This plan has Excellent accreditation from the NCQA
See 2016 NCQA Guide for more information on Accreditation
IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Box 6831
2101 East Jefferson Street
Rockville, MD 20852
(301) 468-6000 or toll-free (800) 777-7902

We recommend that you familiarize yourself with our Getting Assistance; Claims and Appeal Procedures; and Customer Satisfaction Procedure as described in Section 5 of Your Group Evidence of Coverage, and make use of it before taking any other action.

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

State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Consumer Services: (804) 371-9741 or toll-free (800) 552-7945
National toll-free (877) 310-6560

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, Kaiser Permanente or the Bureau of Insurance, have your policy number available.
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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”, “us”, or “Kaiser Permanente.” 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.

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

Kaiser Permanente SignatureSM

Kaiser Permanente SignatureSM provides health care Services 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 physicians, all working together at our state-of-the-art Plan Medical Centers. In addition, we have added pharmacy, optical, laboratory, and x-ray facilities at most of our Plan Medical Centers.

Who is Eligible

The SHOP Exchange will determine if an individual is a Qualified Employee under this plan in accordance with 45 CFR §155.715 and 45 CFR §156.710. The Qualified Employee under this plan is the “Subscriber.” The Subscriber may enroll their eligible Dependents.

Subscribers

You are eligible to enroll if you are employed by a Qualified Employer and the Qualified Employer offers you coverage as a Qualified Employee.

Dependents

If you are a Subscriber, and 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 children, who are under age 26;

C. Other Dependent persons (including foster children) who meet all of the following requirements:
   (1) they are under age 26; and
   (2) you or your Spouse or Domestic Partner is the child’s court-appointed guardian (or was when the person reached age 18); or
   (3) a child for whom you or your Spouse or Domestic Partner have the legal obligation to provide coverage pursuant to a child support order or other court order or court-approved agreement or testamentary appointment.

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

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

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

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

Disabled Dependent Certification

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

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

- If your dependent is not a Member and you are requesting enrollment, you must provide us documentation of his or her incapacity and dependency within 60 days after we request it so that we can determine if he or she is eligible to enroll as a disabled dependent. If we determine that your dependent is eligible as a disabled dependent, you must provide us documentation of his or her incapacity and dependency annually within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled dependent.

**Genetic Information**

*Note:* We will not use, require or request a genetic test, the results of a genetic test, genetic information, or genetic Services for the purpose of rejecting, limiting, canceling or refusing to renew a health insurance policy or Contract. In addition, genetic information or the request for such information shall not be used to increase the rates of, affect the terms or conditions of, or otherwise affect a Member's coverage.

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

**Enrollment and Effective Date of Coverage**

**Annual Open Enrollment**

The SHOP Exchange will provide an annual open enrollment period each year prior to the first day of the contract year. During the annual open enrollment period a Qualified Employee may enroll or discontinue enrollment in this health benefit plan; or change their enrollment from this health benefit plan to a different health benefit plan offered by us.

The SHOP Exchange will let you know when the open enrollment period begins and ends. Your membership will be effective at 12:00 a.m. (the time at the location of the administrative office of carrier at 2101 East Jefferson Street, Rockville, Maryland, 20852) on the first day of the contract year.

**New Employees and Their Dependents**

The SHOP Exchange will provide an enrollment period for employees who become eligible outside the annual open enrollment period. The enrollment period will begin on the first day of eligibility as a Qualified Employee and will extend for a minimum of 30 days. Your memberships will become effective as determined by the SHOP Exchange.

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during the annual open enrollment period as described above, unless you become eligible for a special enrollment as described in this section.

**Special Enrollment due to court or administrative order**

If a parent eligible for family coverage is required under a court or administrative order to provide health care coverage for a child who meets the eligibility requirements as a dependent, the Subscriber may add the child as a dependent regardless of enrollment period restrictions.

If the Subscriber fails to enroll a child under a court or administrative order, the child's other parent or the Department of Social Services may apply for coverage. A dependent child enrolled under this provision may not be unenrolled unless we receive satisfactory written proof that: (a) the court or administrative order is no longer in effect; and (b) the child is or will be enrolled in comparable health coverage that will take effect not later than the
Your Group Evidence of Coverage

effective date of termination under this EOC; or (c) family coverage has been eliminated under this EOC.

Special Enrollment Periods Due to a Triggering Event
The SHOP Exchange will provide a special enrollment period when a triggering event occurs. During the special enrollment period you and/or your Dependent may enroll in this health benefit plan or change to another health benefit plan offered by us.

A “triggering event” occurs when:
1. You or your dependent:
   a. Loses Minimum Essential Coverage. Loss of Minimum Essential Coverage includes, but is not limited to, loss of coverage due to losing your job or a reduction in hours, loss of individual coverage, or loss of Medicare. Loss of Minimum Essential Coverage does not include loss of coverage due to: (a) failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; (b) a rescission of coverage as specified under 45 C.F.R. §147.128; (c) voluntary termination of coverage.

   The date of the loss of coverage is the last day you and/or your dependent would have coverage under the previous plan or coverage;


   The date of the loss of coverage is the last day the you and/or your dependent would have pregnancy-related coverage;

   c. Loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act. This triggering event allows you a special enrollment period only once per contract year.

   The date of the loss of coverage is the last day you and/or your dependent would have medically needy coverage; or

   d. Are enrolled in any non-contract year group health plan or individual health plan coverage and such non-contract year plan or policy year is ending, even if you and/or your dependent have the option to renew such coverage, except when the loss of coverage is due to entitlement to coverage as an American Indian/Native Alaskan (as described in paragraph 8, below), exceptional circumstances determined by the Exchange (as described in paragraph 9, below).

   The date of the loss of coverage is the last day of the expiring non-contract year plan or policy year;

2. You gain or become a Dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or through a child support order or other court or administrative order. In the case of birth or adoption, the Spouse or Domestic Partner may also enroll as a Dependent;

3. You lose a Dependent or you are no longer considered to be a Dependent due to divorce or legal separation as defined by State law in the State where the divorce or legal separation occurs. For the purposes of this paragraph 3, State includes the District of Columbia;

4. The Subscriber or a Dependent dies;

5. Your or your dependent’s enrollment or non-enrollment in a Qualified Health Plan (QHP) is, as evaluated and determined by the SHOP Exchange:
   a. Unintentional, inadvertent, or erroneous; and
   b. The result of the error, misrepresentation, misconduct (including the failure to comply with applicable standards applicable under federal or state laws as determined by the Exchange) or inaction of an officer, employee, or agent of the SHOP Exchange or the U.S. Department of Health and Human Services (HHS) or its instrumentalities, or a non-SHOP Exchange entity providing enrollment assistance or conducting enrollment activities;

   Note: the SHOP Exchange may take action as may be necessary to correct or eliminate the effects of the error, misrepresentation, misconduct or inaction.

6. You, or your Dependent who is enrolled in this qualified health plan, adequately demonstrates to the SHOP Exchange that we substantially violated a material provision this EOC;

7. You or your dependent gains access to new QHP plans as a result of a permanent move or a recent release from incarceration;

8. You or your dependent qualify as an Indian, as defined by §4 of the federal Indian Health Care
Improvement Act, and you or your dependent choose to (i) enroll in a (QHP) or (ii) change from one QHP to another one time per month; or

9. You or your Dependent demonstrates to the SHOP Exchange, in accordance with guidelines issued by the U.S. Department of Health and Human Services (HHS), that you or Dependent meets other exceptional circumstances as the SHOP Exchange may provide;

10. You or your dependent:
   a. Loses eligibility for coverage under a Medicaid plan under Title XIX of the Social Security Act or a State Child Health Plan under Title XXI of the Social Security Act; or
   b. Becomes eligible for assistance, with respect to coverage under the SHOP Exchange, under a Medicaid Plan or State Child Health Plan, including any waiver or demonstration project conducted under or in relation to a Medicaid plan or a State Child Health Plan.

