payer Model Agreement applicable to the item or service, in a State that has in effect a specified State law, the amount for the item or service determined in accordance with such specified State law.

3. If neither an All-Payer Model Agreement or a specified State law apply to the item or service, the lesser of: the amount billed by the Non-Participating Provider or Non-Participating Emergency Facility, or the Qualifying Payment Amount.

SAMPLE

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

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

Sickness: Illness or a disease of a Member. Sickness includes congenital defects or birth abnormalities and pregnancy.

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 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest Facility, or Facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

Small Employer: An employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the contract year.

Spouse: The person to whom you are legally married under applicable law.

Stabilize: With respect to an Emergency Medical Condition, to provide such medical treatment as may be 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 individual from a Facility, or, with respect to a pregnant woman, that the woman has delivered, including the placenta.

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status (unless coverage is provided under a continuation of coverage provision) and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who is Eligible" in the "Eligibility and Enrollment" section).

Surgical or Ancillary Service: Professional Services, including surgery, anesthesiology, pathology, radiology, or hospitalist Services and laboratory Services.

Surrogacy Arrangement: An arrangement in which a woman (the surrogate) agrees to become pregnant and surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate.

Treating Provider: A physician or Other Health Care Provider who has evaluated the Member's Emergency Medical Condition.

SAMPLE

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 52 weeks of the disability. After the first 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.

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.

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

SAMPLE

SECTION A. OUTPATIENT PRESCRIPTION DRUG BENEFIT

DEFINITIONS

Allowable Charge: Has the same meaning as defined in Definitions section in your Group Evidence of Coverage.

Brand Name Drug: A prescription drug that has been patented and is produced by only one manufacturer.

Biosimilar: FDA-approved biologics that are highly similar to a brand biologic product.

Coinsurance: A percentage of the Allowable Charge that you must pay for each prescription or prescription refill.

Complex or Chronic Medical Condition: A physical, behavioral, or developmental condition that: (1) may have no known cure; (2) is progressive; or (3) can be debilitating or fatal if left untreated or undertreated. Complex or Chronic Medical Condition includes, but is not limited to: Multiple Sclerosis, Hepatitis C, and Rheumatoid Arthritis.

Contraceptive drug: A drug or device that is approved by the FDA for use as a contraceptive and requires a prescription.

Co-payment: The specific dollar amount that you must pay for each prescription or prescription refill.

Food & Drug Administration (FDA): The United States Food and Drug Administration.

Formulary: A list of prescription drugs covered by this Plan.

Generic Drug: A prescription drug that does not bear the trademark of a specific manufacturer. It is chemically the same as a Brand Name Drug.

Limited Distribution Drug (LDD): Prescription drug that is limited in distribution by the manufacturer or FDA.

Mail Service Delivery Program: A program operated or arranged by Health Plan that distributes prescription drugs to Members via mail. Some medications are not eligible for the Mail Service Delivery Program. These may include, but are not limited to, drugs that are time or temperature sensitive, drugs that cannot legally be sent by U.S. mail, and drugs that require professional administration or observation. The Mail Service Delivery Program can mail to addresses in MD, VA, DC and certain locations outside the Service Area.

Maintenance Medications: A covered drug anticipated to be required for six months or more to treat a chronic condition.

Medical Literature: Scientific studies published in a peer-reviewed national professional medical journal.

Non-Plan Pharmacy: A pharmacy that has not contracted with Health Plan, or Health Plan's agent, to provide pharmacy services.

Non-Preferred Drug: Includes all other Generic and Brand Name Drugs on Tier 3.

Participating Pharmacy: A pharmacy that has a Participating Pharmacy agreement in effect with KPIC or its Administrator at the time services are rendered. Please consult with your Group administrator for a

SAMPLE

list of Participating Pharmacies, or visit the company's web site at: www.MedImpact.com.

Plan Pharmacy: A pharmacy that is owned and operated by Health Plan.

Preferred Drug: Generic or Brand Name Drug that is on the Formulary on Tier 1 or Tier 2.

Prescription Drug (Rx) Deductible: The amount, based on Allowable Charge, you must pay in a calendar year for covered Brand Name Drugs before you may purchase covered Brand Name Drugs for the rest of the calendar year, subject to the Co-payment or Coinsurance listed in the ***Appendix – Summary of Cost Shares***, under Co-payment/Coinsurance.

Rare Medical Condition: A disease or condition that affects 200,000 individuals in the United States or approximately 1 in 1,500 individuals worldwide. Rare Medical Condition includes, but is not limited to: Cystic Fibrosis, Hemophilia, and Multiple Myeloma.

Specialty Drugs: A prescription drug that:

1. Is prescribed for an individual with a Complex or Chronic Medical Condition, or a Rare Medical Condition;
2. Costs $600 or more for up to a thirty (30)-day supply;
3. Is identified as a specialty drug by the Health Plan Pharmacy and Therapeutics Committee;
4. Is subject to dispensing limitations set by the Health Plan Pharmacy and Therapeutics Committee in accordance with therapeutic guidelines based on Medical Literature and research.

Standard Manufacturer's Package Size: The volume or quantity of a drug or medication that is placed in a receptacle by the maker/distributor of the drug or medication, and is intended by the maker/distributor to be distributed in that volume or quantity.

Standard Reference Compendia: Any authoritative compendia as recognized periodically by the federal Secretary of Health and Human Services or the Commissioner.

Tobacco Cessation Drugs: Over-the-Counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.

SAMPLE

Option 1 (HMO)

For Option 1 of your Flexible Choice Plan, Health Plan will provide coverage for prescription drugs as follows:

Except as provided in the Limitations and Exclusions sections below, we cover drugs described below when prescribed by a Plan Physician, a non-Plan Physician to whom you have an approved referral, or a dentist. Each prescription refill is subject to the same conditions as the original prescription. A Plan Provider prescribes drugs in accordance with Health Plan's Formulary. If the price of the drug is less than the Co-payment, you will pay the price of the drug. You must obtain covered drugs from a Plan Pharmacy. You may also obtain prescription drugs using our Mail Service Delivery Program; ask for details at a Plan Pharmacy.

We cover the following prescription drugs:

- FDA-approved drugs for which a prescription is required by law.
- Compounded preparations that contain at least one ingredient requiring a prescription.

- Insulin including self-injected insulin and its administration.
- Self-administered injectable drugs.
- Flu shots and their administration.
- Injectable drugs and drugs administered in an outpatient setting, including injections administered at authorized pharmacies.
- Oral chemotherapy drugs, including chemical or biological antineoplastic agents.
- inpatient or outpatient (including home visits) visit.
- Drugs for the treatment of intractable cancer pain.
- Drugs that are FDA-approved for use as contraceptives and diaphragms at no cost. For coverage of other types of contraception, including contraceptive injections, implants and devices, refer to ***Family Planning Services in Section 3 - Benefits*** - of this Group Evidence of Coverage.
- Off label use of drugs when a drug is recognized in Standard Reference Compendia or certain Medical Literature as appropriate in the treatment of the diagnosed condition.
- Non-prescription drugs when they are prescribed by a Plan Provider and are listed on the Formulary.
- Growth hormone therapy (GHT) for treatment of children under age 18 with a growth hormone deficiency; or when prescribed by a Plan Physician, pursuant to clinical guidelines for adults.
- Limited Distribution Drugs (LDD) Regardless of where they are purchased, LDD's will be covered on the same basis as if they were purchased at a Plan Pharmacy.
- Any prescription drug approved by the FDA as an aid for the cessation of the use of tobacco products. Tobacco products include cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco, and candy-like products that contain tobacco. Smoking cessation products and over the counter nicotine replacement products (limited to nicotine patches and gum) when obtained with a Prescription will be covered under the "Preventive Care" benefit.

SAMPLE

In the following circumstances, you can obtain an additional 30-day supply from your pharmacist:

- You've lost your medication;
- Your medication was stolen; or
- Your physician increases the amount of your dosage.

The Health Plan Pharmacy and Therapeutics Committee sets dispensing limitations in accordance with therapeutic guidelines based on the Medical Literature, Standard Reference Compendia and research. The Committee also meets periodically to consider adding and removing prescribed drugs on the Formulary.

Certain covered outpatient prescription drugs may be subject to utilization management such as Prior Authorization, step therapy and other requirements. A list of drugs subject to utilization management is available to you upon request.

If you would like information about whether a particular drug is included in our Formulary, please visit us

on line at:

https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/mas/marketplace-formulary-mas-en-2023.pdf

Or call the Member Services Monday through Friday from 7:30 a.m. until 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or TTY is 711.

