guide to
YOUR 2016 BENEFITS
AND SERVICES
kaiserpermanente.org

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

GROUP
EVIDENCE OF COVERAGE
MARYLAND

SIGNATURE CARE DELIVERY SYSTEM

This plan has Excellent accreditation from the NCQA
See 2016 NCQA Guide for more information on Accreditation

KFHP-EOC COVER (01/14)MD

POS
# Table of Contents

## SECTION 1 – INTRODUCTION........................................................................................................... 1.1

- **Kaiser Permanente SignatureSM** ................................................................................................ 1.1
- **Who is Eligible** .......................................................................................................................... 1.1
  - General ...................................................................................................................................... 1.1
  - Subscribers ................................................................................................................................. 1.2
  - Dependents ............................................................................................................................... 1.2
  - Disabled Dependent Certification ............................................................................................. 1.2
  - Genetic Information .................................................................................................................. 1.2
- **Enrollment and Effective Date of Coverage** .......................................................................... 1.3
  - New Employees and Their Dependents .................................................................................... 1.3
  - Special Enrollment ................................................................................................................... 1.3
  - Special Enrollment due to new Dependents ........................................................................... 1.3
  - Special Enrollment due to court or administrative order ....................................................... 1.4
  - Special Enrollment due to loss of other coverage ................................................................. 1.5
  - Special Enrollment Due to Re-employment After Military Service ...................................... 1.5
  - Special Enrollment due to Eligibility for Premium Assistance Under Medicaid or CHIP ....... 1.5
- **Open Enrollment** .................................................................................................................... 1.5
  - **Premium** ............................................................................................................................. 1.5

## SECTION 2 – HOW TO OBTAIN SERVICES....................................................................................... 2.1

- **Your Primary Care Plan Physician** ........................................................................................ 2.1
- **Continuity of Care for New Members** .................................................................................... 2.1
- **Getting a Referral** .................................................................................................................... 2.2
- **Standing Referrals to Specialists** .......................................................................................... 2.2
- **Referrals to Non-Plan Specialists and Non-Plan Non-Physician Specialists** ...................... 2.2
- **Second Opinions** .................................................................................................................... 2.2
- **Getting the Care You Need; Emergency Services, Urgent Care, and Advice Nurses** ............ 2.2
- **Making Appointments** ........................................................................................................... 2.3
- **Missed Appointment Fee** ........................................................................................................ 2.3
- **Using Your Identification Card** .............................................................................................. 2.3
- **Visiting Other Kaiser Permanente Regions or Group Health Cooperative Service Areas** ........ 2.3
- **Moving to Another Kaiser Permanente Region or Group Health Cooperative Service Area** .... 2.4

## SECTION 3 – BENEFITS....................................................................................................................... 3.1

- **A. Outpatient Care** .................................................................................................................. 3.1
- **B. Hospital Inpatient Services** ................................................................................................ 3.2
- **C. Accidental Dental Injury Services** ..................................................................................... 3.2
- **D. Allergy Services** ................................................................................................................ 3.3
- **E. Ambulance Services** .......................................................................................................... 3.3
- **F. Anesthesia for Dental Services** .......................................................................................... 3.3
- **G. Blood, Blood Products and Their Administration** ............................................................. 3.3
- **H. Chemical Dependency and Mental Health Services** ......................................................... 3.4
- **I. Cleft Lip, Cleft Palate or Both** ............................................................................................ 3.4
- **J. Clinical Trials** ..................................................................................................................... 3.5
- **K. Diabetic Equipment, Supplies, and Self-Management** ..................................................... 3.5
- **L. Dialysis** .............................................................................................................................. 3.6
- **M. Drugs, Supplies, and Supplements** .................................................................................. 3.6
- **N. Durable Medical Equipment** ............................................................................................ 3.6

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

MDLG-ALL-TOC(1/05)
Basic Durable Medical Equipment .......................................................... 3.7
Supplemental Durable Medical Equipment ........................................... 3.7
Oxygen and Equipment ........................................................................... 3.7
Positive Airway Pressure Equipment .................................................... 3.7
Apnea Monitors ...................................................................................... 3.7
Asthma Equipment ................................................................................ 3.7
Bilirubin Lights ....................................................................................... 3.7

O. EMERGENCY SERVICES ........................................................................ 3.7
Inside our Service Area: ........................................................................... 3.7
Outside our Service Area: ........................................................................ 3.8
Continuing Treatment Following Emergency Services ...................... 3.8
Inside our Service Area: ........................................................................... 3.8
Inside another Kaiser Permanente Region: ......................................... 3.8
Outside our Service Area: ........................................................................ 3.8
Continuing Treatment Following Emergency Surgery: ...................... 3.8
Outside our Service Transport to a Service Area: ................................. 3.8
Continuing Care in Non-Plan Facility Limitation: ................................ 3.8
Filing Claims for Non-Plan Emergency Services .................................. 3.8

P. FAMILY PLANNING SERVICES .............................................................. 3.9
Q. HABILITATIVE SERVICES ...................................................................... 3.9
R. HEARING SERVICES ............................................................................. 3.9
S. HOME HEALTH CARE .......................................................................... 3.10
T. HOSPICE CARE SERVICES ................................................................. 3.10
U. INFERTILITY SERVICES ........................................................................ 3.11
V. MATERNITY SERVICES .......................................................................... 3.12
W. MEDICAL FOODS ................................................................................. 3.12
X. MORBID OBESITY SERVICES ............................................................. 3.13
Y. ORAL SURGERY .................................................................................. 3.13
Z. PREVENTIVE HEALTH CARE SERVICES .......................................... 3.13

AA. PROSTHETIC DEVICES ..................................................................... 3.15
Internally Implanted Devices ................................................................. 3.15
Artificial Arms, Legs or Eyes ................................................................. 3.15
Ostomy and Urological Supplies ......................................................... 3.15
Breast Prosthetics and Hair Prosthetics ................................................. 3.15

BB. RECONSTRUCTIVE SURGERY ........................................................... 3.15
CC. SKILLED NURSING FACILITY CARE ............................................. 3.16
DD. TELEMEDICINE SERVICES ............................................................... 3.16
EE. THERAPY AND REHABILITATION SERVICES .................................. 3.16
Physical, Occupational, and Speech Therapy Services .................... 3.16
Multidisciplinary Rehabilitation Services ........................................... 3.17
Cardiac Rehabilitation Services ......................................................... 3.17

FF. TRANSPLANTS ..................................................................................... 3.17

GG. URGENT CARE .................................................................................. 3.17
Inside our Service Area: ........................................................................... 3.17
Outside our Service Area: ........................................................................ 3.17

HH. VISION SERVICES ............................................................................. 3.18
Medical Treatment .................................................................................. 3.18
Eye Exams ............................................................................................... 3.18
Pediatric Eye Exams ............................................................................... 3.18
Pediatric Lenses and Frames ............................................................... 3.18
Eyeglass Lenses ...................................................................................... 3.18
Frames ...................................................................................................... 3.18
II. X-RAY, LABORATORY, AND SPECIAL PROCEDURES .......................................................... 3.19

SECTION 4 – EXCLUSIONS, LIMITATIONS, AND REDUCTIONS .............................................. 4.1

EXCLUSIONS ........................................................................................................................................ 4.1
LIMITATIONS ........................................................................................................................................ 4.3
REDUCTIONS .......................................................................................................................................... 4.3

SECTION 5 – GETTING ASSISTANCE, FILING CLAIMS, AND THE APPEALS PROCEDURE ................................................................. 5.1

GETTING ASSISTANCE .................................................................................................................... 5.1
DEFINITIONS ........................................................................................................................................ 5.1
THE HEALTH CARE SERVICE REVIEW PROGRAM ........................................................................ 5.2
  Pre-Service Reviews ......................................................................................................................... 5.2
  Expedited Pre-Service Reviews .................................................................................................... 5.2
  Concurrent Reviews ....................................................................................................................... 5.3
  Filing for Payment/Reimbursement of a Post Service Claim .......................................................... 5.3
  Post-Service Claim Reviews ......................................................................................................... 5.3
INTERNAL GRIEVANCE AND APPEAL PROCESSES .................................................................. 5.4
  The Health Education and Advocacy Unit of the Office of the Attorney General ....................... 5.4
  Maryland Insurance Commissioner ............................................................................................... 5.4
  Internal Grievance Process .......................................................................................................... 5.5
  Expedited Grievances for Emergency Cases ............................................................................... 5.6
  Notices of Adverse Grievance Decision ...................................................................................... 5.6
  Internal Appeals Process .............................................................................................................. 5.7
FILING COMPLAINTS ABOUT HEALTH PLAN ............................................................................. 5.8

SECTION 6 – TERMINATION OF MEMBERSHIP ......................................................................... 6.1

TERMINATION OF GROUP AGREEMENT .................................................................................... 6.1
TERMINATION DUE TO LOSS OF ELIGIBILITY ........................................................................... 6.1
TERMINATION FOR CAUSE ........................................................................................................... 6.1
TERMINATION FOR NONPAYMENT ............................................................................................... 6.1
EXTENSION OF BENEFITS ............................................................................................................. 6.1
DISCONTINUATION OF A PRODUCT OR ALL PRODUCTS .......................................................... 6.2
CONTINUATION OF GROUP COVERAGE UNDER FEDERAL LAW (COBRA) ............................. 6.2
USERRA ........................................................................................................................................... 6.2
CONTINUATION OF GROUP COVERAGE UNDER STATE LAW ................................................ 6.2

SECTION 7 – MISCELLANEOUS PROVISIONS .............................................................................. 7.1

ADMINISTRATION OF AGREEMENT ............................................................................................. 7.1
ADVANCE DIRECTIVES .................................................................................................................... 7.1
AMENDMENT OF AGREEMENT .................................................................................................... 7.1
APPLICATIONS AND STATEMENTS ............................................................................................... 7.1
ASSIGNMENT .................................................................................................................................... 7.1
ATTORNEY FEES AND EXPENSES ............................................................................................... 7.1
CONTESTABILITY ............................................................................................................................ 7.1
CONTACTS WITH PLAN PROVIDERS .............................................................................................. 7.1
GOVERNING LAW ............................................................................................................................. 7.2
NOTICE OF NON-GRANDFATHERED COVERAGE ................................................................... 7.2
GROUPS AND MEMBERS NOT HEALTH PLAN’S AGENTS ........................................................... 7.2
MEMBER RIGHTS AND RESPONSIBILITIES .................................................................................. 7.2
NAMED FIDUCIARY .......................................................................................................................... 7.3
APPENDICES

DEFINITIONS
SUMMARY OF SERVICES AND COST SHARES
SECTION 1 – Introduction

This Evidence of Coverage (EOC) describes “Kaiser Permanente SignatureSM” health care coverage provided under the Agreement between Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and your Group. In this EOC, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. is sometimes referred to as “Health Plan,” “we,” or “us.” 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 Group’s contract year and your effective date of coverage. Your Group’s benefits administrator can confirm that this EOC is still in effect.

Health Plan provides health care services directly to its Members through an integrated medical care system, rather than reimburse expenses on a fee-for-service basis. The EOC should be read with this direct-service nature in mind. 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 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.

Kaiser Permanente SignatureSM
Kaiser Permanente SignatureSM provides health care benefits to Members using Plan Providers located in our Plan Medical Centers and through affiliated Plan Providers located throughout our Service Area, which is described in the “Definitions” section of this EOC.

To make your health care easily accessible, Health Plan provides conveniently located Plan Medical Centers and medical offices throughout the Washington and Baltimore metropolitan areas. We have placed an integrated team of specialists, nurses, and technicians alongside our network physicians, all working together at our state-of-the-art Plan Medical Centers. In addition, we include pharmacy, optical, laboratory, and X-ray facilities at most of our Plan Medical Centers.

Through our medical care system, you have convenient access to all of the covered health care Services you may need, such as routine care with your own Plan Physician, hospital care, nurses, laboratory and pharmacy Services and supplies, and other benefits described in the “Benefits” section.

Who is Eligible

General
To be eligible to enroll and to remain enrolled, you must meet the following requirements:

A. You must meet your Group’s eligibility requirements that we have approved (your Group is required to inform Subscribers of the Group’s eligibility requirements) and meet the Subscriber or Dependent eligibility requirements below.

B. You must live or work in our Service Area (our Service Area is described in the “Definitions” section).

However, you or your Spouse’s or Domestic Partner’s eligible children who live outside our Service Area may be eligible to enroll if you are required to cover them pursuant to any court order, court-approved agreement, or testamentary appointment. Please note that coverage is limited to only Emergency Services and Urgent Care Services provided outside of our Service Area, unless you elect to bring the Dependent within our Service Area to receive covered Services from Plan Providers. Visiting member care outside of our Service area, does not apply to Members who attend an accredited college or accredited vocational school.

C. You may not enroll under this EOC until you pay all amounts owed by you and your Dependents if you were ever a subscriber in this or any other plan who had entitlement to receive Services through us terminated for:

(i) failure of you or your Dependent to pay any amounts owed to us, Kaiser Foundation Hospitals, or Medical Group, or

(ii) failure to pay your Cost Share to any Plan Provider, or

(iii) failure to pay non-group Premium.
Subscribers
You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements that we have approved (i.e., an employee of your Group who works at least the number of hours specified in those requirements).

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

A. Your Spouse or Domestic Partner;

B. Your or your Spouse’s or Domestic Partner’s child who is under the age limit specified in the Summary of Services and Cost Shares section of the Appendix, including:
   
(i) a natural child,

(ii) a stepchild,

(iii) an adopted child,

(iv) a grandchild of the Subscriber or Subscriber’s Spouse or Domestic Partner, who is:
   
(a) unmarried;
   
(b) is in the court-ordered custody of the Subscriber;
   
(c) resides with the Subscriber;
   
(d) is the dependent of the Subscriber and has not attained the limiting age under the terms of the policy or contract.

(v) , or

(vi) a child who is: (a) under the testamentary or court-appointed guardianship, other than temporary guardianship of less than 12 months duration, of the Subscriber or Subscriber’s Spouse or Domestic Partner, (b) resides with the Subscriber, and (c) is a dependent of the Subscriber or the Subscriber’s Spouse or Domestic Partner;

(vii) a child for whom the Subscriber, Subscriber’s Spouse or Domestic Partner has received a child support order or other court order.

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

A. They are incapable of self-sustaining employment because of a mental or physical incapacity that occurred prior to reaching the age limit for Dependents;

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

C. You provide us proof of their incapacity and dependency at the time that the individual has been certified as a disabled dependent. (see the “Disabled Dependent Certification” section below for additional eligibility requirements)

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:

A. If your Dependent is incapacitated, we require you to provide your Dependent's documentation of his or her incapacity and dependency at the time that the individual reaches the dependent age limit. Upon receipt of the documentation, we will determine if the individual is eligible as a disabled Dependent.

B. 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.

C. 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. Documentation of your Dependent’s incapacity and dependency may be requested less than once per year; however, such documentation must be provided within 60 days after we request it.

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 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**

Membership begins at 12:00 a.m. (the time at the location of the administrative office of Health Plan at 2101 East Jefferson Street, Rockville, Maryland 20852) on the membership effective date. Eligible individuals may enroll as follows:

**New Employees and Their Dependents**

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible (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 the Group Agreement as specified on the Face Sheet, or is different than the dates specified under “Special Enrollment Due to New Dependents” listed below.

**Special Enrollment**

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during Open Enrollment as described below, unless one of the following is true:

A. You become eligible as described in this “Special enrollment” section.

B. You did not enroll 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**

You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, within 31 days after marriage, Domestic Partnership, birth, adoption, or placement for adoption by submitting to your Group a Health Plan-approved enrollment application.

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

A. For new Spouse or Domestic Partner, no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber.

B. 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 31 days from the date of birth, notification of birth and payment of additional Premium must be provided within 31 days of the date of birth, otherwise coverage for the newborn will terminate 31 days from the date of birth.

C. For children, stepchildren, grandchildren, or adopted children who become eligible through Subscriber’s marriage, the date of the marriage.

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

D. For children, stepchildren, grandchildren, or adopted children who become eligible through Subscriber’s new Domestic Partner arrangement, the date of the signed Affidavit of Domestic Partnership.

If payment of additional Premium is required to provide coverage for the child(ren) then, in order for coverage to continue beyond 31 days from the date of eligibility, notification of eligibility and payment of additional Premium must be provided within 31 days of the date of eligibility, otherwise coverage for the newly eligible child(ren) will terminate 31 days from the date of eligibility.
E. For newly adopted children (including children newly placed for adoption), the “date of adoption.”

The “date of adoption” means the earlier of: (1) a judicial decree of adoption, or (2) the assumption of custody or placement with the Subscriber or Subscriber’s Spouse or Domestic Partner, pending adoption of a prospective adoptive child by a prospective adoptive parent.

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

F. For a newly eligible grandchild, the date the grandchild is placed in your or your Spouse’s or Domestic Partner’s custody.

If payment of additional Premium is required to provide coverage for the child then, in order for coverage to continue, notification of the court ordered custody and payment of additional Premium must be provided within 31 days of the date of the court ordered custody; otherwise enrollment of the child will be void.

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

If payment of additional Premium is required to provide coverage for the child then, in order for coverage to continue, notification of the court or testamentary appointment may be provided at any time but, payment of additional Premium must be provided within 31 days of the age of the court or testamentary appointment; otherwise enrollment of the child terminates 31 days from the date of the court or testamentary appointment.

Special Enrollment due to court or administrative order

If you are enrolled as a Subscriber and you are required under a court or administrative order to provide coverage for a Dependent child, you may enroll the child at any time pursuant to the requirements specified by §15-405(f) of the Maryland Insurance Article. You must submit a Health Plan approved enrollment application along with a copy of the order to your employer.

The membership effective date for children who are newly eligible for coverage as the result of a court or administrative order received by you or your Spouse or Domestic Partner, will be the date specified in the court or administrative order.

If payment of additional Premium is required to provide coverage for the child, notification of the court or administrative order may be provided at any time but, payment of additional Premium must be provided within 31 days of enrollment of the child; otherwise, enrollment of the child will be void.

Enrollment for such child will be allowed in accordance with Section 15-405(c) of the Insurance Article which provides for the following:

A. An insuring parent is allowed to enroll in family member’s coverage and include the child in that coverage regardless of enrollment period restrictions;

B. A noninsuring parent, child support agency, or Department of Health and Mental Hygiene is allowed to apply for health insurance coverage on behalf of the child and include the child in the coverage regardless of enrollment period restrictions; and

C. Health Plan may not terminate health insurance coverage for a child eligible under this subsection unless written evidence is provided that:

(i) the court or administrative order is no longer in effect;

(ii) the child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;

(iii) the employer has eliminated family member’s coverage for all of its employees; or

(iv) the employer no longer employs the insuring parent, except the parent elects to enroll in COBRA, coverage shall be provided for the child consistent with the employer’s plan for
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 Health Plan coverage

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; however the special enrollment period is still applicable even if the other coverage continues because the enrolling person is paying the amounts previously paid by the employer;
   (3) loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. 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 eligibility for Medicaid coverage or Child Health Insurance Program coverage, but not termination for cause; or
   (5) reaching a lifetime maximum on all benefits

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 31 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for Medicaid or Child Health Insurance Program 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 reenrolled 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 CHIP
You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, if the Subscriber or at least one of the enrolling Dependents becomes eligible to receive premium assistance under Medicaid or CHIP. To request enrollment, the Subscriber must submit a Health Plan-approved enrollment or change of enrollment application to your Group within 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.

Open Enrollment
You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and your membership effective date.

Premium
Members are entitled to health care coverage only for the period for which we have received the appropriate Premium from your Group. You are responsible for any Member contribution to the Premium and your Group will tell you the amount and how you will pay it to your Group (through payroll deduction, for example).
SECTION 2 – How to Obtain Services

To receive covered Services, you must be a current Health Plan 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. You must receive all covered Services from Plan Providers inside our Service Area, except as described under the following headings:

- Emergency Services, in Section 3: “Benefits”
- Urgent Care Outside our Service Area, in Section 3: “Benefits”
- Continuity of Care for New Members as described in Section 2
- Approved Referrals, as described in Section 2, under “Getting a Referral” including referrals for Clinical Trials as described in Section 3
- Authorized Referrals
- Visiting Other Kaiser Permanente Regions or Group Health Cooperative Service Areas, in this section

Your Primary Care Plan Physician

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 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 a primary care Plan Physician who is available to accept new members from any of 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 Web site address:

www.kp.org

To learn how to choose or change your primary care Plan Physician, please call our Member Services Department at:

Inside the Washington, D.C., Metropolitan area
301-468-6000
TTY 711

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

Our Member Services Representatives are available to assist you Monday through Friday from 7:30 a.m. until 9:00 p.m.

Continuity of Care for New Members

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

- Accept a preauthorization issued by the member’s prior carrier, managed care organization or third party administrator; and
- Allow a new enrollee to continue to receive health care Services being rendered by a non-Plan provider at the time of the member’s enrollment under this Agreement. If this Agreement is an Added Choice Point of Service (POS) plan the cost share will be covered at the In-Plan level as shown in the Summary of Services and Cost Shares.

As described below, Health Plan will accept the preauthorization; and allow a new member to continue to receive Services from a non-Plan Provider for:

1. The lesser of the course of treatment or 90 days; and
2. The duration of up to three trimesters of a pregnancy and the initial postpartum visit.

Getting a Referral

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 Signature provider 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.

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), you will be referred to a 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) Obstetric and gynecological Services provided by an obstetrician/gynecologist, a certified nurse-midwife, or any other Plan Provider authorized to provide obstetric and gynecological Services, if the care is Medically Necessary, including routine care and the ordering of related obstetrical and gynecological Services that are covered under the Agreement.

(3) Optometry Services.

(4) Urgent Care Services provided within our Service Area.

For the most up-to-date list of Plan Medical Centers and other Plan Providers, visit our website at www.kp.org. To request a provider directory, please call our Member Services Department at the number listed on your Health Plan identification card.

Standing Referrals to Specialists

If you suffer 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 you and the specialist, that you need continuing care from the specialist. In such instances, your primary care Plan Physician will issue a standing referral to the specialist.

The standing referral shall be made in accordance with a written treatment plan for covered Services developed by the specialist, your primary care Plan Physician and you. The treatment plan may limit the number of visits to the specialist; limit the period of time in which visits to the specialist are authorized; and require the specialist to communicate regularly with your primary care Plan Physician regarding the treatment and your health status.

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’s policies and procedures, through the postpartum period. A written treatment plan is not required for a standing referral to an Obstetrician.

Referrals to Non-Plan Specialists and Non-Plan Non-Physician Specialists

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

(1) The Member has been diagnosed with a condition or disease that requires specialized medical care; and

(2) Health Plan does not have a Plan specialist or a Non-Physician Specialist with the professional training and expertise to treat or provide health care Services for the condition or disease; or

(3) Health Plan cannot provide reasonable access to a specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care Services for the condition or disease without unreasonable delay or travel.

You must have an approved oral or written referral to the non-Plan specialist or non-Plan Non-Physician Specialist in order for us to cover the Services. Any additional radiology studies, laboratory Services, or Services from any other professional not named in the referral are not authorized and will not be reimbursed. If the non-Plan Provider recommends Services not indicated in the approved referral, your primary care Plan Physician will work with you to determine whether those Services can be provided by a Plan Provider. Copayments and Coinsurance for approved referral Services are the same as those required for Services provided by a Plan Provider.

Second Opinions

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

Getting the Care You Need: Emergency Services, Urgent Care, and Advice Nurses

If you think you are experiencing an Emergency Medical Condition, call 911 (where available) or go to the nearest emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition we cover Emergency Services you receive from Plan Providers or Non-Plan Providers anywhere in the world, as long as the Services would have been covered under the “Benefits” section (subject to the “Exclusions, Limitations, and Reductions” section).
Emergency Services are available from Plan Hospital emergency departments 24 hours a day, seven days a week.

**Getting Advice from our Advice Nurses**

If you are not sure you are experiencing a medical emergency, or for 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*
1-800-777-7904
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**

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

*Inside the Washington, D.C. Metropolitan Area*
703-359-7878
TTY 711

*Outside the Washington, D.C. Metropolitan Area*
1-800-777-7904
TTY 711

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

**Missed Appointment Fee**

If you cannot keep a scheduled medical appointment, please notify your health care professional’s office at least one day prior to the appointment. If you fail to cancel your appointment, you may be responsible for the payment of an administrative fee for the missed appointment. The fee for a missed appointment at a Plan Medical Center is shown in the Summary of Services and Cost Shares section of the Appendix. This fee will not count toward your Copayment or Out-of-Pocket Maximum, if applicable.

**Using Your Identification Card**

Each Member has a Health Plan ID card with a Medical Record Number on it to use when you call for advice, 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 our Member Services Department in the Washington, D.C., Metropolitan area at 301-468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902. Our TTY is 711.

*Your ID card is for identification only.* You will be issued a Kaiser Membership card that will serve as evidence of your membership status. In addition to your Membership 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.

**Visiting Other Kaiser Permanente Regions or Group Health Cooperative Service Areas**

When you temporarily visit a different Kaiser Permanente Region or Group Health Cooperative service, you can receive visiting member care from designated providers in that area. The covered Services, Copayments, Coinsurance and Deductibles, if applicable, may differ from those in this Service Area, and are governed by the Kaiser Permanente program for visiting members. This program does not cover certain Services, such as transplant Services or infertility Services. To receive more information about visiting member Services, including facility locations across the United States, you may call our Member Services Department:

*Inside the Washington, D.C. Metropolitan Area*
301-468-6000
TTY 711

*Outside the Washington, D.C. Metropolitan Area*
1-800-777-7902

Service areas and facilities where you may obtain visiting member care may change at any time.

The following visiting member care is covered when it is provided or arranged by a Plan Physician in the visited service area. The benefits may not be the same as those you receive in your home service area. Except for outpatient prescription drugs, these
benefits are provided at no charge to you.

**Hospital Inpatient Care:**
- Physician Services
- Room and board
- Necessary Services and supplies
- Maternity Services
- Prescription drugs

**Outpatient Care:**
- Office visits
- Outpatient surgery
- Physical, speech and occupational therapy (up to 20 visits for physical therapy per incident; up to two months for occupational and speech therapy)
- Allergy tests and allergy injections
- Dialysis care

**Laboratory and X-Ray:**
- Covered in or out of the hospital

**Outpatient Prescription Drugs:**
- Covered only if you have an outpatient prescription drug benefit (regular home Service Area Copayments, Coinsurance, Deductibles, exclusions and limitations apply)

**Mental Health Services Other than for Emergency or Urgent Care Services:**
- Outpatient visits and inpatient hospital days

**Substance Abuse Treatment Other than for Emergency or Urgent Care Services:**
- Inpatient and outpatient medical detoxification and other outpatient visits

**Skilled Nursing Facility Care:**
- Up to 100 days per calendar year

**Home Health Care:**
- Home health care Services inside the visited service area

**Hospice Care:**
- Home-based hospice care inside the visited service area

**Preauthorization Required for Certain Services**
- Inpatient physical rehabilitation services covered in your home region may also be available to you as a visiting member. Preauthorization from your home region is required.
- Other Services that require preauthorization in your home region may also be available to you when you are visiting another Kaiser Foundation Health Plan or Group Health Cooperative service area, once you have obtained preauthorization from your home region.

Also, some services require preauthorization from the visited region or service area. Please contact Member Services in the region or Group Health Cooperative service area you’ll be visiting for more information.

**Visiting Member Service Exclusions**
The following Services are not covered under your visiting member benefits. ("Services" include equipment and supplies.) However, some of these Services, such as Emergency Services, may be covered under your home Service Area benefits, and applicable Copayments, Coinsurance and/or Deductibles will apply. For coverage information, refer to the “Benefits” section of this EOC.

- Services that are not Medically Necessary
- Physical examinations and related Services for insurance, employment, or licensing
- Drugs for the treatment of sexual dysfunction disorders
- Dental care and dental X-rays
- Services to reverse voluntary infertility
- Infertility Services
- Services related to conception by artificial means, such as IVF and GIFT
- Experimental Services and all clinical trials
- Cosmetic surgery or other Services primarily to change appearance
- Custodial care and care provided in an intermediate care facility
- Services related to sexual reassignment
- Transplants and related care
- Complementary and alternative medicine Services, such as chiropractic Services
- Services received as a result of a written referral from a Plan provider in your home service area
- Emergency Services, including emergency ambulance Services
- Services that are excluded or limited in your home Service Area

**Moving to Another Kaiser Permanente Region or Group Health Cooperative Service Area**

If you move to another Kaiser Permanente 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, Premium, Copayments, Coinsurance and Deductibles, if applicable, may not be the same in the other service area. You should contact your Group’s employee benefits coordinator before you move.
SECTION 3 – Benefits

The Services described in this “Benefits” section are covered only if all of the following conditions are satisfied:

• You are a Member on the date the Services are rendered, except as provided for “Extension of Benefits” as described in Section 6 of this EOC;
• You have not met the maximum benefit for the Service, if any. A maximum benefit applies per Member per contract year.
• 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, as described in Section 3
• Urgent Care outside our Service Area, as described in Section 3
• Continuity of Care for New Members, as described in Section 2
• Authorized referrals to non-Plan Providers, as described in Section 2 under “Getting a Referral”, including referrals for Clinical Trials as described in this Section
• Visiting Member Services as described in Section 2

Exclusions and Limitations: Exclusions and limitations that apply only to a particular benefit are described in this section. Other exclusions, limitations, and reductions that affect benefits are described in the “Exclusions, Limitations, and Reductions” section and the Summary of Services and Cost Shares Appendix.

Note: The Summary of Services and Cost Shares Appendix lists the Copayments, Coinsurances and Deductibles, if any, that apply to the following covered Services. Your Cost Share will be determined by the type and place of Service.

A. Outpatient Care

We cover the following outpatient care for preventive medicine, diagnosis, and treatment:

• Primary care visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics and gynecology Services (refer to “Preventive Health Care Services” for coverage of preventive care Services);
• Specialty care visits (refer 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 limited not to:
• Diagnostic examinations, including digital rectal exams and prostate antigen (PSA) tests provided:
  • for men who are between 40 and 75 years of age;
  • when used for male patients who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society;
  • when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; or
  • when used for staging in determining the need for a bone scan in patients with prostate cancer;
• Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiological imaging, for persons, who are at high risk of cancer, in accordance with the most recently published guidelines of the American Cancer Society;
• Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis is provided when the bone mass measurement is requested by a health care provider for a qualified individual. A “qualified individual” means:
  • an estrogen deficient individual at clinical risk for osteoporosis;
  • an individual with a specific sign suggestive of spinal osteoporosis, including roentgeno-graphic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one 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;
• an individual with primary hyperparathyroidism; or
• an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

**Note:** As described here, diagnostic testing is not preventive care and may include an office visit, outpatient surgery, diagnostic imaging, or x-ray and lab. The applicable Cost Share will apply based on the place and type of Service provided. (Refer to “Preventive Health Care Services” for coverage of preventive care tests and screening Services);

- Outpatient surgery;
- Anesthesia, including Services of an anesthesiologist;
- Chemotherapy and radiation therapy;
- Respiratory therapy;
- Medical social services;
- House calls when care can best be provided in your home as determined by a Plan Provider; and
- 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.

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

**B. Hospital Inpatient Care**

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

- Room and board (includes bed, meals and special diets), including private room when deemed Medically Necessary;
- Specialized care and critical care units;
- General and special nursing care;
- Operating and recovery room;
- Plan Physicians’ and surgeons’ Services, including consultation and treatment by specialists;
- Anesthesia, including Services of an anesthesiologist;
- Medical supplies;
- Chemotherapy and radiation therapy;
- Respiratory therapy; and
- Medical social Services and discharge planning.

**Hospitalization and Home Health Visits Following Mastectomy**

We cover the cost of inpatient hospitalization services for a minimum of 48 hours following a mastectomy. A Member may request a shorter length of stay following a mastectomy if the Member decides, in consultation with the Member’s attending physician, that less time is needed for recovery.

For a Member who remains in the hospital for at least 48 hours following mastectomy, we cover the cost of a home visit if prescribed by the attending physician. Refer to the Home Health Care Benefit for home health visits covered following a mastectomy or removal of a testicle.