**Length of The Special Enrollment Periods**

Based on the triggering event that you or your Dependent experience, your special enrollment period will last 30 days from the date of the triggering event, except:

1. That you will have 31 days from the date of the triggering event when you or your Spouse or Domestic Partner gains a new dependent through birth, adoption, placement for adoption.

2. That you will have 60 days from the date of the triggering event when you and/or your Dependent experiences a change in eligibility as described in paragraph 10, above.

**Effective Date for Special Enrollment Periods**

If an individual enrolls in or changes QHP coverage during a special enrollment period as the result of a triggering event, the effective date of such coverage will be determined as described below:

1. In the case of marriage, the coverage effective date shall be the first day of the month following plan selection or, if you choose and the SHOP Exchange permits, according to the plan selection rule in paragraph 6, below.

2. In the case of birth, adoption, placement for adoption, or placement in foster care, the coverage effective date shall be the date of birth, adoption, placement for adoption, or placement in foster care or, if you choose and the SHOP Exchange permits, (a) the first of the month following the date of birth, adoption, placement for adoption or placement in foster care or (b) according to the plan selection rule in paragraph 6, below. The “date of adoption” means the earlier of: (i) a judicial decree of adoption, or (ii) the assumption of custody, pending adoption of a prospective adoptive child by a prospective adoptive parent.

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

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

3. In the case of a child who is newly eligible as the result of a child support order or other court or administrative order received by the Subscriber or the Subscriber’s Spouse, the coverage will be effective on an appropriate date based on the specific circumstances, as determined by the SHOP Exchange.

4. In the case of triggering event described in paragraphs 5, 6, or 9, above, coverage will be effective on an appropriate date based on the specific circumstances, as determined by the SHOP Exchange.

5. In the case of the death of a Member (either you or your Dependent), the coverage effective date shall be the first of the month following plan selection or, if you choose and the SHOP Exchange permits, according to the plan selection rule in paragraph 6, below;

6. For all other triggering events, for a plan selection received by the SHOP Exchange:
   a. Between the 1st and the 15th day of any month, the coverage effective date will be the first day of the following month; and
   b. Between the 16th and the last day of any month, the coverage effective date will be the first day of the second following month.
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.
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 the “Benefits” section
- Urgent Care Outside our Service Area, in the “Benefits” section
- Getting a Referral, in this section
- Visiting Other Kaiser Permanente Regions or Group Health Cooperative Service Areas, in this section
- Visiting Member Services, in the “Benefits” section

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 any primary care Plan Physician, who is available to accept new Members, from the following areas: internal medicine, family practice and pediatrics. A listing of all primary care Plan Physicians is provided to you on an annual basis.

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

www.kp.org

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

Continuity of Care

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

In addition, under the following special situations, Health Plan will continue to provide benefits for Plan Provider’s care beyond the period of 90 days as defined above when the Member:

1. Has entered at least the second trimester of pregnancy at the time of the provider's termination, except when terminated for cause. Such treatment may continue, at the Member's option, through the provision of postpartum care; or

2. Is determined to be terminally ill at the time of the Plan Provider's termination, except when terminated for cause. Such treatment may continue, at the Member's option, for the remainder of the Member's life.

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.

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 Plan Physician will work with you to determine whether those services can be provided by a Plan Provider.

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

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

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

1. The initial consultation for treatment of mental illness, emotional disorders, drug or alcohol abuse provided by a Plan Provider. For continued treatment, you or your Plan Provider must contact the Behavioral Health Access Unit for assistance with arranging for and scheduling of covered Services. The Behavioral Access Unit may be reached at 866-530-8778.
2. Female Members do not need a referral or prior authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.
3. Optometry services
4. Urgent Care Services provided inside our Service Area.

Although a referral or prior authorization is not required to receive care from these providers, the provider may have to get prior authorization for certain Services in accord with this "Getting a Referral" section.

**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 your needs would be best served through the continued care of a specialist. In such instances, your primary care Plan Physician will issue a standing referral to the specialist.

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

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

**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.

**Getting Advice from Our Advice Nurses**

If you are not sure you are experiencing an Emergency Medical Condition, 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 Center, please call:

- **Inside the Washington, D.C. Metropolitan Area**
  - (703) 359-7878
  - TTY 711
- **Outside the Washington, D.C. Metropolitan Area**
  - 1-800-777-7904
  - TTY 711

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

**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 this EOC. This will not count toward your Deductible or Out-of-Pocket maximum, if applicable.

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

Each Health Plan ID card has 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.

**Visiting Other Kaiser Permanente Health Plan Regions or Group Health Cooperative Service Areas**
If you visit a different Kaiser Permanente Health Plan Region or Group Health Cooperative service area temporarily, you can receive visiting member care from designated providers in that area. The covered Services, Copayments, Coinsurance and Deductibles 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.

**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 Use Disorder 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 stay

**Home Health Care:**
Your Group Evidence of Coverage

- Home health care Services inside the visited service area

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

Pre-Authorization Required for Certain Services
The following Services require preauthorization from your home Service Area while you are visiting another Kaiser Permanente Region or Group Health Cooperative service area:
- Inpatient physical rehabilitation
- Any other Service that would require pre-authorization in your home Service Area

In addition, some Services require pre-authorization from the visited region or service area. Please contact Member Services in the other Kaiser Permanente region or Group Health Cooperative (GHC) service area, once you have obtained pre-authorization from your home region or GHC service area.

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
- Services related to conception by artificial means, such as in vitro fertilization (IVF) and gamete intrafallopian tube transfer (GIFT)
- 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
- Services received as a result of a written referral from a Plan provider in your home Service Area

- Services that are excluded or limited in your home Service Area

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

Value Added Services
Health Plan makes available a variety of value added services to its Members in order to aid Members in their quest for better health by providing access to additional services, which may not be covered under this plan. Examples may include discounted eyewear, non-covered health education classes and publications, discounted fitness club memberships, health promotion and wellness programs and rewards for participating in those programs. Some of these value added services are available to all Members, and others may be available only to Members enrolled in certain groups and/or plans. To take advantage of these services, a Member need only identify himself/herself as a Health Plan Member by showing his/her ID card and paying the fee, if any, at the time of service. Because these value added services are not covered Services, any fees you pay will not accrue to any coverage calculations, such as Deductibles and Out-Of-Pocket maximum calculations.

For information concerning these services, including which ones are available to you, you may contact 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 7:30am until 9:00pm.

The value added services are neither offered nor guaranteed under your Health Plan coverage. Some of these services may be provided by entities other
than the Health Plan. We may change or discontinue some or all of these services at any time.

These value added services are not offered as an inducement to purchase a health care plan from Health Plan. Although they are not covered Services, we may include their costs in the calculations of your Premium.

Health Plan does not endorse or make any representations regarding the quality of such services or their medical efficacy, nor the financial integrity of the entities providing the value added services. The Health Plan expressly disclaims any liability for these services provided by these entities. If you have a dispute regarding these products or services, you must resolve it with the entity offering the product or service. Although we have no obligation to assist with such resolution, should a problem arise with any of these products or services, you may call the Member Services Call Center, and a representative may try to assist in getting the issue resolved.