Where to Purchase Covered Drugs

Except for Emergency Services and Urgent Care Services, you must obtain prescribed drugs from a Plan Pharmacy, a Participating Plan Pharmacy, or through Health Plan's Mail Service Delivery Program subject to the Cost Shares listed below under "Copayment/Coinsurance." Most non-refrigerated prescription medications ordered through the Health Plan's Mail Service Delivery Program can be delivered to addresses in MD, VA and D.C., and certain locations outside the Service Area.

Members may obtain prescribed drugs and accessories from either a Plan Pharmacy and a Non-Plan Pharmacy or its intermediary that has previously notified Health Plan, by facsimile or otherwise, of its agreement to accept as payment in full reimbursement for its Services at rates applicable to Plan Network Pharmacies, including any Rx Coinsurance consistently imposed by the Plan, as payment in full.

Services of Non-Plan Pharmacies

Notwithstanding any provision in this EOC to the contrary, you have coverage for outpatient prescription drug services provided to you by a Non-Plan Pharmacy that has previously notified Health Plan of its agreement to accept reimbursement for its services at rates applicable to our Health Plan Pharmacy network providers. This shall include any applicable Co-payment, Coinsurance and/or Deductible (if any) amounts as payment in full, to the same extent as coverage for outpatient prescription drug services provided to you by Plan Pharmacies participating in our pharmacy network. Note, however, that this paragraph shall not apply to any pharmacy which does not execute a participating pharmacy agreement with Health Plan or its designee within 30 days of being requested to do so in writing by Health Plan, unless and until the pharmacy executes and delivers the agreement.

If you have a prescription filled at a Non-Plan Pharmacy, you must complete and submit a claim form. Reimbursement will be based on what a Plan Pharmacy would receive had the prescription been filled at a Plan Pharmacy. If you have questions or need a claim form, call Member Services or visit our website at **www.kp.org**. This provision does not apply when prescription drugs are purchased from a Non-Plan Pharmacy that has agreed to accept reimbursement for its services at rates applicable to a Plan Pharmacy. In this case you are not required to submit a claim for reimbursement.

Generic and Preferred Drug Requirements

Generic vs. Brand Name Drugs

We cover Generic and Brand Name Drugs, including those for Specialty Drugs and biological drugs. Plan Pharmacies and our Mail Service Delivery Program will substitute a generic equivalent for a Brand Name Drug when a generic equivalent is listed as a Preferred Drug unless one of the following is met:

1. The Provider has prescribed a Brand Name Drug and has indicated "dispense as written," also sometimes referred to as ("DAW") on the prescription;
2. The Brand Name Drug is listed on our Formulary as a Preferred Drug;

SAMPLE

3. The Brand Name Drug is prescribed by a:
    a. Plan Physician;
    b. Non-Plan Physician to whom you have an approved referral;
    c. Non-Plan Physician consulted due to an emergency or for out-of-area urgent care; or
    d. Dentist; and
        i. There is no equivalent Generic Drug; or
        ii. An equivalent Generic Drug has:
            a. Been ineffective in treating the disease or condition of the Member; or
            b. Caused or is likely to cause an adverse reaction or other harm to the Member.

If a Member requests a Brand Name Drug, not on the Formulary, for which there is a generic equivalent and items #3(d)(ii)(a) and #3(d)(ii)(b) have not been met, the Member will be responsible for the full Allowable Charge for the Brand Name Drug.

Step Therapy Exception Process

A step therapy exception request will be granted if your Plan Provider's submitted justification and supporting clinical documentation are determined to support their statement that:

1. The required prescription drug is contraindicated;
2. The required drug would be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;
3. The Member has tried the step therapy required prescription drug while under their current or previous health benefit plan and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; or
4. The Member is currently receiving a positive therapeutic outcome on a prescription drug recommended by their provider for the medical condition under consideration while on a current or the immediately preceding health benefit plan;

If a step therapy exception is granted, we will authorize coverage for the prescription drug prescribed by your Plan Provider provided that the prescription drug is covered by us.

We will respond to a step therapy exception request within seventy-two (72) hours of receiving the request and notify you of our Coverage Decision or if the request requires supplementation. If waiting up to seventy-two (72) hours could be harmful to your health, either you, your Kaiser Permanente physician, or Plan Provider can request an expedited exception. If the expedited exception request is approved, we will respond within twenty-four (24) hours of receiving the request.

You may Appeal any step therapy exception request denial following the Appeals process as described in ***Section 5: Filing Claims, Appeals and Grievances***.

General Formulary Exception Process

Without any additional Cost Share beyond that provided for a Formulary prescription drug covered by us, a Member may request a specific, Medically Necessary non-Formulary prescription drug if the Formulary drug is determined by us, after reasonable investigation and consultation with the prescribing physician, to be an inappropriate therapy for the medical condition of the Member. Such a request will be reviewed and a Coverage Decision provided by us within one (1) business day of receipt.

Without any additional Cost Share beyond that provided for a Formulary prescription drug covered by us, a Member may request a specific, Medically Necessary non-Formulary prescription drug they have been

SAMPLE

receiving for at least six (6) months previous to the development or revision of the Formulary and the prescribing physician has determined that the Formulary drug is an inappropriate therapy for the Member or that changing drug therapy presents a significant health risk to the Member. Such a request will be reviewed a Coverage Decision provided by us within one (1) business day of receipt.

If you would like detailed information on the formulary exception process, please visit www.kp.org or call our Member Services Call Center, Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1800-777-7902 or 711 (TTY).

Except for modifications that occur at time of coverage renewal, we will provide at least thirty (30)-days prior written notice of modification to a Formulary that results in the movement of a prescription drug to a tier with higher Cost Sharing requirements.

Preferred vs. Non-Preferred Drugs

We cover Preferred and Non-Preferred Drugs, including Specialty Drugs and biological drugs. Plan Pharmacies and our Mail Service Delivery Program will dispense a Preferred Drug unless the following criteria are met:

The Non-Preferred Drug is prescribed by a:

1. Plan Physician;
2. Non-Plan Physician to whom you have a referral; or
3. Non-Plan Physician consulted due to an emergency or for out-of-area urgent care; or
4. Dentist; and
   a. There is no equivalent drug in our Formulary; or
   b. An equivalent drug in our Formulary has:
      i. Been ineffective in treating the disease or condition of the Member; or
      ii. Caused or is likely to cause an adverse reaction or other harm to the Member.

If the above criteria are met, the applicable Tier Cost Share will apply based on the Formulary. If the Member requests a drug, not on the Formulary, and the criteria are not met, the Member will be responsible for the full Allowable Charge. The Health Plan, upon consultation with the prescribing provider, shall act on urgent requests within one business day of receipt of the request.

The Health Plan will treat the drug(s) obtained as prescribed above, under ***Generic vs. Brand Name Drugs*** and ***Preferred vs. Non-Preferred Drugs***, as an Essential Health Benefit, including by counting any Cost Sharing towards the health benefit plan's Out-of-Pocket Maximum described in the ***Appendix – Summary of Cost Shares*** of this Agreement.

Dispensing Limitations

Except for Maintenance Medications and contraceptive drugs as described below, Members may obtain up to a 30-day supply and will be charged the applicable Co-payment or Coinsurance based on: (a) the prescribed dosage, (b) Standard Manufacturers Package Size, and (c) specified dispensing limits.

Drugs that have a short shelf life may require dispensing in smaller quantities to assure that the quality is maintained. Such drugs will be limited to a 30-day supply. If a drug is dispensed in several smaller quantities (for example, three 10-day supplies), you will be charged only one Cost Share at the initial dispensing for each 30-day supply.

Except for Maintenance Medications and contraceptive drugs as described below, injectable drugs that

SAMPLE

are self-administered and dispensed from the pharmacy are limited to a 30-day supply.

Maintenance Medication Dispensing Limitations

Members may obtain up to a 90-day supply of Maintenance Medications in a single prescription, when authorized by the prescribing Plan Provider or by a dentist or a referral physician. This does not apply to the first prescription or change in a prescription. The day supply is based on: (a) the prescribed dosage; (b) Standard Manufacturer's Package Size; and (c) specified dispensing limits.

Contraceptive Drug Dispensing Limitations

Members may obtain up to a 12-month supply of prescription contraceptives in a single prescription when authorized by the prescribing Plan Provider or a referral physician.