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

**C. Accidental Dental Injury Services**

We cover restorative Services necessary to promptly repair, but not replace, Sound Natural Teeth that have been injured as the result of an external force. Coverage is provided when all of the following conditions have been satisfied:

- The accident has been reported to your primary care Plan Physician within 72 hours of the accident.
- A Plan Provider provides the restorative dental Services.
- The injury occurred as the result of an external force that is defined as violent contact with an external object, not force incurred while chewing.
- The injury was sustained to Sound Natural Teeth.
- The covered Services must begin within 60 days of the injury.
- The covered Services are provided during the 12 consecutive month period commencing from the date that treatment for the injury started.

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

For the purposes of this benefit, Sound Natural Teeth are defined as a tooth or teeth that (a) have not been weakened by existing dental pathology such as decay or periodontal disease, or (b) have not been previously restored by a crown, inlay, onlay, porcelain restoration, or treatment by endodontics.

**Accidental Dental Injury Services Exclusions:**
• Services provided by non-Plan Providers.
• Services provided after 12 months from the date treatment for the injury commenced.
• Services for teeth that have been avulsed (knocked out) or that have been so severely damaged that in the opinion of the Plan Provider, restoration is impossible.

D. Allergy Services
We cover the following allergy Services:
• Evaluations and treatment
• Injection visits and serum

E. Ambulance Services
We cover licensed ambulance Services only if: (1) your condition requires either the basic life support, advanced life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer, and (2) the ambulance transportation has been ordered by a Plan Provider. Coverage is also provided for Medically Necessary transportation or Services, including Medically Necessary air ambulance transport to the nearest hospital able to provide needed Services, rendered as the result of a 911 call. Your Cost Share will apply to each encounter, whether or not transport was required.

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

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

We will not cover emergency ambulance or non-emergent transportation Services in any other circumstances, even if no other transportation is available. We cover licensed ambulance non-emergent transportation Services ordered by a Plan Provider only inside our Service Area, except as covered under the “Emergency Services” provision in this section of the EOC.

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

F. Anesthesia for Dental Services
We cover general anesthesia and associated hospital or ambulatory facility Services for dental care provided to Members:
• Who are 7 years of age or younger or are developmentally disabled;
• For whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition; and
• For whom a superior result can be expected from dental care provided under general anesthesia; or
• Who are 17 years of age or younger who is extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred; and
• Whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity; or
• For adults age 17 and older when the Member’s medical condition requires that dental service be performed in a hospital or ambulatory surgical center for the safety of the Member (e.g., heart disease and hemophilia).

General anesthesia and associated hospital and ambulatory facility charges will be covered only for dental care that is provided by:
• A fully accredited specialist in pediatric dentistry; or
• A fully accredited specialist in oral and maxillofacial surgery; and
• For whom hospital privileges have been granted.

Anesthesia for Dental Services Exclusions:
• The dentist or specialist’s professional Services.
• Anesthesia and associated facility charges for dental care for temporomandibular joint (TMJ) disorders.

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

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

**Blood, Blood Products and their Administration Limitations:**
- Member recipients must be designated at the time of procurement of cord blood.

**Blood, Blood Products and their Administration Exclusions:**
- Directed blood donations.

### H. Chemical Dependency and Mental Health Services

#### Mental Illness, Emotional Disorders, Drug and Alcohol Abuse Services
We cover the treatment of mental illnesses, emotional disorders, drug abuse and alcohol abuse for conditions that in the opinion of a Plan Provider would be Medically Necessary and treatable. For the purposes of this benefit provision, drug and alcohol abuse means a disease that is characterized by a pattern of pathological use of a drug and/or alcohol with repeated attempts to control its use and with significant negative consequences in at least one the following areas of life: medical, legal, financial, or psycho-social.

We cover inpatient in a licensed or certified facility or program, including a licensed or certified residential treatment center. Covered Services include all medical Services of physicians and other health professionals as performed, prescribed or directed by a Physician including:
- Individual therapy
- Group therapy
- Shock therapy
- Drug therapy
- Education
- Psychiatric nursing care
- Appropriate Hospital Services

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

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

In an outpatient setting, we cover all necessary Services of physicians and other health care professionals to treat mental illness, emotional disorders, drug abuse and alcohol abuse, as performed, prescribed, or directed by a physician including, but not limited to:
- Evaluations
- Crisis intervention
- Individual therapy
- Group therapy
- Psychological and neuropsychological testing for diagnostic purposes
- Medical treatment for withdrawal symptoms
- Visits for the purpose of monitoring drug therapy

#### Chemical Dependency and Mental Health Services Exclusions:
- Services for Members who, in the opinion of the Plan Provider, are seeking services and supplies for other than therapeutic purposes.
- Psychological and neuropsychological testing for ability, aptitude, intelligence, or interest.
- Services on court order or as a condition of parole or probation, unless determined by the Plan Provider to be necessary and appropriate.
- Evaluations that are primarily for legal or administrative purposes, and are not medically indicated.

#### Psychiatric Residential Crisis Services
We cover residential crisis Services that are:
- Provided to a Member with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the individual’s ability to function in the community;
- Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay;
- Provided out of the Member’s residence on a short-term basis in a community-based residential setting; and
- Provided by entities that are licensed by the Department of Health and Mental Hygiene to provide residential crisis Services.

#### Psychiatric Residential Crisis Services Exclusion:
- Long-term residential treatment Services

### I. Cleft Lip, Cleft Palate or Both
We cover inpatient and outpatient Services arising from orthodontics, oral surgery and otologic, audiological and speech/language treatment as the result of the congenital defect known as cleft lip, cleft palate, or both.
J. Clinical Trials
We cover the patient costs you incur for clinical trials provided on an inpatient and an outpatient basis as the result of: (i) treatment for a life-threatening condition; or (ii) prevention, early detection, and treatment studies on cancer. “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:
(a) The cost of an investigational drug or device, except as provided below for off-label use of an FDA-approved drug or device;
(b) The cost of non-health care services that may be required as a result of treatment in the clinical trial; or
(c) Costs associated with managing the research for the clinical trial.
We cover the patient costs incurred for clinical trials if:
(a) the treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer or any other life-threatening condition;
(b) the treatment is being provided in a clinical trial approved or funded by:
   • one of the National Institutes of Health (NIH);
   • an NIH cooperative group or an NIH center;
   • the FDA in the form of an investigational new drug application, including drug trials that are exempt from having an investigational new drug application reviewed by the FDA;
   • the Federal Department of Veterans Affairs;
   • an institutional review board of an institution in the state which has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the National Institutes of Health;
   • Centers for Disease Control and Prevention;
   • the Agency for Health Care Research and Quality;
   • the Centers for Medicare & Medicaid Services;
   • the Department of Defense;
   • a cooperative group or center for the four previously mentioned entities;
   • a cooperative group or center for the Department of Veterans Affairs;
   • a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
   • the Department of Energy;
(c) the facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
(d) there is no clearly superior, non-investigational treatment alternative; and
(e) the available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.

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

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

K. Diabetic Equipment, Supplies, and Self-Management
We cover diabetes equipment, diabetes supplies, and in-person diabetes outpatient self-management training and educational Services, including medical nutrition therapy, when prescribed by a Plan Provider and purchased from a Plan preferred vendor, for the treatment of:
• Insulin-using diabetes;
• Insulin-dependent diabetes;
• Non-insulin using diabetes; or
• Elevated blood glucose levels induced by pregnancy, including gestational diabetes.

Note: Insulin is not covered under this benefit. Refer to the “Outpatient Prescription Drug Rider,” if applicable.

Diabetic Equipment, Supplies, and Self-Management 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. To obtain information about Plan preferred vendors, you may call our Member Services Department:

Inside the Washington, D.C. Metropolitan Area
(301) 468-6000
TTY 711

Outside the Washington, D.C. Metropolitan Area
1-800-777-7902

**L. Dialysis**

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. 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:

- Hemodialysis;
- Home intermittent peritoneal dialysis (IPD);
- Home continuous cycling peritoneal dialysis (CCPD); and
- Home continuous ambulatory peritoneal dialysis (CAPD).

**M. Drugs, Supplies and Supplements**

We cover the following during a covered stay in a Plan Hospital or Skilled Nursing Facility, or if they require administration or observation by medical personnel and are administered to you in a Plan Medical Office 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 including dressing, casts, 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. See: “Outpatient Prescription Drug Rider,” if applicable, 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.

**Drugs, Supplies and Supplements Exclusions**

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

**N. 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.

Durable Medical Equipment does not include coverage for prosthetic devices, such as artificial eyes or legs, or orthotic devices, such as braces or therapeutic shoes. Refer to “Prosthetic Devices” for coverage of 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 also cover Durable Medical Equipment used during a covered stay in a Plan Hospital or Skilled Nursing Facility, but only if the Skilled Nursing Facility ordinarily furnishes Durable Medical Equipment.

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

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

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

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 every 30 days.

2. **Positive Airway Pressure Equipment**
   We cover continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BIPAP) equipment when prescribed by a Plan Provider and your medical condition meets Health Plan’s criteria for Medical Necessity. A Plan Provider must certify the continued medical need every 30 days.

3. **Apnea Monitors**
   We cover apnea monitors for infants, who are under age 3, for a period not to exceed 6 months.

4. **Asthma Equipment**
   We cover the following asthma equipment for pediatric and adult asthmatics when purchased from a Plan Provider:
   - Spacers
   - Peak-flow meters
   - Nebulizers

5. **Bilirubin Lights**
   We cover bilirubin lights for infants who are under age 3, for a period not to exceed 6 months.

**Durable Medical Equipment Exclusions:**
- 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.
- Devices for testing blood or other body substances (except as covered under “Diabetes Equipment, Supplies and Self Management”).
- Electronic monitors of the heart or lungs, except infant apnea monitors.
- Services not preauthorized by Health Plan.

**O. Emergency Services**

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

If you think you are experiencing an Emergency Medical Condition, you should call 911 immediately. If you are not sure whether you are experiencing an Emergency Medical Condition, please contact us at the number listed on the reverse side of your ID card for immediate medical advice. You or your representative should notify Health Plan as soon as possible, not to exceed 48 hours or the next business day, whichever is later, after you receive care at a hospital emergency room (ER) to ensure coverage. If the emergency room visit was not due to an “Emergency Medical Condition,” as defined in the “Definitions” Appendix of this EOC, and was not authorized by the Health Plan, you will be responsible for all charges.

We cover Emergency Services as follows:

**Inside our Service Area:**
We cover reasonable charges for Emergency Services provided within our Service Area by a Plan Provider or a non-Plan Provider. Coverage provided by a non-Plan Provider is limited to Emergency Services required before you can, without medically harmful
consequences, be transported to a Plan Hospital or your primary care Plan Physician’s office.

Outside our Service Area:
We cover reasonable charges for Emergency Services if you are injured or become ill while temporarily outside our Service Area.

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

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
Except for Emergency Services received for emergency surgery described below, 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.

Continuing Treatment Following Emergency Surgery
If we authorize, direct, refer, or otherwise allow you to access a hospital emergency facility or other urgent care facility for a medical condition that requires emergency surgery, we will reimburse the physician, oral surgeon, periodontist or podiatrist who performed the surgical procedure for follow-up care that is:

- Medically Necessary;
- directly related to the condition for which the surgical procedure was performed; and
- provided in consultation with the Member’s primary care Plan Physician.

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

Transport to a Service Area
If you obtain prior approval from us, or from the nearest Kaiser Foundation Health Plan Medical Center, 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 “Ambulance 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, or if you choose not to be transferred, we will not cover any Services you receive after transfer would have been possible.

Filing Claims for Non-Plan Emergency Services
Keep all your receipts for Emergency Services provided by non-Plan Providers and verify that the non-Plan Provider has submitted the claims. All claims must be filed with us within six months of the date of the Service, or as soon as reasonably possible, and except in the absence of legal capacity no later than one year from the time proof was otherwise required.

Emergency Services Limitations:

- Notification: If you are admitted to a non-plan hospital, you, or someone on your behalf, should notify us as soon as possible, but not later than 48 hours or the end of the first business day, whichever is later, after the hospital admission unless it was not reasonably possible to notify us. If you are admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us as provided herein, we will not cover the hospital care you receive after transfer would have been possible.

If possible, we urge you or your authorized representative to notify us of any emergency room visits to assist you in coordinating any necessary follow-up care.
• **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 Permanente Region or Group Health Cooperative service area.

• **Hospital Observation**: Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit Copayment will not be waived.

**P. Family Planning Services**

We cover the following:

• 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, the insertion or removal of contraceptive devices, including any Medically Necessary examination associated with the use of contraceptive drugs and devices; and
  • Female sterilization.

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

• Additional family planning counseling, including pre-abortion and post-abortion counseling;

• Vasectomies

• Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (i) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (ii) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.

**Voluntary termination of pregnancy limitations:**

• We cover up to a maximum of two voluntary terminations of pregnancy during a contract year.

**Note:** Diagnostic procedures are not covered under this section (see “X-ray, Laboratory and Special Procedures”).

**Q. Habilitative Services**

**Children under age 19**

We cover Medically Necessary habilitative Services for children under the age of 19 years with a congenital or genetic birth defect, to enhance the child’s ability to function. Medically Necessary habilitative Services are those Services, including occupational therapy, physical therapy, and speech therapy, that are designed to help an individual 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. Congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. Congenital or genetic birth defect includes, but is not limited to (1) autism or an autism spectrum disorder, (2) cerebral palsy (3) intellectual disability, (4) down syndrome, (5) spina bifida, (6) hydroencephalocele and (7) congenital or genetic developmental disabilities.

Medical Necess ary Services to treat autism and autism spectrum disorders shall include Applied Behavioral Analysis (ABA) in accordance with regulations adopted by the Commissioner of the State of Maryland.

**Habilitation Services Exclusions:**

• Services provided through federal, state or local early intervention programs, including school programs.

• Services not preauthorized by Health Plan.

• Services for a Member that has plateaued and is able to demonstrate stability of skills and functioning even when Services are reduced.

**R. Hearing Services**

**Hearing Exams**

We cover hearing tests to determine the need for hearing correction, when ordered by a Plan Provider. (Refer to “Preventive Health Care Services” for coverage for newborn hearing screenings.)

**Hearing Aids**

We cover one hearing aid for each hearing impaired ear every 36 months.

A "hearing aid" is defined as a device that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children; and is non-disposable.

**Hearing Services Exclusions:**

Except as listed above for hearing aids, the following exclusions apply:

• Tests to determine an appropriate hearing aid.

• Hearing aids or tests to determine their efficacy.
• Replacement parts and batteries.
• Replacement of lost or broken hearing aids.
• Comfort, convenience, or luxury equipment or features.

S. Home Health Care

Except as provided for Visiting Member Services, we cover the following home health care Services only within our Service Area, only if you are substantially confined to your home, and only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home:

• Skilled nursing care
• Home health aide Services
• Medical social services

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

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

For a Member who remains in the hospital for at least 48 hours following mastectomy, we cover the cost of a home visit if prescribed by the attending physician.

For Members undergoing a mastectomy or removal of a testicle on an outpatient basis, as well as Members who receive less than 48 hours of inpatient hospitalization following the surgery, we cover the following:

• One home visit scheduled to occur within 24 hours following his or her discharge from the hospital or outpatient facility; and
• One additional home visit, when prescribed by the patient’s attending physician.

If a visit maximum applies, the maximum will not include home visits following mastectomy or testicle removal; and home visits following mastectomy or testicle removal do not count toward the visit maximum.

Home Health Care Limitations:

• Home HealthCare visits shall be limited to two (2) hours per visit. Intermittent care shall not exceed three (3) visits in one day.

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

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

Home Health Care Exclusions:

• Custodial care (see definition under “Exclusions” in the “Exclusions, Limitations, and Reductions” section of this EOC).
• Routine administration of oral medications, eye drops, ointments.
• General maintenance care of colostomy, ileostomy, and ureterostomy.
• Medical supplies or dressings applied by a Member or family caregiver.
• Corrective appliances, artificial aids, and orthopedic devices.
• Homemaker Services.
• Services not preauthorized by Health Plan.
• Care that a Plan Provider determines may be provided in a Plan Facility and we provide or offer to provide that care in one of these facilities.
• Transportation and delivery service costs of Durable Medical Equipment, medications and drugs, medical supplies, and supplements to the home.

T. 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 Services through home or inpatient care instead of traditional Services otherwise provided for your illness. We cover Hospice Care Services in the home if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

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

• Nursing care;
• Physical, occupational, speech, and respiratory therapy;
• Medical social Services;
Your Group Evidence of Coverage

- Home health aide Services;
- Homemaker Services;
- Medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the terminally ill Member.
- Palliative drugs in accord with our drug formulary guidelines;
- Physician care;
- Short-term inpatient care; including care for pain management and acute symptom management as Medically Necessary;
- Respite Care for up to 14 days per contract year, limited to 5 consecutive days for any one inpatient stay;
- Counseling services for the Member and his Family Members, including dietary counseling for the Member; and bereavement counseling for the Member’s Family for a period of one year after the Member’s death; and
- Services of hospice volunteers.

Definitions:

**Family Member** means a relative by blood, marriage, domestic partnership or adoption of the terminally ill Member.

**Hospice Care Services** mean 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 to (a) individuals who have no reasonable prospect of cure as estimated by a physician; and (b) Family Members and Caregivers of those individuals.

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

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

**U. Infertility Services**

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

- Artificial insemination; and
- In vitro fertilization, if:
  (a) For a Member whose spouse is of the opposite sex, the Member’s oocytes are fertilized with the Member’s spouse’s sperm;
  (b) the Member and the Member’s spouse have a history of involuntary infertility, which may be demonstrated by a history of:
    (i) if the Member and the Member’s Spouse are of opposite sexes, intercourse of at least 2 years duration failing to result in pregnancy; or
    (ii) if the Member and the Member’s Spouse are of the same sex, six (6) attempts of artificial insemination over the course of 2 (two) years failing to result in pregnancy; or
  (2) or the infertility is associated with any of the following:
    (i) endometriosis;
    (ii) exposure in utero to diethylstilbestrol, commonly known as DES;
    (iii) blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
    (iv) abnormal male factors, including oligospermia, contributing to the infertility;
  (c) the Member has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this EOC; and
  (d) the in vitro fertilization procedures are performed at medical facilities that conform to applicable guideline or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.
- Intracytoplasmic Sperm Injection (ICSI) if the Member meets medical guidelines;
- Preimplantation Genetic Diagnosis (PGD) if the Member meets medical guidelines.

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

**Infertility Limitations**

- Coverage for in-vitro fertilization embryo transfer cycles, including frozen embryo transfer (FET) procedure, is limited to three attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.
Infertility Exclusions:
- Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member’s eggs and/or male Member’s sperm for future attempts.
- Any charges associated with donor eggs, donor sperm or donor embryos.
- Infertility Services, except for covered Services for in vitro fertilization, when the member does not meet medical guidelines established by the American College of Obstetricians and Gynecologists.
- Services to reverse voluntary, surgically induced infertility.
- Infertility Services when the infertility is the result of an elective male or female sterilization surgical procedure.
- Assisted reproductive technologies and procedures other than those described above, including, but not limited to: gamete intrafallopian transfers (GIFT); zygote intrafallopian transfers (ZIFT); and prescription drugs related to such procedures.

V. Maternity Services
We cover Services for routine global maternity care and non-routine obstetrical care.

"Routine global maternity care” means care provided after the first visit where pregnancy is confirmed, and includes all of the following as a single Service, subject to a single Cost Share: (a) the normal series of regularly scheduled preventive prenatal care exams; (b) labor and delivery, including cesarean section; and (c) routine postpartum follow-up consultations and exams.

Non-routine obstetrical care includes: (a) Services provided for a condition not usually associated with pregnancy; (b) Services provided for conditions existing prior to pregnancy; (c) Services related to the development of a high risk condition(s) during pregnancy; and (d) Services provided for the medical complications of pregnancy.

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

Services for diagnostic and treatment services for illness or injury received during a non-routine maternity care visit are subject to the applicable Cost Share.

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 care visits upon release, when prescribed by the attending provider.

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

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

Comprehensive lactation (breastfeeding) education and counseling, by trained clinicians during pregnancy and/or postpartum period in conjunction with each birth. Breastfeeding equipment is issued, per pregnancy. The breast feeding pump (including any equipment that is required for pump functionality) is covered at no cost sharing to the member.

Exclusions:
- Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.

W. Medical Foods
We cover medical foods and low protein modified food products for the treatment of inherited metabolic diseases 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 and low protein food products are prescribed as Medically Necessary for the therapeutic treatment of inherited metabolic diseases, and 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 or administered enterally (i.e., by tube directly into the stomach or small intestines) under the direction of a Plan Provider.

Low protein modified foods are food products that are (a) specially formulated to have less than one 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 disease.

Medical Foods Exclusions:
- Medical food for treatment of any conditions other than an inherited metabolic disease.
Amino Acid-based Elemental Formula (Drugs, Supplies and Supplements)
We cover amino acid-based elemental formula, regardless of delivery method, for the diagnosis and treatment of:
- Immunoglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins;
- Severe food protein induced enterocolitis syndrome;
- Eosinophilic disorders, as evidenced by the results of a biopsy; and
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

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

Amino Acid Based Elemental Formula Exclusions:
Amino-acid based elemental formula for treatment of any condition other than those listed above.

X. Morbid Obesity Services
We cover diagnosis and surgical treatment of morbid obesity that is:
- recognized by the National Institutes of Health as effective for long-term reversal of morbid obesity; and
- consistent with guidelines approved by the National Institutes of Health.

Such treatment shall be covered to the same extent as for other Medically Necessary surgical procedures under this EOC.

Morbid obesity means a body mass index that is: (i) greater than 40 kilograms per meter squared; or (ii) equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

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

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

We also cover treatment of significant congenital defects, causing functional impairment, found in the oral cavity or jaw area which are similar to disease or which occur in other parts of the body, including Medically Necessary medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses.

For the purposes of this benefit, coverage for diseases and injuries of the jaw include:
- fractures of the jaw or facial bones;
- removal of cysts of non-dental origin or tumors, including any associated lab fees prior to removal; and
- surgical correction of malformation of the jaw when the malformation creates significant impairment in the Member’s speech and nutrition, and when such impairments are demonstrated through examination and consultation with appropriate Plan Providers.

For the purposes of this benefit, coverage of significant congenital defects causing functional impairment must be:
- evidenced through documented medical records showing significant impairment in speech or a nutritional deficit; and
- based on examination of the Member by a Plan Provider.

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

Health Plan provides coverage for cleft lip and cleft palate under a separate benefit. Please see the “Cleft Lip, Cleft Palate, or Both” section of this EOC for coverage.

Oral Surgery Exclusions:
- Oral surgery services when the functional aspect is minimal and would not in itself warrant surgery.
- Lab fees associated with cysts that are considered dental under our standards.
- Services for the condition known as TMJ (temporomandibular joint).
- Orthodontic services.
- Dental appliances.

Z. Preventive Health Care Services
We cover the following preventive Services without any Cost Sharing requirements, such as Deductibles, Copayment amounts or Coinsurance
amounts to any Member receiving any of the following benefits for Services from Plan Providers:

(a) Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009 (To see an updated list of the USPSTF “A” or “B” rated services, visit www.uspreventiveservicestaskforce.org);

(b) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (Visit the Advisory Committee on Immunization Practices at www.cdc.gov/vaccines/recs/ACIP);

(c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (To see the current guidelines, visit HRSA at http://mchb.hrsa.gov); and

(d) 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 (To see the current guidelines, visit HRSA at http://mchb.hrsa.gov).

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

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

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

- 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;
- Routine and 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;
- Breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society. The Deductible, if any, will not apply to this provision;
- Bone mass measurement to determine risk for osteoporosis;
- Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to men who are age 40 or older;
- Colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society;
- Cholesterol test (lipid profile);
- Diabetes screening (fasting blood glucose test);
- Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis and HPS), subject to the following:
  - Annual chlamydia screening is covered for (1) women under the age of 20, if they are sexually active; and (2) women 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 Screening (HPS) at the intervals recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;
- HIV tests;
- TB tests;
- Hearing loss screenings for newborns provided by a hospital prior to discharge; and
- Associated preventive care radiological and lab tests not listed above.
Preventive Health Services Limitations:
While treatment may be provided in the following situations, the following services are not considered Preventive Care Services. Applicable Cost Share will apply:
- Monitoring chronic disease,
- Follow-up Services after you have been diagnosed with a disease,
- Testing and diagnosis for specific diseases for which you have been determined to be at high risk for contracting,
- Services provided when you show signs or symptoms of a specific disease or disease process,
- Non-routine gynecological visits.

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

AA. Prosthetic Devices
We cover the devices listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or injured. Coverage includes fitting and adjustment of these devices, repair or replacement (unless due to loss or misuse), and Services to determine whether you need the prosthetic. If we do not cover the prosthetic, we will try to help you find facilities where you may obtain what you need at a reasonable price. Coverage is limited to the prosthetic that is considered Medically Necessary by meeting the indications and limitations of coverage and medical necessity established under the Medicare Coverage Database.

Internally Implanted Devices
We cover Medically Necessary internal devices implanted during surgery, such as pacemakers, ocular lens implants, artificial hips and joints, breast implants following mastectomy (see “Reconstructive Surgery” benefits below), and cochlear implants, that are approved by the federal Food and Drug Administration for general use.

Artificial Arms, Legs or Eyes
We cover:
- Artificial devices to replace, in whole or in part, a leg, an arm, or an eye;
- Components of an artificial device to replace, in whole or in part, a leg, an arm, or an eye; and
- Repairs to an artificial device to replace, in whole or in part, a leg, an arm, or an eye.

The artificial arm, leg, eye or component will be considered Medically Necessary if it meets the indications and limitations of coverage and medical necessity established under the Medicare Coverage Database.

Ostomy and Urological Supplies and Equipment
We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets Health Plan’s criteria for Medical Necessity. Covered equipment and supplies include, but is not limited to flanges, collection bags, clamps, irrigation devices, sanitizing products, ostomy rings, ostomy belts, and catheters used for drainage of urostomies.

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

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

Prosthetic Device Limitations:
- Coverage for mastectomy bras is limited to a maximum of two per contract year.
- Coverage for hair prosthesis is limited to one prosthesis per course of chemotherapy and/or radiation therapy, not to exceed a maximum benefit of $350 per prosthesis.

Prosthetic Device Exclusions:
- Internally implanted breast prosthetics for cosmetic purposes.
- External prosthetics or orthotics, except as specifically provided in this Section 3; or as provided under a “Prosthetic and Orthotic Devices Rider,” if applicable.
- Repair or replacement of prosthetics due to loss or misuse.
- Microprocessor and robotic-controlled external prosthetics not covered under the Medicare Coverage Database.

BB. Reconstructive Surgery
We cover reconstructive surgery (a) to correct significant disfigurement resulting from an injury or Medically Necessary surgery, (b) to correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function, and (c) to treat congenital hemangioma
known as port wine stains on the face for Members age 18 or younger, (d) breast augmentation is covered only if determined to be a medical necessity.

Following mastectomy, we also cover reconstructive breast surgery and all stages of reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. 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.

**Reconstructive Surgery Exclusions:**
Cosmetic surgery, plastic surgery, or other services, supplies, dermatological preparations and ointments, other than those listed above, that are intended primarily to improve your appearance, or are not likely to result in significant improvement in physical function. Examples of excluded cosmetic dermatology services are:
- Removal of moles or other benign skin growths for appearance only
- Chemical peels
- Pierced earlobe repairs, except for the repair of an acute bleeding laceration

**CC. Skilled Nursing Facility Care**
We cover skilled inpatient services in a licensed Skilled Nursing Facility. The skilled inpatient Services must be those customarily provided by Skilled Nursing Facilities. A prior three-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;
- Medical and biological supplies; and
- Respiratory therapy.

**Note:** The following Services are covered, but not under this section:
- Blood (see “Blood, Blood Products and Their Administration”);
- Drugs (see “Drugs, Supplies and Supplements”);
- 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”).

**Skilled Nursing Facility Care Exclusions:**
- Custodial care (see definition under “Exclusions” in the “Exclusions, Limitations, and Reductions” section of this EOC).
- Domiciliary care.

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

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

**Telemedicine Services Exclusion:**
Services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions. Not all medical services are conducive to telemedicine, as such the provider will make a determination whether the member should instead be seen in a face-to-face medical office setting.

**EE. Therapy and Rehabilitation Services**

**Physical, Occupational and Speech Therapy Services**
If, in the judgment of a Plan Physician, significant improvement is achievable within a two-month period, we cover physical, occupational and speech therapy:
1. while you are confined in Plan Hospital; and
2. for up to 30 visits of physical therapy or 90 consecutive days of occupational or speech therapy per contract year per injury, incident or condition in a Plan Medical Center, a Plan Provider’s medical office, or a Skilled Nursing Facility, or as part of home health care. These limits do not apply to necessary treatment of cleft lip or cleft palate.

**Physical, Occupational and Speech Therapy Limitations:**
- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Speech therapy is limited to treatment for speech impairments due to injury or illness.
- Physical therapy is limited to the restoration of an existing physical function, except as provided
in the “Habilitative Services” section of this benefit.

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

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

**Cardiac Rehabilitation Services**
We cover Medically Necessary cardiac rehabilitation Services following coronary surgery or a myocardial infarction for up to 12 weeks, or 36 sessions, whichever occurs first.

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

**Therapy and Rehabilitation Services Exclusions:**
- Except as provided for cardiac rehabilitation Services, no coverage is provided for any therapy that the Plan Physician determines cannot achieve measurable improvement in function within a two-month period.
- Long-term therapy and rehabilitation Services.

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

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

**Transplant Exclusions:**
- Services related to non-human or artificial organs and their implantation.

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

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

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

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

1) If your primary care Plan Physician is located at a Plan Medical Office please call:
   - Inside the Washington, D.C. Metropolitan Area 703-359-7878
   - TTY at 711
   - Outside the Washington, D.C. Metropolitan Area 1-800-777-7904
   - TTY at 711

2) 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 our Service Area:**
If you are injured or become ill while temporarily outside the Service Area, we will cover reasonable charges for Urgent Care Services as defined in this section. Except as provided for emergency surgery below, all follow-up care must be provided by a Plan Provider or Plan Facility.
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 Medical Center in the Service Area, or in the nearest Kaiser Foundation Health Plan Region, for continuing or follow-up treatment.

**Follow-up Care for Emergency Surgery**

In those situations when we authorize, refer or otherwise allow you access to a hospital emergency facility or other urgent care facility for a medical condition that requires emergency surgery, we will reimburse the Physician, Oral Surgeon, Periodontist or Podiatrist who performed the surgical procedure for any follow-up care that is:

- Medically Necessary; and
- directly related to the condition for which the surgical procedure was performed; and
- provided in consultation with your primary care Plan Physician.

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

**Urgent Care Limitations:**

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

**Urgent Care Exclusions:**

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

**HH. 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.

**Eye Exams**

We cover routine and necessary eye exams, 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.

**Vision Exam Services Exclusions:**

- Eyeglass lenses and eyeglass frames.
- Eye exercises.
- All Services related to contact lenses including examinations, fitting and dispensing, and follow-up visits.
- Orthoptic (eye training) therapy.

**Note:** Discounts are available for lenses and frames.

**Pediatric Eye Exams**

We cover the following for children under age 19:

- One routine eye exam per year, including
  - Routine tests such as eye health and glaucoma tests; and
  - Routine eye refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.

**Pediatric Lenses and Frames**

We cover the following for children under age 19 at no charge:

- One pair of lenses per year;
- One pair of frames per year from a select group of frames;
- Regular contact lenses (in lieu of lenses and frames) up to a 3 month supply per year; or
- Medically Necessary contact lenses up to two pair per eye per year.

In addition, we cover the following Services:

**Eyeglass Lenses**

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

**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.

**Contact Lenses**

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

- Fitting of contact lenses;
Your Group Evidence of Coverage

- Initial pair of diagnostic lenses (to assure proper fit);
- Insertion and removal of contact lens training; and
- Three 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.

**Vision Exclusions:**
- Sunglasses without corrective lenses unless Medically Necessary;
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures;
- Eye exercises;
- Non-corrective contact lenses;
- Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section;
- Replacement of lost or broken lenses or frames; and
- Orthoptic (eye training) therapy.