Payment toward your Cost Share (and when you may be billed)

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

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

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

- **You receive diagnostic Services during a treatment visit.** For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay your Cost Share for these additional diagnostic Services;

- **You receive treatment Services during a diagnostic visit.** For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay your Cost Share for these additional treatment Services;

- **You receive non-preventive Services during a no-charge courtesy visit.** For example, you go in for a blood pressure check or meet and greet visit and the provider finds a problem with your health and performs diagnostic or treatment Services. You may be asked to pay your Cost Share for these additional diagnostic or treatment Services; or

- **You receive Services from a second provider during your visit.** For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay your Cost Share for the consultation with the specialist.
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;
- You have not met the maximum benefit for the Service, if any. A maximum benefit applies per Member per contract year.
- The Services are provided by a Plan Provider (unless the Service is to be provided by a non-Plan Provider subject to an approved referral as described in Section 2) in accordance with the terms and conditions of this EOC including but not limited to the requirements, if any, for prior approval (authorization);
- The Services are Medically Necessary; and
- You receive the Services from a Plan Provider except as specifically described in this EOC.

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

- Emergency Services
- Urgent Care outside our Service Area
- Authorized referrals to non-Plan Providers (as described in Section 2)

Exclusions and Limitations: Exclusions and limitations that apply only to a particular benefit are described in this section. Other exclusions, limitations, and coordination of benefits that generally affect benefits are described in the “Exclusions, Limitations, and Coordination of Benefits” section of this EOC.

Note: The “Summary of Services and Cost Shares” lists the Copayments, Coinsurances and Deductibles 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:

- Primary care visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics/gynecology Services (refer to “Preventive Health Care Services” for coverage of preventive care Services);
- Walk-in Services available from any Health Plan Medical Facility. These Services are available 24 hours a day in certain Plan Medical Centers, including Services provided by nurse practitioners and physician assistants. Call Member Services for location and hours of operation of all of our Plan Medical Facilities.
- Specialty care visits (refer to Section 2 “How to Obtain Services” for information about referrals to Plan specialists);
- Consultations and immunizations for foreign travel;
- Diagnostic testing for care or treatment of an illness, or to screen for a disease for which you have been determined to be at high risk for contracting, including, but not limited to:
  - Diagnostic examinations, including digital rectal exams and prostate antigen (PSA) tests provided in accordance with American Cancer Society guidelines to:
    i. persons age fifty and over; and
    ii. persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society;
  - Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.
- Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A “qualified individual” means:
  - an estrogen deficient individual at clinical risk for osteoporosis;
  - an individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic 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.
(Refer to “Preventive Health Services” for coverage of preventive care tests and screening Services);
- Outpatient surgery received at an outpatient or ambulatory surgery facility, or doctor’s office. We will not pay separately for pre- and post-operative services;
- Anesthesia, including services of an anesthesiologist;
- Chemotherapy and radiation therapy;
- Respiratory therapy;
- Sleep treatment;
- Medical social Services;
- House calls when care can best be provided in your home as determined by a Plan Provider;
- After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to the Urgent Care provision for covered Services; and
- Equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care professional legally authorized to prescribe or provide such items under law.

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

B. Hospital Inpatient Care
We cover inpatient Services in a Plan Hospital, or a non-Plan Hospital in an emergency, when you are an inpatient because of illness, injury, or pregnancy (see Maternity below for additional pregnancy benefits). We cover Services that are generally and customarily provided by an acute care general hospital in our Service Area for:
- Room and board in a semi-private room or a private room when deemed Medically Necessary. Room and board includes your bed, meals, and special diets;
- Specialized care and critical care units;
- General and special nursing care;
- Medically Necessary Services and supplies provided by the hospital;
- Operating and recovery room;
- Plan Physicians’ and surgeons’ Services, including consultation and treatment by specialists;
- Anesthesia, including services of an anesthesiologist;
- Medical and surgical supplies, including hypodermic needles and syringes;
- Drugs, injectable drugs, blood, and oxygen;
- Nuclear medicine;
- Chemotherapy and radiation therapy;
- Respiratory therapy; and
- Medical social Services and discharge planning.

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.

Minimum Hospital Stay
We cover inpatient hospitalization Services for you and your newborn child for a minimum stay of at least 48 hours following an uncomplicated vaginal delivery; and at least 96 hours following an uncomplicated cesarean section. We also cover postpartum home health visits upon release, 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.

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

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

C. Accidental Dental Injury Services
We cover:
- Medically Necessary dental Services as a result of accidental injury, regardless of the date of such injury. For an injury occurring on or after your effective date of coverage, you seek treatment within 60 days after the injury;
- The cost of dental services and dental appliances only when provided by a Plan Provider To diagnose or treat an accidental injury to the teeth;
- The repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face.
Accidental Dental Injury Services Exclusions:
- Services provided by non-Plan Providers except in an emergency;
- Treatment of natural teeth due to diseases;
- Treatment of natural teeth due to accidental injury occurring on or after your effective date of coverage, unless treatment was sought within 60 days after the injury;
- Damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered.

Refer to the Adult and Pediatric Dental Plan sections for additional dental coverage.

D. Allergy Services
We cover the following allergy Services:
- Evaluations, and treatment
- Injections and serum

E. Ambulance Services
We cover licensed ambulance Services only if your medical condition requires either: (1) the basic life support, advanced life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer; or (2) the ambulance transportation has been ordered by a Plan Provider. Coverage is also provided for Medically Necessary transportation or Services including Medically Necessary air ambulance transport to the nearest hospital able to provide needed Services, provided during an encounter with an ambulance Service, as a result of a 911 call.

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

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

Ambulance Services Exclusions:
- 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 hospitalization Services for:
- Members who are children under the age of 5;
- Members who are severely disabled; and
- Members who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the Member’s treating physician that such Services are required to effectively and safely provide dental care.

Anesthesia for Dental Services Exclusions:
- The dentist’s or specialist’s professional Services.

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 prescribed whole blood and blood products are also covered.

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

H. Chiropractic Services
For musculoskeletal illness or injury only, we cover spinal manipulations and other manual medical interventions for a minimum of 30 visits per contract year.

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

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

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

a. The Services would be covered if they were not related to a clinical trial.

b. The Member is eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition or disease (a condition or disease from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   (1) A Plan Provider makes this determination;
   (2) The Subscriber or Member provides us with medical and scientific information establishing this determination;
   (3) If any Plan Providers participate in the clinical trial and will accept the Member as a participant in the clinical trial, the Member must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where the Member lives.

c. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition or disease and it meets one of the following requirements:
   (1) The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
   (2) The study or investigation is a drug trial that is exempt from having an investigational new drug application;
   (3) The study or investigation is approved or funded by at least one of the following:
      • The National Institutes of Health.
      • The Centers for Disease Control and Prevention.
      • The Agency for Health Care Research and Quality.
      • The Centers for Medicare & Medicaid Services.
      • A cooperative group or center of any of the above entities or of the Department of Defense or 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.
      • The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
         • It is comparable to the National Institutes of Health system of peer review of studies and investigations.
         • It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

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

**Clinical trials exclusions:**

a. The investigational Service.

b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

**K. Diabetic Services**

We cover diabetes equipment, diabetes supplies, and in-person diabetes outpatient self-management training and educational Services, including medical nutrition therapy and routine foot care when prescribed by a Plan Provider and purchased from a Plan Provider, 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.

Covered medical supplies and equipment include the following:

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

**Note:** Insulin is covered under the “Outpatient Prescription Drug Benefit”.

**Diabetic Equipment and Supplies Limitation:**
Diabetic equipment and supplies are limited to Health Plan preferred equipment and supplies unless the equipment or supply: (1) was prescribed by a Plan Provider; and (2) (a) there is no equivalent preferred equipment or supply available, or (b) an equivalent preferred equipment or supply (i) has been ineffective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member. “Health Plan preferred equipment and supplies” are those purchased from a Plan preferred vendor.