Prescriptions Covered Outside the Service Area: Obtaining Reimbursement

The Health Plan covers drugs prescribed by non-Plan Providers and purchased at Non-Plan Pharmacies when the drug was prescribed during the course of an emergency care visit or an urgent care visit (see "Emergency Services" and "Urgent Care Services" sections of the Group Evidence of Coverage), or associated with a covered, authorized referral inside or outside Health Plan's Service Area. To obtain reimbursement, the Member must submit a copy of the itemized receipts for their prescriptions to Health Plan. We may require proof that urgent or emergency care Services were provided. Reimbursement will be made at the Allowable Charge less the applicable Co-payment the applicable Cost Share as described in the ***Appendix – Summary of Cost Shares*** section of this Evidence of Coverage. Claims should be submitted to:

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

Limitations and Exclusions

Limitations:

Benefits are subject to the following limitations:

- For drugs prescribed by dentists, coverage is limited to antibiotics and pain relief drugs that are included on our Formulary and purchased at a Plan Pharmacy, unless the criteria for coverage of Non-Preferred Drugs has been met. The Non-Preferred Drugs coverage criteria is detailed in the subsection titled, "Preferred vs. Non-Preferred Drugs".
- In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with the Health Plan's emergency management department and/or our Pharmacy and Therapeutics Committee. If limited, the applicable Cost Share per prescription will apply. However, a Member may file a claim for the difference between the Cost Share for a full prescription and the pro-rata Cost Share for the actual amount received. Instructions for filing a claim can be found in Section 5 of your Group Evidence of Coverage. Claims should be submitted to:

  Kaiser Permanente National Claims Administration- Mid Atlantic States

SAMPLE

Attention: Claims Department
P.O. Box 371860
Denver, CO 80237-9998

Exclusions:

The following are not covered under the Outpatient Prescription Drug Benefit. Please note that certain Services excluded below may be covered under other benefits in Section 3 of your Group Evidence of Coverage. Please refer to the applicable benefit to determine if drugs are covered

- Drugs for which a prescription is not required by law, except for non-prescription drugs that are prescribed by a Plan Provider and are listed in our Formulary.
- Compounded preparations that do not contain at least one ingredient requiring a prescription and are not listed in our Formulary.
- Take-home drugs received from a hospital, Skilled Nursing Facility, or other similar Facility. Refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care" in Section 3 – Benefits of your Group Evidence of Coverage.
- Drugs that are not listed in our Formulary, except as described in this Outpatient Prescription Drug Benefit.
- Drugs that are considered to be experimental or investigational. Refer to "Clinical Trials" in Section 3 – Benefits of your Group Evidence of Coverage.
- Except as specifically covered under this Outpatient Prescription Drug Benefit, a drug (a) which can be obtained without a prescription, or (b) for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug, unless otherwise prohibited by state or federal laws governing Essential Health Benefits.
- Drugs for which the Member is not legally obligated to pay, or for which no charge is made.
- Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes including but not limited to drugs used to retard or reverse the effects of skin aging or to treat nail fungus or hair loss.
- Medical foods. Refer to "Medical Foods" in Section 3 – Benefits of your Agreement.
- Drugs for the palliation and management of terminal illness if they are provided by a licensed hospice agency to a Member participating in our hospice care program. Refer to "Hospice Care Services" in Section 3 – Benefits of your Group Evidence of Coverage.
- Prescribed drugs and accessories that are necessary for Services that are excluded under this Agreement.
- Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from the Health Plan's standard packaging for prescription drugs.
- Alternative formulations or delivery methods that are (1) different from the Health Plan's standard formulation or delivery method for prescription drugs and (2) deemed not Medically Necessary.
- Drugs and devices that are provided during a covered stay in a hospital or Skilled Nursing Facility,

SAMPLE

or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits. This includes the equipment and supplies associated with the administration of a drug. Refer to "Drugs, Supplies, and Supplements" and "Home Health Services" in Section 3 – Benefits of your Group Evidence of Coverage.

- Bandages or dressings. Refer to "Drugs, Supplies, and Supplements" and "Home Health Services" in Section 3–Benefits of your Group Evidence of Coverage.
- Diabetic equipment and supplies. Refer to "Diabetic Services" in Section 3 – Benefits of this Group Evidence of Coverage.
- Growth hormone therapy (GHT) for treatment of adults age 18 or older, except when prescribed by a Plan Physician, pursuant to clinical guidelines for adults.
- Immunizations and vaccinations solely for the purpose of travel. Refer to "***Outpatient Care***" in Section 3 – Benefits of your Group Evidence of Coverage.
- Any prescription drug product that is therapeutically equivalent to an over-the-counter drug, upon a review and determination by the Pharmacy and Therapeutics Committee. The determination by the Pharmacy and Therapeutics Committee is subject to appeal if the prescribing physician believes the over-the-counter therapeutically equivalent drug is inappropriate therapy for treatment of the patient's condition.
- Drugs for weight management.
- Drugs for treatment of sexual dysfunction disorder, such as erectile dysfunction.
- Drugs that can be obtained without a prescription, except for over-the-counter contraceptive drugs.
- Drugs for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to the prescription drug, unless otherwise prohibited by federal or state laws governing Essential Health Benefits.

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Options 2 (PPO) and 3 (Indemnity)

For Options 2 and 3 of your Flexible Choice Plan, KPIC will provide coverage for prescription drugs as follows:

Prescribed drugs, medicines, and supplies purchased on an outpatient basis are covered, provided they: a) can be lawfully obtained only with the written prescription of a Physician; b) are purchased by Members on an outpatient basis; c) are covered under the Group Plan; d) do not exceed the maximum daily supply shown in the Schedule of Coverage, except that in no case may the supply be larger than that normally prescribed by a Physician or dentist; and e) do not exceed: an amount equal to one hundred fifty percent (150%) of the average wholesale price of the ingredients contained in the prescription, plus a dispensing fee. The part of a charge that does not exceed this limit will not be considered a covered charge.

Covered outpatient prescription drugs may be subject to certain utilization management protocols such as prior authorization and step therapy described below in this section. Refer to the Formulary for a complete list of medications requiring prior authorization or step therapy protocols. The most current Formulary can be obtained by visiting:

https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/mas/marketplace-formulary-mas-en-2023.pdf.

Outpatient Prescription Drugs Covered

Charges for the items listed below are also considered covered charges. Except as specifically stated below, such covered charges are subject to the Outpatient Prescription Drug Benefit Percentage Payable and may be subject to Pre-certification. Please refer to Section 2 - How to Obtain Services for more details.

- FDA-approved drugs for which a prescription is required by law.
- Compounded preparations that contain at least one ingredient requiring a prescription.
- Insulin and the following diabetic supplies:
  - Syringes and needles; and
  - Blood glucose and ketone test strips or tablets.
- Oral Chemotherapy drugs.
- Any contraceptive drug or device that is approved by the United States Food and Drug Administration (FDA).
- Any prescription drug approved by the FDA as an aid for the cessation of the use of tobacco products. Tobacco products include cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco, and candy-like products that contain tobacco.
- Off-label use of drugs when a drug is recognized in Standard Reference Compendia or certain Medical Literature as appropriate in the treatment of the diagnosed condition.
- Non-prescription drugs when they are prescribed by a Physician.
- Growth hormone therapy (GHT) for treatment of children under age eighteen (18) with a growth hormone deficiency; or when prescribed by a Physician, pursuant to clinical guidelines for adults.
- Limited Distribution Drugs (LDD).
- Up to a 90-day supply of a maintenance drug in a single dispensing of the prescription.
- Self-administered injectable drugs.

Outpatient Prescription Drugs Limitations and Exclusions

The following items are excluded from Outpatient Prescription Drug coverage in addition to those set forth elsewhere in this EOC.

- Administration of a drug or medicine.
- Any drug or medicine administered as Necessary Services and Supplies. (See the Definitions section.)
- Drugs not approved by the United States Food and Drug Administration (FDA).
- Drugs and injectables for the treatment of sexual dysfunction disorders.
- Drugs and injectables for the treatment of cosmetic services.

SAMPLE

- Replacement of lost or damaged drugs and accessories.
- Experimental Drugs and Medicines. This exclusion will not apply if such experimental or investigational drug, device or procedure, as certified by the Physician is the only procedure, drug or device medically appropriate to the Member's condition. In addition, this exclusion will not apply to routine patient care costs related to Clinical Trial if the Member's treating Physician recommends participation in the Clinical Trial after determining that participation in such Controlled Clinical Trial has a meaningful potential to benefit the Member.
- Drugs associated with non-covered services;
- Infant formulas, except for amino acid-modified products used to treat congenital errors of amino acid metabolism. Such coverage for formula and special food products are limited to the extent that the cost of such formulas or special food products exceed the cost of a normal diet;
- Human Growth Hormone (HGH), except for children with either Turner's syndrome or with classical growth hormone deficiency.
- Anorectic or any drug or injectable used for the purpose of weight loss or weight management unless prescribed in the treatment of morbid obesity.
- Drugs used to treat infertility.
- Non-prescription drugs or medicines; vitamins, nutrients and food supplements, even if prescribed or administered by a Physician.
- Biotechnology drugs and diagnostic agents. The following biotechnology drugs are excepted from this exclusion: Human insulin, vaccines, biotechnology drugs administered for the treatment or diagnosis of cancer, and Dornase for the treatment of cystic fibrosis, human growth hormones prescribed or administered for the treatment of documented human growth hormone deficiency such as Turner's Syndrome.