**II. 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 imaging;
- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
- Special procedures, such as:
  - Electrocardiograms;
  - Electroencephalograms; and
  - Bone mass measurement for the 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 glucocorticoid (steroid) therapy;
    - an individual with primary hyperparathyroidism; or
    - an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

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

- Sleep lab and sleep studies; and
- Specialty imaging, including CT, MRI, PET Scans, Nuclear Medicine studies, and interventional radiology.
SECTION 4 – Exclusions, Limitations, and Reductions

The following section provides you with information on what Services Health Plan will not pay for regardless of whether the Service is medically necessary or not.

It also provides information on how your benefits may be reduced as the result of other types of coverage.

Exclusions
The Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the “Benefits” section. When a Service is excluded, all Services related to the excluded Service are also excluded, even if they would otherwise be covered under this EOC.

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

Certain Exams and Services
Physical examinations and other Services (a) required for obtaining or maintaining employment or participation in employee programs, or (b) required for insurance, licensing, or disability determinations, or (c) on court-order or required for parole or probation, except for medically necessary services covered under the Benefits section of this agreement.

Cosmetic Services
Services that are intended primarily to improve your appearance and that are not likely to result in significant improvement in physical function, except for Services covered under “Reconstructive Surgery” or “Cleft Lip, Cleft Palate or Both” in the “Benefits” section.

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, correction of malocclusion, dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any dental treatment involved in temporomandibular joint (TMJ) pain dysfunction syndrome, unless otherwise covered under a Rider attached to this EOC. This exclusion does not apply to medically necessary dental care covered under “Accidental Dental Injury Services,” “Cleft Lip, Cleft Palate or Both,” or “Oral Surgery” in the “Benefits” section.

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

Durable Medical Equipment
Except for Services covered under “Durable Medical Equipment” in the “Benefits” section.

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 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, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

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

MDLG-ALL-SEC4 (01-2016) DHMO HMO 3TPOS
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, or unless otherwise covered under a Rider attached to this EOC.

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

Routine Foot Care Services
Routine foot care Services. This exclusion does not exclude Services when you are under active treatment for a metabolic or peripheral vascular disease

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

Surrogacy Arrangements
You must pay us charges for Services you receive related to conception, pregnancy or delivery in connection with a surrogacy arrangement (“Surrogacy Health Services”). Your obligation to pay us for Surrogacy Health Services is limited to the compensation you are entitled to receive under the surrogacy arrangement. A surrogacy arrangement is one in which you agree to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

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

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

Kaiser Permanente
Other Party Liability and Recovery Unit
2101 E. Jefferson Street, 4 East
Rockville, MD 20852
Attn: Surrogacy Coordinator

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

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

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 Immunizations
All Services related to immunization in anticipation of traveling outside the country.

Vision Services
Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).

Workers’ Compensation or Employer’s Liability
Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as “Financial Benefit”), is provided under any workers’ compensation or employers’ liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit; but we may recover the value of any covered Services from the following sources:

• Any source providing a Financial Benefit or from whom a Financial Benefit is due; or
• You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers’ compensation or employers’ liability law.

Limitations
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, civil insurrection, disability of a large share of personnel of a Plan Hospital or Plan Medical Center, complete or partial destruction of facilities, and labor disputes not involving Health Plan, Kaiser Foundation Hospitals, or Medical Group. However, Health Plan, Kaiser Foundation Hospitals, Medical Group, and Medical Group Physicians shall be liable for reimbursement of the expenses necessarily incurred by a Covered Person in procuring the Services through other providers, to the extent prescribed by the Insurance Commissioner of Maryland.

Reductions
Injury or Illness Caused by Third Party
Except for any covered Services that would be (a) payable under Personal Injury Protection (PIP) coverage, and/or (b) payable under any capitation agreement Health Plan has with a Participating Provider, if you become ill or injured through the fault of a third party and you collect any money from the third party or from his or her insurance company for medical expenses, Health Plan will be subrogated for any Service provided by or arranged as a result of the occurrence that gave rise to the cause of action as follows: (a) per Health Plan’s fee schedule for Services provided or arranged by Medical Group, or (b) any actual expenses that were made for Services provided by Participating Providers.

Except for any covered Services that would be (a) payable under Personal Injury Protection (PIP) coverage, and/or (b) payable under any capitation agreement Health Plan has with a Participating Provider, when you recover for medical expenses in a cause of action, Health Plan has the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. Health Plan will also be subrogated as of the time it mails or delivers a written notice of its exercise of this option to you or to your attorney as follows: (a) per Health Plan's fee schedule for services provided by Medical Group at one of our Medical Offices, or (b) any actual expenses that were made for Services provided by a Participating Provider. The subrogated amount will be reduced by any court costs and attorney’s fees.

To secure Health Plan’s rights, the Health Plan will have a lien on the proceeds of any judgment or settlement you obtain against a third party for covered medical expenses, in accordance with the first paragraph of this section. The Health Plan's recovery shall be made only to the extent that the Health Plan provided covered Services or made payments for covered Services as a result of the occurrence that gave rise to the cause of action. The proceeds of any judgment or settlement that the Member or Health Plan obtains shall first be applied to satisfy Health Plan’s lien, regardless of whether the total amount of recovery is less than the actual losses and damages you incurred.

Within 30 days after submitting or filing a claim or legal action against the third party, you must send written notice of the claim or legal action to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Other Party Liability & Recovery Dept.
2101 East Jefferson Street
Rockville, Maryland 20852.

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

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

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

Medicare and TRICARE Benefits
Your benefits are reduced by any benefits to which you are entitled under Medicare, except for Members whose Medicare benefits are secondary by law. TRICARE benefits are usually secondary benefits by law.

Coordination of Benefits (COB)
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.

1. The Primary Plan then provides benefits as if it would in the absence of any other coverage.
2. 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 100 percent of the total Allowable Expenses, not to exceed the maximum liability of the Secondary Plan. The Secondary Plan is never liable for more expenses than it would cover if it had been Primary.

If you have any questions about COB, please call our Member Services Call Center.

Inside the Washington, D.C., Metropolitan Area
301-468-6000
Outside the Washington, D.C. Metropolitan Area
1-800-777-7902
TTY 711

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.

1. 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).
2. If the Health Plan is the Primary Plan, it will provide or pay its benefits without considering the other Plan(s) benefits.
3. 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% of the total Allowable Expenses.

Definitions
“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 group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits group or individual automobile contracts (personal injury protection benefits are not required to be paid before benefits under this Plan will be paid) and Medicare or any other federal governmental plan, as permitted by law. “Plan” does not include hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law. “Health Plan”: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., providing services or benefits for health care. Health Plan is a Plan.

“Allowable Expense” means a health care service or expense, including Deductibles, Coinsurance or Copayments 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...
Order of Benefit Determination Rules
Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
   a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
      ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
   b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      i. If a court decree states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree; ii. If a court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
   iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
   iv. If there is no court decree allocating responsibility for the dependent child’s health care expenses or health care coverage, the order of benefits for the child are as follows:
      • The Plan covering the Custodial parent;
      • The Plan covering the spouse of the Custodial parent;
      • The Plan covering the non-custodial parent; and then
      • The Plan covering the spouse of the non-custodial parent.
   c. For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph a or b above shall determine the order of benefits as if those individuals were the parents of the child.
   d. (i) For a dependent child who has coverage under either or both parents’ plans and also has his or her own coverage as a dependent under a spouse’s plan, the rule in item 2f applies; (ii) in the event the dependent child’s coverage under the spouse’s plan began on the same date as the dependent child’s coverage under either or both parents’ plans, the order of benefits shall be determined by applying the birthday rule in item 2a. to the dependent child’s parent(s) and the dependent’s spouse.
   e. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the
order of benefits, this rule is ignored. This rule does not apply if paragraph 1 can determine the order of benefits.

f. **COBRA or State Continuation Coverage.**
If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if paragraph 1 can determine the order of benefits.

g. **Longer or Shorter Length of Coverage.**
The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

h. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary plan.

**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 provided by Health Plan. At the Member’s request, Health Plan will provider or arrange for covered services and then seek coordination with a Primary Plan.

1. 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:
   a. 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
   b. 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 thereon is made; exceeds Allowable Expenses in a Claim Determination Period. In that case, the Health Plan benefits will be coordinated, or a portion of 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.

2. Right to Reserve and Release Needed Information. 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.

3. Facility of Payment. 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.

4. Right of Recovery. 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 or more of:
   a. The persons it has paid or for whom it has paid;
   b. Insurance companies; or
   c. Other organizations.

5. Benefit Reserve Account. When Health Plan does not have to pay full benefits, or recovers the reasonable cash value of the services provided because of COB, the savings will be credited to the Member in a Benefit Reserve Account. These savings can be used by the Member for any unpaid Covered Expense during the calendar year. A Member may request detailed information concerning the Benefits Reserve Account from Health Plan’s Patient Accounting Department.
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 Services from the Department of Veterans Affairs.
SECTION 5 – Getting Assistance; Health Care Service Review; and the Grievance and Appeal Process

Getting Assistance

Member Services representatives are available at most of our Plan Medical Offices and through our Call Center to answer any questions you have about your benefits, available services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace an ID card. These representatives can also help you submit a request for payment and/or reimbursement for Emergency Services and Urgent Care Services outside our Service Area (see “Filing for Payment/Reimbursement of a Post Service Claim” for information) or to initiate an Appeal or a Grievance for any unresolved problem.

We want you to be satisfied with your health care. Please discuss any problems with your primary care Plan Provider or other health care professionals treating you. If you are not satisfied with your primary care Plan Provider, you can request a different Plan Provider by calling our Member Services Call Center.

Inside the Washington, D.C., Metropolitan area
301-468-6000

Outside the Washington, D.C. Metropolitan area
1-800-777-7902
TDD 711

Definitions:

As used in this section, the terms below have the following meanings:

Adverse Decision: A utilization review decision made by Health Plan that:
(a) a proposed or delivered Service is or was not medically necessary, appropriate or efficient; and
(b) may result in non-coverage of the Health Care Service.

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

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

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

Authorized Representative: An individual authorized by the Member in writing or otherwise authorized by state law to act on the Member’s behalf to file claims and to submit Appeals or Grievances to Health Plan. A Health Care Provider (as defined below) may act on behalf of a Member with the Member’s express consent, or without such consent in an Emergency Case.

Commissioner: The Maryland Insurance Commissioner.

Complaint: A protest filed with the Commissioner of Insurance involving a Coverage Decision or Adverse Decision as described in this section.

Coverage Decision: An initial determination by Health Plan or a representative of Health Plan that results in non-coverage of a Health Care Service. Coverage Decision includes: a determination by a Health Plan that an individual is not eligible for coverage under the Health Plan’s health benefit plan; any determination by Health Plan that results in the rescission of an individual's coverage under a health benefit plan; or nonpayment of all or any part of a claim. A Coverage Decision does not include an Adverse Decision.

Emergency Case: A case in which an Adverse Decision was rendered pertaining to Health Care Services which have yet to be delivered and such Health Care Services are necessary to treat a condition or illness that, without medical attention would: (a) seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function; or (b) cause the Member to be in danger to self or others.

Grievance: A protest filed by a Member or his or her Authorized Representative with Health Plan through our internal grievance process regarding an Adverse Decision concerning the Member. A Grievance does not include a verbal request for reconsideration of a Utilization Review determination.

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

Health Care Provider: (a) An individual who is: licensed or otherwise authorized in this State to provide health care services in the ordinary course of business or practice of a profession and is the treating provider of the Member; or (b) a hospital.

Health Care Service: A health or medical care procedure or service rendered by a Health Care Provider that: (a) provides testing, diagnosis, or treatment of a human disease or dysfunction; or (b) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction; or (c) provides any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well-being of human beings.

Urgent Medical Condition: As used in this section, a condition that satisfies either of the following:

(a) A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of Health Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
- Placing the Member's life or health in serious jeopardy;
- The inability of the Member to regain maximum function;
- Serious impairment to bodily function;
- Serious dysfunction of any bodily organ or part; or
- The Member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others; or

(b) A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Coverage Decision.

The Health Care Service Review Program

Pre-Service Reviews
If you do not have an Urgent Medical Condition and you have not received the Health Care Service you are requesting, then within two working days of receiving all necessary information, but no later than 15 calendar days after your request for pre-service review is received, Health Plan will make its determination. We may extend this time period for an additional 15 calendar days if we do not have the necessary information to make our decision. We will notify you or your Authorized Representative of the need for an extension within three calendar days of the initial request and explain in detail what information is required. Necessary information includes, but is not limited to, the results of any face-to-face clinical evaluation or any second opinion that may be required. We must receive the information requested by the notice, within 45 calendar days from the receipt of the notice identifying the additional necessary information, or we will make our decision based upon the information we have available to us at that time.

If the authorization procedures are not followed, we will notify you and/or your Authorized Representative of the failure to follow the procedures within five calendar days of the request for authorization. The notice will include the proper procedures to be followed to request authorization.

If an admission, procedure or service is pre-authorized, Health Plan will:

(a) Notify the provider by telephone within one working day of pre-authorization; and
(b) Confirm the pre-authorization with you and the provider in writing within five working days of our decision.

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

(a) Notify the provider by telephone within one working day of making the denial or alternate treatment or service recommendation; and
(b) Confirm the denial decision with you and your Authorized Representative in writing within five working days of making our decision.

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

 Expedited Pre-Service Reviews
If you have an Urgent Medical Condition and you have not received the Health Care Service for which you are requesting review, then within 24 hours of your request, we will notify you if we need additional information to make a decision, or if you or your Authorized Representative failed to follow proper procedures which would result in a denial decision. If additional information is requested, you will have only 48 hours in which to submit the requested information. We will make a decision for this type of claim within 48 hours following the earlier of (1) receipt of the information from you; or (2) the end of the period for submitting the requested information.
Decision regarding pre-service review if you have an urgent Medical Condition will be communicated to you by telephone within 24 hours. Such decisions will be confirmed in writing within three calendar days of our decision.

**Concurrent Reviews**

When you make a request for additional treatment, when we had previously approved a course of treatment that is about to end, Health Plan will make concurrent review determinations within one working day of receiving the request or within one working day of obtaining all the necessary information so long as the request for authorization of additional services is made prior to the end of prior authorized services. In the event that the our review results in the end or limitation of Health Care Services, we will make a review determination with sufficient advance notice so that you can file a timely Grievance or Appeal of our decision. If you have an Urgent Medical Condition, then a request for concurrent review will be handled like any other pre-service request for review when an Urgent Medical Condition is involved, except that our decision will be made within one working day.

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

(a) Notify the provider by telephone within one working day of the authorization; and

(b) Confirm the authorization in writing with you or your Authorized Representative within five working days after the telephone notification. The written notification will include the number of extended days or next review date, or the new total number of Health Care Services approved.

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

(a) Notify the provider and/or you or your Authorized Representative of the denial by telephone within one working day of making the denial decision; and

(b) Confirm the denial in writing with you or your Authorized Representative and/or the provider within five working days after the telephone notification. Coverage will continue for Health Care Services until you or your Authorized Representative and the provider rendering the Health Care Service have been notified of the denial decision in writing.

You or your Authorized Representative may then file an Appeal or Grievance, as appropriate, as described below. 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 Appeal or Grievance is under consideration. If your Appeal or Grievance is then denied, you will be financially responsible for the entire cost of those services. Otherwise, if your request for additional services was not timely filed, 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 the Appeal or Grievance was received.

**Filing for Payment/Reimbursement of a Post Service Claim**

When you receive an itemized bill from a hospital, physician, or ancillary provider not contracting with us, please forward that bill directly to us for processing. Simply indicate the medical record number of the patient on the bill and submit it directly to us.

A request for payment or reimbursement of the cost of covered services received from physicians, hospitals or other health care providers not contracting with us must be submitted to us within 6 months, or as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required.

You 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.

Reimbursement for covered Services will be made to the applicable provider of the Services, or if the claim has been paid, to you or in the case of a child, to the parent who incurred the expenses resulting from the claim or the Department of Health and Mental Hygiene.

**Post-Service Claim Reviews**

Health Plan will make its determination on post-service review within 30 days of receiving a claim. This time period may be extended one time by us, for up to 15 calendar days, if we determine that an extension is necessary because (1) the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary, or (2) the claim is not clean and, therefore, we need more information to process such claim. We will notify you of the extension within the initial 30 day period. Our notice will explain the circumstances requiring the extension and the date upon which we expect to render a decision. If such an extension is necessary because we need information from you, then our notice of extension will specifically describe the required information which you need to submit. You must respond to
requests for additional information within 45 calendar days or we will make our decision based upon the information we have available to us at that time.

We will send a notice to you or your Authorized Representative explaining that:
(a) The claim was paid; or
(b) The claim is being denied in whole or in part; or
(c) Additional information is needed to determine if all or part of the claim will be reimbursed and what specific information must be submitted; or
(d) The claim is incomplete and/or unclean and what information is needed to make the claim complete and/or clean.

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

**Internal Grievance and Appeal Processes**

A Member may file a Grievance or an Appeal on their own behalf or through an Authorized Representative.

1. **The Health Education and Advocacy Unit of the Office of the Attorney General**

The Health Education and Advocacy Unit can help you or your Authorized Representative prepare a Grievance or an Appeal to file with Health Plan as follows:

(a) The Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a Grievance or Appeal under the internal grievance and appeals processes. However, the Health Education and Advocacy Unit is not available to represent or accompany you and/or your Authorized Representative during the proceeding of the internal grievance and appeals process;

(b) The Health Education and Advocacy Unit can assist you and/or your Authorized Representative in mediating a resolution of the Adverse Decision or Coverage Decision with Health Plan, but at any time during the mediation, you and/or your Authorized Representative may file a Grievance or Appeal; and

(c) You and/or your Authorized Representative may file a Complaint with the Commissioner without first filing a Grievance or Appeal as explained below under Maryland Insurance Commissioner.

(d) The Health Education and Advocacy Unit may be contacted at:

   Office of the Attorney General
   Consumer Protection Division
   Health Education and Advocacy Unit
   200 St. Paul Place
   Baltimore MD, 21202
   410-528-1840
   1-877-261-8807 (toll free out-of-area)
   410-576-6571 (facsimile)
   www.oag.state.md.us (Web site)
   heau@oag.state.md.us (E-mail address)

2. **Maryland Insurance Commissioner**

You, your Authorized Representative, or a Health Care Provider must file a Grievance or Appeal with us and exhaust our internal grievance or internal appeals process as described in this section prior to filing a Complaint with the Insurance Commissioner except when:

(a) The Coverage Decision involves an Urgent Medical Condition for which care has not been rendered;

(b) You, your Authorized Representative, or a Health Care Provider provides sufficient information and supporting documentation in the Complaint that supports a compelling reason to not exhaust our internal process for resolving Grievances (protests regarding Adverse Decisions), such as, when a delay in receiving the Health Care Service could result in loss of life, serious impairment to bodily organ or part, or your remaining seriously mentally ill with symptoms that cause you to be in danger to self or others;

(c) We failed to make a Grievance Decision for a pre-service Grievance within 30 working days after the filing date, or the earlier of 45 working days or 60 calendar days after the filing date for a post-service Grievance;

(d) We or our representative failed to make a Grievance Decision for an expedited Grievance for an Emergency Case within 24 hours after you or your Authorized Representative filed the Grievance;

(e) We have waived the requirement that our internal grievance process must be exhausted before filing a Complaint with the Commissioner;

(f) We have failed to comply with any of the requirements of the internal grievance process;

(g) The member, member’s Authorized Representative or the health care provider provides sufficient information and documentation in the complaint that demonstrates a compelling reason to do so.
The Maryland Insurance Commissioner may be contacted at:

Maryland Insurance Administration  
Attn: Consumer Complaint Investigation  
Life and Health/Appeals and Grievance  
200 St. Paul Place, Suite 2700  
Baltimore, MD 21202  
Telephone: 410-468-2000 or 1-800-492-6116  
TTY: 711  
Fax: 410-468-2270 or 410-468-2260

3. Internal Grievance Process

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

Initiating a Grievance

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

Member Services Appeals Unit  
Kaiser Permanente  
2101 East Jefferson Street  
Rockville, MD 20852  
Fax: 301-816-6192

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

If within five working days after you or your Authorized Representative file a Grievance we need additional information to complete our internal Grievance process, we shall notify you or your Authorized Representative that we cannot proceed with review of the Grievance unless we receive the additional information. If assistance is needed and requested, we will assist you or your Authorized Representative in gathering the necessary additional information without further delay.

Grievance Acknowledgment

We will acknowledge receipt of a Grievance within five working days of the filing date of the written Grievance notice. The filing date is the earliest of five calendar days after the date of mailing (postmark) or the date of receipt.

(a) Pre-service Grievance

If the Grievance is for a Health Care Service that the Member is requesting (that is, the Health Care Service has not been rendered), an acknowledgment letter will be sent requesting any additional information that may be necessary within five working days after the filing date. We will also inform you and your Authorized Representative that a decision will be made regarding the Grievance in writing, and such written notice will be sent within 30 working days of the filing date of the Grievance.

(b) Post-service Grievance

If the Grievance is asking for payment for Health Care Services already rendered, a retrospective acknowledgment letter will be sent requesting additional information that may be necessary within five working days after the filing date. We will also inform you and your Authorized Representative that a decision will be made in writing and such written notice will be made within the earlier of 45 working days or 60 calendar days of the filing date of the Grievance.

For both pre-service and post-service Grievances, if there will be a delay in our concluding the Grievance in the designated period, we will send you and your Authorized Representative a letter requesting an extension. Such extension period shall not exceed more than 30 working days. If you or your Authorized Representative do not agree to the extension, then the Grievance will be completed in the original designated period. Any agreement to extend the period for a Grievance decision will be documented in writing.

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

If the pre-service or post-service Grievance results in a denial, we will notify you and your Authorized Representative of the decision within 30 working days or no later than the last day of the extension period for a pre-service Grievance or the earlier of 45 working days or 60 calendar days from the date of filing or no later than the last day of the extension period for a post-service Grievance.

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

If we fail to make a Grievance Decision within the stated timeframes herein, or an extension of such timeframe, you or your Authorized Representative may file a Complaint with the Commissioner without waiting to hear from us.

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

4. Expedited Grievances for Emergency Cases

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

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

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

If we determine that an Emergency Case does exist, then the expedited review request will be reviewed by a physician who is board certified or eligible in the same specialty as the treatment under review and who is not the individual (or the individual’s subordinate) who made the initial decision. If additional information is needed to proceed with the review, we will contact you or your Authorized Representative by telephone or facsimile.

Within 24 hours of the filing date of the expedited review request, we will verbally notify you or your Authorized Person of our decision. We will send written notification to you or your Authorized Representative within one calendar day after the decision is verbally communicated. If approval is recommended, then we will assist you in arranging the authorized treatment or benefit. If the expedited review results in a denial, we will notify you and your Authorized Representative within one calendar day after the decision is verbally communicated.

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

5. Notice of Adverse Grievance Decision

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

(a) the specific factual basis for the decision in clear understandable language;
(b) references to any specific criteria or standards on which the decision was based, including but not limited to interpretive guidelines used by us;
(c) 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;
(d) the name, business address, and business telephone number of the medical director who made the Grievance Decision;
(e) a description of your or your Authorized Representative’s right to file a complaint with
the Commissioner within 4 months after receipt of our Grievance Decision;
(f) the Commissioner’s address, telephone number and facsimile number;
(g) a statement that the Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a complaint about the Health Plan with the Commissioner;
(h) the Health Education and Advocacy Unit’s address, telephone number, facsimile number, and electronic mail address; and
(i) the Health Plan must provide notice of an adverse decision in a non-English language if certain thresholds are met for the number of people who are literate in the same non-English language. A threshold language applies to a county if at least 10% of the population is literate only in the same foreign language that is identified as a federally mandated non-English language. If we send you a notice of an 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. You or your Authorized Representative may request translation of the notice by contacting Member Services.

6. Internal Appeal Process

This process applies to our Coverage Decisions and you must exhaust our internal Appeal process prior to filing a Complaint with the Commissioner, except if our Coverage Decision involves an Urgent Medical Condition for which care has not been rendered.

Initiating an Appeal

These internal appeal procedures are designed by Health Plan to assure that concerns are fairly and properly heard and resolved. These procedures apply to a request for reconsideration of a Coverage Decision rendered by Health Plan regarding any aspect of Health Plan’s health care Service.

The Member or the Member’s Authorized Representative must file an internal appeal within 180 calendar days from the date of receipt of the Coverage Decision. The Appeal should be sent to us at the following address:

Member Services Appeals Unit
Kaiser Permanente
2101 East Jefferson Street
Rockville, MD 20852
Fax: 301-816-6192

In addition, the Member or the Member’s Authorized Representative may request an internal appeal by contacting the Member Services Department. The Member or the Member’s 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 how internal appeals are processed and resolved and to assist with filing an internal appeal. The Member Service Representative can be contacted Monday through Friday from 7:30 AM to 9:00 PM at 301-468-6000, if calling within the local area, or 711 TTY (Telephonic Device for the Deaf).

Along with your appeal you may also send additional information including comments, documents or additional medical records which you believe supports your claim. If we had asked for additional information before and you did not provide it, you may still submit the additional information with your appeal. In addition, you may also provide testimony in writing or by telephone. Written testimony may be sent along with your appeal to the address listed above. To arrange to give testimony by telephone, you may contact the Member Services Appeal Unit. Health Plan will add all additional information to your claim file and will revise all new information without regard to whether this information was submitted and/or considered in its initial decision.

In addition, prior to rendering its final decision, Health Plan will provide the Member or Member’s Authorized Representative, without charge, any new or additional evidence considered, relied upon, or generated by (or at the direction of) Health Plan in connection with the Member or Member’s Authorized Representative appeal. If during the Health Plan’s review of the Member or Member’s Authorized Representative appeal, it determines that an adverse coverage decision can be made based on a new or additional rationale, the Health Plan will provide the Member or Member’s Authorized Representative with this new information prior to issuing its final coverage decision and explain how you can respond to the information if you choose to do so. The additional information will be provided to the Member or Member’s Authorized Representative as soon as possible and sufficiently before the deadline to give the Member or Member’s
Authorized Representative a reasonable opportunity to respond to the new information.

Health Plan will respond in writing to an Appeal within 30 calendar days for a pre-service claim, or 60 calendar days for a post-service claim after our receipt of the Appeal.

If our review results in a denial, we will notify your and your Authorized Representative in writing within three calendar days after the Appeal Decision has been verbally communicated. This notification will include:

(a) the specific factual basis for the decision in clear understandable language;
(b) reference to the specific plan provision on which determination was based. 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;
(c) a description of you or your Authorized Representative’s right to file a Complaint with the Commissioner within 4 months after receipt of our Appeals Decision;
(d) the Commissioner’s address, telephone number and facsimile number;
(e) a statement that the Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a complaint about the Health Plan with the Commissioner;
(f) the Health Education and Advocacy Unit’s address, telephone number, facsimile number, and electronic mail address; and

(g) the Health Plan must provide notice of an appeal decision in a non-English language if certain thresholds are met for the number of people who are literate in the same non-English language. A threshold language applies to a county if at least 10% of the population is literate only in the same foreign language that is identified as a federally mandated non-English language. If we send you a notice of an appeal decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. You or your Authorized Representative may request translation of the notice by contacting Member Services.

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

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Telephone: 410-468-2000 or 1-800-492-6116
TTY:711
Fax: 410-468-2260
SECTION 6 – Termination of Membership

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

If a Subscriber’s membership ends, the Subscriber’s Dependents’ membership ends at the same time.

If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. You will be billed the applicable fee for any Services you receive after your membership terminates. Health Plan and Plan 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.

Termination of Group Agreement

If the Group’s Agreement with us terminates for any reason, your membership ends on the same date. The Subscriber’s group is required to inform the Subscriber of the date your coverage terminates.

Termination Due to Loss of Eligibility

Your membership will terminate if you no longer meet the conditions under which you became eligible to be enrolled, as described under “Who is Eligible” in Section 1 of this EOC.

If you are eligible 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 us to terminate at a time other than the last day of the month. Please check with the Group’s benefits administrator to confirm your termination date.

If the Subscriber no longer lives or works within Health Plan’s Service Area, we may terminate the membership of the Subscriber and all Dependents in his or her Family Unit by sending notice of termination at least 30 days prior to the termination date.

Termination for Cause

We may terminate the memberships of the Subscriber and all Dependents in his or her Family Unit, by sending written notice to the Subscriber at least 30 days before the termination date, if the Subscriber knowingly enrolls noneligible persons as dependents, or intentionally fails to notify us that a Dependent is no longer eligible.

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

- You or your Dependent(s) knowingly perform an act, practice or omission that constitutes fraud, which under certain circumstances may include, but is not limited to, presenting a fraudulent prescription or physician order, selling your prescription, or allowing someone else to obtain Services using your membership ID card; or
- You or your Dependent(s) make an intentional misrepresentation of material fact.

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

Nonpayment of Premium

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

Extension of Benefits

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

- If you are Totally Disabled at the time your coverage ends, we will continue to provide benefits for covered services related to the condition causing the disability. Coverage will stop at the point you no longer qualify as being Totally Disabled, or up to 12 months from the date your coverage ends, whichever comes first.
- If you have ordered eyeglasses or contact lenses before the date your coverage ends, we will provide benefits for covered eyeglasses or
contact lenses received within 30 days following the date you placed the order.

- If you are in the midst of a course of covered dental treatment at the time your coverage ends, we will continue to provide benefits, in accordance with the EOC in effect at the time your coverage ended, for a period of 90 days following the date your coverage ended.

- If you are in the midst of a course of covered orthodontic treatment at the time your coverage ends, we will continue to provide benefits, in accordance with the EOC in effect at the time your coverage ended, for a period of:
  - 60 days following the date your coverage ended if the orthodontist has agreed to or is receiving monthly payments; or
  - until the latter of 60 days following the date your coverage ended, or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

To assist us, if you believe you qualify under this “Extension of Benefits” provision, we encourage you to notify us in writing.

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

- Failure to pay Premium by the Member;
- Members’ whose coverage ends because of fraud or material misrepresentation by the Member;
- When coverage is provided by another health plan and that health plan’s coverage:
  - is provided at a cost to the individual that is less than or equal to the cost to the individual of the extended benefit available under this EOC; and
  - will not result in an interruption of benefits to the Member.

**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 90 days prior written notice to the Subscriber. If we discontinue offering all products to groups in a market, we will give 180 days prior written notice to the Subscriber.

**Continuation of Group Coverage under Federal Law**

**COBRA**
You or your Dependents may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if permitted by the federal COBRA law. Members are not ineligible for COBRA continuation coverage solely because they live in another Kaiser Foundation Health Plan or allied plan service area. Please contact your Group to know whether you or your Dependents are eligible for COBRA coverage, how to elect COBRA coverage or how much you will have to pay your Group for it.

**USERRA**
If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. Members are not ineligible for USERRA continuation coverage solely because they move or live outside our Service Area. You must submit a USERRA election form to your Group within 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.

**Continuation of Coverage under State Law**

**Death of the Subscriber**
If you would otherwise lose coverage due to the Subscriber’s death, you may continue uninterrupted coverage hereunder, upon arrangement with the Group in compliance with applicable Maryland law.

The election period for such coverage shall begin on the date on which there has been an applicable change in status, and end no sooner than 45 days after such date.

- Group coverage under this section continues, for those Dependents who are eligible for state continuation coverage, only upon payment of applicable monthly charges, which may include an allowable reasonable administrative fee, not to exceed 2% of the entire cost to the employer, allocated predetermined amount to your Group’s Premium charge, and terminates on the earliest of:
  - Termination of this Agreement; or
  - Eligibility of the Member under any other group health plan or entitlement to Medicare benefits; or
  - Acceptance of coverage under any non-group health insurance plan or health maintenance organization; or
  - Dependent Child that ceases to qualify as a dependent child under dependent eligibility requirements; or
  - Expiration of 18 calendar months after the death of the Subscriber;
• Termination by Subscriber.

**Divorce of the Subscriber and his/her Spouse**

If you who would otherwise lose coverage due to divorce from the Subscriber, you may continue uninterrupted coverage hereunder, upon arrangement with the Group in compliance with applicable Maryland law.

The notification period for the applicable change in status provided under Maryland law shall begin with the date on which there has been a change in status and end no sooner than 60 days after such date.