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

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

We cover the following renal dialysis Services:

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

We cover the following self-dialysis Services:

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

We cover home dialysis, which includes:

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

**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 dressings 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.

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

**Note:** Health Plan will not deny prescription drugs (or inpatient or IV therapy drugs) used in the treatment of cancer pain on the basis that the dosage exceeds the recommended dosage of the pain relieving agent, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain.

**Drugs, Supplies and Supplements Exclusions:**

- Drugs, supplies, and supplements which can be self-administered or do not require administration or observation by medical personnel.
• Drugs for which a prescription is not required by law.
• Drugs for the treatment of sexual dysfunction disorders.

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.

Refer to “Prosthetic Devices” for coverage of internal and external prosthetic and orthotic devices.

Basic Durable Medical Equipment

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

We cover the following types of equipment:
• Hospital type beds;
• Wheelchairs;
• Traction equipment;
• Walkers; and
• Crutches.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. We will repair or replace the equipment. 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 through 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. Early Intervention Services

We cover Medically Necessary early intervention Services for Dependents from birth to age 3. As used here, “early intervention Services” means speech and language therapy, occupational therapy, physical therapy and assistive technology Services and devices for Dependents who are certified by the Department of Mental Health, Mental Retardation and Substance Use Disorder as eligible for Services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

“Medically Necessary early intervention Services” means those Services 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 affecting a cure. These Services are provided in addition to the “Therapy; Habilitative and Rehabilitation Services” described in this EOC.

P. Emergency Services

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

An Emergency Medical Condition is 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 include all of the following with respect to an Emergency Medical Condition:

- A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition.
- 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.

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 must notify the Health Plan as soon as possible, not to exceed forty-eight (48) hours or the next business day, whichever is later, if you receive care at a hospital emergency room (ER) to ensure coverage. If you are incapacitated and unable to notify us within 48 hours, you or your representative must notify us as soon as reasonably possible.

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:

If you are injured or become ill while temporarily outside the Service Area, but within the United States, we will cover charges for Emergency Services as defined in this section. We cover Services received outside of the Service Area until you can, without medically harmful consequences, be transported to a Plan Hospital or primary care Plan Physician’s office. Emergency Services provide outside of the Service Area subject to the same Cost Shares amounts that would apply if the Services were provided inside our Service Area.

We will only reimburse charges by a non-Plan Provider outside the Service Area the amount that would have been paid a Plan Provider for the same Service. You will be responsible for the difference between the billed amount, and the amount we reimbursed the non-Plan Provider.

Outside the United States

If you are injured or become ill while temporarily outside the United States, we will cover charges for Emergency Services as defined in this section; subject to the same Cost Shares that would apply if the Service was provided inside our Service Area.

We will only reimburse charges by a non-Plan Provider outside the United States for the amount that would have been paid a Plan Provider for the same Service. You will be responsible for the difference between the billed amount, and the amount we reimbursed the non-Plan Provider.

Continuing Treatment Following Emergency Services

Inside our Service Area

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

Inside another Kaiser Permanente Region:

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

Outside our Service Area:

All other continuing or follow-up care for Emergency Services received outside our Service Area must be authorized by us, until you can safely return to the Service Area.
Transport to a Service Area
If you obtain prior approval from us, or from the nearest Kaiser Foundation Health Plan Region, we will cover necessary ambulance Services or other special transportation arrangements medically required to transport you to a Plan Hospital or Medical Office in our Service Area, or in the nearest Kaiser Foundation Health Plan Region, for continuing or follow-up treatment.

Note: All ambulance transportation is covered under the “Ambulatory Services” benefit in this section.

Continued Care in Non-Plan Facility Limitation
If you are admitted to a non-Plan Hospital, you or someone on your behalf must notify us within the later of 48 hours of any hospital admission, or on the first working day following the admission, unless it was not reasonably possible to notify us within that time. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us, 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 in order to assure payment.

Emergency Services Limitations:
• Notification: If you receive care at a hospital emergency room or are admitted to a non-Plan hospital, you, or someone on your behalf, must notify us as soon as possible, but not later than 48 hours after the emergency room visit or hospital admission, or the next business day, whichever is later, unless it was not reasonably possible to notify us. If you are admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. Once your emergency condition has been stabilized, all continuing and follow-up treatment must be authorized by us. If you do not notify us and obtain authorization for a continued hospital stay once your condition has stabilized, we will not cover the inpatient hospital charges you incur after transfer would have been possible.

• Continuing or Follow-up Treatment: Except as provided for under “Continuing Treatment Following Emergency Surgery,” we do not cover continuing or follow-up treatment after Emergency Services unless authorized by Health Plan. We cover only the out-of-Plan emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Foundation Health Plan or allied plan service area.

• Hospital Observation: Transfer to an observation bed or observation status does not qualify as an admission to a hospital. Your emergency room visit copayment, if applicable, will not be waived.

Q. Family Planning Services
We cover the following:
• Women’s preventive services, 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.
• Other family planning counseling, including pre-abortion and post-abortion counseling.
• Contraceptive devices (other than diaphragms) and implantable contraceptive drugs are supplied by the provider, and are covered under this benefit. Contraceptive drugs and diaphragms are covered under the “Outpatient Prescription Drug Benefit.”
• Vasectomies

R. Hearing Tests
We cover hearing tests to determine the need for hearing correction. (Refer to Preventive Health Care Services for coverage for newborn hearing screenings.)

Hearing Services Exclusions:
• Tests to determine an appropriate hearing aid; and
• Hearing aids or tests to determine their efficacy.

S. Home Health Services
We cover treatment provided in your home on a part-time or intermittent basis. This coverage allows for an alternative to repeated hospitalizations that will
provide the quality and appropriate level of care to treat your condition. To ensure benefits, your Plan Provider must provide a description of the treatment you will receive at home. Your coverage includes the following home health services:

- visits by a licensed health care professional, including a nurse, therapist, or home health aide; and
- physical, speech, and occupational therapy.

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

**Home private duty nurse’s Services**

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

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

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

**Home Health Visits Following Mastectomy or Removal of Testicle**

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

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

**Home Health Care Limitations:**

- Home HealthCare visits are limited to 100 visits per contract year.
- Home private duty nurses Services are limited to 16 hours per contract year.

**Home Health Care Exclusions:**

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

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

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

- Skilled nursing care, including IV therapy Services;
- Physical, occupational, speech, and respiratory therapy;
- Medical social Services;
- Home health aide Services;
- Homemaker Services;
- Medical supplies and appliances;
- Palliative drugs in accord with our drug formulary guidelines;
- Physician care;
- Nutritional counseling;
- General hospice inpatient Services for acute symptom management including pain management;
- Respite Care that may be limited to 5 consecutive days for any one inpatient stay up to 4 times in any contract year;
- Counseling Services for the Member and his Family Members, including dietary counseling for the Member; and bereavement counseling for the Member’s Family Members, for a period of one year after the Member’s death; and
- Services of hospice volunteers.

**Definitions:**

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

**Hospice Care** means a coordinated, inter-disciplinary program of hospice care Services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health Services through home or
inpatient care during the illness and bereavement counseling following the death of the Member.

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

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

### U. Infertility Services
We cover the following:
- Services for diagnosis and treatment of involuntary infertility for females and males;

**Note:** Involuntary infertility means the inability to conceive after one year of unprotected vaginal intercourse.

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

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

### W. Maternity Services
**Pregnancy Testing**
We cover tests to determine if you are pregnant.

**Prenatal and Newborn Care**
If you (or your covered Dependent) become pregnant, Health Plan provides coverage for maternity care, maternity-related checkups, and delivery of the baby in the hospital.