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Utilization Management Program

Step Therapy Process

Selected outpatient prescription drugs require step therapy. Step therapy is a process that defines how and when a particular outpatient prescription drug can be dispensed by requiring the use of one or more prerequisite drugs (first line agents), as identified through Your drug history, prior to the use of another drug (second line agent). The step therapy process encourages safe and cost-effective medication use. Under this process, a "step" approach is required to receive coverage for certain high-cost medications. Refer to the Formulary for a complete list of medications requiring step therapy. This means that to receive coverage, You may first be required to try a proven, cost-effective medication before using a more costly medication. Treatment decisions are always between You and Your Provider.

Your prescribing Physician should prescribe a first-line medication appropriate for Your condition. If Your prescribing Physician determines that a first-line drug is not appropriate or effective for You, a second-line medication may be covered after meeting certain conditions.

Prior Authorization

Prior authorization is a review and approval procedure that applies to some outpatient prescription drugs and is used to encourage safe and cost-effective medication use. Prior authorization is generally applied to outpatient prescription drugs that have multiple medical uses, are higher in cost, or have a significant safety concern.

The purpose of prior authorization is to ensure that You receive the right medication for Your medical condition. This means that when Your Physician prescribes a drug that has been identified as subject to prior authorization, the drug must be reviewed by the utilization management program to determine Medical Necessity before the prescription is filled. Prior authorization reviews address clinical appropriateness, including genomic testing, safety issues, dosing restrictions and ongoing treatment criteria.

If a drug requires prior authorization, Your prescribing Physician must work with Us to authorize the drug for Your use. Drugs requiring prior authorization have specific clinical criteria that You must meet in order for the prescription to be eligible for coverage. Refer to the Formulary for a complete list of medications requiring prior authorization. The most current Formulary can be obtained by visiting kp.org/formulary. If You have questions about prior authorization or about the outpatient prescription drugs covered under Your plan, You can call 1-800-788-2949 or 711 (TTY), 24 hours a day, 7 days a week (closed holidays).

When an outpatient prescription drug requiring prior authorization has been prescribed, You or the prescribing Physician must notify the Utilization Management Program as follows:

- You or Your prescribing Physician can begin the prior authorization process by calling 1-800-788-2949;
- Following completion of the prior authorization intake process as set forth in item 1 above, we will notify the requestor within 72 hours for non-urgent requests and within 24 hours when exigent circumstances exist, that:
    - The request is approved; or
    - The request is disapproved due to:
        - Not Medically Necessary; or
        - Missing material information required to determine Medical Necessity; or
        - The patient is no longer eligible for coverage.
- If We fail to respond within 72 hours for non-urgent requests or within 24 hours when exigent circumstances exist, the request shall be deemed to have been approved.
- In the event the prior authorization request is disapproved:
    - The notice of disapproval will contain an accurate and clear written explanation of the specific reasons for disapproving the request.
    - If the disapproval is due to missing material information required to determine Medical Necessity, the notice of disapproval will contain an accurate and clear explanation that specifically identifies the missing material information.
- The prior authorization request shall be deemed approved if the notice of disapproval is not sent

SAMPLE

to the requestor within 72 hours for non-urgent request or within 24 hours when exigent circumstances exit.

- Notices required to be sent to the requestor shall be delivered by Us in the same manner the request was submitted to Us or by any other mutually agreeable accessible method of notification.

Exception Requests

You or Your designated assignee or the prescribing Physician may request an exception to the step therapy process described above if:

- The prescribing Physician submits justification and supporting clinical documentation to KPIC that a covered outpatient prescription drug:
  - Is contraindicated;
  - Would be ineffective based on the known clinical characteristics of the Member and the known characteristics of the outpatient prescription drug regimen;
  - The Member has tried the step therapy-required outpatient prescription drug while under his or her current or a previous health benefit plan, and such outpatient prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; or
  - The Member is currently receiving a positive therapeutic outcome on an outpatient prescription drug recommended by his or her provider for the medical condition under consideration while under the current or the immediately preceding health benefit plan.

KPIC will respond to a step therapy exception request within seventy-two (72) hours of receipt, including hours on weekends, to indicate that the request is approved, denied, or requires supplementation. In cases where exigent circumstances exist, KPIC will respond within twenty-four (24) hours of receipt, including hours on weekends, to indicate that the request is approved, denied, or requires supplemental documentation.

SAMPLE

An exception to the prior authorization process will be granted under the following circumstances:

- If the prescribing Physician, of the prescribing Physician's designee provides documentation of a prior authorization from the Your immediate prior carrier. We will honor the previous authorization for at least an initial thirty (30) days of the Member's coverage. During this time period, We may perform our own review to grant a prior authorization for the Prescription Drug.
- We will honor a prior authorization previously issued under another KPIC health plan if:
  - The prescription drug is a covered benefit under the current Plan; or
  - The dosage for the approved prescription drug changes and the change is consistent with federal Food and Drug Administration labeled dosages.

We will not accept a previously granted prior authorization for a change in dosage for an opioid. Prior authorization may be required for the continued coverage of an outpatient prescription drug prescribed under Your prior health insurance coverage.

To request an exception please call MedImpact at: 1-800-788-2949

If Your request for reimbursement of a Non-Participating Pharmacy claim or request for exception to the prior authorization or step therapy processes is denied, altered, or delayed. You have the right to Appeal the denial, alteration or delay. Please refer to the **Claims and Appeals Information** section for details regarding the grievance and Appeals process and the Your right to an independent medical review.

Member Reimbursement

If You purchased a covered medication without the use of Your identification card or at a Non-Participating Pharmacy, and paid full price for Your prescription, You must request a direct member reimbursement.

To submit a claim for direct member reimbursement You may access the direct member reimbursement form via www.MedImpact.com. For assistance You may call the MedImpact Customer Contact Center 24 hours a day 7 days a week at 1-800-788-2949 or email via customerservice@medimpact.com.

SAMPLE

Kaiser Permanente
Your Small Group Agreement and Evidence of Coverage

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

Kaiser Permanente Smile Kids SG Embedded Dental C-POS Plan Appendix

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

Definitions

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

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

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

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

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

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

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

Non-Participating Dental Provider or Out-of-Network Dentist: A licensed dentist who has not entered into an agreement with the Dental Administrator for the purposes of providing dental services to Members. Where your plan does include Out-of-Network benefits, Covered Dental Services are covered, and the Out-of-Network Dentist can charge you for any amount over the Maximum Allowable Charge for each procedure. Please review the Schedule of Dental Benefits for details on your plan's Out-of-Network benefits.

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

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

SAMPLE

General Provisions

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

This Appendix includes a Schedule of Dental Benefits, which lists what you will be charged for each Covered Dental Service you receive. The Schedule of Dental Benefits will also explain whether your plan includes Out-of-Network benefits in addition to In-Network benefits.

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

To find a dentist in your area, you can go to our website at www.libertydentalplan.com, download the mobile app on your smart phone, or call us toll-free at 1-888-703-6999/TTY: 1-877-855-8039. Once you have located a Participating Provider, you can call the office to schedule an appointment. The dental office will contact us to verify your eligibility. Be sure to identify yourself as a Kaiser member when you call the dentist for an appointment. We also suggest that you take this information with you when you go to your appointment. You can then reference benefits and applicable charges which are the out-of-pocket costs associated with your plan.

Alternate Treatment

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

Dental Administrator

The Health Plan has entered into an agreement with LIBERTY Dental Plan Corporation (LIBERTY), to provide Covered Dental Services as described in this Pediatric Dental Appendix. For assistance concerning dental coverage questions or for help finding a Participating Dental Provider, you can go to our website at www.libertydentalplan.com, download the mobile app on your smart phone, or call us toll-free 1-888-703-6999/TTY: 1-877-855-8039, Monday through Friday from 7:30 a.m. to 6 p.m. (Eastern Time).

SAMPLE

Specialist Referrals

Participating Specialist Referrals

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

Extension of Benefits

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

1. If you are in the midst of a course of covered dental treatment at the time your coverage ends, we will continue to provide benefits, in accordance with this Agreement and Dental Appendix in effect

at the time your coverage ended, for a period of ninety (90) days following the date your coverage ended.

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

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

Extension of Benefits Limitations

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

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

Dental Emergencies

When you have a dental emergency within the Service Area but are unable to make arrangements to receive care through your General Dentist, contact the Dental Administrator at 1-888-703-6999/TTY: 1-877-855-8039 for assistance in locating another Participating Dental Provider.