• Group coverage under this section continues, for those Dependents who are eligible for state continuation coverage, only upon payment of applicable monthly charges to Group at the time specified by Group, and terminates on the earliest of:
  • Termination of this Agreement; or
  • Eligibility of the Member under any other group health plan or entitlement to Medicare benefits; or
  • Acceptance of coverage under any non-group health insurance plan or health maintenance organization; or
  • Ceasing to qualify as a dependent child; or
  • Marriage of the Member who is the divorced spouse of the Subscriber;

• Dependent Child that ceases to qualify as a dependent child under dependent eligibility requirements; or
• Expiration of 18 calendar months after the termination of Subscriber's employment;
• Termination by Subscriber.

**Coverage Under the Continuation Provision of Group’s Prior Plan**

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

For purposes of this section, “Member” includes a child born to a surviving or divorced spouse who is enrolled under this section.

Unless otherwise agreed to by Group, subject to these provisions, a person who is a Member hereunder on the first day of a month is covered for the entire month.

• Coverage under this section continues only upon payment of applicable monthly charges, which may include an allowable reasonable administrative fee not to exceed 2% of the entire cost to the employer, to your Group’s Premium charge at the time specified by Group, and terminates on the earliest of:
  • Termination of this Agreement; or
  • Eligibility of the Subscriber under any other group health plan or entitlement to Medicare benefits; or
  • The Subscriber’s acceptance of coverage under any non-group health plan or health maintenance organization; or
• Voluntary or Involuntary Termination of a Subscriber’s Employment for Reasons Other Than for Cause

If you would otherwise lose coverage due to the voluntary or involuntary termination of the Subscriber’s employment, for any reason other than for cause, you may continue uninterrupted coverage hereunder, upon arrangement with Group in compliance with applicable Maryland law, if the Subscriber lives in Maryland.

• Coverage under this section continues only upon payment of applicable monthly charges, which may include an allowable reasonable administrative fee not to exceed 2% of the entire cost to the employer, to your Group’s Premium charge at the time specified by Group, and terminates on the earliest of:
  • Termination of this Agreement; or
  • Eligibility of the Subscriber under any other group health plan or entitlement to Medicare benefits; or
  • The Subscriber’s acceptance of coverage under any non-group health plan or health maintenance organization; or
SECTION 7 – Miscellaneous Provisions

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

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, including the information sheet developed by the Maryland Department of Health and Mental Hygiene and the Attorney General, and instructions, visit our website at kp.org or contact our Member Services Call Center.

Inside Washington, D.C., Metropolitan area 301-468-6000, or in the Baltimore, Maryland
TTY 711

Outside the Washington, D.C. Metropolitan area 1-800-777-7902

Amendment of Agreement
Your Group’s Agreement with us will change periodically. If these changes affect this EOC, a revised EOC will be issued to you.

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

Attorney Fees and Expenses
In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys’ fees and other expenses.

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

A statement made by a Member covered under the contract relating to insurability may not be used in contesting the validity of coverage with respect to which the statement was made after coverage had been in force before the contest for a period of two (2) years during the Member’s lifetime.

Absent of fraud, each statement made by an applicant, employer or Member is considered a representation and not a warranty. Therefore, a statement made to effectuate coverage may not be used to void coverage or reduce benefits under the contract unless:
- the statement is contained in a written instrument signed by the applicant, employer, or Member; and
- a copy of the statement is provided to the applicant, employer or Member.

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 call our Member Services Call Center in the Washington, D.C., Metropolitan area at 301-468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902. Our TTY is 711.

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 as provided in this EOC for:
- Emergency Services;
- Urgent Care outside our Service Area;

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

MD-LG-SEC7(01/16) NGF 7.1
• Authorized referrals; or
• Care in other Health Plan Regions.

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 Copayments, Coinsurance or Deductibles for a period not to exceed 90 days from the date we have notified you of the Plan Provider’s termination.

Governing Law
Except as preempted by federal law, this EOC will be covered in accord with the State of Maryland law 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.

Notice of Non-Grandfathered Coverage
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. believes that your Plan is a “non-grandfathered health plan” under the PPACA.

Groups and Members not Health Plan’s Agents
Neither your Group nor any Member is the agent or representative of Health Plan.

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 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.
   h. Receive access to your medical records and any information that pertains to you, except as prohibited by law. This includes the right to ask us to make additions or corrections to your medical record. We will review your request based on 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.
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.
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, race, ethnicity, religion, disability, medical condition, national origin, educational background, reading skills, ability to speak or read English, or economic or health status including any mental or physical disability you may have.
f. Request interpreter Services in your primary language at no charge.
g. Receive health care in facilities that are environmentally safe and accessible to all.

1. Promote your own good health:
a. Be active in your health care and engage in healthy habits.
b. Select a primary care Plan Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics, or Family Practice as your primary care Plan Physician.
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 Copayment, Coinsurance or Deductible.
c. Let us know if you have any questions, concerns, problems or suggestions.

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

**Members Responsibilities**

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

**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.

**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.

**Nondiscrimination**

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

**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 in the Washington, D.C., Metropolitan area at 301-468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902 as soon as possible to give us their new address. Our TTY is 711.

**Overpayment Recovery**

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.

**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, 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*. Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. For a more detailed explanation of our privacy practice please refer to the *Notice of Privacy Practices*, which provides additional information about our privacy practices and your rights regarding your PHI, mailed with your enrollment materials.
APPENDICES

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

Allowable Charges (AC): means either:
- For 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;
- For items obtained at a Plan Pharmacy, the “Member Standard Value” which means the cost of the item calculated on a discounted wholesale price plus a dispensing fee;
- For all other Services,
  - the amount the provider has contracted to accept;
  - the amount the provider has negotiated with the Health Plan;
  - the amount stated in the fee schedule that providers have agreed to accept as payment for those Services; or,
  - the amount that the Health Plan pays for those Services.

For non-Plan Providers, the Allowable Charge shall not be less than the amount the Health Plan must pay pursuant to §19-710.1 of the Health General Article of the Annotated Code of Maryland.

Copayment: A specific dollar amount that you must pay when you receive a covered Service as listed under “Copayments and Coinsurance” in the Summary of Services and Cost Shares section of the Appendix.

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

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” in Section 1, Introduction).

Domestic Partner: An individual in a relationship with another individual of the same or opposite sex, provided both individuals:
- Are at least 18 years old;
- Are not related to each other by blood or marriage within four degrees of consanguinity under civil law rule;
- Are not married or in a civil union or domestic partnership with another individual;
- Have been financially interdependent for at least 6 consecutive months prior to application in which each individual contributes to some extent to the other individual’s maintenance and support with the intention of remaining in the relationship indefinitely; and
- Share a common primary residence.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:
- Placing the person’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency Services: With respect to an Emergency Medical Condition, as defined above:
- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and,
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

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

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.

**Health Plan:** Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. This EOC sometimes refers to Health Plan as “we” or “us”.

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

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

**Medically Necessary:** Medically Necessary means that the Service is 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 your provider; and (iv) the most appropriate level of Service which 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; (c) the view of physicians practicing in the Kaiser Permanente Medical Care Program; and/or (d) any other relevant factors reasonably determined by us. Unless otherwise required by law, we decide if a Service (described in Section 3) is Medically Necessary and our decision is final and conclusive subject to your right to appeal as set forth in Section 5.

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

**Member:** A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premium. This EOC sometimes refers to Member as “you” or “your.”

**Non-Physician Specialist:** A health care provider who:

- Is not a physician;
- Is licensed or certified under the Health Occupations Article; and
- Is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider.

**Participating Network Pharmacy:** Any pharmacy with whom we have entered into an agreement to provide pharmaceutical Services to Members.

**Plan:** Kaiser Permanente.

**Plan Facility:** A Plan Medical Center, a Plan Hospital or another freestanding facility that (i) is operated by us or contracts to provide Services and supplies to Members, and (ii) is included in your Signature provider network.

**Plan Hospital:** A hospital that (i) contracts to provide inpatient and/or outpatient Services to Members and (ii) is included in your Signature provider network.

**Plan Medical Center:** Medical office and specialty care facilities such as imaging centers operated by us in which Medical Group and other health care providers including Non-Physician Specialists employed by us provide primary care, specialty care, and ancillary care Services to Members.

**Plan Pharmacy:** Any pharmacy located at a Plan Medical Center.

**Plan Physician:** Any licensed physician who is an employee of Medical Group, or any licensed physician (except for those physicians who contract only to provide Services upon referral) who (1) contracts to provide Services and supplies to Members and (ii) is included in your Signature provider network.

**Plan Provider:** A Plan Physician, or other health care provider including but not limited to a Non-Physician Specialist, and Plan Facility that (i) is employed by or operated by an entity that participates in the Kaiser Permanente Medical Care Program, or (ii) contracts with an entity that participates in the Kaiser Permanente Medical Care Program.

**Premium:** Periodic membership charges paid by Group.

**Service Area:** The areas of the District of Columbia; the following Virginia counties – Arlington, Fairfax, King George, Loudoun, Spotsylvania, Stafford, Prince William, and specific ZIP codes within Caroline, Culpeper, Fauquier, Hanover, Louisa, Orange and Westmoreland; the following Virginia cities – Alexandria, Falls Church, Fairfax, Fredericksburg, Manassas and Manassas Park; the following Maryland areas: the City of Baltimore; the following Maryland counties: Anne Arundel, Baltimore, Carroll, Harford, Howard, Montgomery, and Prince George’s, and specific ZIP codes.
codes within Calvert, Charles, and Frederick counties. A listing of these ZIP codes may be obtained from any Health Plan office.

**Services:** Health care Services or items.

**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.

**Spouse:** The person to whom you are legally married under applicable law.

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

**Subscriber:** A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status (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 Section 1, Introduction).

**Totally Disabled:**

For Subscribers and Adult Dependents: In the judgment of a Medical Group Physician, a person is totally disabled by reason of injury or sickness if the Member is unable to perform each and every duty pertaining to his or her occupation during the first 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 requires prompt attention, but are not of an emergent nature.
KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, California 94612

CERTIFICATE OF INSURANCE

This Certificate describes benefit coverages funded through a Group Insurance Policy (Group Policy) issued to Your group by Kaiser Permanente Insurance Company. It becomes Your Certificate of Insurance (Certificate) when You have met certain eligibility requirements.

This Certificate is not an insurance policy. The complete terms of the coverage are set forth in the Group Policy. Benefit payment is governed by all the terms, conditions and limitations of the Group Policy. If the Group Policy and this Certificate differ, the Group Policy will govern. The Group Policy and the Certificate are governed by the laws of the state in which the Group Policy was delivered. The Group Policy may be amended at any time without Your consent or prior notice to you. Any such amendment will not affect a claim starting before the amendment takes effect. The Group Policy is available for inspection at the Policyholder’s office.

This Certificate automatically supersedes and replaces any and all certificates that may have been issued to You previously for the coverage described herein.

In this Certificate, Kaiser Permanente Insurance Company will be referred to as: “KPIC”, “We”, “Us”, or “Our”. The Insured Employee will be referred to as: “You” or “Your”.

This Certificate is important to You and Your family. Please read it carefully and keep it in a safe place.

Please refer to the General Limitations and Exclusions section of this Certificate for a description of this plan's general limitations and exclusions. Likewise, the Schedule of Coverage contains specific limitations for specific benefits.

Your coverage under the Group Policy includes coverage for Covered Services received from Participating and Non-Participating Providers. The provider you select can affect the dollar amount you must pay. To verify the current participation status of a provider, please call the toll free number listed in the Participating Provider directory.

Note: If you are insured under a separate group medical insurance policy, you may be subject to coordination of benefits as explained in the COORDINATION OF BENEFITS section.
## TABLE OF CONTENTS

The sections of the Certificate appear in the order set forth below.

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Schedule of Coverage</strong>*</td>
<td></td>
</tr>
<tr>
<td>CERTIFICATE FACE PAGE</td>
<td>1</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>3</td>
</tr>
<tr>
<td>Introduction to Your Plan</td>
<td>3</td>
</tr>
<tr>
<td>Who Can Answer Your Questions</td>
<td>4</td>
</tr>
<tr>
<td>GENERAL DEFINITIONS</td>
<td>5</td>
</tr>
<tr>
<td>ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE</td>
<td>20</td>
</tr>
<tr>
<td>PRE-CERTIFICATION, MEDICAL REVIEW, GRIEVANCE AND APPEALS</td>
<td>26</td>
</tr>
<tr>
<td>DEDUCTIBLE AND MAXIMUMS</td>
<td>41</td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>41</td>
</tr>
<tr>
<td>Family Deductible Maximum</td>
<td>41</td>
</tr>
<tr>
<td>Common Accident</td>
<td>41</td>
</tr>
<tr>
<td>Percentage Payable</td>
<td>41</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>42</td>
</tr>
<tr>
<td>Effect of Prior Coverage on Deductible and Out-of Pocket</td>
<td>42</td>
</tr>
<tr>
<td>Maximum Allowable Charge</td>
<td>42</td>
</tr>
<tr>
<td>Maximum Benefit While Insured Under the Group Policy</td>
<td>42</td>
</tr>
<tr>
<td>Other Maximums</td>
<td>43</td>
</tr>
<tr>
<td>Reinstatement of Your Maximum Benefit While Insured</td>
<td>43</td>
</tr>
<tr>
<td>GENERAL BENEFITS</td>
<td>44</td>
</tr>
<tr>
<td>Insuring Clause</td>
<td>44</td>
</tr>
<tr>
<td>Covered Services</td>
<td>44</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>52</td>
</tr>
<tr>
<td>Extension of Benefits</td>
<td>57</td>
</tr>
<tr>
<td>Benefits for Inpatient Maternity Care</td>
<td>58</td>
</tr>
<tr>
<td>GENERAL LIMITATIONS AND EXCLUSIONS</td>
<td>59</td>
</tr>
<tr>
<td>Optional Outpatient Prescription Drug Benefits, Limitations,</td>
<td>62</td>
</tr>
<tr>
<td>and Exclusions</td>
<td></td>
</tr>
<tr>
<td>OTHER OPTIONAL BENEFITS, LIMITATIONS, AND EXCLUSIONS</td>
<td>65</td>
</tr>
<tr>
<td>CONTINUATION OF COVERAGE PROVISIONS</td>
<td>66</td>
</tr>
<tr>
<td>Federal Continuation of Coverage Provisions</td>
<td>66</td>
</tr>
<tr>
<td>State Continuation Provisions</td>
<td>67</td>
</tr>
<tr>
<td>COORDINATION OF BENEFITS</td>
<td>71</td>
</tr>
<tr>
<td>CLAIM PROVISIONS</td>
<td>74</td>
</tr>
<tr>
<td>GENERAL PROVISIONS</td>
<td>77</td>
</tr>
</tbody>
</table>

*Please consult with Your group administrator if the Schedule of Coverage was not included when this Certificate was issued to You.*
INTRODUCTION

This Certificate includes a Schedule of Coverage that will give You a quick overview of Your coverage. It is very important, however, that You read Your entire Certificate of Insurance for a more complete description of your coverage.

Introduction To Your Plan

Please read the following information carefully. It will help you understand how the provider you select can affect the dollar amount you must pay in connection with receiving Covered Services.

This Certificate uses many terms that have very specific definitions for the purpose of this group insurance plan. These terms are capitalized so that You can easily recognize them, and are defined in the General Definitions section. Other parts of this Certificate contain definitions specific to those provisions. Terms that are used only within one section of the Group Policy are defined in those sections. Please read all definitions carefully.

This Certificate is issued in conjunction with Health Plan’s Evidence of Coverage (which will be sent to you under separate cover). KPIC and Health Plan issue these documents to explain the coverage available under the Point of Service plan which entitles a Covered Person to choose among three options when treatment or services are requested or rendered. The three options are the Kaiser Permanente Providers (Option 1), which is underwritten by Health Plan and is explained in the Evidence of Coverage; and the Participating Providers (Option 2) and the Out-of-Network Providers (Option 3), both of which are underwritten by KPIC and are explained in this Certificate of Insurance which is part of the Group Policy.

For the Kaiser Permanente Providers option, Health Plan covers Covered Services provided, prescribed and/or directed by a Physician employed by or affiliated with Mid-Atlantic Permanente Medical Group, P.C., (Health Plan’s exclusive contractor for medical services) or by a facility or other health care provider which contracts with Health Plan or Kaiser Foundation Hospitals (Health Plan’s exclusive contractor for hospital services). Under the Evidence of Coverage, Covered Services (as the term is defined therein) also include certain other medical and hospital services including, but not limited to Emergency Services, which are rendered by non-affiliated Physicians, facilities and providers, as further described in the Evidence of Coverage. The Evidence of Coverage sets forth the terms of the coverage underwritten by Health Plan.

For the Participating Providers and Out-of-Network Provider options, KPIC is responsible for paying for the medical and hospital services described in this Certificate/Group Policy. If You receive Covered Services from a Non-Participating Provider, benefits under the Group Policy will be payable by KPIC at the Non-Participating Provider level at the Out-of-Network option level. Your financial responsibility is different for Covered Services rendered by Participating and Non-Participating Providers and you should consult the Schedule of Coverage to determine the amount which KPIC will pay for a Covered Service.

You may not have the option to choose among the three options for all Covered Services and therefore, you should review the Health Plan’s Evidence of Coverage as well as this Certificate and KPIC’s Schedule 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. All Covered Services must be Medically Necessary.
Neither Health Plan nor KPIC is responsible for any Covered Person’s/Member’s decision to receive treatment, services or supplies at any option level. Neither Health Plan nor KPIC is liable for the qualifications of providers or treatment, services or supplies rendered under the other payor’s coverage. This Certificate and the Group Policy set forth the terms of the coverage underwritten by KPIC.

**IMPORTANT:** If a Covered Person is diagnosed with a condition or disease that requires specialized medical care and: (1) KPIC’s Participating Provider network does not have a specialist with the professional training and expertise to treat the condition or disease, or (2) KPIC cannot provide reasonable access to a specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel, then the Covered Person may obtain Covered Services from a specialist who is not part of KPIC’s Participating Provider network and such Covered Services will be payable at the Participating Provider benefit level.

No payment will be made by KPIC under the Group Policy for treatment (including confinement(s)), services or supplies to the extent such treatment, services or supplies were arranged, paid for, or payable by Health Plan under Option 1. Payment will be made either under the Health Plan’s coverage (Option 1) or under the KPIC levels of coverage (Options 2 or 3), but not under both.

This Certificate and the Schedule of Coverage form the remainder of the Group Policy. The provisions set forth herein, are incorporated and made part of, the Group Policy.

**Who Can Answer Your Questions?**

For assistance with questions regarding Your coverage, such as Your benefits, Your current eligibility status, or name and address changes, please have Your ID card available when You call:

For coverage: 1-800-392-8649
Eligibility, name or address change: 1-800-392-8649

Or You may write to the Administrator:

Dell
2300 West Plano Parkway
Plano, Texas 75075

For information or verification of eligibility for coverage, please call the number listed on Your ID card.

If You have any questions regarding services, facilities, or care You receive from a Participating Provider, please call the toll free number listed in the Participating Provider directory.

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

The following terms have special meaning throughout this Certificate. Other parts of this Certificate contain definitions specific to those provisions. Terms that are used only within one section of the Certificate are defined in those sections.

Abuse-deterrent opioid analgesic drug product means a brand name or generic opioid analgesic drug product approved by the U.S. Food and Drug Administration with abuse-deterrent labeling that indicates the drug product is expected to result in a meaningful reduction in abuse.

Administrator means Dell, 2300 West Plano Parkway, Plano, Texas 75075 and refers to the administrator of the Group Policy only. KPIC reserves the right to change the Administrator at any time during the term of the Group Policy 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 federal Employee Retirement Income Security Act of 1974 (ERISA), as then constituted or later amended.

Alcohol Abuse means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical; legal; financial; or psycho-social.

Amino Acid-Based Elemental Formula(s) means formulas that are made from individual (single) non-allergenic amino acids unlike regular dairy (milk or soy based) formulas as well as foods that contain many complete proteins. Amino acid-based elemental formulas are made of proteins broken down to their “elemental level” so that they can be easily absorbed and digested.

Benefit Maximum 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 Certificate and/or are shown in the Schedule of Coverage. 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.

Birth Center means an outpatient facility which:
1. Complies with licensing and other legal requirements in the jurisdiction where it is located;
2. Is engaged mainly in providing a comprehensive Maternity Services program to pregnant individuals who are considered normal to low risk patients;
3. Has organized facilities for Maternity Services on its premises;
4. Has Maternity Services performed by a Physician specializing in obstetrics and gynecology, or by a Licensed Midwife or Certified Nurse Midwife under the direction of a Physician specializing in obstetrics and gynecology; and
5. Have 24-hour-a-day Registered Nurse services.

Brand Name Drug means a prescription drug that has been patented and is only produced by a manufacturer under that name or trademark and is listed by Us as a drug preferred or favored to be dispensed.

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.

Calendar Year means a period of time: 1) beginning at 12:01 a.m. on January 1st of any year; and 2) terminating at midnight on December 31st of that same year.
GENERAL DEFINITIONS

Certified Nurse-Midwife or Licensed Midwife means any person duly certified or licensed as such in the state in which treatment is received and is acting within the scope of his or her license at the time the treatment is performed.

Certified Nurse Practitioner (CNP) means a Registered Nurse duly licensed in the state in which the treatment is received who has completed a formal educational nurse practitioner program. He or she must be certified as such by the: 1) American Nurses’ Association; 2) National Board of Pediatric Nurse Practitioners and Associates; or 3) Nurses’ Association of the American College of Obstetricians and Gynecologists.

Certified Psychiatric-Mental Health Clinical Nurse Specialist means any Registered Nurse licensed in the state in which the treatment is received who: 1) has completed a formal educational program as a psychiatric-mental health clinical nurse specialist; and 2) is certified by the American Nurses’ Association.

Child Wellness Services means preventive activities designed to protect children from morbidity and mortality and promote child development.

Chlamydia Screening Test means any laboratory test that: 1) specifically detects for infection by one or more agents of chlamydia trachomatis; and 2) is approved for this purpose by the federal Food and Drug Administration.

Coinsurance means the amount of a Covered Charge that You must pay in connection with receiving a Covered Service. The Coinsurance amount is the difference between the amount paid by KPIC and the Maximum Allowable Charge for that Covered Service.

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.

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.

Comprehensive Rehabilitation Facility means a facility primarily engaged in providing diagnostic, therapeutic, and restorative services through licensed health care professionals to injured, ill or disabled individuals. The facility must be accredited for the provision of these services by the Commission on Accreditation For Rehabilitation Facilities or the Professional Services Board of the American Speech-Language Hearing Association.

Confinement means physically occupying a room and being charged for room and board in a Hospital or other covered facility on a 24 hour a day basis as a registered inpatient upon the order of a Physician.

Co-payment means the predetermined amount, as shown in the Schedule of Coverage, which is to be paid by the Covered Person directly to a provider. Co-payments are applied on a per visit or per service basis.

Cosmetic Surgery means surgery that: a) is performed to alter or reshape normal structures of the body in order to change the patient’s appearance; and b) will not result in significant improvement in physical function.
GENERAL DEFINITIONS

**Cost Share** means a Covered Person’s share of Covered Charges. Cost Share is limited to the following: 1) Coinsurance; 2) Copayments; 3) Deductible; and 4) any Benefit Specific Deductible.

**Covered Charge** means the Maximum Allowable Charge for a Covered Service.

**Covered Person** means a person covered under the terms of the Group Policy and who is duly enrolled as an Insured Employee or Insured Dependent under the plan. No person may be covered as both an Insured Employee and a Dependent at the same time.

**Covered Services** means services as defined and listed under the section of this Certificate entitled GENERAL BENEFITS.

**Creditable Coverage** means
1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Champus supplement, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.
3) The Medicaid program pursuant to Title XIX of the Social Security Act.
4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.
5) A health plan offered under 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (CHAMPUS).
6) A medical care program of the Indian Health Service or of a tribal organization.
7) A state health benefits risk pool.
8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (FEHBP).
9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(l) of the Public Health Service Act, as amended by Public Law 104-191.
10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. 2504).

**Deductible** means the amount of Covered Charges a Covered Person must incur, while insured under the Group Policy, before any benefits will be payable during a Policy Year. The Deductible will apply to each Covered Person separately, and must be met within each Policy Year. When Covered Charges equal to the Deductible are incurred during that Policy Year, and are submitted to Us, the Deductible will have been met for that Covered Person. Benefits will not be payable for Covered Charges applied to satisfy the Deductible. Charges in excess of the Maximum Allowable Charge, and additional expenses a Covered Person must pay because Pre-certification was not obtained, will not be applied toward satisfying the Deductible or the Out-of-Pocket Maximum.

Some Covered Services are subject to additional or separate deductible amounts as shown in the Schedule of Coverage. These additional or separate deductibles are not subject to, nor do they contribute towards satisfaction of, the Individual or Family Deductibles nor the Out-of-Pocket Maximum.
GENERAL DEFINITIONS

Preventive Benefits required under the Patient Protection and Affordability Care Act (PPACA) that are received at the Non-Participating Provider level may be subject to Deductible.

**Dependent** means a Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements see the “Eligibility, Effective Date and Termination Date section).

**Domestic Partner** means an individual in a relationship with an Insured Employee of the same or opposite sex, provided both individuals:
1. Are at least 18 years old;
2. Are not related to each other by blood or marriage within four degrees of consanguinity under civil law rule;
3. Are not married or in a civil union or domestic partnership with another individual;
4. Have been financially interdependent for at least 6 consecutive months prior to application in which each individual contributes to some extent to the other individual’s maintenance and support with the intention of remaining in the relationship indefinitely; and
5. Share a common primary residence.

**Drug Abuse** means a disease which is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with significant negative consequences in at least one of the following areas of life; medical, legal, financial, or psycho-social.

**Drug Formulary** means the listing of prescription medications which are preferred for use by Us and which will be dispensed through participating and non-participating pharmacies to Covered Persons. You may obtain a current copy of the Drug Formulary from Your employer or visit the following website: kp.org/formulary.

**Durable Medical Equipment** means medical equipment which is:
1. designed for repeated use;
2. mainly and customarily used for medical purposes;
3. not generally of use to a person in the absence of a Sickness or Injury;
4. approved for coverage under Medicare, except for apnea monitors and breast pumps;
5. not primarily and customarily for the convenience of the Covered Person;
6. appropriate for use in the home; and

Durable Medical Equipment will not include:
1. Oxygen tents;
2. 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);
3. Deluxe equipment such as motor driven wheelchairs and beds, except when such deluxe features are necessary for the effective treatment of a Covered Person’s condition and in order for the Covered Person to operate the equipment;
4. Disposable supplies, exercise and hygiene equipment, experimental or research equipment, and devices 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;
5. Devices for testing blood or other body substances, except diabetic testing equipment and supplies;
6. Electronic monitors of bodily functions, except infant apnea monitors;
7. Replacement of lost equipment;
8. Repair, adjustments or replacements necessitated by misuse;
9. 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
10. Spare or alternate use equipment.

**Emergency Medical Condition** means a medical condition, including psychiatric conditions, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:
1. Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; and/or
3. Serious dysfunction of any bodily organ or part.

Emergency medical conditions are covered by the Health Plan as an In-Plan benefit. For details of coverage see the Health Plan's Evidence of Coverage.

**Emergency Services (Emergency Care)** means all of the following with respect to an Emergency Medical Condition:
1. A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, and rendered therein, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition;
2. Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act requires to Stabilize the patient.

Emergency services are covered by the Health Plan as an In-Plan benefit. For details of coverage see the Health Plan's Evidence of Coverage.

**Essential Health Benefits** means the general categories of benefits including the items and services covered within these categories of benefits that comprise an essential health benefit package as defined under the Patient Protection and Affordable Care Act of 2010 (PPACA) as then constituted or later amended. Essential Health Benefits are not subject to the Maximum Benefit While Insured or any dollar maximum.

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

**Experimental or Investigational** means that one of the following is applicable:
1. The service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or use in testing or other studies on human patients; or
2. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered.

**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:
1. Has permanent operating rooms;
2. Has at least one recovery room;
3. Has all necessary equipment for use before, during and after surgery;
4. Is supervised by an organized medical staff, including Registered Nurses, available for care in an operating or recovery room;
5. 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;
6. Is other than: a) a private office or clinic of one or more Physicians; or b) part of a Hospital; and
7. Requires that admission and discharge take place within the same working day.

**Generic Drug** is a prescription drug that does not bear the trademark of a specific manufacturer. It is chemically the same as and generally costs less than a Brand Name Drug.

**Habilitative Services** means 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 therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**Health Plan** means Kaiser Foundation Health Plan of the Mid-Atlantic States, Incorporated.

**Home Health Care Agency** means an agency or other provider licensed under state law, if required, to provide Home Health Care.

**Home Health Aide** means a person, other than a RN or nurse, who provides maintenance or personal care services to persons eligible for Home Health Care Services.

**Home Health Care Services** means services and supplies that can be safely and effectively provided in the Covered Person’s home by health care by a Home Health Care Agency when the Covered Person is bedridden or functionally limited due to a Sickness or Injury that restricts his or her ability to leave his or her residence.

Home Health Care Services include:
1. Part-time or intermittent skilled nursing care provide by or under the supervision of a Registered Nurse;
2. Part-time or intermittent care by a Home Health Aide, provide in conjunction with skilled nursing care; and
3. Therapeutic care services provided by or under the supervision of a speech, occupational, physical or respiratory therapist licensed under state law (if required).
4. Assistance with activities of daily living;
5. Respite care services; and
6. Homemaker services.

Services by a private duty nurse are excluded under this benefit.

**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 to:
(a) Covered Persons who have no reasonable prospect of cure as estimated by a Physician; and 
(b) the immediate families or family caregivers of those individuals. As used in this definition: (1) “bereavement counseling” means counseling provided to the immediate family or family caregiver of the Covered Person after the Covered Person’s death to help the immediate family or family caregiver cope with the death of the Covered Person; (2) “family caregiver” means a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the terminally ill Covered Person; (3) “family counseling” means counseling given to the immediate family or family caregiver of the terminally ill Covered Person for the purpose of learning to care for the Covered Person and to adjust to the death
GENERAL DEFINITIONS

of the Covered Person; (4) “immediate family” means the spouse, parents, siblings, grandparents, and children of the terminally ill Covered Person; (5) “respite care” means temporary care provided to the terminally ill Covered Person to relieve the family caregiver from the daily care of the Covered Person; (6) “terminally ill” means a medical prognosis given by a Physician that the Covered Person’s life expectancy is six (6) months or less.

Hospital means an institution that is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO), or other similar organization approved by KPIC, which:
1. Is legally operated as a Hospital in the jurisdiction where it is located;
2. Is engaged mainly in providing inpatient medical care and treatment for Injury and Sickness in return for compensation, except a state, county, or municipal hospital deemed charitable;
3. Has organized facilities for diagnosis and major surgery on its premises;
4. Is supervised by a staff of at least two Physicians;
5. Has 24-hour-a-day nursing services by Registered Nurses; and
6. Is not: a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; or a Skilled Nursing Facility or similar institution.

Hospital - based physician means:
1. a physician licensed in the State who is under contract to provide health care services to patients at a hospital; or
2. a group physician practice that includes physicians licensed in the State that is under contract to provide health care services to patients at a hospital.

Hospital Confinement means being registered as an inpatient in a Hospital upon the order of a Physician.

Human Papillomavirus Screening means the use of any laboratory test that specifically detects for infection by one or more agents of the human papillomavirus; and is approved for this purpose by the Federal Food and Drug Administration.

Indemnity Plan means an insurance plan in which Covered Persons are reimbursed for Covered Charges.

In-Plan means those benefits covered and/or provided by Health Plan under a group agreement.

Inherited Metabolic Disease means a disease caused by an inherited abnormality of body chemistry.

Injury means an accidental bodily injury sustained by a Covered Person.

Insured Dependent means a Covered Person who is a Dependent of the Insured Employee.

Insured Employee means a Covered Person who is an employee of the Policyholder or who is entitled to coverage under the Group Policy through a welfare trust agreement.

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

**Late Enrollee** means, as determined by Health Plan, an otherwise eligible employee or
dependent who requests enrollment under the Group Policy other than during: (1) the first
period in which the individual is eligible to enroll; or (2) a special enrollment period.

**Licensed Vocational Nurse (LVN)** means an individual who has: 1) received specialized
nursing training; 2) acquired vocational nursing experience; and 3) is duly licensed to
perform nursing service by the state in which he or she performs such service. An LVN will
include a licensed practical nurse and a certified nurse practitioner.