We cover the following:
- use of the delivery room and care for normal deliveries;
- home setting covered with nurse midwives;
- anesthesia services to provide partial or complete loss of sensation before delivery;
- hospital services for routine nursery care for the newborn during the mother’s normal hospital stay;
- prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary;
- initial examination of a newborn and circumcision of a covered male dependent;
- services for interruption of pregnancy, limited to the following circumstances:
  i. when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself; or
  ii. when the pregnancy is the result of an alleged act of rape or incest; and
iii. fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies.

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

### X. Medical Foods
We cover special medical formulas which are the primary source of nutrition for Members with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies.

Coverage is provided if the medical foods and low protein food products are prescribed as Medically Necessary for the therapeutic treatment and required to maintain adequate nutritional status 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.

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

### Y. Mental Health Services and Substance Use Disorder

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

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

We cover inpatient and outpatient Mental Health Services, which includes partial day Mental Health Services and Substance Use Disorder services, and intensive outpatient programs for treatment of alcohol or drug dependence.

While you are an inpatient in a Plan facility or program, we cover all medical Services of physicians and other health professionals as performed, prescribed or directed by a Plan Physician including:

- Individual psychotherapy
- Group psychotherapy
- Psychological testing
- Convulsive therapy
- Shock therapy
- Drug therapy
- Education
- Psychiatric nursing Services
- Appropriate Hospital Services
- Structured program of treatment and rehabilitation, including 24 hour-a-day nursing care
- Counseling with family members to assist with patient’s diagnosis and treatment

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

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

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

**Outpatient Service**

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

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

**Mental Health Services and Substance Use Disorder Exclusions:**

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

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

Morbid obesity is defined as:
• A weight that is at least 100 pounds over or twice the ideal weight for a patient’s frame, age, height, and gender, as specified in the 1983 Metropolitan Life Insurance tables; or
• A body mass index (BMI) that is equal to or greater than 35 kilograms per meter squared with a comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary condition, sleep apnea, or diabetes; or
• A BMI of 40 kilograms per meter squared without such comorbidity.

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

Morbid Obesity Services Exclusion:
Services not preauthorized by Health Plan.

AA. Oral Surgery
We cover diagnosis and oral surgery for:
• surgical treatment of tumors in the oral cavity, where a biopsy is needed for evaluation of pathology;
• removal of cysts or tumors of non-dental origin;
• maxillary or mandibular frenectomy when not related to a dental procedure;
• alveolecetomy when related to tooth extraction;
• orthognathic surgery, including surgery to correct temporomandibular joint (TMJ) pain dysfunction syndrome, that is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part;
• surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures; and
• the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia (see also “Cleft Lip, Cleft Palate, or Ectodermal Dysplasia” in this Section).

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

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

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. You may see a list of the most recent services described in this provision at: www.healthcare.gov;
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;
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; 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.
Health Plan shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

Health Plan also covers medically appropriate preventive health care Services based on your age, sex, and other factors as determined by your primary care Plan Physician in accordance with national preventive health care standards.

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

- Preventive care exams, including:
  - routine physical examinations and health screening tests appropriate to your age and sex;
  - well-woman examinations; and
  - well child care examinations, including child health supervision services for the periodic review of a child’s physical and emotional status and immunizations offered at the following age intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, and 6 years;
- Hemoglobinopathies screening for newborn children;
- Gonorrhea prophylactic medication;
- Hypothyroidism screening;
- PKU screening;
- Rh incompatibility screening;
- Routine and Medically Necessary immunizations (travel immunizations are not preventive and are covered under Outpatient Services in this section) for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;
- An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
- High-risk human papillomavirus DNA testing every three years for women age 30 years and over whether or not they have normal Pap test results;
- Screening for gestational (pregnancy-related) diabetes in pregnant women between 24-28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes;
- Comprehensive lactation (breastfeeding) education and counseling, by trained clinicians during pregnancy and/or in the postpartum period in connection with each birth;
- Breastfeeding equipment issued, per pregnancy and in accordance with Health Plan coverage guidelines;
- Annual screening and counseling for sexually transmitted infections for all sexually active women;
- Annual screening and counseling for human immune-deficiency virus (HIV) infection for all sexually active women;
- Annual screening and counseling for interpersonal and domestic violence;
- Patient education and contraceptive counseling for all women with reproductive capacity;
- All prescribed FDA-approved contraceptive methods, including implanted contraceptive devices, hormonal contraceptive methods, barrier contraceptive methods, and female sterilization surgeries. Note that contraceptive methods that do not require clinician administration such as birth control pills will not be covered if you have outpatient drug coverage separate from your Health Plan coverage through another prescription drug provider;
- Low dose screening mammograms to determine the presence of breast cancer are covered as follows: (i) one mammogram for persons age 35 through 39; (ii) one mammogram biennially for persons age 40 through 49; and (iii) one mammogram annually for person 50 and over;
- 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 50 and over and for persons age 40 and over who are at high risk;
- Colorectal cancer screening in accordance with screening guidelines issued by the American Cancer Society including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy;
- 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) as recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;  
• HIV tests;  
• TB tests;  
• Nutritional counseling when received as part of a covered wellness service screening, diabetes education, and for hospice with respect to person’s care and death;  
• Smoking and tobacco cessation counseling;  
• Newborn hearing screenings that include follow up audiological examinations, as recommended by a physician or audiologist, and performed by a licensed audiologist to confirm the existence or absence of hearing loss when ordered by a Plan Provider; and  
• Associated preventive care radiological and lab tests not listed above.

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

• Monitoring chronic disease.  
• Follow-up Services after you have been diagnosed with a disease.  
• Testing and diagnosis for specific diseases for which you have been determined to be at high risk for contracting, based on factors determined by national standards.  
• Services provided when you show signs or symptoms of a specific disease or disease process,  
• Non-routine gynecological visits.  
• Lab, imaging, and other ancillary Services not included in routine prenatal care.  
• Non-preventive Services performed in conjunction with a sterilization.  
• Lab, imaging, and other ancillary Services associated with sterilizations.  
• Complications that arise after a sterilization procedure.  
• Treatment of a medical condition or problem identified during the course of the preventive screening exam, such as removal of a polyp during a sigmoidoscopy.

• Over-the-counter contraceptive pills, supplies, and devices.  
• Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.  
• Replacement or upgrades for breastfeeding equipment that is not rented Durable Medical Equipment.  
• Prescription contraceptives that do not require clinical administration for certain group health plans that provide outpatient prescription drug coverage that includes FDA-approved contraception that is separate from Health Plan coverage and furnished through another prescription drug provider.

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

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

• Prosthetic devices and components;  
• Orthopedic braces;  
• Leg braces, including attached or built-up shoes attached to a leg brace;  
• Orthotics, other than foot orthotics, including the cost of fitting, adjustment, and repair;  
• Molded, therapeutic shoes and inserts for diabetics with peripheral vascular disease;  
• Arm, back, and neck braces;  
• Head halters;  
• Catheters and related supplies; and  
• Splints.

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

Internally Implanted Devices  
We cover Medically Necessary internal devices implanted during surgery, such as pacemakers, monofocal intraocular lens implants, artificial hips and joints, breast implants (see “Reconstructive Surgery Benefits ” below) and cochlear implants, that are approved by the federal Food and Drug Administration for general use.
Ostomy and Urological Supplies
We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets Health Plan’s criteria for medical necessity.

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

Breast Prosthetics Limitation:
Coverage for mastectomy bras is limited to a maximum of two (2) per contract year.

Prosthetic Devices Exclusions:
- Internally implanted breast prosthetics for cosmetic purposes.
- External prosthetics, except as provided in this Section.