Submission of Claims

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

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

LIBERTY Dental Plan
Claims Department
P.O. Box 26110
Santa Ana, CA, 92799-6110

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

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

SAMPLE

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

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

Appeals

If a claim is denied, you or your Authorized Representative may file an appeal with the Dental Administrator in accordance with the ***Section 5: Filing Claims, Appeals and Grievances*** section of the Small Group Evidence of Coverage.

Submit your Appeal to:

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

SAMPLE

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

By: ______________________________
Gracelyn McDermott
Vice President, Marketing, Sales & Business Development

Kaiser Permanente
Your Small Group Agreement and Evidence of Coverage

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Kaiser Permanente Smile Kids SG Embedded Dental C-POS Plan
2024 Schedule of Dental Benefits (up to 19)

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

This Schedule does not guarantee benefits. All services are subject to eligibility and dental necessity at the time of service.

Dental services are limited to the least costly treatment. Dental procedures not listed are available at the dental office's usual and customary fee.

Annual Out-of-Pocket Maximum

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

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

SAMPLE

In-Network Services

You may go to any contracted dental office to utilize In-Network covered benefits. For services performed by a Dental Specialist, your dental office will initiate a treatment plan or recommend you see a participating Dental Specialist if the services are medically necessary and outside the scope of general dentistry. You may directly refer to a participating Dental Specialist in the network. For information on locating a Participating Dental Provider, please contact us Toll Free at 1-888-703-6999/TTY: 1-877-855-8039), Monday through Friday, 7:30am to 6pm (Eastern Time).

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

Out-of-Network Services

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

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

Pre-Determination of Benefits

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

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

SAMPLE

CDT Code	Description	Limitations
TYPE I - DIAGNOSTIC & PREVENTIVE SERVICES		
D0120	Periodic oral evaluation	1 of (D0120, D0145, D0150) every 6 months, per provider or location. Coverage begins with the eruption of the first tooth
D0140	Limited oral evaluation	1 (D0140) per date of service
D0145	Oral evaluation under age 3	1 of (D0120, D0145, D0150) every 6 months, per provider or location.
D0150	Comprehensive oral evaluation	1 of (D0120, D0145, D0150) every 6 months, per provider or location
D0160	Oral evaluation, problem focused	
D0170	Re-evaluation, limited, problem focused	
D0171	Re-evaluation, post operative office visit	
D0180	Comprehensive periodontal evaluation	
D0210	Intraoral, comprehensive series of radiographic images	1 of (D0210, D0330, D0701, D0709) every 36 months, per provider or location
D0220	Intraoral, periapical, first radiographic image	
D0230	Intraoral, periapical, each add 'l radiographic image	

CDT Code	Description	Limitations
D0240	Intraoral, occlusal radiographic image	
D0250	Extra-oral 2D projection radiographic image, stationary radiation source	
D0270	Bitewing, single radiographic image	
D0272	Bitewings, two radiographic images	1 of (D0272-D0274, D0277) every 6 months, per provider or location
D0273	Bitewings, three radiographic images	1 of (D0272-D0274, D0277) every 6 months, per provider or location
D0274	Bitewings, four radiographic images	1 of (D0272-D0274, D0277) every 6months, per provider or location
D0277	Vertical bitewings, 7 to 8 radiographic images	1 of (D0272-D0274, D0277) every 6 months, per provider or location
D0310	Sialography	
D0320	TMJ arthrogram, including injection	
D0321	Other TMJ radiographic images, by report	
D0330	Panoramic radiographic image	1 of (D0210, D0330, D0701, D0709) every 36 months, per provider or location
D0340	2D cephalometric radiographic image, measurement and analysis	
D0350	2D oral/facial photographic image, intra-orally/extra-orally	
D0391	Interpretation, diagnostic image by a practitioner, not associated with image, including report	
D0460	Pulp vitality tests	
D0470	Diagnostic casts	
D0486	Accession of transepithelial cytologic sample, prep, written report	
D0601	Caries risk assessment and documentation, low risk	1 of (D0601-D0603) every 6 months
D0602	Caries risk assessment and documentation, moderate risk	1 of (D0601-D0603) every 6 months
D0603	Caries risk assessment and documentation, high risk	1 of (D0601-D0603) every 6 months
D0701	Panoramic radiographic image, image capture only	1 of (D0701, D0709, D0210, D0330) every 36 months, per provider or location
D0702	2-D cephalometric radiographic image, image capture only	
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally, image capture only	
D0705	Extra-oral posterior dental radiographic image, image capture only	
D0706	Intraoral, occlusal radiographic image, image capture only	
D0707	Intraoral, periapical radiographic image, image capture only	
D0708	Intraoral, bitewing radiographic image, image capture only	

SAMPLE

CDT Code	Description	Limitations
D0709	Intraoral, comprehensive series of radiographic images, image capture only	1 of (D0701, D0709, D0210, D0330) every 36 months, per provider or location
D1110	Prophylaxis, adult	1 of (D1110, D1120, D4346) every 6 months
D1120	Prophylaxis, child	1 of (D1110, D1120, D4346) every 6 months
D1206	Topical application of fluoride varnish	Age 0-2: 8 (D1206) every 12 months; Age 3 over: 4 (D1206) every 12 months
D1208	Topical application of fluoride, excluding varnish	1(D1208) every 6 months
D1310	Nutritional counseling for control of dental disease	
D1320	Tobacco counseling, control/prevention oral disease	
D1321	Counseling for the control and prevention of adverse oral, behavioral, health effects associated with high-risk substance use	
D1330	Oral hygiene instruction	
D1351	Sealant, per tooth	1 (D1351) per tooth every 36 months, limited to unrestored permanent molars
D1352	Preventive resin restoration, permanent tooth	
D1354	Application of caries arresting medicament, per tooth	1 (D1354) per tooth every 6 months, no more than twice per tooth in a lifetime
D1355	Caries preventive medicament application, per tooth	
D1510	Space maintainer, fixed, unilateral, per quadrant	1 of (D1510, D1520, D1575) per quadrant every 2 years
D1516	Space maintainer, fixed, bilateral, maxillary	1 of (D1516, D1517, D1526, D1527) per arch every 2 years
D1517	Space maintainer, fixed, bilateral, mandibular	1 of (D1516, D1517, D1526, D1527) per arch every 2 years
D1520	Space maintainer, removable, unilateral, per quadrant	1 of (D1510, D1520, D1575) per quadrant every 2 years
D1526	Space maintainer, removable, bilateral, maxillary	1 of (D1516, D1517, D1526, D1527) per arch every 2 years
D1527	Space maintainer, removable, bilateral, mandibular	1 of (D1516, D1517, D1526, D1527) per arch every 2 years
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	
D1556	Removal of fixed unilateral space maintainer, per quadrant	1 of (D1556) per quadrant every 2 years
D1557	Removal of fixed bilateral space maintainer, maxillary	1 of (D1557, D1558) per arch every 2 years

SAMPLE

CDT Code	Description	Limitations
D1558	Removal of fixed bilateral space maintainer, mandibular	1 of (D1557, D1558) per arch every 2 years
D1575	Distal shoe space maintainer, fixed, per quadrant	1 of (D1510, D1520, D1575) per quadrant every 2 years
D9995	Teledentistry, synchronous; real-time encounter	Must be accompanied by a covered procedure
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review	Must be accompanied by a covered procedure
TYPE II - ROUTINE (Basic) SERVICES		
Guideline: Posterior Composite Fillings - Payable at the least expensive covered material		
D2140	Amalgam, one surface, primary or permanent	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2150	Amalgam, two surfaces, primary or permanent	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2160	Amalgam, three surfaces, primary or permanent	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2161	Amalgam, four or more surfaces, primary or permanent	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2330	Resin-based composite, one surface, anterior	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2331	Resin-based composite, two surfaces, anterior	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2332	Resin-based composite, three surfaces, anterior	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2335	Resin-based composite, four or more surfaces, involving incisal angle	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2390	Resin-based composite crown, anterior	1 (D2390) per tooth every 12 months
D2391	Resin-based composite, one surface, posterior	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2392	Resin-based composite, two surfaces, posterior	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2393	Resin-based composite, three surfaces, posterior	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D2394	Resin-based composite, four or more surfaces, posterior	1 of (D2140-D2335, D2391-D2394) per tooth per surface every 12 months
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 24 months
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 24 months
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 24 months
D4240	Gingival flap procedure, four or more teeth per quadrant	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 24 months