**Low Protein Modified Food Product** means a food product that is: (1) specially formulated
to have less than 1 gram of protein per serving; and (2) intended to be used under the
direction of a Physician for the dietary treatment of an inherited metabolic disease. Low
Protein Modified Food Product does not include a natural food that is naturally low in
protein.

**Maintenance drug** means a drug anticipated to be required for 6 months or more to treat a
chronic condition.

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

**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.. 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.

**Maximum Allowable Charge** means:

1. For Participating Providers, the Negotiated Rate.

   KPIC or its authorized Administrator may have a contractual 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 any applicable Deductible, Copayment,
and Coinsurance by the Covered Person.

2. For Non-Participating Providers, the lesser of the following:

   a. 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. In no instance, however,
shall the UCR be less than the Maximum Allowable Charge paid applicable to the
same service rendered by a similarly licensed provider who is a Participating Provider
in the same geographic region. With regard to Non-preferred on-call Physicians and
GENERAL DEFINITIONS

Non-preferred Hospital-based Physicians, the UCR shall be calculated in accordance with the requirements of Maryland Insurance Article 14-205.2.

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.

Except as provided below, if the Maximum Allowable Charge is the UCR, the Covered Person 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 the Group Policy.

b. The charges actually billed by the provider for Covered Services.

In some instances, KPIC or its Administrator may negotiate rates and/or discounts with Non-Participating Providers for Covered Services. In such instances, the Maximum Allowable Charge will be limited to the Negotiated Rate.

An on-call physician or a hospital based physician who has accepted an assignment of benefits, will accept the payment as payment in full for Covered Services, subject to payment of any applicable Deductible, Copayment, and Coinsurance by the Covered Person.

KPIC’s allowed amount for a health care service provided by Non-Participating Providers will not be less than the allowed amount paid to a similarly licensed provider who is a Participating Provider for the same health care service in the same geographic area.

An ambulance service provider that obtains an assignment of benefits and receives direct reimbursement may only collect from the insured any copayment, deductible or coinsurance owed by the insured or the charge for services that are not covered services.

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

Notwithstanding the above, KPIC will base payment of hospital services rendered at Maryland Hospitals on the basis of the rate approved by the Health Services Cost Review Commission.

Medical Food means a food that is: (1) intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and (2) formulated to be consumed or administered enterally under the direction of a Physician.

Medically Necessary means services that, in the judgment of KPIC, are:
1. Essential for the diagnosis or treatment of a Covered Person’s Injury or Sickness;
2. In accord with generally accepted medical practice and professionally recognized standards in the community;
3. Appropriate with regard to standards of medical care;
GENERAL DEFINITIONS

4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the Covered Person or the convenience of the health care provider or facility; and
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility. When applied to Confinement in a Hospital or other facility, this test means that the Covered Person needs to be confined as an inpatient due to the nature of the services rendered or due to the Covered Person’s condition and that the Covered Person can not receive safe and adequate care through outpatient treatment.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; and (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’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 twenty-four (24) hours per day, seven days per week.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Member means a person covered under the terms of the Health Plan Point-of-Service Group Agreement.

Mental Health Illness means mental or nervous condition, including an emotional disorder that is of sufficient severity to result in substantial interference with the activities of daily living.

Month means a period of time: 1) beginning with the date stated in the Group Policy; 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.

Morbid Obesity means a body mass index (BMI) equal to or greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

Necessary Services and Supplies means Medically Necessary Services and Supplies actually administered during any covered Hospital Confinement or other covered treatment. Only drugs and materials that require administration by medical personnel during self-administration are covered as Necessary Services and Supplies. Necessary Services and Supplies include, but are not limited to surgically implanted prosthetic devices, oxygen, blood, blood products, biological sera, internally implanted medications, contraceptive devices and implantable contraceptives. The term does not include charges for: 1) Room and Board; 2) an Intensive Care Unit; or (3) the services of a private duty nurse, Physician or other practitioner.

Negotiated Rate means the fees KPIC has negotiated with Participating Provider (or Participating Provider Organization) to accept as payment in full for Covered Services rendered to Covered Persons.

Nicotine Replacement Therapy means a product that: 1) Is used to deliver nicotine to an individual attempting to cease the use of tobacco products; and 2) Is obtained under a
prescription written by an authorized prescriber. Nicotine Replacement Therapy does not include any over-the-counter products that may be obtained without a prescription.

**Non Emergency use of Emergency Services** means services rendered in an Emergency Department which do not meet the definition of Emergency Services.

**Non-participating Pharmacy** means a pharmacy that does not have a Participating Pharmacy agreement with KPIC or its Administrator in effect at the time services are rendered. In most instances, You will be responsible for a larger portion of Your pharmaceutical bill when You fill prescriptions at a Non-participating Pharmacy.

**Non-Participating Provider** means a Hospital, Physician or other duly licensed health care provider or facility that does not have a participation agreement with KPIC or its Administrator in effect at the time services are rendered. In most instances, You will be responsible for a larger portion of Your bill when You visit a Non-Participating Provider.

**Non-Preferred Brand Name Drug** means a prescription drug that has been patented and is only produced by one manufacturer under that name or trademark and is not listed by Us as a drug preferred or favored to be dispensed.

**On-call physician** means a physician who:

1. has privileges at a hospital;
2. is required to respond within an agreed upon time period to provide health care services for unassigned patients at the request of a hospital or a hospital emergency department; and
3. is not a hospital-based physician.

**Open Enrollment Period** means a fixed period of time, occurring at least once annually, during which Eligible Employees of the Policyholder may elect to enroll under this plan without incurring the status of being a Late Enrollee.

**Opioid analgesic drug product** means a drug product that contains an opioid agonist and is indicated by the U.S. Food and Drug Administration for the treatment of pain, regardless of whether the drug product:

1. is in immediate release or extended release form; or
2. contains other drug substances.

**Order** means a ruling that:

1. Is issued by a Maryland court or a court or administrative agency of another state; and
2. Creates or recognizes the right of a child to receive benefits under a parent’s health insurance or establishes a parent’s obligation to pay child support and provide health insurance coverage for a child.

**Out-of-Plan** means those benefits underwritten by KPIC and set forth in the Group Policy. Unless specifically stated otherwise in the Group Policy, KPIC will not pay for services arranged, provided or reimbursed under Health Plan’s In-Plan coverage.

**Out-of-Pocket Costs** means a Covered Person’s share of Covered Charges. For purposes of the Out-of-Pocket Maximum, a Covered Person’s Out-of-Pocket cost means the difference between the amount payable by KPIC for Covered Charges and the Maximum Allowable Charge. Out-of-Pocket does not include Covered Charges applied towards satisfying deductibles, Co-payment amounts or any amount in excess of the Maximum Allowable Charge.
GENERAL DEFINITIONS

Out-of-Pocket Maximum means the total amount of Covered Charges a Covered Person will be responsible for in a Policy Year.

Partial Hospitalization means medically directed intensive or intermediate short term treatment of not more than 24 hours and not less than 4 hours for mental illness, emotional disorders, Substance Abuse in a licensed or certified facility or program.

Participating Pharmacy means 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 list of Participating Pharmacies, or visit the company’s web site at: www.MedImpact.com.

Participating Provider means health care provider 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 covered persons. 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) means an organization under a written contract with KPIC in which Covered Persons have access to a network of Participating Providers. In most instances, Your Out-of-Pocket costs are lower when you receive Covered Services from Participating Providers.

Patient Protection and Affordable Care Act (PPACA) means Title XXVII of the Public Health Service Act (PHS), as then constituted or later amended.

Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable and the Covered Service to which it applies is set forth in the Schedule of Coverage. The Percentage Payable is applied against the Maximum Allowable Charge for Covered Services to calculate the benefit payable under the Group Policy.

Pharmacy means a location where prescription medications are prepared and dispensed.

Physician means 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 GENERAL DEFINITIONS section.

Policyholder means the employer(s) or trust or other entity named in the Group Policy as the Policyholder and who conforms to the administrative and other provisions established under the Group Policy.

Policy Year means a period of time: 1) beginning with the Group Policy’s Effective Date of any year; and 2) terminating, unless otherwise noted on the Group Policy, on the same date shown on the Group Policy. If the Group Policy’s Effective Date is February 29, such date will be considered to be February 28 in any year having no such date.

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

Preventive Services means medical services rendered to prevent diseases. Preventive Services are limited to those services set forth in the General Benefits section.
GENERAL DEFINITIONS

Primary Care Physician means a Physician specializing in internal medicine, family practice, general practice, general internal medicine, pediatrics and obstetrics and gynecology.

Prosthetics means internally implanted devices and/or external devices that are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person in the absence of a sickness or injury. Internally implanted devices include, but are not limited to, devices implanted during surgery, such as pacemakers, ocular lens implants, artificial hips and joints, breast implants and cochlear implants that are approved by the Federal Food and Drug Administration. External devices are limited to ostomy and urological supplies; hair prosthesis; breast prosthesis, including a mastectomy bra, needed following a mastectomy, and custom-made prosthetics, and an artificial device to replace, in whole or in part, a leg, an arm, or an eye.

Prosthetics will not include:
1. Internally implanted breast prosthetics for cosmetic purposes;
2. Dental prosthetics and appliances. This exclusion does not include treatment of children with congenital and genetic birth defects to enhance the child’s ability to function, such as cleft lip, cleft palate, or both;
3. Hearing aids, except for the treatment of children with congenital or genetic birth defects;
4. Corrective lenses and eyeglasses, except as provided under the “Vision Care” benefit;
5. Repair or replacement of prosthetics due to misuse or loss;
6. More than one device for the same part of the body, except for replacements, spare devices or alternative use device;
7. Non-rigid supplies, such as elastic stockings;
8. Electronic voice producing machines; and

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.

Registered Nurse (RN) means a duly licensed registered graduate professional nurse acting within the scope of his or her license at the time the treatment or service is performed in the state in which services are provided.

Rehabilitation Services means services provided to restore previously existing physical function when a physician determines that therapy will result in a practical improvement in the level of functioning within 60 days.

Residential Crisis Services means intensive health and support services that are:
1. Provided to a child or an adult with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the individual’s ability to function in the community;
2. Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay;
3. Provided out of the individual’s residence on a short-term basis in a community-based residential setting; and
4. Provided by entities that are licensed by the Maryland Department of Health and Mental Hygiene to provide Residential Crisis Services.

Room and Board means all charges commonly made by a Hospital or other inpatient medical facility on its own behalf for room and meals essential to the care of registered bed patients.

Routine Prenatal Care means an office visit that includes one or more of the following:
GENERAL DEFINITIONS

1. The initial and subsequent histories;
2. Physical examinations;
3. Recording of weight, blood pressures;
4. Fetal heart tones; and
5. Routine chemical urinalysis.

**Sickness** means illness or a disease of a Covered Person. Sickness will include congenital defects or birth abnormalities and pregnancy.

**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.

**Skilled Nursing Facility** means an institution (or a distinct part of an institution) which: 1) provides 24-hour-a-day licensed nursing care; 2) has in effect a transfer agreement with one or more Hospitals; 3) is primarily engaged in providing skilled nursing care as part of an ongoing therapeutic regimen; and 4) is licensed under applicable state law.

**Specialty Care Visits** means consultations with Physicians other than Primary Care Physicians in departments other than those listed under the definition of Primary Care Physicians.

**Specialty Drugs** means 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 30-day supply; (3) is not typically stocked at retail pharmacies; and (4) requires a difficult or unusual process of delivery to the Member in the preparation, handling, storage, inventory, or distribution of the drug; or requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug.

**Complex or chronic medical condition** means 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.

**Rare medical condition** means a disease or condition that affects fewer than: (1) 200,000 individuals in the United States; or (2) approximately 1 in 1,500 individuals worldwide.

**Spouse** means the person to whom you are legally married under applicable law.

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

**Standard Reference Compendia** means any authoritative compendia as recognized periodically by the federal Secretary of Health and Human Services or the Commissioner.

**Substance Abuse** means: (a) Alcohol Abuse and (b) Drug Abuse.

**Telemedicine** means, as it relates to the delivery of Covered Services, the use of interactive audio, video, or other telecommunications or electronic technology by a Physician to deliver a Covered Service within the scope of practice of the Physician at a site other than the site
GENERAL DEFINITIONS

at which the Covered Person is located. Telemedicine does not include: (1) an audio-only telephone conversation between a Physician and a Covered Person; (2) an electronic mail message between a Physician and a Covered Person; or (3) a facsimile transmission occurring between a Physician and a Covered Person.

Total Disability means: a) inability of the Insured Employee and Dependent Adult, due solely to Sickness or Injury, to perform with reasonable continuity the substantial and material duties of regular and customary work; and b) an Insured Dependent minor complete inability, due solely to Sickness or Injury, to engage in the normal activities of a person of the same sex and age. The Covered Person must not, in fact, be working for pay or profit.

Urgent Care means non-life threatening medical and health services for the treatment of a covered Sickness or Injury. Urgent care received outside of the Health Plan Service Area is covered under Health Plan’s In-Plan coverage.

Urgent Care Center means a facility legally operated to provide health care services in emergencies or after hours. It is not part of a Hospital. Urgent Care center means a facility that meets all of the tests that follow:

1. It mainly provides urgent or emergency medical treatment for acute conditions;
2. It does not provide services or accommodations for overnight stays;
3. It is open to receive patients each day of a Calendar Year;
4. It has on duty at all times a Physician trained in emergency medicine and nurse and other supporting personnel who are specially trained in emergency care;
5. It has: x-ray and laboratory diagnostic facilities; end emergency equipment, and supplies for use in life-threatening events;
6. It has a written agreement with a local acute care hospital for the immediate transfer of patients who require greater care than can be finished at the facility; written guidelines for stabilizing and transporting such patients; and direct communication channels with the acute care hospital that are immediate and reliable; and
7. It complies with all licensing and other legal requirements.

You/Your refers to the Insured Employee who is enrolled for benefits under the Group Policy.
ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

Eligibility for Insurance

To be eligible to enroll, You must meet the following requirements:

A. You must meet the Policyholder’s eligibility requirements that We have approved (the Policyholder is required to inform Insured Employees of the Policyholder’s eligibility requirements) and meet the Insured Employee or Dependent eligibility requirements below.

B. You must live or work in the Health Plan Service Area (the Service Area is described in the “Definitions” section of the Health Plan Evidence of Coverage). You or Your Spouse’s or Domestic Partner’s eligible children who live outside of the Service Area may be eligible to enroll if You are required to cover them pursuant to any court order, court-approved agreement, or testamentary appointment.

C. Neither You nor any member of Your family may enroll under the Group Policy if:

(1) You or any Dependent has ever had entitlement to coverage and/or services through KPIC and/or Health Plan terminated due to cause.

(2) You were ever an Insured Employee and/or Health Plan subscriber, in this or any other plan, who had entitlement to receive Services through KPIC and/or Health Plan terminated for: (a) failure of You or your Dependent to pay any amounts owed to KPIC; or (b) failure to pay any amounts due under this Certificate. If so, You may not enroll under the Group Policy until you pay all amounts owed by You and Your Dependents.

D. If You are an Insured Employee, your eligible Dependents may enroll under the Group Policy.

E. You, and any eligible Dependents to be covered, must be eligible for enrollment and enrolled in Health Plan as Members.

Insured Employee

You may be eligible to enroll as a Covered Person if you are an employee of the Policyholder or You are entitled to coverage under the Group Policy through a welfare trust agreement.

Dependent means:

A. The Insured Employee’s Spouse or Domestic Partner;

B. Your or Your Spouse’s or Domestic Partner’s child who is under age 26, including:

(i) a natural child,

(ii) a stepchild,

(iii) an adopted child,

(iv) a qualifying grandchild of the Insured Employee or Insured Employee’s Spouse or Domestic Partner, as described in 26 U.S.C §152 (or U.S.C §104, 105, and 106)

(v) a child placed with the Insured Employee or Insured Employee’s Spouse or Domestic Partner for legal adoption, or
ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

(vi) a child who is: (a) under the testamentary or court-appointed guardianship, other than temporary guardianship of less than 12 months duration, of the Insured Employee or Insured Employee’s Spouse or Domestic Partner, (b) resides with the Insured Employee, and (c) is a dependent of the Insured Employee or the Insured Employee’s Spouse or Domestic Partner.

Extension of Dependent Eligibility

Your or Your Spouse’s or Domestic Partner’s currently enrolled Dependents may continue coverage beyond the age limit for Dependents, as shown in the Schedule of Coverage, if all of the following requirements are met:

A. he or she is incapable of self-sustaining employment because of mental or physical incapacity that occurred prior to reaching the age limit for Dependents; and

B. he or she is chiefly dependent upon You or Your Spouse or Domestic Partner for their support; and

C. You provide us with proof of their incapacity and dependency within 60 days after we request proof.

Enrollment and Effective Date of Coverage

The Effective Date of an eligible employee’s or Dependent’s insurance will be the date the person becomes covered by Health Plan as a Member. Health Plan membership begins at 12 Midnight (the time at the location of the administrative office of Health Plan at 2101 East Jefferson Street, Rockville, Maryland, 20849 on the membership effective date. Eligible individuals may enroll as follows:

New Employees and their Dependents: If You are a new employee, You may enroll yourself and any eligible Dependents by submitting a KPIC approved enrollment form to the Policyholder within 31 days after You become eligible (You should check with the Policyholder to see when new employees become eligible).

The Policyholder shall notify its employees and their enrolled dependents of their effective date of coverage if such date is different than the effective date of the Group Policy, or is different than the dates specified under the provision entitled “Special Enrollment Due to Newly Acquired Dependents” set forth below.

Special Enrollment Due to Newly Acquired Dependents: You may enroll as an Insured Employee (along with any eligible Dependents) and existing Insured Employees may add any and all eligible Dependents, within 31 days after marriage, birth, adoption, or placement for adoption by submitting a KPIC-approved enrollment form to the Policyholder. An otherwise eligible employee who is not enrolled for coverage under the Group Policy at the time he/she acquires a new Dependent, may also enroll at the same time as the newly acquired Dependent. The effective date for an eligible employee and/or Spouse or Domestic Partner that enrolls at the time of birth of a Dependent is the moment of birth. The effective date for an eligible employee and/or Spouse or Domestic Partner that enrolls at the time of adoption or placement for adoption of a Dependent is the date of adoption.

The membership effective date for newly acquired Dependents will be:

A. For a new Spouse or Domestic Partner, no later than the first day of the month following the date your Group receives an enrollment application from the Insured Employee.
ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

B. 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 the 31 days from the date of birth, notification of birth and payment of additional premium must be provided within 31 days of the date of birth. Otherwise, coverage under the Group Policy will terminate 31 days from the date of birth.

C. For newly adopted children (including children newly placed for adoption), the “date of adoption.” The date of adoption means the earlier of: (1) a judicial decree of adoption, or (2) the assumption of custody or placement with the Insured Employee or Insured Employee’s Spouse or Domestic Partner, pending adoption of a prospective adoptive child by a prospective adoptive parent. If payment of additional premium is required to provide coverage for the child, then, in order for coverage to continue beyond the 31 days from the date of adoption, notification of adoption and payment of the additional premium must be provided within 31 days of the date of adoption. Otherwise, coverage for the newly adopted child will terminate 31 days from the date of adoption.

D. For a newly eligible grandchild, the date the grandchild is placed in Your or Your Spouse’s or Domestic Partner’s custody. If payment of additional premium is required to provide coverage for the child, then, in order for the coverage to continue, notification of the court ordered custody and payment of the additional premium must be provided within 31 days of the date of the court ordered custody. Otherwise, coverage terminates 31 days from the date of the court ordered custody.

E. For children who are newly eligible for coverage as a result of a court or administrative order received by You or Your Spouse or Domestic Partner, the date of the court or administrative order. If payment of additional premium is required to provide coverage for the child, notification of the court or administrative order may be provided at any time, but payment of additional premium must be provided within 31 days of enrollment of the child. Otherwise, enrollment of the child will be void. Enrollment for such child will be allowed in accordance with the requirements and time frames established by Section 15-405(c) of the Maryland Insurance Article, which provides for the following:

1. An insuring parent is allowed to enroll in family member’s coverage and include the child in that coverage regardless of enrollment period restrictions;

2. A non-insuring parent, child support agency, or Department of Health and Mental Hygiene is allowed to apply for health insurance coverage on behalf of the child and include the child in the coverage regardless of enrollment period restrictions; and

3. Health Plan may not terminate health insurance coverage for a child eligible under this subsection unless written evidence is provided that:

   i. the court or administrative order is no longer in effect;
   ii. the child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;
   iii. the employer has eliminated family member’s coverage for all of its employees; or
   iv. the employer no longer employs the insuring parent, except the parent elects to enroll in COBRA, coverage shall be provided for the child
ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

consistent with the employer’s plan for post employment health insurance coverage for dependents.

If a child’s parent, subject to the court or administrative order, is an otherwise eligible employee, but has not enrolled for coverage under the Group Policy, We will enroll both the employee and child without regard to enrollment period restrictions, pursuant to the requirements and time periods specified by Sections 15-405(f) and (g) of the Maryland Insurance Articles. Children enrolled subject to a court or administrative order may not have their coverage terminated unless written evidence is provided to Us that: (i) the order is no longer in effect; (ii) the child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination; (iii) the employer has eliminated family members’ coverage for all its employees; or (iv) the employer no longer employs the insuring parent, except that if the parent elects to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage shall be provided for the child consistent with the employer’s plan for post employment health insurance coverage for dependents.

F. For children who are newly eligible for coverage as the result of guardianship granted by court or testamentary appointment, the date of court or testamentary appointment. If payment of additional premium is required to provide coverage for the child, notification of the court or testamentary appointment may be provided at any time, but payment of the premium must be provided within 31 days of the enrollment of the child, otherwise, enrollment of the child terminates 31 days from the date of court or testamentary appointment.

G. For children, stepchildren, grandchildren, or adopted children who are newly eligible for coverage as the result of the Insured Employee’s new Domestic Partner arrangement, the date of the signed Affidavit of Domestic Partnership. If payment of additional premium is required to provide coverage for the child, in order for coverage to continue beyond the 31 days from the date of eligibility, notification of eligibility and payment of additional premium must be provided within 31 days of the date of eligibility. Otherwise, coverage for the newly eligible child will terminate 31 days from the date of eligibility.

H. For children, stepchildren, grandchildren, or adopted children who are newly eligible for coverage as the result of the Insured Employee’s marriage, the date of the marriage. If payment of additional premium is required to provide coverage for the child, in order for coverage to continue beyond the 31 days from the date of eligibility, notification of eligibility and payment of additional premium must be provided within 31 days of the date of eligibility. Otherwise, coverage for the newly eligible child will terminate 31 days from the date of eligibility.

Special Enrollment due to Loss of other Coverage: You may enroll as an Insured Employee (along with any of Your eligible Dependents), and an existing Insured Employee may add eligible Dependents by submitting a KPI-C approved enrollment form to the Policyholder within 31 days after the enrolling persons lose other coverage if:

A. The Employee or at least one of the Dependents had other coverage when he or she previously declined KPI-C’s coverage (some groups require you to have stated in writing when declining KPI-C coverage that other coverage was the reason), and

B. The loss of the other coverage is due to (1) exhaustion of COBRA coverage or Continuation of Coverage under Maryland law; (2) in the case of non-COBRA
ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

coverage, loss of eligibility or termination of employer contributions, but not cause or individual nonpayment; or (3) reaching a lifetime maximum on all benefits. If the

loss of eligibility is for Medicaid coverage or Child Health Insurance program coverage, but not termination for cause, the timeframe for submitting the application for enrollment is 60 days. If the loss of eligibility for a dependent child is due to the death of a Spouse or Domestic Partner, the child may be added at any time; however the timeframe for submitting the application for enrollment is within 6 months after the death of the Spouse or Domestic Partner.

Note: If You are enrolling yourself as a Insured Employee along with at least one eligible Dependent, only one of You need lose other coverage, and only one of You must have had other coverage when you previously declined KPIC coverage. The Policyholder will let You know the membership effective date. 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 the Policyholder receives the enrollment or change of enrollment form from the Employee.

Special Enrollment due to Loss of Medicaid or Child Health Insurance Program (CHIP) Coverage: If you are requesting enrollment due to loss of eligibility for Medicaid or Child Health Insurance Program coverage you must request special enrollment within 60 days of the loss of coverage.

Special Enrollment due to Eligibility for Premium Subsidy under Medicaid or a State CHIP: If You declined enrollment for yourself and/or your Dependents because You or they were enrolled in Medicaid or your state’s CHIP, You may be able to enroll yourself along with any Dependents and existing Covered Persons may add Dependents under this Group Policy when You or your Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, providing You request special enrollment within 60 days of when eligibility is determined. The effective date of an enrollment resulting from eligibility for premium assistance under Medicaid or CHIP is no later than the first day of the month following the date the Policyholder receives the enrollment or change of enrollment form from the Employee.

Special Enrollment due to a Section 125 qualifying event: If your Policyholder’s plan is a Section 125 cafeteria plan, you may enroll as a Covered Person (along with any eligible Dependents), and existing Covered Persons may add eligible Dependents, if you experience an event that your Policyholder designates as a special enrollment qualifying event. Please ask your Policyholder whether your Policyholder’s plan is a Section 125 cafeteria plan and, if it is, which events your Policyholder designates as special enrollment qualifying events. To request enrollment, the Covered Person must submit a Health Plan approved enrollment or change of enrollment application to your Policyholder within the timeframes specified by your Policyholder for making elections due to a section 125 qualifying event.

Open Enrollment

You may enroll as an Insured Employee (along with any of your eligible Dependents), and an existing Insured Employee may add eligible Dependents, by submitting a KPIC-approved enrollment form to the Policyholder during the open enrollment period. The Policyholder will let you know when the open enrollment period begins and ends and Your membership effective date.

Member Contribution

Insured Employees are entitled to coverage under the Group Policy only for the period for which we have received the appropriate premiums from the Policyholder. You are responsible for any contribution to the premiums and the Policyholder will tell You the amount and how You are to pay Your contribution (through payroll deduction, for example).
ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

Open Enrollment due to Termination of Spouse’s Employment

A continuous Open Enrollment Period will exist for the purpose of allowing an Insured Employee to add his/her Spouse or Domestic Partner and/or Dependent children if the Insured Employee’s Spouse or Domestic Partner loses coverage under another group health insurance contract or policy because of the involuntary termination of the Spouse’s or Domestic Partner’s employment other than for cause. Coverage provided in accordance with this provision will not be subject to evidence of insurability. To be eligible for coverage, the Insured Employee must notify the Policyholder within 6 months after the date on which his/her Spouse’s or Domestic Partner’s coverage under another group health insurance contract or policy terminates.

Termination of a Covered Person’s Insurance

A Covered Person’s insurance will automatically terminate on the earlier of:

1. The date the Covered Person ceases to be covered by Health Plan as a Member;
2. The date the Group Policy terminates;
3. The end of the grace period after the employer group fails to pay any required premium to KPIC, Health Plan or its Administrator when due or KPIC does not receive the premium payment in a timely fashion;
4. The date the Insured Employee and/or his/her Dependents cease to be eligible for coverage under the Group Policy or Health Plan’s Evidence of Coverage;
5. The date You no longer live or work in Health Plan’s Service Area (as that term is defined in the Evidence of Coverage and is hereby incorporated by reference); or
6. The date the Group Agreement between Your group and Health Plan terminates.

Rescission for Fraud or Intentional Misrepresentation

A rescission of coverage means that coverage may be legally voided all the way back to the day KPIC began to provide coverage, just as if the coverage never existed. Subject to any applicable state or federal law, if KPIC makes a determination that a Covered Person performed an act, practice or omission that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Group Policy, KPIC may rescind coverage under the Group Policy by giving no less than 31 days advance written notice. The rescission will be effective, on:

1. The effective date of coverage, if we relied upon such information to provide coverage; or
2. 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 and before the policy has been in force 2 years.

You or Your Dependent have the right to request an appeal from Us for the rescission of coverage. Please refer to the CLAIMS AND APPEALS PROCEDURES section for a detailed discussion of the claims and appeals process.

In no event will Your insurance continue beyond the earlier of the date Your employer is no longer a Policyholder or the date the Group Policy terminates.
PRE-CERTIFICATION, MEDICAL REVIEW, GRIEVANCE AND APPEALS

Pre-certification through the Medical Review Program

This section describes:
1. The Medical Review Program and Pre-certification procedures;
2. How failure to obtain pre-certification affects coverage;
3. Pre-certification administrative procedures;
4. Which clinical procedures require Pre-certification;
5. How to appeal an adverse determination by the Medical Review Program; and
6. The Independent External review program.

A Covered Person 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 Covered Person, the Covered Person’s attending Physician, or the Covered Person’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.

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% (percent). 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 the Group Policy.

Continuity of Care when transitioning carriers Precertification

At the request of the Covered Person, the Covered Person’s authorized representative, or the Covered Person’s health care provider; a preauthorization for behavioral health and dental benefits if covered, to the extent they are authorized by a third-party administrator, shall be accepted by KPIC for Covered Persons who may be transitioning from the Maryland Medical Assistance Program to KPIC, for the time periods described in item 2, below.

At the request of the Covered Person, the Covered Person’s authorized representative, or the Covered Person’s health care provider; a preauthorization from a relinquishing carrier, managed care organization, or third-party administrator shall be accepted by KPIC for:
1. The procedures, treatment, medications, or services covered by the benefits offered by this plan; and
2. for the following time periods:
   i.) the lesser of the course of treatment or 90 days; and
   ii.) the duration of the three trimesters of a pregnancy and the initial postpartum visit.

A copy of the preauthorization from the relinquishing carrier shall be provided within 10 days after receipt of the request from KPIC.

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; and (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’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 twenty-four (24) hours per day, seven days per week.

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. Amino Acid-Based Elemental Formulas  
9. Low Protein Modified Foods  
10. Clinical Trials  
11. Medical Foods  
12. Applied Behavioral Analysis (ABA)  
13. Bariatric Surgery  
14. Cardiac Rehabilitation  
15. Dental & Endoscopic Anesthesia  
16. Durable Medical Equipment  
17. Genetic Testing  
18. Habilitative Therapy (physical therapy, occupational therapy, and speech therapy)  
19. Home Health & Home Infusion Services  
20. Hospice (home, inpatient)  
21. Infertility Procedures  
22. Imaging Service: (Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography Angiography (CTA), Positron Emission Tomography (PET), Electronic Beam Computed Tomography (EBCT), SPECT, not including x-ray or ultrasound)  
23. Outpatient Injectable Drugs  
24. Outpatient Surgery (performed at hospital, ambulatory surgery center of licensed facility)  
25. Orthotics/Prosthetics  
26. Implantable prosthetics (includes breast, bone conduction, cochlear)  
27. Pain Management services (radiofrequency ablation, implantable pumps, spinal cord stimulator, injections)  
28. Radiation Therapy Services  
29. Reconstruction Surgery  
30. Outpatient Rehab Therapy (physical, occupational, speech, pulmonary)  
31. TMJ/Orthognathic Surgery  
32. The following outpatient procedures:  
   (a) Hyperbaric oxygen  
   (b) Sclerotherapy  
   (c) Plasma Pheresis (MS)  
   (d) Anodyne Therapy  
   (e) Sleep Studies  
   (f) Vagal Nerve Stimulation  
   (g) Hemispherectomy  
   (h) Implants  
   (i) Pill Endoscopy  
   (j) Stab phlebotomy  
   (k) Radiofrequency ablation  
   (l) Enhanced External Counterpulsation (EECP)  
   (m) Resection  
   (n) Corpus Colostomy surgery  
   (o) Uvulo-palato-pharyngoplasty (UPPP) & laser-assisted UPPP  

An Adverse Decision regarding an admission of a Covered Person may not be rendered during the first 24 hours after the admission when: 1) the admission is based on a determination that the Covered Person is in imminent danger to self or others; 2) the determination has been made by the Covered Person’s Physician or psychologist in conjunction with a member of the medical staff of the facility who has privileges to make the admission; and 3) the hospital immediately notifies the Medical Review Program of the admission of the Covered Person, and the reason for the admission.