DD. Reconstructive Surgery
We cover reconstructive surgery. This shall include plastic, cosmetic and related procedures required to: (a) correct significant disfigurement resulting from an injury or Medically Necessary surgery; (b) correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function; and (c) treat congenital hemangioma known as port wine stains on the face for Members age 18 or younger.

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. 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:
- 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

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

Skilled Nursing Facility Care Exclusions:
- Custodial care (see definition under “Exclusions” in the “Exclusions, Limitations, and Coordination of Benefits” section of this EOC).
- Domiciliary care.
- See “Therapy; Habilitative and Rehabilitative Services” for coverage of therapy during an inpatient stay.

FF. Telemedicine Services
We cover interactive telemedicine services. Telemedicine is the real-time two-way transfer of medical data and information, and such services include the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment as it pertains to the delivery of covered health care services. Equipment utilized
for interactive telemedicine should be of sufficient audio quality and visual clarity as to be functionally equivalent to a face-to-face encounter for professional medical services.

**Telemedicine Exclusion:**
Non-interactive telemedicine services include an audio-only telephone conversation, electronic mail message, or facsimile transmission.

**GG. Therapy; Habilitative and Rehabilitative Services**

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

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

Rehabilitative Services includes coverage for health care Services, devices, and therapies to restore and in some cases, maintain capabilities lost due to disease, illness, injury, or in the case of speech therapy, loss additionally due to congenital anomaly or prior medical treatment.

We provide coverage for the following habilitative and rehabilitative Services including the professional Services, when Medically Necessary and provided by a licensed or certified therapist.

**Cardiac Rehabilitation Services**
We cover outpatient cardiac rehabilitation Services following coronary surgery or a myocardial infarction.

Cardiac rehabilitation Services must be provided or coordinated by a facility approved by Health Plan, and that offers the process of restoring, maintaining, teaching, or improving physiological, psychological, social and vocational capabilities of patients with heart disease.

**Multidisciplinary Rehabilitation**
We cover multidisciplinary rehabilitation Services in a Plan Hospital, Plan Medical Center, Plan Provider’s medical office, or a Skilled Nursing Facility.

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

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

**Physical, Occupational, and Speech Therapy**
The visit limits listed below for physical, occupational and speech therapy apply to habilitative and rehabilitative Services combined. The limits do not apply to therapy provided while you are an inpatient in a hospital or to home health services.

**Physical Therapy**
We cover physical therapy, which is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb. Your coverage includes benefits for physical therapy to treat lymphedema. Coverage for outpatient physical therapy and occupational therapy is limited to a combined maximum of 30 visits per contract year.

**Occupational Therapy**
We cover inpatient and outpatient occupational therapy, which is treatment to restore a physically disabled person’s ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing. Coverage for outpatient physical therapy and occupational therapy is limited to a combined maximum of 30 visits per contract year.

**Occupational Therapy Limitation:**
Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.

**Speech Therapy**
We cover inpatient and outpatient speech therapy. Speech therapy is treatment for the correction of a speech impairment, or Services necessary to improve or teach speech, which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment.

Coverage for outpatient speech therapy is limited to a maximum of 30 visits per contract year.

**Radiation Therapy**
We cover radiation therapy, including the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Coverage includes the rental or cost of radioactive materials. We also cover the dental Services needed to prepare the mouth for radiation therapy to treat head and neck cancer.

**Respiratory Services**
We cover respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury.
Therapy, Habilitation and Rehabilitation Services Exclusion:
Long-term rehabilitation therapy, except as provided for cardiac rehabilitation Services
Refer to the following benefits in this section for the Habilitative and Rehabilitative devices that are also covered under this Agreement:

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

III. Transplant Services
We cover stem cell rescue, organ and tissue transplants and transusions, including autologous bone marrow transplants for breast cancer, if the following criteria are met:

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

Coverage also includes necessary acquisition procedures, harvest and storage, and preparatory myeloablative therapy.

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

- Unless otherwise authorized by Medical Group, transplants are covered only in our Service Area.
- If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for transplant, we will pay only for covered Services you receive before that determination was made.

Health Plan, Plan Hospitals, Medical Group and Plan Providers are not responsible for finding, furnishing, or ensuring the availability of a bone marrow or organ donor.

When a human organ or tissue transplant is provided from a living donor to a Member, both the recipient and the donor may receive the benefits of the Health Plan. We may cover expenses for medical, hospital, transportation, and lodging, that we pre-authorize in accordance with our travel and lodging guidelines, as long as services are directly related to a covered transplant for a donor, or an individual identified by Medical Group as a potential donor even if not a Member.

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

II. Urgent Care Services
As described below you are covered for Urgent Care Services anywhere in the world. “Urgent Care Services” are defined as Services required as the result of a sudden illness or injury, which requires prompt attention, but is not of an emergent nature.” 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, as shown in the Summary of Benefits section.

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. 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 Plan Medical Office in the Service Area, or in the nearest Kaiser Foundation Health Plan Region for continuing or follow-up treatment.
Urgent Care Exclusions:
Urgent Care Services within our Service Area that were not provided by a Plan Provider or Plan Facility.

JJ Vision Services

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

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

- Prescribed to replace the human lens lost due to surgery or injury;
- “Pinhole” glasses are prescribed after surgery for a detached retina; or
- Lenses are prescribed instead of surgery due to:
  a. contact lenses used for treatment of infantile glaucoma;
  b. corneal or sclera lenses prescribed in connection with keratoconus;
  c. scleral lenses prescribed to retain moisture when normal tearing is not possible or inadequate; or
  d. corneal or sclera lenses are required to reduce a corneal irregularity other than astigmatism.

In addition, we cover the following Services:

Eye Exams
We cover routine and necessary eye exams for adults and children, including:
- Routine tests such as eye health and glaucoma tests; and
- Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.

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

Eyeglass Lenses
We provide a discount on the purchase of regular eyeglass lenses, including add-ons, when purchased at a Kaiser Permanente Optical Shop. Regular eyeglass lenses are any lenses with a refractive value. If only one eye needs correction, we also provide a balance lens for the other eye. Children are provided one pair of standard eyeglass lenses per contract year from a select group of lenses at no charge.

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

Contact Lenses
We provide a discount on the initial fitting for contact lenses, when purchased at a Kaiser Permanente Optical Shop. Initial fitting means the first time you have ever been examined for contact lens wear at a Plan Facility. The discount includes the following Services:
- Fitting of contact lenses;
- Initial pair of diagnostic lenses (to assure proper fit);
- Insertion and removal of contact lens training; and
- Three (3) months of follow-up visits.

You will also receive a discount on your initial purchase of contact lenses, if you choose to purchase them at the same time. Note: Additional contact lens Services are available without the discount from any Kaiser Permanente Optical Shop. Children may select contact lenses in lieu of lenses/frames on initial purchases at no charge.

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

Vision Exclusions:
- Industrial and athletic safety frames.
- Eyeglass lenses and contact lenses with no refractive value.
  - Sunglasses without corrective lenses unless Medically Necessary.
  - Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), and astigmatism
(for example, radial keratotomy, photorefractive 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, broken, or damaged lenses frames and contact lenses.
- Plano lenses.
- Lens adornment, such as engraving, faceting, or jewelling.
- Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits.
- Orthoptic (eye training) therapy.

** KK. X-ray, Laboratory, and Special Procedures **

We cover the following Services only when prescribed as part of care covered in other parts of this “Benefits” section (for example, diagnostic imaging and laboratory tests are covered for outpatient Services only to the extent the outpatient Services are covered under “Outpatient Care”):

- Diagnostic EKGs, EEGs;
- Diagnostic imaging and interventional diagnostic tests;
- Laboratory and pathology services or tests, including tests for specific genetic disorders for which genetic counseling is available;
- Special procedures, such as electrocardiograms and electroencephalograms;
- Sleep testing; including sleep lab and sleep studies;
- Specialty imaging: including CT, MRI, PET scans, and Nuclear Medicine studies, and
- Radiology including x-rays, mammograms, and ultrasounds.