SAMPLE

CDT Code	Description	Limitations
D4241	Gingival flap procedure, one to three teeth per quadrant	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 24 months
D4249	Clinical crown lengthening, hard tissue	Prior Authorization Required
D4260	Osseous surgery, four or more teeth per quadrant	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 24 months
D4261	Osseous surgery, one to three teeth per quadrant	1 of (D4210, D4211, D4212, D4240, D4241, D4260, D4261) per site/quadrant every 24 months
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	
D4264	Bone replacement graft, retained natural tooth, each additional site	
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	
D4268	Surgical revision procedure, per tooth	
D4270	Pedicle soft tissue graft procedure	
D4273	Autogenous connective tissue graft procedure, first tooth	
D4274	Mesial/distal wedge procedure, single tooth	
D4275	Non-autogenous connective tissue graft, first tooth	
D4276	Combined connective tissue and pedicle graft	
D4277	Free soft tissue graft, first tooth	
D4278	Free soft tissue graft, each additional tooth	
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	
D4322	Splint, intra-coronal; natural teeth or prosthetic crowns	
D4323	Splint, extra-coronal; natural teeth or prosthetic crowns	
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	1 of (D4341, D4342) per site/ quadrant, every 24 months;
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	1 of (D4341, D4342) per site/ quadrant, every 24 months;
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	2 of (D1110, D1120, D4346) every 12 months
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit	1 (D4355) every 12 months
D4910	Periodontal maintenance	Only covered after active therapy as been performed
D4921	Gingival irrigation with a medicinal agent, per quadrant	1 per quadrant every 36 months, not payable within 4 weeks of periodontal scaling and root planing
D7111	Extraction, coronal remnants, primary tooth	

SAMPLE

CDT Code	Description	Limitations
D7140	Extraction, erupted tooth or exposed root	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	
D7220	Removal of impacted tooth, soft tissue	
D7230	Removal of impacted tooth, partially bony	
D7240	Removal of impacted tooth, completely bony	
D7241	Removal impacted tooth, complete bony, complication	
D7250	Removal of residual tooth roots (cutting procedure)	
D9110	Palliative treatment of dental pain, per visit	
D9420	Hospital or ambulatory surgical center call	Prior Authorization Required
D9440	Office visit, after regularly scheduled hours	
TYPE III - MAJOR SERVICES		
Guideline: Single Crowns - Payable at the least expensive covered material. Copayment includes all costs for lab bills and materials		
D2510	Inlay, metallic, one surface	1 of (D2510-D2794) per tooth every 60 months
D2520	Inlay, metallic, two surfaces	1 of (D2510-D2794) per tooth every 60 months
D2530	Inlay, metallic, three or more surfaces	1 of (D2510-D2794) per tooth every 60 months
D2542	Onlay, metallic, two surfaces	1 of (D2510-D2794) per tooth every 60 months
D2543	Onlay, metallic, three surfaces	1 of (D2510-D2794) per tooth every 60 months
D2544	Onlay, metallic, four or more surfaces	1 of (D2510-D2794) per tooth every 60 months
D2610	Inlay, porcelain/ceramic, one surface	1 of (D2510-D2794) per tooth every 60 months
D2620	Inlay, porcelain/ceramic, two surfaces	1 of (D2510-D2794) per tooth every 60 months
D2630	Inlay, porcelain/ceramic, three or more surfaces	1 of (D2510-D2794) per tooth every 60 months
D2642	Onlay, porcelain/ceramic, two surfaces	1 of (D2510-D2794) per tooth every 60 months
D2643	Onlay, porcelain/ceramic, three surfaces	1 of (D2510-D2794) per tooth every 60 months
D2644	Onlay, porcelain/ceramic, four or more surfaces	1 of (D2510-D2794) per tooth every 60 months
D2650	Inlay, resin-based composite, one surface	1 of (D2510-D2794) per tooth every 60 months
D2651	Inlay, resin-based composite, two surfaces	1 of (D2510-D2794) per tooth every 60 months
D2652	Inlay, resin-based composite, three or more surfaces	1 of (D2510-D2794) per tooth every 60 months
D2662	Onlay, resin-based composite, two surfaces	1 of (D2510-D2794) per tooth every 60 months

SAMPLE

CDT Code	Description	Limitations
D2663	Onlay, resin-based composite, three surfaces	1 of (D2510-D2794) per tooth every 60 months
D2664	Onlay, resin-based composite, four or more surfaces	1 of (D2510-D2794) per tooth every 60 months
D2710	Crown, resin-based composite (indirect)	1 of (D2510-D2794) per tooth every 60 months
D2712	Crown, ¾ resin-based composite (indirect)	1 of (D2510-D2794) per tooth every 60 months
D2720	Crown, resin with high noble metal	1 of (D2510-D2794) per tooth every 60 months
D2721	Crown, resin with predominantly base metal	1 of (D2510-D2794) per tooth every 60 months
D2722	Crown, resin with noble metal	1 of (D2510-D2794) per tooth every 60 months
D2740	Crown, porcelain/ceramic	1 of (D2510-D2794) per tooth every 60 months
D2750	Crown, porcelain fused to high noble metal	1 of (D2510-D2794) per tooth every 60 months
D2751	Crown, porcelain fused to predominantly base metal	1 of (D2510-D2794) per tooth every 60 months
D2752	Crown, porcelain fused to noble metal	1 of (D2510-D2794) per tooth every 60 months
D2753	Crown, porcelain fused to titanium and titanium alloys	1 of (D2510-D2794) per tooth every 60 months
D2780	Crown, ¾ cast high noble metal	1 of (D2510-D2794) per tooth every 60 months
D2781	Crown, ¾ cast predominantly base metal	1 of (D2510-D2794) per tooth every 60 months
D2782	Crown, ¾ cast noble metal	1 of (D2510-D2794) per tooth every 60 months
D2783	Crown, ¾ porcelain/ceramic	1 of (D2510-D2794) per tooth every 60 months
D2790	Crown, full cast high noble metal	1 of (D2510-D2794) per tooth every 60 months
D2791	Crown, full cast predominantly base metal	1 of (D2510-D2794) per tooth every 60 months
D2792	Crown, full cast noble metal	1 of (D2510-D2794) per tooth every 60 months
D2794	Crown, titanium and titanium alloys	1 of (D2510-D2794) per tooth every 60 months
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	
D2920	Re-cement or re-bond crown	
D2928	Prefabricated porcelain/ceramic crown, permanent tooth	

SAMPLE

CDT Code	Description	Limitations
D2929	Prefabricated porcelain/ceramic crown, primary tooth	
D2930	Prefabricated stainless steel crown, primary tooth	
D2931	Prefabricated stainless steel crown, permanent tooth	
D2932	Prefabricated resin crown	
D2933	Prefabricated stainless steel crown with resin window	
D2934	Prefabricated esthetic coated stainless steel crown, primary tooth	
D2940	Protective restoration	
D2941	Interim therapeutic restoration, primary dentition	
D2950	Core buildup, including any pins when required	
D2951	Pin retention, per tooth, in addition to restoration	
D2952	Post and core in addition to crown, indirectly fabricated	
D2954	Prefabricated post and core in addition to crown	
D2955	Post removal	
D2962	Labial veneer (porcelain laminate), indirect	1 (D2962) per tooth every 60 months
D2980	Crown repair necessitated by restorative material failure	
D2981	Inlay repair necessitated by restorative material failure	
D2982	Onlay repair necessitated by restorative material failure	
D2983	Veneer repair necessitated by restorative material failure	
D2990	Resin infiltration of incipient smooth surface lesions	
D3110	Pulp cap, direct (excluding final restoration)	
D3120	Pulp cap, indirect (excluding final restoration)	
D3220	Therapeutic pulpotomy (excluding final restoration)	
D3221	Pulpal debridement, primary and permanent teeth	
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	1 of (D3310-D3330) in a lifetime, per tooth
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	1 of (D3310-D3330) in a lifetime, per tooth
D3330	Endodontic therapy, molar tooth (excluding final restoration)	1 of (D3310-D3330) in a lifetime, per tooth
D3333	Internal root repair of perforation defects	

SAMPLE

CDT Code	Description	Limitations
D3346	Retreatment of previous root canal therapy, anterior	1 of (D3346-D3348) in a lifetime, per tooth
D3347	Retreatment of previous root canal therapy, premolar	1 of (D3346-D3348) in a lifetime, per tooth
D3348	Retreatment of previous root canal therapy, molar	1 of (D3346-D3348) in a lifetime, per tooth
D3351	Apexification/recalcification, initial visit	
D3352	Apexification/recalcification, interim medication replacement	
D3353	Apexification/recalcification, final visit	
D3355	Pulpal regeneration, initial visit	
D3356	Pulpal regeneration, interim medication replacement	
D3357	Pulpal regeneration, completion of treatment	
D3410	Apicoectomy, anterior	
D3421	Apicoectomy, premolar (first root)	
D3425	Apicoectomy, molar (first root)	
D3426	Apicoectomy, (each additional root)	
D3430	Retrograde filling, per root	
D3450	Root amputation, per root	
D3471	Surgical repair of root resorption, anterior	
D3472	Surgical repair of root resorption, premolar	
D3473	Surgical repair of root resorption, molar	
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption, anterior	
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption, premolar	
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption, molar	
D3920	Hemisection, not including root canal therapy	
D3921	Decoronation or submergence of an erupted tooth	
D3950	Canal preparation and fitting of preformed dowel or post	
D5110	Complete denture, maxillary	1 of (D5110-D5120) per arch every 60 months
D5120	Complete denture, mandibular	1 of (D5110-D5120) per arch every 60 months
D5130	Immediate denture, maxillary	
D5140	Immediate denture, mandibular	
D5211	Maxillary partial denture, resin base	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5212	Mandibular partial denture, resin base	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5213	Maxillary partial denture, cast metal, resin base	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5214	Mandibular partial denture, cast metal, resin base	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5221	Immediate maxillary partial denture, resin base	