An Adverse Decision regarding a Hospital admission of a Covered Person may not be rendered for up to 72 hours when: 1) the Hospital admission is determined to be Medically Necessary by the Covered Person’s treating Physician; 2) the admission is an involuntary admission (as defined in the MD code); and 3) the hospital immediately notifies the Medical Review Program of the admission of the Covered Person, and the reason for the admission.
If our review results in an adverse decision, we will notify the covered person, authorized representative or health care provider in writing within 5 working days after the adverse decision has been verbally communicated. This notification will include:

1. The specific factual basis for the decision in clear understandable language;
2. References to any specific criteria or standards on which the decision was based including but not limited to interpretive guidelines used by us;
3. The name, business address and business telephone number of the medical director who made the decision;
4. A description of your, your authorized representative, or health care provider’s right to file a complaint with the commissioner within four (4) months following receipt of our grievance decision;
5. That a complaint may be filed without first filing a grievance if you, your authorized representative, or health care provider filing a grievance on your behalf can demonstrate a compelling reason to do so as determined by the commissioner;
6. The commissioner’s address, telephone number and facsimile number;
7. A statement that the health advocacy unit is available to assist you or your authorized representative in both mediating and filing a grievance under our internal grievance process; and
8. The address, telephone number, facsimile number, and electronic mail address of the health advocacy unit.

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 inpatient care 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 Precertification: When a covered person is admitted to a hospital for delivery of a child, the covered person is authorized to stay in the hospital for a minimum of:

1. Forty-eight (48) hours for an uncomplicated vaginal delivery; and
2. Ninety-six (96) hours for an uncomplicated cesarean section delivery.

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. Under no circumstances will kpic require that a provider reduce the mother’s or child’s hospital confinement below the allowable minimums cited above.

The following benefits will not be subject to a deductible, co-payment or coinsurance amount:

1. For a mother and newborn child who have a shorter hospital stay than that allowed above, kpic will cover on the same basis as normal pregnancy the cost of: (i) one home visit scheduled to occur within 24 hours after hospital discharge; and (ii) an additional home visit if prescribed by the attending physician.

2. For a mother and newborn child who remain in the hospital for at least the minimum authorized stay allowed above, kpic will cover on the same basis as normal pregnancy the cost of a home visit if prescribed by the attending physician.

As used above, “home visit” means a visit by a registered nurse in the covered person’s home for care of a mother and newborn child and includes any services required by the attending provider. To be eligible for coverage, the visit must: (i) be provided in accordance with generally
accepted standards of nursing practice for home care of a mother and newborn child; and (ii) be provided by a Registered Nurse with at least one year of experience in maternal child health nursing or community health nursing with an emphasis on maternal and child health.

In addition, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, KPIC will treat on the same basis as normal pregnancy the cost of additional hospitalization for the newborn for up to 4 days.

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

Pre-certification Procedures

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

1. Planned Hospital Confinement - as soon as reasonably possible after the Covered Person 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 Covered Person 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 Covered Person, or provider acting on behalf of the Covered Person, must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person, or provider acting on behalf of the Covered Person, 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 Covered Person is required to obtain a second opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program’s case management, Hospital discharge planning and long-term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person’s medical condition and the requested treatment or service. If the Covered Person or the Covered Person’s provider does not provide the necessary information or will not release necessary information, pre-certification will be denied.

If a course of treatment has been precertified or approved for a Covered Person, the Medical Review Program may not retrospectively render an adverse decision regarding the precertified or approved services delivered to that Covered Person except as outlined below.

The Medical Review Program may retrospectively render an adverse decision regarding precertified or approved services delivered to a Covered Person if:

1. The information submitted to the Medical Review Program regarding the services to be delivered to the Covered Person was fraudulent or intentionally misrepresentative;
2. Critical information requested by the Medical Review Program regarding services to be delivered to the Covered Person was omitted such that the Medical Review Program determination would have been different had the Medical Review Program known the critical information; or
3. the planned course of treatment for the Covered Person that was approved by the Medical Review Program was not substantially followed by the provider.

I. The Medical Review Program

Pre-Service Reviews: If You do not have an Urgent Medical Condition and You have not received the Covered Service which You are requesting, then within 2 working days of receiving all necessary information, but no later than 15 calendar days after Your request for pre-service review is received, the Medical Review Program will make its determination. We may extend this time period for an additional 15 calendar days if We do not have the necessary information to make the authorization decision. We will notify the Covered Person, the Authorized Representative or Health Care Provider of the need for an extension within 3 calendar days of the initial request and explain in detail what information is required. 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. We must receive any additional necessary information requested by the notice within 45 calendar days from the receipt of the notice identifying the additional necessary information or We will make Our decision based upon the information We have available to Us at that time.

If the authorization procedures are not followed, We will notify the Covered Person, the Authorized Representative or Health Care Provider of the failure to follow the procedures within 5 calendar days of the request for authorization. The notice will include the proper procedures to be followed to request authorization.

If an admission, procedure or service is pre-certified, KPIC will:

1. Notify the provider by telephone within 1 working day of pre-certification; and
2. confirm the pre-certification with You and the provider in writing within 5 working days of Our decision.

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 denial decision with the Covered Person and Authorized Representative in writing within 5 working days of making Our decision.

The Covered Person, Authorized Representative or Health Care Provider may then file an Appeal or Grievance as appropriate, as described below.

If You are requesting pre-certification for admission for Residential Crisis Services, the Medical Review Program will make its determination within 2 hours after receipt of all necessary information to make the determination; and will promptly notify the health care provider of the determination.

If You have an Urgent Medical Condition and You have not received the Covered Service for which You are requesting review, then within 72 hours of Your request, We will notify You if We need additional information to make a decision, or if You or your Authorized Representative failed to follow proper procedures which would result in a denial decision. If additional information is requested, You will have only 48 hours in which to submit the requested information. We will make a decision for this type of claim within 48 hours following the earlier of (1) receipt of the information from You; or (2) the end of the period for submitting the requested information. Decisions regarding Pre-service Review if You have an Urgent Medical Condition will be communicated to You by telephone within 24 hours. Such decisions will be confirmed in writing within 3 days of Our decision.
PRE-CERTIFICATION, MEDICAL REVIEW, GRIEVANCE AND APPEALS

Concurrent Reviews: When You make a request for additional treatment, when We had previously approved a course of treatment that is about to end, the Medical Review Program will make concurrent review determinations within 1 working day of receiving the request or within 1 working day of obtaining all the necessary information so long as the request for authorization of additional services is made prior to the end of prior authorized services. In the event that the Medical Review Program results in the end or limitation of Covered Services, We will make a review determination with sufficient advance notice so that You can file a timely Grievance or Appeal of Our decision. If You have an Urgent Medical Condition, then a request for concurrent review will be handled like any other Pre-service request for review when an Urgent Medical Condition is involved except that Our decision will be made within 1 working day.

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 1 working day of the certification;
2. Confirm the certification in writing with the Covered Person, Authorized Representative or Health Care Provider within 5 working days 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 and/or the Covered Person or Authorized Representative of the denial by telephone within 1 working day of making the denial decision; and
2. Confirm the denial in writing with the Covered Person and/or provider within 5 working days of the telephone notification. Coverage will continue for Covered Services until the Covered Person and provider rendering the service has been notified of the denial decision in writing.

The Covered Person, Authorized Representative or Health Care Provider may then file an Appeal or Grievance, as appropriate, as described below.

Post-Service Reviews: The Medical Review Program will make its determination on Post-Service Reviews within 30 calendar days of receiving a claim. This time period may be extended one time by Us, for up to 15 calendar days, if We determine that an extension is necessary because (1) the legitimacy of the claim or the appropriate amount of the benefit is in dispute and additional information is necessary or (2) the claim is not clean and, therefore, We need more information to process such claim. We will notify You of the extension within the initial 30 day period. Our notice will explain the circumstances requiring the extension and the date upon which We expect to render a decision. If such an extension is necessary because We need information from You, then Our notice of extension will specifically describe the required information which You need to submit. You must respond to requests for additional information within 45 calendar days or We will make Our decision based upon the information We have available to Us at that time.

We will send an Explanation of Benefits to the Covered Person, Authorized Representative or Health Care Provider to inform the Covered Person, Authorized Representative or Health Care Provider that:

1. the claim was paid; or
2. the claim is being denied in whole or in part; or
3. additional information is need to determine all or part of the claim benefit and what specific information must be submitted; or
PRE-CERTIFICATION, MEDICAL REVIEW, GRIEVANCE AND APPEALS

4. the claim is incomplete and/or unclean and what information is needed to make the claim complete and/or clean.

If We deny payment of the claim, in whole or in part, the Covered Person, Authorized Representative or Health Care Provider may then file an Appeal or Grievance, as appropriate, as described below.

II. Health Advocacy Unit and the Maryland Insurance Commissioner

A. The Health Advocacy Unit of the office of the Maryland Attorney General can help a Covered Person, Authorized Representative or Health Care Provider prepare a Grievance or an Appeal to file with KPIC.

1. The Health Advocacy Unit is available to assist the Covered Person or Authorized Representative with filing a Grievance or Appeal under the internal grievance and appeals processes. However, the Health Advocacy Unit is not available to represent or accompany the Covered Person and/or Authorized Representative during the proceeding of the internal grievance process;

2. The Health Advocacy Unit can assist the Covered Person or Authorized Representative in mediating a resolution of the Adverse Decision or Coverage Decision with KPIC, but at any time during the mediation, the Covered Person, or Authorized Representative, may file a Grievance or Appeal; and

3. The Covered Person or Authorized Representative may file a complaint with the Commissioner without first filing a Grievance or Appeal as explained in Section II, B, below.

The Health Advocacy Unit may be contacted at:

Health Education and Advocacy Unit, Consumer Protection Division
Office of the Attorney General
200 St. Paul Place
Baltimore, MD, 21202
(410) 528-1840
(877) 261-8807 (toll free out-of-area)
(410) 576-6571 (facsimile)
consumer.oag.state.md.us (internet address)

B. A Covered Person, Authorized Representative or Health Care Provider must file a Grievance or Appeal with Us and exhaust Our internal grievance and appeals process as described in this section of the certificate prior to filing a Complaint with the Maryland Insurance Commissioner except when:

1. The Coverage Decision involves an Urgent Medical Condition for which care has not been rendered;

2. The Covered Person, Authorized Representative or Health Care Provider provides sufficient information and supporting documentation in the Complaint that supports a compelling reason to not exhaust Our internal process for resolving Grievances (protests regarding Adverse Decisions), such as, when a delay in receiving the Health Care Service could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be in danger to self or others;

3. We failed to make a Grievance Decision for a Pre-service Grievance within 30 working days after the filing date or the earlier of 45 working days or 60 calendar days after the filing date for a Post-service Grievance;
4. We or Our representative failed to make a Grievance Decision for an expedited Grievance for an Emergency Case within 24 hours after the Covered Person, Authorized Representative or Health Care Provider filed the Grievance;
5. We fail to comply with any of the requirements of Our internal grievance process; or
6. We waive the requirement that Our internal grievance and appeals process be exhausted before filing a Complaint with the Commissioner.

The Maryland Insurance Commissioner may be contacted at:

Maryland Insurance Administration
Appeal and Grievance Unit
200 St. Paul Place
Suite 2700
Baltimore, MD 21202
(800) 492-6116 (toll free out-of-area)
(410) 468-2000
(410) 468-2260 Facsimile

III. Grievance and Appeals Processes

A. Internal Grievance Process: This process applies to a utilization review determination made by Us that a proposed or delivered Health Care Service was not Medically Necessary, appropriate or efficient thereby resulting in noncoverage of a Health Care Service.

Pre Service, Concurrent and Expedited Medical Review Grievance

The Covered Person, Authorized Representative or Health Care Provider acting on behalf of the Covered Person may initiate an Appeal by submitting a written request including all necessary information that relates to the Grievance to:

Permanente Advantage
Appeals Department
Manager of Appeals
5855 Copley Drive, Suite 250
San Diego, CA  92111
Telephone number: 1-888-567-6847
Fax number: 1-866-338-0266

If there is an initial determination made not to certify a Health Care Service and the health care provider believes the determination warrants an immediate reconsideration, We may provide the health care provider the opportunity to speak with the physician that rendered the determination, by telephone on an expedited basis, within a period of time not to exceed 24 hours of the health care provider seeking the reconsideration.

Post Service Grievance

The Covered Person, Authorized Representative or Health Care Provider acting on behalf of the Covered Person may initiate a Grievance by submitting a written request including all necessary information that relates to the Appeal to:

Dell
Manager of Appeals
KPIC Appeals
PO Box 261155
Dallas, TX 75026
The Grievance must be filed in writing within 180 days from the date of receipt of the Adverse Decision notice. If the Grievance is filed after the 180 days, We will send a letter denying any further review due to lack of timely filing.

If within 5 working days after a Covered Person, Authorized Representative or Health Care Provider files a Grievance, We need additional information to complete Our internal Grievance process, We shall notify the Covered Person, Authorized Representative or Health Care Provider that We cannot proceed with review of the Grievance unless We receive the additional information. If assistance is needed and requested, We will assist the Covered Person, Authorized Representative, or Health Care Provider in gathering the necessary additional information without further delay.

Please send all additional information to:

Kaiser Permanente Insurance Company
Manager of Grievance and Appeals
1800 Harrison Street, 20th Floor
Oakland, CA 94612
or fax number 1-877-727-9664

When You Appeal, You may give testimony in writing or by telephone. Please send Your written testimony to:

Kaiser Permanente Insurance Company
Manager of Grievance and Appeals
1800 Harrison Street, 20th Floor
Oakland, CA 94612
or fax number 1-877-727-9664

To arrange to give testimony by telephone, You should contact Grievance and Appeals Department at 1 877-847-7572.

We will add the information that You provide through testimony or other means to Your Claim file and We will review it without regard to whether this information was submitted and/or considered in Our initial decision regarding Your Claim.

We will acknowledge receipt of the Grievance within 5 working days of the filing date of the written Grievance notice. The filing date is the earlier of 5 days after the date of mailing (postmark) or the date of receipt.

1. Pre-service Grievance

If the Grievance is for a service that the Covered Person is requesting (that is, the service has not been rendered), an acknowledgement letter will be sent requesting any additional information which may be necessary within 5 working days after the filing date. We will also inform You and Your Authorized Representative that a decision will be made regarding the Grievance in writing and such written notice will be sent within 30 calendar days of the filing date of the Grievance.

2. Post-service Grievance

If the Grievance is asking for payment for Health Care Services already rendered, a retrospective acknowledgement letter will be sent requesting any additional information that may be necessary within 5 working days after the filing date. We will also inform You and Your Authorized Representative that a decision will be made in writing and such written notice will be made within the earlier of 45 working days or 60 calendar days of the filing date of the Grievance.
PRE-CERTIFICATION, MEDICAL REVIEW, GRIEVANCE AND APPEALS

For both Pre-service and Post-service Grievances, if there will be a delay in Our concluding the Grievance in the designated period, We will send You and Your Authorized Representative a letter requesting an extension. Such extension period shall not exceed more than 30 working days. If You or Your Authorized Representative do not agree to the extension, then the Grievance will be completed in the original designated period. Any agreement to extend the period for a Grievance decision will be documented in writing.

If the Pre-service or Post-service Grievance is approved, a letter will be sent to the Covered Person and Authorized Representative stating the approval. If the Grievance was filed by an Authorized Representative, then a letter stating the Grievance Decision will also be sent to the Covered Person.

If the Pre-service or Post-service Grievance results in a denial, We will notify You and Your Authorized Representative of the decision within 30 calendar days or no later than the last day of the extension period for a Pre-service Grievance or the earlier of 45 working days or 60 calendar days from the date of filing or no later than the last day of the extension period for a Post-service Grievance. This notification will include:

1. the specific factual basis for the Grievance Decision in clear understandable language;
2. references to any specific criteria or standards on which the Grievance Decision was based including but not limited to interpretive guidelines used by Us;
3. the name, business address and business telephone number of the medical director who made the Grievance Decision;
4. a description of Your or Your Authorized Representative’s right to file a Complaint within four (4) months following receipt of Our Grievance Decision;
5. the Commissioner’s address, telephone number and facsimile number.
6. a statement that the Health Advocacy Unit is available to assist You or Your Authorized Representative in filing a complaint with the Commissioner; and
7. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

We may communicate our decision to You verbally and will sent a written notice of such verbal communication within 5 working days of the verbal communication to You and Your Authorized Representative. If We fail to make a Grievance Decision within the stated timeframes herein or an extension of such timeframe, You or Your Authorized Representative may file a Complaint with the Commissioner without waiting to hear from Us.

3. Expedited Grievances for Emergency Cases

A Covered Person or Authorized Representative may seek an expedited review in the event of an Emergency Case as that term is defined in this Section of this Certificate. An expedited review of an Emergency Case may be initiated by calling 1-(800) 777-7902.

Once expedited review is initiated, clinical review will determine if the Covered Person has a medical condition which meets the definition of an Emergency Case. A request for expedited review must contain the telephone number where We may reach the Covered Person or Authorized Representative in an effort to communicate regarding Our review. In the event that additional information is necessary for Us to make a determination regarding the expedited review, We will notify the Covered Person or Authorized Representative by telephone to inform him/her that review of the expedited review may not proceed unless certain additional information is received. Upon
request, We will assist You or Your Authorized Representative in gathering such
information so that a determination may be made within the prescribed timeframes.

If the clinical review determines that the Covered Person does not have the requisite
medical condition, the request will be managed as a non-expedited Grievance pursuant
to the procedure outlined in Section III, A, above. If We determine that an Emergency
Case does not exist, We will verbally notify the Covered Person or Authorized
Representative within 24 hours, and inform You or the Authorized Representative of
the right to file a Complaint with the Commissioner.

If We determine that an Emergency Case does exist, then the expedited review request
will be reviewed by a Physician who is board certified or eligible in the same specialty
as the treatment under review and who is not the individual (or the individual’s
subordinate) who made the initial decision. If additional information is needed to
proceed with the review, We will contact the Covered Person or Authorized
Representative by telephone or facsimile.

Within 24 hours of the filing date of the expedited review request, We will verbally
notify the Covered Person or Authorized Person of Our decision. We will send written
notification to the Covered Person and Authorized Representative within 1 calendar day
after the decision is verbally communicated. If approval is recommended, then We will
assist the Covered Person in arranging the authorized treatment or benefit. If the
expedited review results in a denial, We will notify the Covered Person and Authorized
Representative within 1 calendar day after the decision is verbally communicated. This
notification shall include:

(1) the specific factual basis for the Grievance Decision in clear understandable
language;
(2) references to any specific criteria or standards on which the Grievance Decision
was based including but not limited to interpretive guidelines used by Us:
(3) the name, business address and business telephone number of the medical
director who made the Grievance Decision;
(4) a description of Your or Your Authorized Representative’s right to file a
Complaint within four (4) months following receipt of Our Grievance Decision;
(5) the Commissioner’s address, telephone number, facsimile number;
(6) a statement that the Health Advocacy Unit is available to assist You or Your
Authorized Representative in filing a complaint with the Commissioner; and
(7) the address, telephone number, facsimile number, and electronic mail address of
the Health Advocacy Unit.

If We fail to make a decision within the stated timeframes for an expedited review, You,
Your Authorized Representative or Health Care Provider may file a Complaint with the
Commissioner without waiting to hear from Us.

B. Internal Appeal Process: This process applies to Our Coverage Decisions and a Covered
Person or his/her Authorized Representative or Health Care Provider must exhaust Our
internal Appeal process prior to filing a Complaint with the Commissioner, except if Our
Coverage Decision involved an Urgent Medical Condition. The Covered Person or Authorized Representative must file an Appeal within 180 days from the date of receipt of the Coverage Decision. This Appeal should be sent to KPIC’s
Internal Grievance manager at the address shown below:
PRE-CERTIFICATION, MEDICAL REVIEW, GRIEVANCE AND APPEALS

Dell
KPIC Grievance and Appeals
PO Box 261155
Dallas, TX 75026

We will respond in writing to an Appeal within 30 days for a Pre-service claim or 60 days for a Post-service claim after Our receipt of the Appeal. If Our review results in a denial, We will notify the Covered Person, Authorized Representative or Health Care Provider in writing within 5 working days after the Appeal Decision has been verbally communicated. This notification will include:

1. the specific factual basis for the decision in clear understandable language;
2. references to any specific criteria or standards on which the Grievance Decision was based including but not limited to interpretive guidelines used by Us;
3. the name, business address and business telephone number of the medical director who made the Grievance Decision;
4. a description of Your, Your Authorized Representative, or Health Care Provider’s right to file a Complaint with the Commissioner within four (4) months following receipt of Our Appeals Decision;
5. the Commissioner’s address, telephone number and facsimile number;
6. a statement that the Health Advocacy Unit is available to assist You or Your Authorized Representative in both mediating and filing a Complaint with the Commissioner; and
7. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

For medical claims only, if Your appeal decision is not wholly in Your favor, You are entitled to a voluntary second review. We must receive Your voluntary second review request within 180 days of Your receiving this notice of Our first appeal decision. Please note that We will count the 180 days starting 5 business days from the date of the first appeal notice to allow for delivery time unless You can prove that You received the notice after that 5 business day period. Contact Us at 877-847-7572 with any questions about Your appeal rights. You must either mail Your second review request to Us, or fax Your second review request to Us at:

Kaiser Permanente Insurance Company
Manager of Grievance and Appeals (Second Review)
1800 Harrison Street, 20th Floor
Oakland, CA 94612
or fax number 1-877-727-9664

C. Independent External review: After We have rendered a final Adverse decision or Grievance Decision upon Your completing Our internal appeals process, You have a right, under applicable Maryland law, to request an independent external review of Our final Adverse decision or Grievance decision through the Maryland Insurance Administration. You, Your Authorized Representative, or Health Care Provider, in accordance with the applicable regulations of the Maryland Insurance Administration, may file an Appeal. Your, Your Authorized Representative or Health Care Provider’s Appeal must be filed within four (4) months of the final Adverse Decision or Grievance Decision.

IV. Definition of Terms Used With Regard to Medical Review and Grievances and Appeals

As used in this Section of this Certificate, the terms below have the following meanings:

Adverse Decision means a utilization review determination by Us that: (i) a proposed or delivered Health Care Service covered under the Group Policy is or was not Medically
PRE-CERTIFICATION, MEDICAL REVIEW, GRIEVANCE AND APPEALS

Necessary, appropriate, or efficient; and (ii) may result in noncoverage of the Health Care Service. An Adverse Decision does not include a decision about Your status as a Covered Person.

Appeal means a protest filed in writing by a Covered Person or his/her Authorized Representative with KPIC under its internal appeal process regarding a Coverage Decision concerning a Covered Person. An Appeal does not include a verbal request for reconsideration of a benefits and/or eligibility determination.

Appeal Decision means a final determination by KPIC that arises from an Appeal filed with Us under Our appeal process regarding a Coverage Decision concerning a Covered Person.

Authorized Representative means an individual authorized by the Covered Person or state law to act on the Covered Person’s behalf to file claims and to submit Appeals or Grievances to Us. A Health Care Provider (as that term is defined in this Section of this Certificate) may act on behalf of a Covered Person with the Covered Person’s express (written) consent, or without such consent.

Commissioner means the Maryland Insurance Commissioner.

Complaint means a protest filed with the Commissioner involving a Coverage Decision or Adverse Decision as described herein.

Coverage Decision means (1) an initial determination by KPIC or a representative of KPIC that results in noncoverage of a Health Care Service including a determination of nonpayment for all or part of a claim because the eligibility of the person for such Health Care Service is in question; (2) a determination by KPIC that You are not eligible for coverage; or (3) any determination by KPIC that results in the recession of Your coverage. A Coverage Decision does not include an Adverse Decision.

Emergency Case means a case in which an Adverse Decision was rendered pertaining to Covered Services which have yet to be delivered and such Covered Services are necessary to treat a condition or illness that, without medical attention would (1) seriously jeopardize the life or health of the Covered Person or the Covered Person’s ability to regain maximum function or (b) cause the Covered Person to be in danger to self or others.

Grievance means a protest filed in writing by a Covered Person or Authorized Representative with KPIC through Our internal grievance process regarding an Adverse Decision concerning a Covered Person. A Grievance does not include a verbal request for reconsideration of a utilization review determination.

Grievance Decision means a final determination by KPIC that arises from a Grievance filed with Us under Our internal grievance process regarding an Adverse Decision concerning a Covered Person.

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

Health Care Provider means an individual who is (1) licensed or otherwise authorized in this State to provide Health Care Services in the ordinary course of business or practice of a profession and is the treating provider of the Covered Person; or (2) A Hospital.

Health Care Service means a health or medical care procedure or service rendered by a health care provider that: (1) provides testing, diagnosis, or treatment of a human disease
or dysfunction; (2) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction; or (3) provides any other care, service or treatment of disease or injury, the correction of defects of the maintenance of the physical or mental well-being of human beings.

Urgent Medical Condition, as used in this Section of this Certificate means a condition that satisfies either of the following:
(a) A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of KPIC, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
   (i) Placing the Covered Person's life or health in serious jeopardy;
   (ii) The inability of the Covered Person to regain maximum function;
   (iii) Serious impairment to bodily function;
   (iv) Serious dysfunction of any bodily organ or part; or
   (v) The Covered Person remaining seriously mentally ill with symptoms that cause the insured to be a danger to self or others; or
(b) A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Coverage Decision.

V. Language and Translation Assistance
If We send You an Adverse Benefit Determination at an address in a county where a federally mandated threshold language applies, then Your notice of Adverse Benefit Determination will include a notice of language assistance (oral translation) in that threshold language. A threshold language applies to a county if at least, 10% of the population is literate only in the same federally mandated non-English language. You may request language assistance with Your Claim and/or Appeal by calling 1-800-392-8649.

ENGLISH: To obtain assistance, call 1-800-392-8649
SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-686-7100.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulongan sa Tagalog tumawag sa 1-800-686-7100.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码1-800-686-7100.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne 1-800-686-7100.

VI. Filing Complaints About KPIC
If You have any complaints about the operation of KPIC or Your care, You may file a Complaint with the Maryland Insurance Administration (MIA). When filing a Complaint with the MIA, You or Your Authorized Representative will be required to authorized the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the Complaint.

How To File A Complaint

Complaints must be received in writing by the MIA, in one of the following three ways. You may (1) file a complaint on-line, (2) download on-line forms to be completed by hand, or (3) submit a written letter.

1. To file a complaint on-line, go to the MIA’s website at:
   www.mdinsurance.state.md.us/. Select the “Consumer Information” option and the
select the “File a Complaint” option. Follow the instructions to submit an on-line complaint.

2. To download on-line forms to be completed by hand, go to the MIA’s website at: www.mdinsurance.state.md.us/. Select the “Consumer Information” option and the select the “File a Complaint” option. Follow the instructions to download complaint forms. These forms should be as complete and detailed as possible and be accompanied by copies of any relevant documentation of your complaint. They may be mailed or faxed to the MIA as directed below.

3. If You choose to submit a written letter, please include or provide the following:
4. Your name, address and daytime and evening phone number
5. Name of Your insurance company, type of insurance (health), policy number and claim number (if applicable)
6. Name of any other insurance company, agent, adjuster, etc. involved in Your problem (provide as many names and phone numbers as possible)
7. A detailed explanation of the problem or situation
8. Copies of any documents that You think are important for the investigator to review. Do not send originals.
9. A copy of Your health insurance card or your policy.

Mail or fax this information to:
Maryland Insurance Administration
Attn: Life and Health Complaint Investigation
200 St. Paul Place
Suite 2700
Baltimore, MD 21202
Telephone: 410-468-2244 or 1-800-492-6116
TTY: 1-800-735-2258
Fax: 410-468-2260
DEDUCTIBLES AND MAXIMUMS

Individual Deductible

The Deductible for an individual, as shown in the Schedule of Coverage, applies to all Covered Services incurred by a Covered Person during a Policy Year, unless otherwise indicated in the Schedule of Coverage. The Deductible may not apply to some Covered Services, as shown in the Schedule of Coverage. When Covered Charges equal to the Deductible are incurred during the Policy Year and are submitted to Us, the Deductible will have been met for that Covered Person for that Policy Year. Benefits will not be payable for Covered Charges applied to the Deductible.

In addition, some Covered Services are subject to additional or separate deductible amounts as shown in the Schedule of Coverage. These additional or separate deductibles do not contribute toward the satisfaction of the Individual or Family Deductible.

NOTE: The Deductible does not apply to Preventive Benefits required under the Patient Protection and Affordable Care Act (PPACA) received at the Participating Provider level. Preventive Benefits required under the Patient Protection and Affordability Care Act (PPACA) that are received at the Non-Participating Provider level, however, are subject to the Policy Year Deductible.

Family Deductible Maximum

The Deductible for a family has been satisfied for a Policy Year when a total of Covered Charges, shown in the Schedule of Coverage, has been applied toward the covered family members' Individual Deductibles.

If the Family Deductible Maximum, shown in the Schedule of Coverage, is satisfied in any one Policy Year by covered family members, then the Individual Deductible will not be further applied to any other Covered Charges incurred during the remainder of that Policy Year.

Some Covered Services are subject to additional or separate deductible amounts as shown in the Schedule of Coverage. These additional or separate deductibles do not contribute toward satisfaction of the individual or Family Deductible.

Benefit-Specific Deductibles

Some Covered Services are subject to additional or separate deductible amounts as shown in the Schedule of Coverage. These additional or separate deductibles do not contribute toward the satisfaction of the Individual Deductible and the Family Deductible.

Common Accident

A Deductible must be satisfied only once with respect to Covered Charges incurred due to one common accident involving two or more Covered Persons of a family. This will only apply to Covered Charges incurred due to accident. The Covered Charges used to satisfy this common accident Deductible must be incurred: (1) in the Policy Year in which the accident occurs; or (2) in the next Policy Year.

Percentage Payable

The Percentage Payable by KPIC is applied to Covered Charges after any applicable Deductible has been met. The Percentage Payable is set forth in the Schedule of Coverage.
DEDUCTIBLES AND MAXIMUMS

Out-of-Pocket Maximums

Any part of a charge that does not qualify as a Covered Charge will not be applied toward satisfaction of the Out-of-Pocket Maximum. Covered Charges applied to satisfy any Deductibles under the Group Policy are also applied toward satisfaction of the Out-of-Pocket Maximum. The Out-of-Pocket Maximum may not apply to all Covered Charges. See the Schedule of Coverage for specific exceptions. Charges in excess of the Maximum Allowable Charge, any Benefit Maximum, or additional expenses a Covered Person must pay because Precertification was not obtained, will not be applied toward satisfaction of the Deductible or the Out-of-Pocket Maximum.

Individual Out-of-Pocket Maximums: When a Covered Person’s share of Covered Charges equals the Out-of-Pocket Maximum (shown in the Schedule of Coverage) during a Policy Year, the Percentage Payable will increase to 100% of further Covered Charges incurred by that same Covered Person during the remainder of that Policy Year.

Family Out-of-Pocket Maximums: When the family’s share of Covered Charges equals the Out-of-Pocket Maximum (shown in the Schedule of Coverage) during a Policy Year, the Percentage Payable will increase to 100% of further Covered Charges incurred by all family members during the remainder of that Policy Year.

The Cost Share for all Essential Health Benefits applies toward satisfaction of the Out-of-Pocket Maximum at the par provider level.

Effect of Prior Coverage on Deductible and Out-of-Pocket Maximum Take-over

Any Expenses Incurred by a Covered Person while covered under the Prior Coverage will be credited toward satisfaction of Deductibles and Out-of-Pocket Maximums, as applicable, under the Group Policy if:

1. the expenses were incurred during the same Policy Year ninety (90) days before the Effective Date this Group Policy becomes effective;
2. the expenses were applied toward satisfaction of the deductibles or Out-of-Pocket maximum under the Prior Coverage during the same Policy Year ninety (90) days before the Effective Date this Group Policy becomes effective; and
3. the expenses would be considered Covered Charges under the Group Policy.

As used in this provision, “Prior Coverage” means the Policyholder’s group medical plan that the Group Policy replaced. KPIC will insure any eligible person under the Group Policy on its Effective Date, subject to the above provisions, which apply only to Covered Persons who on the day before the Group Policy’s Effective Date were covered under the Prior Coverage.

Maximum Allowable Charge

Payments under the Group Policy are based upon the Maximum Allowable Charge for Covered Services. The Maximum Allowable Charge may be less than the amount actually billed by the provider. Covered Persons are responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service. (Refer to the definition of Maximum Allowable Charge shown in the General Definitions section of the Certificate.)