We cover the following outpatient diagnostic imaging tools:

- magnetic resonance angiography (MRA);
- magnetic resonance imaging (MRI);
- magnetic resonance spectroscopy (MRS);
- computed tomographic angiography (CTA);
- positron emission tomography (PET) scans;
- computed tomography (CT) scans;
- single photon emission computed tomography (SPECT) scans; and
- nuclear cardiology.

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

**Note:** See “Preventive Health Care Services” for coverage of lab and radiology Services that are part of preventive care screenings.
SECTION 4 – Exclusions, Limitations, and Coordination of Benefits

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 coordinated with 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 directly related to the excluded Service are also excluded, even if they would otherwise be covered under this EOC. Services that are not Medically Necessary are also excluded.

Alternative Medical Services

Acupuncture Services and the Services of a, Acupuncturist, Naturopath, and Massage Therapist.

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.

Cosmetic Services

Services that are not medically necessary, and 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 Ectodermal Dysplasia” 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, other than those which are medically necessary as a result of an accidental injury, dental appliances, dental implants, orthodontia, shortening of the mandible or maxillae for cosmetic purposes, and 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.

This exclusion does not apply to medically necessary dental care covered under “Accidental Dental Injury Services”, “Cleft-Lip, Cleft-Palate or Ectodermal Dysplasia”, or “Oral Surgery” in the “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 as covered under “Durable Medical Equipment” in Section 3, the following items and Services are excluded:

- Comfort, convenience, or luxury equipment or features;
- Exercise or hygiene equipment;
- Non-medical items such as sauna baths or elevators;
- Modifications to your home or car;
- 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.

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.

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.

Orthotic Devices
Services and supplies for orthotic devices, except as specifically covered under the “Benefits” section of this EOC.

Routine Foot Care Services
Except for patients with diabetes or vascular disease as specifically covered under Section 3, the following foot care Services (palliative or cosmetic) are excluded:

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

Sexual Reassignment
Genital surgery and mastectomy to treat gender dysphoria, including:

- Pre-surgery consultations and post-surgery follow-up exams
- Outpatient surgery and other outpatient procedures
- Hospital inpatient care (including room and board, imaging, laboratory, special procedures, drugs, and Plan Provider Services)

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.

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 employer’s 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, terrorist activity, civil
insurrection, disability of a large share of personnel of a Plan Facility, complete or partial destruction of facilities, and labor disputes not involving Health Plan, Kaiser Foundation Hospitals, or Medical Group. However, in these circumstances Health Plan, Kaiser Foundation Hospitals, Medical Group, and Medical Group Physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying care is safe and will not result in harmful health consequences.

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

**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 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 the maximum liability of the Secondary Plan, not to exceed 100 percent of total Allowable Expenses. The Secondary Plan is never liable for more expenses than it would cover if it had been Primary.

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 at 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: Group insurance or group-type coverage, whether insured or uninsured. This includes prepaid group practice or individual practice coverage.

"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 semi-private room in the hospital and the private room usually is not an Allowable Expense. "Allowable Expense does not include coverage for dental care except as provided under "Accidental Dental Injuries" in the "benefits" section.

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

**Order of Benefit Determination Rules**
1. If another Plan does not have a COB provision, that Plan is the Primary Plan.
2. If another Plan has a COB provision, the first of the following rules that apply will determine which Plan is the Primary Plan:
   a. **Subscriber/Dependent.** A Plan that covers a person as a Subscriber is Primary to a Plan that covers the person as a dependent.
b. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in subparagraph (b)(iii) below, when Health Plan and another Plan cover the same child as a dependent of different persons, called “parents”:
   i. The Plan of the parent whose birthday falls earlier in the year is Primary to the Plan of the parent whose birthday falls later in the year; but
   ii. If both parents have the same birthday, the Plan that covered a parent longer is Primary; or
   iii. If the rules in (i) or (ii) do not apply to the rules provided in the other Plan, then the rules in the other Plan will be used to determine the order of benefits.

c. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   i. First, the Plan of the parent with custody of the child;
   ii. Then, the Plan of the spouse or Domestic Partner of the parent with custody of the child; and
   iii. Finally, the Plan of the parent not having custody of the child.
   iv. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the Plan obligated to pay or provide the benefits of that parent has actual knowledge of those terms, that Plan is primary. This paragraph (iv) does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payer has that actual knowledge.

d. **Active/Inactive Employee.** A Plan that covers a person as an employee who is neither laid off nor retired (or as such an employee's dependent) is Primary to a Plan which covers that person as a laid off or retired employee (or as such an employee's dependent).

e. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the Plan that has covered a Subscriber longer is Primary to the Plan which has covered the Subscriber for the shorter time.

**Effect of COB on the Benefits of this Plan**

When Health Plan is the Primary Plan, COB has no effect on the benefits or services provided under this Agreement. When Health Plan is a Secondary Plan as to one or more other Plans, its benefits may be coordinated with the Primary Plan carrier using the guidelines below. COB shall in no way restrict or impede the rendering of services 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 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 contract 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; Claims and Appeal Procedures; and Customer Satisfaction Procedure

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 file a claim for Emergency Services and Urgent Care Services outside our Service Area (see Post-Service Claims) or to initiate an appeal for any unresolved problem.

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

Who to Contact

By Telephone
Member Services Department telephone numbers:

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

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

TTY 711

In Writing
To contact us in writing, mail your correspondence to:

Kaiser Permanente
Member Services Department
2101 East Jefferson Street
Rockville, MD 20852

For an appeal, send it to the attention of:
Member Services Appeals Unit

By Facsimile
To fax us your correspondence, send it to:

301-816-6192

Definitions

Adverse Decision: Any Health Plan determination or decision (a) that a Service is not a covered benefit, or if it is a covered benefit, such Service does not meet Health Plan’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore payment is not provided or made by Health Plan, in whole or in part, for the Service, thereby making the Member responsible for payment of such Service, in whole or in part, or (b) that cancels or terminates a Member’s membership retroactively for a reason other than a failure to pay premiums or contributions toward the cost of coverage.

Appellant: An appellant is a person eligible to file an Independent External Appeal. The Member or the following persons may be considered an Appellant: (1) an Authorized Representative; or (2) the member’s spouse, parent, committee, legal guardian, or other individual authorized by law to act on the Member’s behalf if the Member is not a minor, but is incompetent or incapacitated.

Authorized Representative: An individual appointed 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. Authorized Representative shall also include a Health Care Provider acting on behalf of a Member with the Member’s express written consent, or without the Member’s express consent in an Emergency situation. With respect to claims and appeals, the term “Member” shall include an Authorized Representative.

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

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

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

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

Such appeal may be made by telephone, facsimile or other available similarly expeditious method.

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

**Pre-Service Claim:** A request that Health Plan provide or pay for a Service that you have not yet received.

**Post-Service Claim:** A request for payment for Services you have already received, including but not limited to, claims for Out-of-Plan emergency services.

**Urgent Medical Condition:** As used in this Section 5, a medical condition for which care has not been rendered and which (a) could seriously jeopardize your life, health or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject the Member to severe pain that cannot be adequately managed without the Services which are the subject of the claim.

**Procedure for Making a Claim and Initial Claim Decisions**

Health Plan will review claims that you make for Services or payment, and we may use medical experts to help us review claims and appeals. You may file a claim or an appeal on your own behalf or through an Authorized Representative. As used with respect to Pre-Service, Concurrent Care, or Post-Service Claims and appeals related thereto, the term “Member” or “you” shall include an Authorized Representative, as defined above.