SAMPLE

CDT Code	Description	Limitations
D5222	Immediate mandibular partial denture, resin base	
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	
D5225	Maxillary partial denture, flexible base	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5226	Mandibular partial denture, flexible base	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5284	Removable unilateral partial denture, one piece flexible base, per quadrant	1 of (D5284, D5286) per quad every 60 months
D5286	Removable unilateral partial denture, one piece resin, per quadrant	1 of (D5284, D5286) per quad every 60 months
D5410	Adjust complete denture, maxillary	Not payable within first 6 months of initial placement by same provider
D5411	Adjust complete denture, mandibular	Not payable within first 6 months of initial placement by same provider
D5421	Adjust partial denture, maxillary	Not payable within first 6 months of initial placement by same provider
D5422	Adjust partial denture, mandibular	Not payable within first 6 months of initial placement by same provider
D5511	Repair broken complete denture base, mandibular	Not payable within first 6 months of initial placement by same provider
D5512	Repair broken complete denture base, maxillary	Not payable within first 6 months of initial placement by same provider
D5520	Replace missing or broken teeth, complete denture	Not payable within first 6 months of initial placement by same provider
D5611	Repair resin partial denture base, mandibular	Not payable within first 6 months of initial placement by same provider
D5612	Repair resin partial denture base, maxillary	Not payable within first 6 months of initial placement by same provider
D5621	Repair cast partial framework, mandibular	Not payable within first 6 months of initial placement by same provider
D5622	Repair cast partial framework, maxillary	Not payable within first 6 months of initial placement by same provider
D5630	Repair or replace broken retentive clasping materials, per tooth	Not payable within first 6 months of initial placement by same provider
D5640	Replace broken teeth, per tooth	Not payable within first 6 months of initial placement by same provider
D5650	Add tooth to existing partial denture	Not payable within first 6 months of initial placement by same provider
D5660	Add clasp to existing partial denture, per tooth	Not payable within first 6 months of initial placement by same provider

SAMPLE

CDT Code	Description	Limitations
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	Not payable within first 6 months of initial placement by same provider
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	Not payable within first 6 months of initial placement by same provider
D5710	Rebase complete maxillary denture	Not payable within first 6 months of initial placement by same provider
D5711	Rebase complete mandibular denture	Not payable within first 6 months of initial placement by same provider
D5720	Rebase maxillary partial denture	Not payable within first 6 months of initial placement by same provider
D5721	Rebase mandibular partial denture	Not payable within first 6 months of initial placement by same provider
D5730	Reline complete maxillary denture, direct	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5731	Reline complete mandibular denture, direct	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5740	Reline maxillary partial denture, direct	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5741	Reline mandibular partial denture, direct	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5750	Reline complete maxillary denture, indirect	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5751	Reline complete mandibular denture, indirect	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5760	Reline maxillary partial denture, indirect	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5761	Reline mandibular partial denture, indirect	1 of (D5730-D5761) per arch every 24 months. Not payable within first 6 months of initial placement by same provider
D5810	Interim complete denture, maxillary	
D5811	Interim complete denture, mandibular	
D5820	Interim partial denture, maxillary	
D5821	Interim partial denture, mandibular	
D5850	Tissue conditioning, maxillary	
D5851	Tissue conditioning, mandibular	
D5863	Overdenture, complete, maxillary	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5864	Overdenture, partial, maxillary	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5865	Overdenture, complete, mandibular	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months

SAMPLE

CDT Code	Description	Limitations
D5866	Overdenture, partial, mandibular	1 of (D5211-D5214, D5225-D5283, D5863-D5866) per arch every 60 months
D5951	Feeding aid	Prior Authorization Required
D5992	Adjust maxillofacial prosthetic appliance, by report	1 (D5992) per arch every 6 months
D5993	Maintenance & cleaning, maxillofacial prosthesis, other than required adjustments, by report	1 (D5993) per arch every 6 months
Guideline: Implants and Implant Related Services - Payable at the least expensive covered material. Copayment includes all costs for lab bills and materials		
D6010	Surgical placement of implant body, endosteal	Prior Authorization Required
D6012	Surgical placement of interim implant body, transitional prosthesis: endosteal implant	Prior Authorization Required
D6040	Surgical placement: eposteal implant	Prior Authorization Required
D6050	Surgical placement: transosteal implant	Prior Authorization Required
D6055	Connecting bar, implant supported or abutment supported	Prior Authorization Required
D6056	Prefabricated abutment, includes modification and placement	Prior Authorization Required
D6057	Custom fabricated abutment, includes placement	Prior Authorization Required
D6058	Abutment supported porcelain/ceramic crown	Prior Authorization Required
D6059	Abutment supported porcelain fused to high noble crown	Prior Authorization Required
D6060	Abutment supported porcelain fused to base metal crown	Prior Authorization Required
D6061	Abutment supported porcelain fused to noble metal crown	Prior Authorization Required
D6062	Abutment supported cast metal crown, high noble	Prior Authorization Required
D6063	Abutment supported cast metal crown, base metal	Prior Authorization Required
D6064	Abutment supported cast metal crown, noble metal	Prior Authorization Required
D6065	Implant supported porcelain/ceramic crown	Prior Authorization Required
D6066	Implant supported crown, porcelain fused to high noble alloys	Prior Authorization Required
D6067	Implant supported crown, high noble alloys	Prior Authorization Required
D6068	Abutment supported retainer, porcelain/ceramic FPD	Prior Authorization Required
D6069	Abutment supported retainer, metal FPD, high noble	Prior Authorization Required
D6070	Abutment supported retainer, porcelain fused to metal FPD, base metal	Prior Authorization Required
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	Prior Authorization Required
D6072	Abutment supported retainer, cast metal FPD, high noble	Prior Authorization Required
D6073	Abutment supported retainer, cast metal FPD, base metal	Prior Authorization Required
D6074	Abutment supported retainer, cast metal FPD, noble	Prior Authorization Required

SAMPLE

CDT Code	Description	Limitations
D6075	Implant supported retainer for ceramic FPD	Prior Authorization Required
D6076	Implant supported retainer for FPD, porcelain fused to high noble alloys	Prior Authorization Required
D6077	Implant supported retainer for metal FPD, high noble alloys	Prior Authorization Required
D6080	Implant maintenance procedures, prosthesis removed/reinserted, including cleansing	Prior Authorization Required
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	Prior Authorization Required
D6087	Implant supported crown, noble alloys	Prior Authorization Required
D6090	Repair implant supported prosthesis, by report	
D6091	Replacement of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	Prior Authorization Required
D6095	Repair implant abutment, by report	
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	Prior Authorization Required
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	Prior Authorization Required
D6100	Surgical removal of implant body	
D6110	Implant/abutment supported removable denture, maxillary	Prior Authorization Required
D6111	Implant/abutment supported removable denture, mandibular	Prior Authorization Required
D6112	Implant/abutment supported removable denture, partial, maxillary	Prior Authorization Required
D6113	Implant/abutment supported removable denture, partial, mandibular	Prior Authorization Required
D6114	Implant/abutment supported fixed denture, maxillary	Prior Authorization Required
D6115	Implant/abutment supported fixed denture, mandibular	Prior Authorization Required
D6116	Implant/abutment supported fixed denture for partial, maxillary	Prior Authorization Required
D6117	Implant/abutment supported fixed denture for partial, mandibular	Prior Authorization Required
D6121	Implant supported retainer for metal FPD, predominantly base alloys	Prior Authorization Required
D6122	Implant supported retainer for metal FPD, noble alloys	Prior Authorization Required
Guideline: Bridge Services - Payable at the least expensive covered material. Copayment includes all costs for lab bills and materials		
D6205	Pontic, indirect resin based composite	Prior Authorization Required
D6210	Pontic, cast high noble metal	Prior Authorization Required
D6211	Pontic, cast predominantly base metal	Prior Authorization Required
D6212	Pontic, cast noble metal	Prior Authorization Required
D6214	Pontic, titanium, and titanium alloys	Prior Authorization Required
D6240	Pontic, porcelain fused to high noble metal	Prior Authorization Required