Maximum Benefit While Insured

KPIC will pay benefits under the Group Policy up to the Maximum Benefit While Insured as shown in the Schedule of Coverage. The limit applies individually to each Covered Person. When benefits in such amount have been paid or are payable for a Covered Person under
DEDUCTIBLES AND MAXIMUMS

the Group Policy, all insurance for that person under the applicable benefit or benefits will terminate, except as provided under the Reinstatement of Your Maximum Benefit While Insured provision.

Essential Health Benefits, as defined under the Policy are not subject to the Maximum Benefit While Insured or any dollar Benefit Maximum specified under the Policy. Unless otherwise prohibited by applicable law, day or visit limits may be imposed on Essential and non-Essential Health Benefits.

Other Maximums

In addition to the Maximum Benefit While Insured, certain treatments, services and supplies are subject to benefit-specific limits or maximums. These additional limits or maximums are shown in the Schedule of Coverage.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Benefit levels for Participating Providers or Non-Participating Providers (For PPO Plans only)

Your coverage provided under the Group Policy may include coverage for Covered Services that are received from either Participating Providers or Non-Participating Provider. See Your Schedule of Coverage to determine if Your coverage includes Participating Providers. Generally, benefits payable are greater for Covered Services received from Participating Providers than those benefits payable for Non-Participating Providers. In order for benefits to be payable at the Participating Provider level, the Covered Person must receive care from a Participating Provider. A current copy of KPIC’s Participating Provider Directory is available from Your employer, or You may call the phone number listed on Your ID card or You may visit KPIC’s contracted provider network web site at: www.Multiplan.com/Kaiser. To verify the current participation status of any provider, please call the toll-free number listed in the provider directory. If the Covered Person receives care from a Non-Participating Provider, benefits under the Group Policy are payable at the Non-Participating Provider level.

Reinstatement of Your Maximum Benefit While Insured

After Covered Charges have been paid for a Covered Person in an amount equal to the Maximum Benefit while Insured shown in the Schedule of Coverage, KPIC will automatically reinstate benefits for such Covered Person each year in an amount equal to the lesser of:

1. $5,000; or
2. the amount paid for all Covered Charges incurred in the prior Policy Year.

Reinstatement does not apply to benefits payable under the Extension of Benefits provision.
GENERAL BENEFITS

This section describes the general benefits under the Group Policy. General limitations and exclusions are listed in the General Limitations and Exclusions section. Optional benefits are set forth under the sections entitled Optional Outpatient Prescription Drug Benefits, Limitations and Exclusions and Optional Benefits, Limitations, and Exclusions. Please refer to Your Schedule of Coverage to determine which, if any, optional benefits were elected by the Policyholder.

Insuring Clause

If KPIC receives satisfactory notice of claim and proof of loss, KPIC will pay the Percentage Payable up to the Maximum Allowable Charge (shown in the Schedule of Coverage) for the treatment of a covered Injury or Sickness, provided:

1. The expense is incurred while the Covered Person is insured for this benefit;
2. The expense is for a Covered Service that is Medically Necessary;
3. The expense is for a Covered Service prescribed or ordered by an attending Physician or those prescribed or ordered by Providers who are duly licensed by the state to provide medical services without the referral of a Physician;
4. The Covered Person has satisfied the applicable Deductibles, Co-payments, and other amounts payable; and
5. The Covered Person has not exceeded the Maximum Benefit while Insured or any other maximum shown in the Schedule of Coverage, subject to the Reinstatement of Your Maximum Benefit while Insured provision.

Payments under the Group Policy:
1. Will be subject to the limitations shown in the Schedule of Coverage;
2. Will be subject to the General Limitations and Exclusions; and
3. May be subject to Pre-certification.

Covered Services:
1. Room and Board in a Hospital.
2. Room and Board in a Hospital Intensive Care Unit.
3. Room and Board and other Skilled Nursing Care Services in a Skilled Nursing Facility or other licensed medical facility. Care in a Skilled Nursing Facility is limited to: a) the maximum number of covered days shown in the Schedule of Coverage; b) care in a licensed Skilled Nursing Facility; c) care under the active medical supervision of a Physician; and d) services consistent with medical needs.
4. Necessary Services and Supplies, including medication dispensed while confined in a Hospital.
5. Physician services, including office visits.
6. Non-emergency transportation by a licensed ground or air ambulance service only if, in the judgment of a Physician, your medical condition requires either basic life support, advanced 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 Provider. Coverage is also provided for medically necessary transportation as the result of a 911 call. Emergency ambulance services are only covered under the (HMO). Ambulance service exclusions: Transportation by car, taxi, bus, gurney-van, wheelchair van, mini-van, and any other type of transportation other than a licensed ambulance, even if the only way to travel to a Plan Provider is not covered.
7. Nursing services by a Registered Nurse, or a Licensed Vocation Nurse, as certified by the attending Physician, if a Registered Nurse is not available. Outpatient private duty nursing will only be covered for the period for which KPIC validates a Physician’s certification that:
   a) the services are Medically Necessary and b) that, in the absence of such nursing care, the Covered Person would be receiving Covered Services as an inpatient in a
GENERAL BENEFITS

Hospital or Skilled Nursing Facility. Private duty nursing will not be covered unless otherwise indicated in the Schedule of Coverage.

8. Services by a Certified Nurse Practitioner; Certified Psychiatric-Mental Health Clinical Nurse Specialist; Licensed Midwife; Physician’s Assistant, or Certified Nurse-Midwife. This care must be within the individual’s area of professional competence.

9. Radiation treatment 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 isotopes, radium or radon for diagnosis or treatment.

10. Chemotherapy.

11. Coverage for one hair prosthesis for hair loss as a result of chemotherapy or radiation treatment for cancer. Limited to a Benefit Maximum of $350 per course of chemotherapy and/or radiation therapy.

12. X-ray, laboratory test and other diagnostic services.

13. Anesthesia and its administration when provided by a licensed anesthesiologist or licensed nurse anesthetist.

14. Coverage for a minimum of 48 hours of hospitalization following a mastectomy; and coverage for a home visit when the member is in the hospital for at least 48 hours following a mastectomy, if prescribed by the patient’s attending physician.

15. Home Health Care Services. Each visit by a member of a Home Health Care Agency of up to 4 hours within any 24-hour period will be considered as one visit. To be eligible for coverage, the Home Health Care Services must be: a) in lieu of Confinement; b) provided in the Covered Person’s home; and c) establish and approve by the Covered Person’s Physician in a written treatment plan. Home Health Care Services will also be available for a Covered Person who receives less than 48 hours of inpatient hospitalization following a mastectomy or surgical removal of a testicle, or who undergoes a mastectomy or the surgical removal of a testicle on an outpatient basis. Such services will be limited to: (i) one home visit scheduled to occur 24-hours after discharge from the Hospital or outpatient health care facility; and (ii) an additional home visit if prescribed by the Covered Person’s attending Physician.

16. Coverage for one home visit to occur within 24 hours of hospital discharge for a mother and newborn that have a shorter hospital stay than 48 hours of inpatient hospitalization after an uncomplicated vaginal delivery or 96 hours of inpatient hospitalization after an uncomplicated cesarean section. An additional home visit if prescribed by the Covered Person’s attending Physician. One home visit for a mother and newborn child who remain in the hospital for the minimum length of stay if prescribed by the attending Physician.

17. Outpatient surgery in a Free-Standing Surgical Facility, other licensed medical facility or in a doctor’s office.

18. Hospital charges for use of a surgical room on an outpatient basis.

19. 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.

20. Maternity Services including those performed in a Birth Center.

21. Additional hospitalization for the newborn for up to 4 days, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital.

22. Prosthetic Devices, components of Prosthetic Devices and repairs to Prosthetic Device. Prosthetic Device or component will be considered medically necessary if it satisfied the requirements of medical necessity established under the Medicare Coverage Database.

23. Prosthetics. Coverage will include fitting and adjustment, 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. Coverage will include internally implanted and external prosthetics. Coverage will also
GENERAL BENEFITS

be provided for a prosthesis prescribed by a physician for the insured who has undergone a mastectomy and has not had breast reconstruction.

24. Rental of Durable Medical Equipment as prescribed by a Physician for use in Your home (or an institution used as Your home). We also cover Durable Medical Equipment used during a covered stay in a hospital or Skilled Nursing Facility, but only if the Skilled Nursing Facility ordinarily furnishes Durable Medical Equipment. Coverage is limited to the standard item of equipment that adequately meets Your medical needs.

Covered Durable Medical Equipment includes, but is not limited to:

a. Apnea Monitors for infants up to age 3 for a period not to exceed 6 months;

b. Asthma Equipment for pediatric and adult asthmatics limited to the following:
   i. Spacers;
   ii. Peak-flow meters; or
   iii. Nebulizers

b. Oxygen and Equipment 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 every 30 days;

d. Continuous Positive Airway Pressure Equipment when your medical condition meets Medicare’s guidelines and is prescribed by a Participating Provider.

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.

25. Coverage for management and treatment of diabetes which includes medically necessary equipment, supplies, and outpatient self-management training and education related to the care of insulin-using diabetes, noninsulin-using diabetes, or elevated blood glucose levels induced by pregnancy, including medical nutrition therapy if prescribed by a health care provider licensed to prescribe such items in accordance with applicable state law. When prescribed, diabetes outpatient self-management and education must be provided by a certified, registered, or licensed health care professional whose scope of practice includes the care of diabetes.

26. Physical therapy rendered by a certified physical therapist. To be eligible for coverage the therapy must be: 1) progressive therapy (not maintenance therapy); 2) rendered according to the attending Physician’s written treatment plan; 3) for a condition that the attending Physician determines is subject to significant improvement in the level of functioning within 60 days; and 4) completed by the Covered Person as prescribed. As used in this provision “maintenance therapy” means ongoing therapy after the Covered Person has: 1) reached maximum rehabilitation potential or functional level; or 2) shown no significant improvement.

27. Speech therapy rendered by a certified speech therapist or certified speech pathologist. To be eligible for coverage the speech disorder must be a result of an Injury or Sickness of specific organic origin. It must be rendered for a condition that the attending Physician determines is subject to significant improvement within 60 days.

28. Habilitative services for medically necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology services and devices for Dependents, who were born with congenital or genetic birth defects, from birth to age 19, except through early intervention or school services. As used herein,
congenital or genetic birth defects means a defect existing at or from birth, including a hereditary defect including, but is not limited to, autism or an autism spectrum disorder; and cerebral palsy, intellectual disability, down syndrome, spina bifida, hydroencephalocele, and congenital or genetic developmental disabilities. These Services are provided in addition to the Physical, Occupational, Speech Therapy and Multidisciplinary Rehabilitation Services described in this Certificate of Insurance.

29. 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. To be eligible for coverage the therapy must be: 1) progressive therapy (not maintenance therapy); and 2) rendered according to a written treatment plan for a condition that the attending Physician determines is subject to significant improvement within 60 days. As used in this provision “maintenance therapy” is defined as ongoing therapy after the Covered Person has: 1) reached maximum rehabilitation potential or functional level; or 2) shown no significant improvement.

30. Respiratory therapy rendered by a certified respiratory therapist. It must be rendered for a condition that the attending Physician determines is subject to significant improvement within 60 days and may not be maintenance therapy.

31. Rehabilitation services while confined in a Hospital or any other licensed medical facility. Rehabilitation services are limited to those provided in an organized, multidisciplinary rehabilitation program including those provided in a Comprehensive Rehabilitation Facility. To be eligible for coverage the therapy must be: 1) progressive therapy (not maintenance therapy); and 2) rendered according to a written treatment plan for a condition that the attending Physician determines is subject to significant improvement within 60 days. As used in this provision, “maintenance therapy” is defined as ongoing therapy after the Covered Person has: 1) reached maximum rehabilitation potential or functional level; or 2) shown no significant improvement.

32. Inpatient and outpatient services arising from orthodontics, oral surgery and otologic, audio logical and speech/language treatment as the result of the congenital defect known as cleft lip, cleft palate, or both.

33. Treatment, services, or supplies covered under the Group Policy if received as an inpatient or outpatient in a Hospital or other licensed medical facility, including Residential Crisis Services or Partial Hospitalization, when received in connection with mental illness, emotional disorders, or Substance Abuse. Outpatient benefits include psychological and neuropsychological testing for diagnostic purposes provided to treat mental illness, emotional disorders, or Substance Abuse.

34. Blood products, derivatives, components and their administration. Covered Services will include the administration of prescribed blood products.

Covered services will not include the following:

1. Whole blood
2. Concentrated red blood cells

35. Coverage for reconstructive breast surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts. Coverage includes: augmentation mammoplasty, reduction mammoplasty, and mastopexy; 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; and Physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the Covered Person.

36. Transplants are covered on an In-Plan basis only.

37. Allergy testing and treatment, services, material and serums.

38. All outpatient expenses for in-vitro fertilization performed on a Covered Person that meet the following criteria: (a) for a patient whose spouse is of the opposite sex, the patient’s oocytes are fertilized with the patient’s spouse’s sperm; (b) the patient and the patient’s spouse have a history of involuntary infertility which may be
demonstrated by a history of: 1) if the patient and the patient’s spouse are of opposite sexes, intercourse of at least 2 years’ duration failing to result in pregnancy; or 2) if the patient and the patient’s spouse are of the same sex, six attempts of artificial insemination over the course of 2 years failing to result in pregnancy; (c) the infertility is associated with any of the following medical conditions: endometriosis; exposure in utero to diethylstilbestrol, commonly known as DES; blockage of, or surgical removal of one or both fallopian tubes (lateral or bilateral salpingectomy); or abnormal male factors, including oligospermia, contributing to the infertility; (d) the patient has been unable to obtain a successful pregnancy through a less costly infertility treatment for which coverage is available under the policy; and (e) the procedures are performed at medical facilities that conform to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.

39. Reconstructive Surgery. Coverage is limited to surgeries that: a) will correct significant disfigurement resulting from a) non-congenital Injury or Medically Necessary surgery; or b) are performed to significantly improve physical function.

40. Coverage for a second medical opinion, limited to charges for Physician consultation, and charges for any additional x-rays, laboratory tests and other diagnostic studies. Benefits will not be payable for x-ray, laboratory tests, or diagnostic studies that are repetitive of those obtained as part of the original medical opinion and/or those for which KPIC paid benefits. For benefits to be payable, the second medical opinion must be rendered by a Physician who agrees not to treat the Covered Person’s diagnosed condition. The Physician offering the second medical opinion may not be affiliated with the Physician offering the original medical opinion.

41. Reimbursement for covered surgical procedures performed on an outpatient basis when such procedures are performed by a licensed medical practitioner operating with the use of local anesthetic at a licensed outpatient surgical facility affiliated with a licensed hospital

42. Coverage for patient cost to a member in a Clinical Trials provided on an inpatient and an outpatient basis of treatment for a life-threatening condition or prevention, early detection, and treatment studies on cancer. The coverage shall be required if:
   a) the treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or phase IV clinical trial for cancer or any other life-threatening condition;
   b) the treatment is being provided in a clinical trial approved or funded by:
      (1). One of the National Institutes of Health (NIH);
      (2). An NIH cooperative group or an NIH center;
      (3). The FDA in the form of an investigational new drug application or the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
      (4). Cooperative group or center of The Department of Defense or Department of Veterans Affairs; or
      (5). An Institutional review board of an institution in the State which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NIH.
      (6). Cooperative group or The Centers of Disease Control and prevention
      (7). Cooperative group or center of The Agency for Health Care Research and Quality
      (8). Cooperative group or The Centers for Medicare & Medicaid Services
      (9). The Department of Energy
      (10). A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   c) the facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
   d) there is no clearly superior, noninvestigational treatment alternative, and
GENERAL BENEFITS

e) the available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative.

Coverage for patient cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient’s particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

A Cooperative Group means a formal network of facilities that collaborate on research projects and have an established NIH-approved (National Institutes of Health) Peer Review Program operating within the group.

Cooperative group" includes: the National Cancer Institute Clinical Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the AIDS Clinical Trials Group; and Community Programs for Clinical Research in AIDS.

A Multiple project assurance contract means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

Patient cost means the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to the Covered Person for purposes of the clinical trial. Patient cost does not include: 1) the cost of an investigational drug or device; 2) the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of the clinical trial; 3) costs associated with managing the research associated with the clinical trial; or 4) costs that would not be covered under the patient’s policy, plan, or contract for noninvestigational treatments.

43. Covered Services rendered to treat Morbid Obesity through a surgical treatment that is: (a) recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity; and (b) consistent with guidelines approved by the National Institutes of Health.

44. Coverage for hearing aids for a minor child if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist. As used herein, "hearing aid" means a device that: (i) is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children; and (ii) is non-disposable.

45. Coverage for Medical Foods and Low Protein Modified Food Products for the treatment of Inherited Metabolic Diseases 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 and Low Protein Modified Food Products are prescribed for the therapeutic treatment of Inherited Metabolic Diseases, and are administered under the direction of a health care provider.

46. Coverage for Amino Acid-Based Elemental Formula(s), regardless of delivery method, for the diagnosis and treatment of: immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders, as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

47. Residential crisis services that are medically necessary.

48. General anesthesia and associated hospital or ambulatory facility charges for dental procedures rendered to a Covered Person who is:
   a. seven years of age or younger; or
   b. developmentally disabled; or
GENERAL BENEFITS

c. an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the enrollee or insure
d. an individual for whom superior result can be expected from dental care provided under general anesthesia; or
e. 17 years old or younger who:
   i. Is extremely uncooperative, fearful, or uncommunicative;
   ii. Has dental needs of such magnitude that treatment should not be delayed or deferred; and
   iii. Is an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.
This provision does not apply to treatment rendered for temporal mandibular joint disorders nor does it provide coverage for any dental procedure or the professional fees or services of the dentist.

49. Accidental dental injuries limited to restorative services necessary to promptly repair, but not replace, Sound Natural Teeth that have been injured as the result of an external force. For benefits to be payable all of the following conditions must be satisfied:
   a. The injury occurred as the result of an external force that is defined as violent contact with an external object, not force incurred while chewing;
   b. The injury was sustained to Sound Natural Teeth;
   c. The Covered Services must be requested within 60 days of the injury;
   d. The restorative services are provided within the 12 consecutive month period commencing from the date that treatment for the injury began.

Benefits are limited to the most cost-effective procedure available that would produce the most satisfactory result.

For purposes of this Covered Service, Sound Natural Teeth are defined as tooth or teeth that:
   a) Have not been weakened by existing dental pathology such as decay or periodontal disease; or
   b) Have not been previously restored by a crown, inlay, onlay, porcelain restoration, or treatment by endodontics.

Restorative Services will not include:

50. Expenses arising from care, including nursing home care and intermediate or custodial nursing care, for a Covered Person diagnosed with Alzheimer’s disease.

51. Expenses arising from the care of an elderly Covered Person, including nursing home care and intermediate or custodial nursing care, who is diagnosed with any disease other than Alzheimer’s disease.

52. Vision services, including routine exams, eye refractions, orthoptics, glasses, contact lenses or the fitting of glasses or contact lenses.

53. Hospice Care. Covered Services will include inpatient care; part-time nursing care by or supervised by a registered nurse; counseling, including dietary counseling; family counseling; bereavement counseling; respite care; medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the terminally ill Covered Person. Please see the definition of “Hospice Care”, as set forth in the General Definitions section, for a complete understanding of the terms used in this benefit.

54. Covered Services will include coverage for qualified individuals for reimbursement for bone mass measurement for the diagnosis and treatment of osteoporosis when the bone mass measurement is requested by a health care provider for the qualified individual. As used herein, the following terms are defined as follows:
GENERAL BENEFITS

"Bone mass measurement" means a radiologic or radioisotopic procedure or other scientifically proven technology performed on a qualified individual for the purpose of identifying bone mass or detecting bone loss.

"Qualified individual" means (i) an estrogen deficient Covered Person at clinical risk for osteoporosis; (ii) an Covered Person with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease; (iii) an individual receiving long-term glucocorticoid (steroid) therapy; (iv) Covered Person with primary hyperparathyroidism; or (v) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

55. Physician services, including diagnosis, consultation, and treatment appropriately provided via Telemedicine. Telemedicine shall be subject to the same Deductible, Coinsurance and/or Copayments as are otherwise applicable to Physician office visits.

56. All medically appropriate and necessary equipment and supplies used for the treatment of ostomies, including but not limited to flanges, collection bags, clamps, irrigation devices, sanitizing products, ostomy rings, ostomy belts, and catheters used for drainage of urostomies.

Pediatric Vision (children up to age 19)

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:

1) Lenses
   a. Single vision
   b. Conventional (Lined) Bifocal

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.

2) Eyeglass frames non-deluxe (designer) frames
3) Contact lenses including evaluation, fitting, or follow-up care relating to contact lenses
4) Medically necessary contact lenses in lieu of other eyewear for the following conditions:
   a. Keratoconus,
   b. Pathological Myopia,
   c. Aphakia,
   d. Anisometropia,
   e. Aniseikonia,
   f. Aniridia,
   g. Corneal Disorders,
   h. Post-traumatic Disorders,
   i. Irregular Astigmatism.
GENERAL BENEFITS

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

In addition to any other preventive benefits described in the Group Policy, KPIC shall cover the following preventive services and shall not impose any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any covered individual receiving any of the following benefits for services received from participating providers:

1. Evidenced-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

For services received from non-participating providers, the preventive service benefits described above shall be covered at 80% of the amount covered for services received from participating providers.

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

Consult with Your physician to determine what preventive services are appropriate for You.

Exams

1. Well-Baby, Child, Adolescent Exam according to the Health Resources and Services Administration (HRSA) guidelines. This includes all visits for and costs of developmental screening as recommended by the American Academy of Pediatrics.

2. Well-woman exam visits to obtain the recommended preventive services, including preconception counseling and Routine Prenatal Care. Routine prenatal office visits include the initial and subsequent histories, physical examinations, recording of weight, blood pressure, fetal heart tones, and routine chemical urinalysis.

3. All visits for and costs of age-appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision as determined by the American Academy of Pediatrics;

4. A physical examination, developmental assessment, any laboratory tests considered necessary by the physician and parental anticipatory guidance services at each of the visits required under:
   (a) childhood and adolescent immunizations;
   (b) hereditary and metabolic newborn screening and follow-up;
GENERAL BENEFITS

(c) screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision;
(d) obesity evaluation and management; and
(e) developmental screening.

Screenings

1. Abdominal aortic aneurysm screening
2. Asymptomatic bacteriuria screening
3. Breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society
4. Cervical cancer and dysplasia screening including HPV screening,
5. Colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society
6. Diagnostic examination which shall include a digital rectal exam and a blood test called the prostate-specific antigen (PSA) test:
   a) For men who are between 40 and 75 years of age;
   b) When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;
   c) When used for staging in determining the need for a bone scan in patients with prostate cancer; or
   d) 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.
7. Depression screening
8. Gestational diabetes screening
9. Hepatitis B virus infection screening; for pregnant women
10. Hematocrit or Hemoglobin screening in children
11. High blood pressure screening
12. Iron deficiency anemia screening for pregnant women
13. Lead Screening
14. Lipid disorders screening
15. Lung cancer screening with low-dose computed tomography in adults who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.
16. Newborn congenital hypothyroidism screening
17. Newborn hearing loss screening
18. Newborn metabolic/hemoglobin screening. This include visits for the collection of adequate samples, the first of which is to be collected before 2 weeks of age, for hereditary and metabolic newborn screening and follow-up between birth and 4 weeks of age.
19. Newborn sickle cell disease screening
20. Newborn Phenylketonuria screening
21. Obesity screening and management
22. Osteoporosis screening
23. Rh (D) incompatibility screening for pregnant women
24. Sexually transmitted infection screening such as chlamydia, human papillomavirus screening, gonorrhea, syphilis and HIV screening. Annual routine Chlamydia screening test for women who are under the age of 20 years if they are sexually active; and at least 20 years old if they have multiple risk factors; and men who have multiple risk factors. Human papillomavirus screening at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists
25. Type 2 diabetes mellitus screening
26. Tuberculin (TB) Testing
27. Visual impairment in children screening
Health Promotion

1. Alcohol and drug misuse assessment and behavioral counseling interventions in a primary care setting to reduce alcohol misuse
2. Healthy diet behavioral counseling
3. Offer Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults and children
4. Tobacco use and tobacco-caused disease counseling and interventions including FDA approved tobacco cessation prescription or over-the-counter medications by a licensed health care professional authorized to prescribe drugs
5. Referral for testing for breast and ovarian cancer susceptibility, referral for genetic risk assessment and BRCA mutation testing
6. Sexually transmitted infections counseling
7. Discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention and when prescribed by a physician for asymptomatic women, with an increased risk of breast cancer and no history of breast cancer, the risk reducing medication such as tamoxifen and raloxifene.
8. When prescribed by a licensed health care professional authorized to prescribe drugs:
   a) aspirin in the prevention of cardiovascular disease and preeclampsia in pregnant women.
   b) iron supplementation for children from 6 months to 12 months of age.
   c) oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
   d) 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.
   e) folic acid supplementation for women planning or capable of pregnancy.
   f) Vitamin D to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.
9. Interventions to promote breastfeeding. The following additional services are covered: breastfeeding support and consulting by a trained provider during pregnancy and/or in the post partum period, 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 pump, rental of a hospital-grade electric breast pump, including any equipment that is required for pump functionality, for 6 months 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.
10. All prescribed FDA-approved contraceptive drugs and prescribed FDA-approved cervical caps, vaginal rings, continuous extended oral contraceptives and patches. This includes contraceptives which require medical administration in Your doctor’s office, implanted devices and professional services to implant them, female sterilization procedures, and patient education and counseling for all women with reproductive capacity. Over the counter FDA approved female contraceptive methods are covered only when prescribed by a licensed health care professional authorized to prescribe drugs.
11. Screening and counseling for interpersonal and domestic violence
12. 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.
GENERAL BENEFITS

Disease Prevention

1. Immunizations as recommended by the Centers for Disease Control and HRSA. This includes all visits for and costs of childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

2. Prophylactic gonorrhea medication for newborns to protect against gonococcal ophthalmia neonatorum.

Exclusions for Preventive Care

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
- Replacement or upgrades of breast-feeding equipment

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 Policy 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: 1-800-392-8649. 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 General Benefits section:

- Lab, 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 a sterilization
- Lab, Imaging and other ancillary services associated with sterilizations
- Treatment for complications that arise after a sterilization procedure

Other Preventive Care

Other Preventive Care covered under this Group Policy not required by the Patient Protection Affordable Care Act listed below are subject to the cost-sharing, if any, as described in the Schedule of Coverage:

The following Preventive Benefits are in addition to the PPACA Preventive Benefits covered under this policy:

1. Routine Adult Physical Exams;
2. Double contrast barium enema as an alternative to colonoscopy
3. Family planning limited to:
   a) The charge of a Physician for consultation concerning the family planning alternatives available to a male Covered Person, including any related diagnostic tests;
   b) Vasectomies;
   c) Services and supplies for diagnosis and treatment of involuntary infertility for females and males;
GENERAL BENEFITS

d) Voluntary termination of pregnancy.

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:

a) The cost of donor semen and donor eggs including retrieval of eggs;
b) Storage and freezing of eggs and/or sperm;
c) Services to reverse voluntary, surgically induced infertility;
d) Services related to conception by artificial means, including, but not limited to, gamete intrafallopian tube transfer; ovum transplants; zygote intrafallopian transfer, and prescription drugs related to such services.
e) Artificial insemination;
f) Other assistive reproductive technologies;
g) Diagnostic procedures;
h) Treatment or any infertility diagnosis services.

Continuity of Care when transitioning carriers

At the request of the Covered Person, the Covered Person’s authorized representative, or the Covered Person’s health care provider, KPIC shall allow the Covered Person to continue to receive health care services being rendered by a nonparticipating provider at the time of the Covered Person’s transition to KPIC.

The services a Covered Person shall be allowed to continue to receive are services for the following conditions:

a) Acute conditions
b) Serious chronic conditions
c) Pregnancy;
d) Mental health conditions and substance use disorders; and
e) Any other condition which the nonparticipating provider and KPIC reach agreement.

The Covered Person shall receive coverage for the following time periods:

1) The lesser of the course of treatment or 90 days;
2) The duration of the three trimesters of a pregnancy and the initial postpartum visit.

KPIC shall pay the nonparticipating provider the rate or method of payment KPIC would pay and use for participating providers who provide similar services in the same or similar geographic area.

The nonparticipating provider may decline to accept the rate or method of payment by giving 10 days’ prior notice to the Covered Person and KPIC.

If the nonparticipating provider does not accept the rate or method of payment, the nonparticipating provider and KPIC may reach agreement on an alternative rate or method of payment for the provision of covered services.

The rates and methods of payment shall: be subject to any State or federal requirements applicable to reimbursement for health care providers, including:

1) § 1302(g) of the Affordable care Act, which applies to reimbursement rates for Federally Qualified Health centers; and
2) Title 19, Subtitle 2 of the Health-General Article, under which the Health Services Cost Review Commission establishes provider rates; and
GENERAL BENEFITS

3) Ensure that the Covered Person is not subject to balance billing; and
4) The copayments, deductibles, and any coinsurance required of a Covered Person for the services rendered are the same as those that would be required if the Covered Person were receiving the services from a KPIC participating provider.

Extension of Benefits

Covered Services under the Group Policy will be extended for the condition causing the Total Disability of a Covered Person when:

1. The Covered Person becomes Totally Disabled while insured for that insurance under the Group Policy; and
2. The Covered Person is still Totally Disabled on the date coverage under the Group Policy terminates.

The extended benefits will be paid only for treatment of the Injury or Sickness that causes the Total Disability. The extension will start on the day that follows the last day for which premiums are paid for the insurance of the Covered Person. It will end on the earlier of the following dates:

1. The date on which the Total Disability ends; or
2. 12 months after the date coverage under the Group Policy terminates.

A Covered Person other than a Dependent minor is totally disabled when the inability of the Insured Employee or Dependent Adult, due solely to Sickness or Injury, is unable to perform with reasonable continuity the substantial and material duties of regular and customary work. The Covered Person must not, in fact, be working for pay or profit.

If a Covered Person has ordered glasses or contact lenses before the date coverage terminates, benefits will be provided in accordance with the Group Policy in effect at the time the Covered Person’s coverage terminates, for the glasses or contact lenses if the Covered Person receives the glasses or contact lenses within 30 days after the date of the order.

In accordance with the Group Policy in effect at the time the Covered Person’s coverage terminates, benefits will be provided for a course of Accidental Dental treatment for at least 90 days after the date coverage terminates if the treatment:
(i) begins before the date coverage terminates; and
(ii) requires two or more visits on separate days to a dentist’s office.

A Covered Person other than a Dependent minor is totally disabled when the inability of the Insured Employee or Dependent Adult, due solely to Sickness or Injury, is unable to perform with reasonable continuity the substantial and material duties of regular and customary work. The Covered Person must not, in fact, be working for pay or profit.

A Covered Person who is a Dependent minor is totally disabled when the inability, due solely to Sickness or Injury, makes the person unable to engage in the normal activities of a person of the same sex and age.

The extension of benefits provided by this provision will not be subject to premium charge.

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

1. Failure to pay Premium by the Covered Person;
GENERAL BENEFITS

2. Covered Person whose coverage ends because of fraud or material misrepresentation by the Covered Person;
3. When coverage is provided by another health plan and that health plan’s coverage:
   (i.) is provided at a cost to the Covered Person that is less than or equal to the cost to the Covered Person of the extended benefit available under this Group Policy and
   (ii) will not result in an interruption of benefits.