SAMPLE

CDT Code	Description	Limitations
D6241	Pontic, porcelain fused to predominantly base metal	Prior Authorization Required
D6242	Pontic, porcelain fused to noble metal	Prior Authorization Required
D6243	Pontic, porcelain fused to titanium and titanium alloys	Prior Authorization Required
D6245	Pontic, porcelain/ceramic	Prior Authorization Required
D6250	Pontic, resin with high noble metal	Prior Authorization Required
D6251	Pontic, resin with predominantly base metal	Prior Authorization Required
D6252	Pontic, resin with noble metal	Prior Authorization Required
D6545	Retainer, cast metal for resin bonded fixed prosthesis	Prior Authorization Required
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis	Prior Authorization Required
D6549	Resin retainer, for resin bonded fixed prosthesis	Prior Authorization Required
D6600	Retainer inlay, porcelain/ceramic, two surfaces	Prior Authorization Required
D6601	Retainer inlay, porcelain/ceramic, three or more surfaces	Prior Authorization Required
D6602	Retainer inlay, cast high noble metal, two surfaces	Prior Authorization Required
D6603	Retainer inlay, cast high noble metal, three or more surfaces	Prior Authorization Required
D6604	Retainer inlay, cast base metal, two surfaces	Prior Authorization Required
D6605	Retainer inlay, cast base metal, three or more surfaces	Prior Authorization Required
D6606	Retainer inlay, cast noble metal, two surfaces	Prior Authorization Required
D6607	Retainer inlay, cast noble metal, three or more surfaces	Prior Authorization Required
D6608	Retainer onlay, porcelain/ceramic, two surfaces	Prior Authorization Required
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	Prior Authorization Required
D6610	Retainer onlay, cast high noble metal, two surfaces	Prior Authorization Required
D6611	Retainer onlay, cast high noble metal, three or more surfaces	Prior Authorization Required
D6612	Retainer onlay, cast base metal, two surfaces	Prior Authorization Required
D6613	Retainer onlay, cast base metal, three or more surfaces	Prior Authorization Required
D6614	Retainer onlay, cast noble metal, two surfaces	Prior Authorization Required
D6615	Retainer onlay, cast noble metal three or more surfaces	Prior Authorization Required
D6634	Retainer onlay, titanium	Prior Authorization Required
D6710	Retainer crown, indirect resin based composite	Prior Authorization Required
D6720	Retainer crown, resin with high noble metal	Prior Authorization Required
D6721	Retainer crown, resin with predominantly base metal	Prior Authorization Required
D6722	Retainer crown, resin with noble metal	Prior Authorization Required
D6740	Retainer crown, porcelain/ceramic	Prior Authorization Required
D6750	Retainer crown, porcelain fused to high noble metal	Prior Authorization Required

SAMPLE

CDT Code	Description	Limitations
D6751	Retainer crown, porcelain fused to predominantly base metal	Prior Authorization Required
D6752	Retainer crown, porcelain fused to noble metal	Prior Authorization Required
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	Prior Authorization Required
D6780	Retainer crown, ¾ cast high noble metal	Prior Authorization Required
D6781	Retainer crown, ¾ cast predominantly base metal	Prior Authorization Required
D6782	Retainer crown, ¾ cast noble metal	Prior Authorization Required
D6783	Retainer crown, ¾ porcelain/ceramic	Prior Authorization Required
D6784	Retainer crown ¾, titanium and titanium alloys	Prior Authorization Required
D6790	Retainer crown, full cast high noble metal	Prior Authorization Required
D6791	Retainer crown, full cast predominantly base metal	Prior Authorization Required
D6792	Retainer crown, full cast noble metal	Prior Authorization Required
D6794	Retainer crown, titanium and titanium alloys	Prior Authorization Required
D6930	Re-cement or re-bond fixed partial denture	
D6980	Fixed partial denture repair, restorative material failure	
D6999	Unspecified fixed prosthodontic procedure, by report	Prior Authorization Required
D7251	Coronectomy, intentional partial tooth removal	
D7260	Oroantral fistula closure	
D7261	Primary closure of a sinus perforation	
D7270	Tooth reimplantation and/or stabilization, accident	
D7272	Tooth transplantation	
D7280	Exposure of an unerupted tooth	
D7282	Mobilization of erupted/malpositioned tooth	
D7283	Placement, device to facilitate eruption, impaction	
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	
D7286	Incisional biopsy of oral tissue, soft	
D7288	Brush biopsy, transepithelial sample collection	
D7290	Surgical repositioning of teeth	1 (D7290) in a lifetime, per tooth
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	
D7350	Vestibuloplasty, ridge extension	
D7410	Excision of benign lesion, up to 1.25 cm	
D7411	Excision of benign lesion, greater than 1.25 cm	
D7413	Excision of malignant lesion, up to 1.25 cm	

SAMPLE

CDT Code	Description	Limitations
D7414	Excision of malignant lesion, greater than 1.25 cm	
D7440	Excision of malignant tumor, up to 1.25 cm	
D7441	Excision of malignant tumor, greater than 1.25 cm	
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	
D7471	Removal of lateral exostosis, maxilla or mandible	
D7472	Removal of torus palatinus	
D7473	Removal of torus mandibularis	
D7485	Reduction of osseous tuberosity	
D7510	Incision & drainage of abscess, intraoral soft tissue	
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	
D7520	Incision & drainage of abscess, extraoral soft tissue	
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	
D7880	Occlusal orthotic device, by report	
D7910	Suture of recent small wounds up to 5 cm	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot, stabilization, per site	
D7961	Buccal/labial frenectomy (frenulectomy)	1 (D7961) in a lifetime, per arch
D7962	Lingual frenectomy (frenulectomy)	1 (D7962) in a lifetime
D7963	Frenuloplasty	1 (D7963) In a lifetime, per arch
D7970	Excision of hyperplastic tissue, per arch	
D7971	Excision of pericoronal gingiva	
D7972	Surgical reduction of fibrous tuberosity	
D7979	Non – surgical sialolithotomy	
D7999	Unspecified oral surgery procedure, by report	
D9210	Local anesthesia not in conjunction, operative or surgical procedures	
D9211	Regional block anesthesia	
D9212	Trigeminal division block anesthesia	
D9215	Local anesthesia in conjunction with operative or surgical procedures	Not payable as separate service
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	
D9222	Deep sedation/general anesthesia, first 15 minute increment	Prior Authorization Required
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	Prior Authorization Required

SAMPLE

CDT Code	Description	Limitations
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	Not allowed on same date of service as D9248
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	Prior Authorization Required
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	Prior Authorization Required
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	Not allowed on same date of service as D9222, D9223, D9230
D9310	Consultation, other than requesting dentist	
D9311	Consultation with a medical health care professional	
D9610	Therapeutic parenteral drug, single administration	Prior Authorization Required
D9612	Therapeutic parenteral drugs, two or more administrations, different meds.	Prior Authorization Required
D9630	Drugs or medicaments dispensed in the office for home use	Prior Authorization Required
D9910	Application of desensitizing medicament	
D9920	Behavior management, by report	
D9930	Treatment of complications, post surgical, unusual, by report	
D9941	Fabrication of athletic mouthguard	1 (D9941) every 12 months
D9944	Occlusal guard, hard appliance, full arch	
D9945	Occlusal guard, soft appliance, full arch	
D9946	Occlusal guard, hard appliance, partial arch	
D9950	Occlusion analysis, mounted case	
D9951	Occlusal adjustment, limited	
D9952	Occlusal adjustment, complete	
D9986	Missed appointment	
TYPE IV - MEDICALLY NECESSARY ORTHODONTIC SERVICES - Prior Authorization required for Orthodontic Services		
Guideline: Medically Necessary Orthodontic Services Orthodontic needs are limited to 1 course of treatment and must meet medically necessary requirements as determined by a verified score of 26 or higher (or other qualify conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.		
D8010	Limited orthodontic treatment of the primary dentition	Prior Authorization Required for medically necessary benefits
D8020	Limited orthodontic treatment of the transitional dentition	Prior Authorization Required for medically necessary benefits
D8030	Limited orthodontic treatment of the adolescent dentition	Prior Authorization Required for medically necessary benefits
D8040	Limited orthodontic treatment of the adult dentition	Prior Authorization Required for medically necessary benefits
D8070	Comprehensive orthodontic treatment of the transitional dentition	Prior Authorization Required for medically necessary benefits
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Prior Authorization Required for medically necessary benefits

SAMPLE

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

SAMPLE

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

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

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

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