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 uncomplicated vaginal delivery and not less than 96 hours following an uncomplicated 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.
GENERAL LIMITATIONS AND EXCLUSIONS

Unless specifically stated otherwise in the Group Policy or elsewhere in this Certificate or in the Schedule of Coverage, no payment will be made under any benefit of the plan for Expenses Incurred in connection with the following:

1. Charges for services approved by or reimbursed by Health Plan.
2. Charges in excess of the Maximum Allowable Charge.
3. Charges for non-Emergency Care in an Emergency Care setting to the extent that they exceed charges that would have been incurred for the same treatment in a non-Emergency Care setting. Final determination as to whether services were rendered in connection with an emergency will rest solely with KPIC.
4. Weekend admission charges for non-Emergency Care Hospital services. This exclusion applies only to such admission charges for Friday through Sunday, inclusive.
5. Confinement, treatment, services or supplies not Medically Necessary. This exclusion does not apply to preventive or other health care services specifically covered under the plan.
6. 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.
7. Injury or Sickness for which benefits are payable under any state or federal workers' compensation, employer's liability, or occupational disease or similar law.
8. Injury or Sickness for which the law requires the Covered Person to maintain alternative insurance, bonding, or third party coverage.
9. Injury or Sickness arising out of or in the course of past or current work for pay, profit, or gain, unless workers' compensation or benefits under similar law are not required or available.
10. Services for military service related conditions regardless of service in any country or international organization.
11. Treatment, services, or supplies provided by the Covered Person; his or her spouse; a child, sibling, or parent of the Covered Person or of the Covered Person's spouse; or a person who resides in the Covered Person's home.
12. Confinement, treatment, services or supplies received where care is provided at government expense. This exclusion does not apply if: a) there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage; or b) payment is required by law.
13. Dental care and dental x-rays; dental appliances; orthodontia; and dental services resulting from medical treatment, or medical condition, including surgery on the jawbone and radiation treatment. This exclusion includes, but is not limited to: services to correct malocclusion; extraction of wisdom teeth (third molars); injury to teeth resulting from chewing; Dental appliances; dental implants; orthodontics; dental services associated with medical treatment. This exclusion does not include visits for repairs or treatment of cleft lip, cleft palate or both. This exclusion does not include visits for repairs or treatment of accidental injury to sound natural teeth when performed or rendered within 12 months following the accident.
14. Cosmetic services, plastic surgery or other services that: a) are indicated primarily to change the Covered Person's appearance; and b) will not result in significant improvement in physical function. This exclusion does not apply to services that: a) will correct significant disfigurement resulting from a non-congenital Injury or Medically Necessary surgery; or b) are incidental to a covered mastectomy; or c) are necessary for treatment of a form of congenital hemangioma known as port wine stains; or d) are needed to treat cleft lip, cleft palate or both.
15. All services and drugs related to sexual reassignment as well as sexual reassignment surgery.
16. Non-prescription drugs or medicines; vitamins, nutrients and food supplements, even if prescribed or administered by a Physician, except as listed under Preventive Care in the GENERAL BENEFITS section.
17. Any treatment, procedure, drug or equipment, or device which KPIC determines to be experimental or investigational. This means that one of the following is applicable:
   a. The service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or use in testing or other studies on human patients; or
   b. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered.
   This exclusion will not apply to clinical trials as a result of: (1) Treatment provided for a life threatening condition; or (2) Prevention, early detection, and treatment studies on cancer.

18. Special education and related counseling or therapy; or care for learning deficiencies or behavioral problems. This applies whether or not the services are associated with manifest Mental Illness or other disturbances.

19. Services, supplies or drugs rendered for the treatment of obesity or weight management; however, Covered Charges made to diagnose the causes of obesity or charges made for treatment of diseases causing obesity or resulting from obesity are covered. This exclusion will not apply to Expenses Incurred subject to the limited benefit for treat Morbid Obesity as set forth in the GENERAL BENEFITS section of this Certificate.

20. Confinement, treatment, services or supplies that are required: a) by a court of law; or b) for insurance, travel, employment, school, camp, government licensing, or similar purposes.

21. Personal comfort items such as telephone, radio, television, or grooming services.

22. Custodial care. Custodial care is: a) assistance with activities of daily living which include, but are not limited to, activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking drugs; or b) care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse. This does not exclude custodial nursing care of individuals who have Alzheimer’s disease.

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

24. Routine foot care such as trimming of corns and calluses

25. Confinement or services that are not Medically Necessary or treatment that is not completed in accordance with the attending Physician’s orders.

26. Services of a private duty nurse in a Hospital, Skilled Nursing Facility or other licensed medical facility, or in the Covered Person's home unless determined by the Physician to be Medically Necessary;

27. Medical social services except those services related to discharge planning in connection with: a) a covered Hospital Confinement; b) covered Home Health Care Services; or c) covered Hospice Care.

28. Living expenses or transportation, except as provided under Covered Services.

29. Reversal of sterilization.

30. Services provided in the home other than Covered Services provided through a Home Health Agency.

31. Maintenance therapy for rehabilitation.

32. The following Home Health Care Services:
   a. treatment of Mental Illness and substance abuse disorders,
   b. meals,
   c. personal comfort items,
   d. housekeeping services.

33. 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
GENERAL LIMITATIONS AND EXCLUSIONS

cystic fibrosis, human growth hormones prescribed or administered for the treatment of documented human growth hormone deficiency such as Turner’s Syndrome.

34. 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.

35. Musculoskeletal therapy involving manual manipulation of the spine to correct subluxation demonstrable by x-ray.

36. Biofeedback or hypnotherapy.

37. Hearing exams, hearing therapy or hearing aids. This exclusion includes hearing exams to determine appropriate hearing aid, as well as hearing aids or tests to determine their efficacy. Internally implanted hearing aids are also excluded. This exclusion will not apply to Expenses Incurred subject to the limited benefit for hearing aids for a minor child as set forth in the GENERAL BENEFITS section of this Certificate.

38. Radial keratotomy or any other surgical procedure to treat a refractive error of the eye.

39. Services for which no charge is normally made in the absence of insurance.

40. Rehabilitation services while confined in a Hospital or any other licensed medical facility. Rehabilitation services are limited to those provided in an organized, multidisciplinary rehabilitation program including those provided in a Comprehensive Rehabilitation Facility. It must be rendered for a condition that the attending Physician determines is subject to significant improvement within two months and may not be maintenance therapy.

41. Transplant services in connection with an organ or tissue transplant procedure, including charges incurred by a donor or prospective donor who is not insured under the plan will be paid as though they were incurred by the insured provided that the services are directly related to the transplant. Charges incurred or in connection with non-human and artificial organs and their implantation are not covered under the transplant benefit.

42. Acupuncture.

43. Treatment for infertility, except in vitro fertilization as set forth under the Covered Services, or as otherwise set forth in the Schedule of Coverage.

44. Treatment of craniomandibular, myofascial pain and temporal mandibular joint disorders. Coverage is limited to medically necessary surgical treatment only.

45. Any claim, bill, or other demand or request for payment for health care services that were provided as a result of a prohibited referral as determined by the appropriate regulatory board.

46. Cardiac Rehabilitation, except as a limited benefit as set forth in the Schedule of Coverage for Covered Persons with: a) history of acute myocardial infarction; b) surgery for coronary artery bypass; c) percutaneous therapeutic coronary artery intervention; d) heart or heart/lung transplant; or e) repair or replacement of a heart valve.
OPTIONAL OUTPATIENT PRESCRIPTION DRUG BENEFITS, LIMITATIONS, AND EXCLUSIONS

To determine if you are covered for the following optional benefits, you must refer to the Schedule of Coverage. If the treatment or service is not listed as covered under your Schedule of Coverage, then the treatment or service is excluded from coverage as provided under the General Exclusions and Limitations section of this certificate.

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 or dentist; b) are purchased by covered persons 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 150 percent of the average wholesale price of the ingredients contained in the prescription, plus a dispensing fee. The part of a charge that exceeds this limit will not be considered a covered charge.

Outpatient Drugs Covered

Charges for the items listed below are also considered covered charges. Except as specifically stated below or on your Schedule of Coverage, such covered charges are subject to the Outpatient Prescription Drug Percentage Payable.

1. Prescription drugs listed as Generic Drugs;
2. Prescription drugs listed as Preferred and Non-Preferred Brand Drugs. Non-Preferred Brand Name Drugs covered as Preferred Brand Name Drugs when there is no equivalent Preferred Brand Name Drugs or Non-Preferred Brand Name Drug is ineffective in treating the member’s disease or condition or has caused or likely to cause adverse reaction or other harm to the member.
3. Drugs and medicines for the purpose of cessation of the use of tobacco products including any drug that is not an over-the-counter product which is approved by the FDA as an aid for the cessation of the use of tobacco products; and is obtained under a prescription written by an authorized prescriber. Coverage shall include two 90-day courses of nicotine replacement therapy during each policy year;
4. Internally implanted time-release medications;
5. Any contraceptive drug or device that is approved by the United States Food and Drug Administration (FDA);
6. Insulin and the following diabetic supplies:
   a. syringes and needles; and
   b. blood glucose and ketone test strips or tablets.
   The standard prescription amount for insulin is one 10 milliliter vial.
7. Compounded dermatological preparations which must be prepared by a pharmacist in accord with a physician's prescription;
8. Antacids;
9. Up to a 90-day supply of a maintenance drug in a single dispensing of the prescription;
10. Oral or nasal inhalers;
11. Compounded dermatological preparations which must be prepared by a pharmacist;
12. Spacer devices;
13. Migraine medications;
14. Ophthalmic, otic, and topical medications;
15. For covered persons with enterostomies and urinary diversions, the following ostomy supplies and equipment:
   a) appliances
   b) adhesives
   c) skin barriers and skin care items
   d) belts and clamps
Outpatient Prescription Drugs Limitations and Exclusions

The following items are excluded from Outpatient Prescription Drug coverage in addition to any set forth in the General Limitations and Exclusions section:

1. All injectable drugs (except insulin and injectable contraceptives);
2. Administration of a drug or medicine;
3. Any drug or medicine administered as Necessary Services and Supplies (See the General Definitions section.);
4. Drugs not approved by the Federal Drug Administration (FDA);
5. Drugs and injectables for the treatment of sexual dysfunction disorders;
6. Drugs or injectables for the treatment of involuntary infertility. This exclusion will not apply to drugs administered during covered in-vitro fertilization;
7. Drugs and injectables for the treatment of cosmetic services;
8. Replacement of lost or damaged drugs and accessories;
9. 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 Covered Person’s condition. In addition, this exclusion will not apply to routine patient care costs related to clinical trial if the Covered Person’s treating Physician recommends participation in the clinical trial after determining that participation in such clinical trial has a meaningful potential to benefit the Covered Person. Additionally, this exclusion will not apply to off-label use of a FDA approved drug if the drug is recognized for treatment in any of the standard reference compendia or in the medical literature.
10. Internally Implanted time-release drugs and medicines
11. Drugs associated with non-covered services;
12. Infant formulas, except for amino acid-based elemental formula and formulas and special food products to treat PKU as set forth as a limited benefit under the GENERAL BENEFITS section of this Certificate;
13. Human Growth Hormone (HGH), except for children with either Turner’s syndrome or with classical growth hormone deficiency; and
14. Anorectic or any drug or injectable used for the purpose of weight loss or weight management unless prescribed in the treatment of morbid obesity.
15. All drugs related to sexual reassignment
16. Non-prescription drugs or medicines; vitamins, nutrients and food supplements, even if prescribed or administered by a Physician
17. 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.
18. Any drug 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.

Direct 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...
OPTIONAL OUTPATIENT PRESCRIPTION DRUG BENEFITS, LIMITATIONS, AND EXCLUSIONS

Customer Contact Center 24 hours a day 7 days a week at 1-800-788-2949 or email via customerservice@medimpact.com.
OPTIONAL BENEFITS, LIMITATIONS, AND EXCLUSIONS

To determine if You are covered for the following optional benefits You must refer to the Schedule of Coverage. If the treatment or service is not listed as covered under Your Schedule of Coverage, then the treatment or service is excluded from coverage as provided under the General Exclusions and Limitations section of this certificate.

1. Routine adult physical examinations. Services must meet prevailing standards. The care shall include: a) examination; b) history; c) appropriate immunizations; and d) x-ray and laboratory tests. Examinations performed by Non-Participating Providers will be subject to the Policy Year Deductible and the standard Percentage Payable and Coinsurance percentage applicable under the Plan purchased by the Policyholder.

2. Vision services, including routine exams, eye refractions, orthoptics, glasses, contact lenses or the fitting of glasses or contact lenses.

3. Expenses arising from care, including nursing home care and intermediate or custodial nursing care, for a Covered Person diagnosed with Alzheimer’s disease.

4. Expenses arising from the care of an elderly Covered Person, including nursing home care and intermediate or custodial nursing care, who is diagnosed with any disease other than Alzheimer’s disease.

5. Hospice Care. Covered Services will include inpatient care; part-time nursing care by or supervised by a registered nurse; counseling, including dietary counseling; family counseling; bereavement counseling; respite care; medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the terminally ill Covered Person. Please see the definition of “Hospice Care”, as set forth in the General Definitions section, for a complete understanding of the terms used in this benefit.

6. Rental of Durable Medical Equipment. However, 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.

7. Allergy testing and treatment, services, material and serums.

8. Chiropractic Services rendered by a Physician for chronic pain management or chronic illness management. Chiropractic Services shall be limited to musculoskeletal therapy involving manual manipulation of the spine to correct subluxation.

9. Coverage for a second medical opinion, limited to charges for Physician consultation, and charges for any additional x-rays, laboratory tests and other diagnostic studies. Benefits will not be payable for x-ray, laboratory tests, or diagnostic studies that are repetitive of those obtained as part of the original medical opinion and/or those for which KPIC paid benefits. For benefits to be payable, the second medical opinion must be rendered by a Physician who agrees not to treat the Covered Person’s diagnosed condition. The Physician offering the second medical opinion may not be affiliated with the Physician offering the original medical opinion.
FEDERAL CONTINUATION OF COVERAGE PROVISIONS

This section only applies to Participating Employers who are subject to Public Law 99-271 (COBRA)

You may be able to continue Your coverage under the Group Policy for a limited time after You would otherwise lose eligibility, if required by the federal COBRA law. Please contact Your Group if you want to know how to elect COBRA coverage or how much You will have to contribute through Your Group.
STATE CONTINUATION PROVISIONS

Continuation Privilege

A Covered Person who has been covered under the Group Policy for at least 3 months, and whose coverage terminates for any reason other than the following:

1. becoming eligible for Medicare;
2. reaching an age limited by the Group Policy; or
3. failure of the insured person to pay a required premium or contribution;

may elect to continue coverage under the Group Policy for up to 6 months, subject to timely premium payments. Notice of Your continuation privileges shall be given to You by the Policyholder upon Your termination of coverage. If the Policyholder fails to notify You within 30 days of Your termination date, then You will have 90 days from such termination date to apply for continuation coverage.

Surviving Spouse and Dependent Child Continuation:

As used in this provision, the terms listed below are defined as follows:

"Dependent child" means a child of the Insured Employee who: (i) was covered under the Group Policy as a qualified or eligible dependent of the Insured Employee immediately before the death of the Insured Employee; or (ii) was born to a Qualified Secondary Beneficiary after the death of the Insured Employee.

"Election Period" means the period that begins on the date of death of the Insured Employee and ends 45 days after that date.

"Insured Employee" means an employee of the Group Policyholder who is a resident of the State of Maryland and covered under the Group Policy current or predecessor group contract with the same employer for at least 3 months before death.

"Qualified Secondary Beneficiary" means an individual who is: (i) a beneficiary under the Group Policy as the spouse of the Insured Employee for at least 30 days immediately preceding the death of the Insured Employee; or (ii) a Dependent Child of the Insured Employee.

A Qualified Second Beneficiary is eligible to elect continuation coverage under the Group Policy within the Election Period. To elect continuation a Qualified Secondary Beneficiary or authorized representative must submit a signed election notification form to the Group Policyholder during the Election Period. Requests for election forms are to be directed to the Group Policyholder. If elected, such continuation coverage will begin on the date of the Insured Employee’s death and end on the earliest of the following dates:

1. 18 months after the date of death of the Insured Employee;
2. the date on which the Qualified Secondary Beneficiary fails to make timely payment of premium;
3. the date the Qualified Secondary Beneficiary becomes eligible for hospital, medical, or surgical benefits under another insured or self-funded group health benefit program or plan that is written on an expense-incurred basis or is with a health maintenance organization;
4. the date the Qualified Secondary Beneficiary becomes entitled to benefits under Medicare;
5. the date the Qualified Secondary Beneficiary accepts hospital, medical, or surgical coverage under any non-group plan or policy written on an expense-incurred basis or is with a health maintenance organization;
STATE CONTINUATION PROVISIONS

6. the date on which the Qualified Secondary Beneficiary elects to terminate coverage under the Group Policy;
7. the date the employer ceases to provide group benefits to his/her employees; or
8. for Dependent Children, the date the Qualified Secondary Beneficiary would no longer be covered under the Group Policy if the Insured Employee had not died.

Continuation coverage for the Qualified Secondary Beneficiary will be subject to all changes, options and modifications that a Covered Person would otherwise be subject to, such as: transfer to another group contract; or plan changes or options for which a Covered Person would be subject to or otherwise eligible.

Continuation coverage provided under this section will: (1) be provided without evidence of insurability or additional waiting periods; and (2) require the Qualified Secondary Beneficiary to pay the required premium payments to the Group Policyholder. If elected by the Qualified Secondary Beneficiary, the Group Policyholder must allow the premium required by item (2) above, to be paid in monthly installments.

Spouse and Dependent Child Continuation upon Divorce:

As used in this provision, the terms listed below are defined as follows:

“Change in Status” means the divorce of the Insured Employee and his/her spouse.

“Dependent Child” means a child of the Insured Employee who: (i) was covered under the Group Policy as a qualified or eligible dependent of the Insured Employee immediately before the change in status; or (ii) was born to a Qualified Secondary Beneficiary after the Change in Status.

“Insured Employee” means an employee of the Group Policyholder who is a resident of the State of Maryland and covered under the Group Policy.

“Qualified Secondary Beneficiary” means an individual who is: (i) a beneficiary under the Group Policy as the spouse of the Insured Employee for at least 30 days immediately preceding the Change in Status; or (ii) a Dependent Child of the Insured Employee.

A Qualified Secondary Beneficiary is entitled to continuation coverage under the Group Policy after a Change in Status. Continuation coverage under this provision will begin on the date of the Change in Status and end on the earliest of the following dates:

a. the date the Qualified Secondary Beneficiary becomes eligible for hospital, medical, or surgical benefits under another insured or self-funded group health benefit program or plan that is written on an expense-incurred basis or is with a health maintenance organization;
b. the date the Qualified Secondary Beneficiary becomes entitled to benefits under Medicare;
c. the date the Qualified Secondary Beneficiary accepts hospital, medical, or surgical coverage under any non-group plan or policy written on an expense-incurred basis or is with a health maintenance organization;
d. the date on which the Qualified Secondary Beneficiary elects to terminate coverage under the Group Policy;
e. the date the employer ceases to provide group benefits to his/her employees;
f. for Dependent Children, the date the Qualified Secondary Beneficiary would no longer be covered under the Group Policy if there had not been a Change in Status; or
g. for an individual who is a Qualified Secondary Beneficiary by reason of having been the Insured Employee’s spouse, the date on which the individual remarries.
STATE CONTINUATION PROVISIONS

h. the date the coverage under the Group Policy terminates with respect to the Insured Employee.
i. the premium due date on which the premium payable is not timely made.

In order to be eligible for the continuation coverage described in this section, the Insured Employee or divorced spouse of the insured employee, must notify the Policyholder of the applicable change in status not later than:

1. 60 days after the applicable change in status if on the date of the applicable change in status the employee is covered under the Group Policy or under another group contract issued to the same employer replacing the Group Policy. The coverage will be retroactive to the applicable change in status.

2. 30 days after the date the Insured Employee becomes eligible for coverage under a group contact issued to another employer, if the Insured Employee becomes covered under the new employer’s group contract after the applicable change in status. The coverage will be retroactive to the date of eligibility.

Continuation coverage for the Qualified Secondary Beneficiary will be subject to all changes, options and modifications that a Covered Person would otherwise be subject to, such as: transfer to another group contract; or plan changes or options for which a Covered Person would be subject to or otherwise eligible.

Continuation coverage provided under this provision will: (1) be provided without evidence of insurability or additional waiting periods; and (2) require the Insured Employee to make arrangements with the Group Policyholder to pay the entire cost for the coverage for a Qualified Secondary Beneficiary.

Continuation of Coverage upon Termination of Employment:

As used in this provision, the terms listed below are defined as follows:

“Change in Status” means (i) involuntary termination of the Insured Employee’s employment other than for cause; or (ii) voluntary termination of the Insured Employee’s employment by the Insured Employee.

“Election Period” means the period that begins on the date of the Change in Status and ends 45 days after that date.

“Insured Employee” means an employee of the Group Policyholder who is a resident of the State of Maryland and covered under the Group Policy current or predecessor group contract with the same employer before the Change in Status.

An Insured Employee, or someone acting on his/her behalf, is eligible to elect continuation coverage under the Group Policy after a Change in Status if done within the Election Period. If elected, continuation coverage under this provision will begin on the date of the Change in Status and end on the earliest of the following dates:

1. 18 months after the date of the Change in Status;
2. the date on which the Insured Employee fails to make timely payment of premium;
3. the date the Insured Employee becomes eligible for hospital, medical, or surgical benefits under another insured or self-funded group health benefit program or plan that is written on an expense-incurred basis or is with a health maintenance organization;
4. the date the Insured Employee becomes entitled to benefits under Medicare;
STATE CONTINUATION PROVISIONS

5. the date the Insured Employee accepts hospital, medical, or surgical coverage under any non-group plan or policy written on an expense-incurred basis or is with a health maintenance organization;

6. the date on which the Insured Employee elects to terminate coverage under the Group Policy; or

7. the date the employer ceases to provide group benefits to his/her employees;

Continuation coverage provided under this provision will: (1) be provided without evidence of insurability or additional waiting periods; and (2) require the Insured Employee to pay the required premium payments to the Group Policyholder (if elected by the Insured Employee, the Group Policyholder must allow the premium to be paid in monthly installments); and (3) be available to the spouse and dependent children of the insured if: (a) the Group Policy provides benefits for spouses and dependent children; and (b) the Insured Employee’s spouse and dependent children were covered under the Group Policy before the Change in Status.

Continuation coverage for the Insured Employee will be subject to all changes, options and modifications that another covered employee would be subject to, such as: transfer to another group contract; or plan changes or options for which a covered employee would be subject to or otherwise eligible.

Addition of Dependents following Death of Spouse:

The Insured Employee may elect to add his or her dependent children as eligible dependents under the Group Policy at any time and without evidence of insurability if: (1) the dependent children were previously covered under the spouse’s policy; and (2) the Insured Employee’s spouse has died. Such election must be made within six months following the death of the Insured Employee’s dependent spouse. This provision will apply regardless of whether the dependent children are eligible for any continuation privileges under the spouse’s policy.
COORDINATION OF BENEFITS

Application

This Coordination of Benefits provision applies when the Covered Person has coverage under more than one Plan. If this provision applies, the benefit determination rules state whether This Plan pays before or after another Plan.

The benefits of This Plan:
1. will not be reduced when This Plan is primary;
2. may be reduced when another Plan is primary and this Plan is secondary. The benefits of this Plan are reduced so that they and the benefits payable under all other Plans do not total more than 100 percent of the Allowable Expenses during any Policy Year; and
3. will not exceed the benefits payable in the absence of other coverage.

Order of Benefit Determination Rules

This Plan determines its order of benefits by using the first of the following that applies:
1. General: A Plan that does not coordinate with other Plans is always the primary Plan.
2. Non-dependent\Dependent: The benefits of the Plan which covers the person as a Covered Person, or subscriber (other than a Dependent) is the primary Plan; the Plan which covers the person as a Dependent is the secondary Plan.
3. Dependent Child--Parents Not Separated or Divorced: When this Plan and another Plan cover the same child as a Dependent of different parents, benefits for the child are determined as follows:
   a) the primary Plan is the Plan of the parent whose birthday (month and day) falls earlier in the year. The secondary Plan is the Plan of the parent whose birthday falls later in the year.
   b) if both parents have the same birthday, the benefits of the Plan which covered the parent the longer time is the primary Plan; the Plan which covered the parent the shorter time is the secondary Plan.
   c) if the other Plan does not have the birthday rule, but has the male\female rule and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
4. 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 as follows:
   a. first, the Plan of the parent with custody of the child;
   b. then, the Plan of the spouse of the parent with custody of the child; and
   c. finally, the Plan of the parent without custody of the child.

However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, that Plan is the primary Plan. This paragraph does not apply with respect to any Policy Year during which any benefits actually paid or provided before the entity has actual knowledge. Also, benefits for the child of a non-custodial parent who is responsible for the health care expenses of the child may be paid directly to the provider, if the custodial parent so requests.
5. Active/Inactive Service: The primary Plan is the Plan which covers the person as a Covered Person who is neither laid off nor retired (or as that employee’s Dependent). The secondary Plan is the Plan which covers that person as a laid off or retired Covered Person (or as that Covered Person’s Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.
6. Longer\Shorter Length Of Coverage: If none of the above rules determines the order of benefits, the primary Plan is the Plan which covered a Covered Person, or subscriber
COORDINATION OF BENEFITS

the longer time. The secondary Plan is the Plan which covered that person the shorter time.

Effect of Medicare
This Plan will be primary to Medicare for an active employee and Dependent spouse of such active employee. This Plan will not be primary to Medicare if the Covered Person is eligible for Medicare as primary. Medicare is primary for an insured retiree or the Dependent spouse of a retiree age 65 or over; this applies whether or not the retiree or spouse is enrolled in Medicare.

Reduction in This Plan's Benefits
When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable Benefit Maximum of his Plan.

Any benefit amount not paid under this Plan because of coordinating benefits becomes a benefit credit under this Plan. This amount can be used to pay any added Allowable Expenses the Covered Person may incur during the remainder of the Policy Year, including any Coinsurance payable under this Plan.

Right to Receive and Release Information
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
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
If the amount of the payments made by KPIC is more than it should have paid, KPIC may recover the excess from one or more of the following:
1. the persons KPIC has paid or for whom it has paid.
2. insurance companies.
3. other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

Definitions Related to Coordination of Benefits
Active Service means that a Covered Person: 1) is present at work with the intent and ability to work the scheduled hours; and 2) is performing in the customary manner all of the regular duties of his or her employment.

Allowable Expenses means the usual and customary fees for medical or dental care or treatment. Part of the expenses must be covered under at least one of the Plans covering the Covered Person.
COORDINATION OF BENEFITS

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 covered persons 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 Covered Person.

- If the Primary Plan is a closed panel plan with no Out-of-Plan 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 covered person 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.

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

Plan means any of the following which provides medical or dental benefits or services:
1. This Plan.
2. Any group, blanket, or franchise health insurance.
3. A group contractual prepayment or indemnity plan.
4. A health maintenance organization (HMO) (other than Health Plan), whether a group practice or individual practice association.
5. A labor-management trustee plan or a union welfare plan.
6. An employer or multi-employer plan or employee benefit plan.
7. A government program.
8. Insurance required or provided by statute.

Plan does not include any:
1. Individual or family policies or contracts.
2. Public medical assistance programs.
3. Group or group-type Hospital indemnity benefits of $100 per day or less.
4. School accident-type coverages.

The benefits provided by a Plan include those that would have been provided if a claim had been duly made.

This Plan means that portion of the Group Policy which provides the benefits that are subject to this provision.

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 may be reduced because of 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.
CLAIM PROVISIONS

All claims under the Group Policy will be administered by:

Dell
2300 West Plano Parkway
Plano, Texas 75075

Questions about claims: For assistance with questions regarding claims filed with KPIC, please have Your ID Card available when You call 1-800-392-8649 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 Percentage Payable or Co-payment.

Non-Participating Provider claims

If you receive services from any other licensed provider, you may need to file the claim yourself and will be reimbursed in accordance with the terms set forth under the Schedule of Coverage.

Notice of Claims

You must give Us written notice of claim within 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. We may not invalidate or reduce a claim if it is shown that it was not reasonably possible to give notice within 20 days, and that the notice was given as soon as was reasonably possible. The notice should give Your name and Your account number shown in Your Schedule of Coverage. The notice should be mailed to Us at Our mailing address or to Our Administrator:

Kaiser Permanente Insurance Company
P.O. Box 261130
Plano, Texas 75026

Claim Forms

When We receive Your notice of claim, We will send You forms for filing proof of loss. If We do not send You these forms within 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 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, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than one year from the time proof is otherwise required. KPIC may require information to validate the occurrence, character and extent of the loss. Such information may include, but will not be 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.
CLAIM PROVISIONS

“Proof of Loss” means written proof of the occurrence, character and extent of the loss.

Time for Payment of Benefits
In accordance with the terms of Your coverage, benefits will be paid within 30 days upon receipt of written Proof of Loss.

If services are received from a Preferred Provider, benefits will be paid directly to the Preferred Provider. Benefits will be paid to any provider who accepts assignment of benefits Any such payment made by KPIC in good faith will fully discharge KPIC’s obligation to the extent of the payment.

KPIC shall provide payment of benefits directly to an ambulance service provider that obtains an assignment of benefits from an insured.

Contested Claims
If KPIC is unable to pay Your claim after receiving Proof of Loss, KPIC will notify You of any contest to or denial of the claim within 30 days of the date the Proof of Loss was received by KPIC. Please see the section entitled “PRECERTIFICATION, INTERNAL APPEALS, AND EXTERNAL REVIEW” for information on how you may file a appeal or grievance.

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 written proof of loss is required to be furnished.

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.

Overpayment
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:

1. the adjustment or correction is for services subject to coordination of benefits with another carrier, the Maryland Medical Assistance Program, or the Medicare Program during the 18-month period after the date that KPIC paid the health care provider; and
2. except as provided in item (i) of this paragraph, may only adjustment or correction during the 6-month period after the date that KPIC paid the health care provider.

The restriction on adjustments and/or corrections noted above do not apply if KPIC makes an adjustment and/or correction to a health care provider because:

1. the information submitted to KPIC was fraudulent;
2. the information submitted to KPIC was improperly coded and the KPIC has provided to the health care provider sufficient information regarding the coding guidelines used by Us at least 30 days prior to the date the services subject to the adjustment and/or correction were rendered; or
CLAIM PROVISIONS

3. the claim submitted to KPIC was a duplicate claim.

Information submitted to KPIC may be considered to be improperly coded if the information submitted by the health care provider:

1. uses codes that do not conform with the coding guidelines used by KPIC applicable as of the date the service or services were rendered; or
2. does not otherwise conform with the contractual obligations of the health care provider to KPIC applicable as of the date the service or services were rendered.

If KPIC makes a adjustment and/or correction under this provision for services as a result of coordination of benefits, the health care provider will have 6 months from the date of denial, to submit a claim for payment of benefits for the service to KPIC, the Maryland Medical Assistance Program, or the Medicare Program responsible for payment.
GENERAL PROVISIONS

Assignment
Payment of benefits under the Group Policy for treatment or services that are not provided, prescribes or directed by a Health Plan Physician:

a) Are not assignable and thereby not binding on KPIC, unless previously approved by KPIC in writing;

b) Shall be made by KPIC, in its sole discretion, directly to the provider or to the Insured Person or Insured Dependent or, in the case of the Insured Person’s death, to his or her executor, administrator, provider, spouse or relative.

Time Effective
The effective time for any dates used is 12:01 A.M. at the address of the Policyholder.

Contestability of Coverage
In the absence of fraud, any statement made by the Policyholder or a Covered Person in applying for insurance under the Group Policy will be considered a representation and not a warranty. After the Group Policy has been in force for two years, its validity cannot be contested except for nonpayment of premiums. After a Covered Person’s insurance has been in force for two years during his or her lifetime, its validity cannot be contested due to a statement made by the Covered Person relating to insurability under the Group Policy. Only statements that are in writing and signed by the Policyholder or a Covered Person can be used in a contest. A copy of the statement will be given to the Policyholder, the Covered Person or his or her beneficiary.

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).

Physical Examination and Autopsy
KPIC, at its 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.

Money Payable
All sums payable by or to KPIC or its Administrator must be paid in the lawful currency of the United States.

Rights of a Custodial Parent
If the parents of a covered Dependent child are:
1. Divorced or legally separated; and
2. 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 Covered Person approved for family health coverage under the Policy, and KPIC must receive:
1. A request from the custodial parent, who is not a Covered Person under the policy; and
GENERAL PROVISIONS

2. A copy of the Order.

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

1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions, and limitations of the Policy;
2. Accept claim forms and requests for claim payment from the custodial parent; and
3. 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:

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

“Order” means a ruling that:

(1) is issued by a court of the State of Maryland or another state or an administrative agency of another state; and

(2) (a) creates or recognizes the right of a child to receive benefits under a parent’s health insurance coverage; or (b) establishes a parent’s obligation to pay child support and provide health insurance coverage for a child.