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

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

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

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

We do not charge you for filing claims or appeals, but you must bear the cost of anyone you hire to represent or help you. You may also contact the Office of the Managed Care Ombudsman (contact information is set forth below) to obtain assistance.

**A. Pre-Service Claims**

Pre-Service claims are requests that Health Plan provide or pay for a Service that you have not yet received. Our clinical peer will decide if your claim involves an Urgent Medical Condition or not. If you receive any of the Services you are requesting before we make our decision, your claim or appeal will become a Post-Service Claim with respect to those Services. If you have any questions about Pre-Service Claims, please contact our Member Services Department at the numbers listed above.

**Procedure for Making a Non-Urgent Pre-Service Claim**

1. Tell the Member Services Department that you want to make a claim for Health Plan to provide or pay for a Service you have not yet received. Your written or oral request and any related documents you give us constitute your claim. You may write or call us at the address and number listed above.

2. We will review your claim, and if we have all the information we need we will communicate our decision within 2 working days after we receive your claim. If we cannot make a determination because
we do not have all the information we need, we will ask you for more information within 15 days of receipt of your claim. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days, we will then make a decision within 15 days of the due date or the receipt date, whichever is earlier, based on the information we have.

3. We will make a good faith attempt to obtain information from the treating provider before we make any Adverse Decision. At any time before we make our decision, the provider shall be entitled to review the issue of medical necessity with a physician advisor or peer of the treating provider. A physician reviewer will review the issue of medical necessity with the provider prior to making any Adverse Decision relating to cancer pain medication.

4. If we make an Adverse Decision regarding your claim, we will notify the treating provider:
(a) in writing within 2 working days of the decision; or
(b) orally by telephone within 24 hours of the decision if the claim is for cancer pain medication.

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

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

Expedited Procedure for an Urgent Medical Condition

1. If you or your treating provider feels that you have an Urgent Medical Condition, you may request an expedited review of your Pre-Service claim.

2. If our clinical peer determines your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Pre-Service Claim.

3. We will review your claim, and if we have all the information we need we will notify you of our decision as soon as possible taking into account your medical condition(s) but no later than 72 hours after receiving your claim. We will send a written or electronic confirmation within 3 days after making our decision. If we cannot make a decision because we do not have all the information we need, we will ask you for more information within 24 hours of receipt of your claim. You will have 48 hours from the time of notification by us to provide the missing information. We will make a decision 48 hours after the earlier of (a) our receipt of the requested information, or (b) the end of the 48-hour period we have given you to provide the specified additional information.

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

5. When you or your Authorized Representative sends an appeal, you or your Authorized Representative may also request simultaneous external review of our initial adverse decision. If you or your Authorized Representative wants simultaneous external review, your or your Authorized Representative’s appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, than you or your Authorized Representative may be able to request external review after we make our decision regarding the appeal. See Section C Bureau of Insurance Independent External Appeals for additional information about filing an external appeal.

B. Concurrent Care Claims

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

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

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

3. If we reduce or terminate coverage for an ongoing course of treatment that we already approved, we will notify the Member sufficiently in advance of the reduction or termination to allow the member to appeal the decision as described below.
**Concurrent Care Claims for an Urgent Medical Condition**

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

If you filed a request for additional services at least 24 hours before the end of an approved course of treatment, you may continue to receive those services during the time your claim is under consideration. If your claim is denied, you will be financially responsible for the entire cost of those services. Otherwise, if your request for additional services was not timely filed, Health Plan will decide your request for review within a reasonable period of time appropriate to the circumstances but in no event later than 30 calendar days from the date on which your claim was received.

1. If our clinical peer determines your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Concurrent Care Claim.

2. We will notify you of our decision orally or in writing within 24 hours after we receive your claim. If we notify you orally, we will send you a written decision within 3 days after that.

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

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

**C. Post-Service Claims**

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

**Procedure for Making a Post-Service Claim**

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

1. You must send the completed claim form to us at the address listed on the claim form within 180 days, or as soon as reasonably possible after the Services are rendered. You should attach itemized bills along with receipts if you have paid the bills. Incomplete claim forms will be returned to you. This will delay any payments which may be owed to you. Also, you must complete and submit to us any documents that we may reasonably need for processing your claim or obtaining payment from insurance companies or other payors.

2. We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. If we tell you we need more time because of circumstances beyond our control, we may take an additional 15 days to send you our written decision. If we tell you we need more time and ask you for more information, you will have 45 days to provide the requested information. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days, we will make a decision based on the information we have. We will issue our decision within 15 days of the deadline for receiving the information.

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

**Reconsideration of an Adverse Decision**

Reconsideration of an Adverse Decision is available only to the treating health care provider, to request a review, on behalf of a Member, of an Adverse Decision by Health Plan. A request for reconsideration is optional. The treating provider may choose to skip this step and the Member or the Authorized Representative may file an appeal as described below. If the provider does request reconsideration, the Member still has a right to appeal.
Health Plan will render its decision regarding the reconsideration request and provide the decision to the treating provider and the Member, in writing, within 10 working days of the date of receipt of the request. If we deny the claim, the notice will include the criteria used and the clinical reason for the Adverse Decision, the alternate length of treatment of any alternate treatment recommended, and the Member’s right to appeal the decision as described below.

**Appeals of Claim Decisions**

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

**A. Standard Appeal**

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

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

   Kaiser Permanente  
   2101 East Jefferson Street  
   Rockville, MD 20849  
   Member Services Appeals and  
   Correspondence  
   301-816-6192 (FAX)

You or your Authorized Representative may request a standard appeal by contacting the Member Services Department. In addition, you or your Authorized Representative, as applicable, may review the Health Plan’s appeal file and provide evidence and testimony to support the appeal request.

Member Service Representatives are available by telephone each day during business hours to describe to Members how appeals are processed and resolved and to assist the Member with filing an appeal. The Member Service Representative can be contacted Monday through Friday from 7:30am to 9:00pm at 301-468-6000, if calling within the local area, or 711 TTY (Telephonic Device for the Deaf).

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

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

a. notify the Member that it cannot proceed with reviewing the appeal unless additional information is provided; and
b. assist in gathering the necessary information without further delay.

2. Standard appeals will either be acknowledged within 5 working days of the filing date of the written appeal request. An acknowledgement letter will be sent as follows:

**Appeal of a Non-urgent Pre-Service or Non-urgent Concurrent Care Claim**

If the appeal is for a Service that the Member is requesting, the acknowledgment letter will: i) request additional information, if necessary; ii) inform the Member when there will be a decision on their appeal; and iii) state that written notice of the appeal decision will be sent within 30 days of the date the appeal was received.

**Appeal of a Post-Service Claim**

If the appeal is asking for payment for completed services, an acknowledgment letter is sent: i) requesting additional information, if necessary; ii) informing the Member when a decision will be made; and iii) that the Member will be notified of the decision within 60 days of the date the appeal was received.

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

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

In addition, you or your Authorized Representative, as applicable, may review (without charge) the information on which Health Plan made its decision. You or your Authorized Representative may also send additional information, including comments, documents, or additional medical records supporting the claim, to:
If the Health Plan asked for additional information before and you or your Authorized Representative did not provide it, you or your Authorized Representative may still submit the additional information with the appeal. In addition, you or your Authorized Representative may also provide testimony by writing or by telephone. Written testimony may be sent along with the appeal to the address above. To arrange to give testimony by telephone, you or your Authorized Representative may contact the Member Services Appeals Unit.

Health Plan will add all additional information to the claim file and review all new information without regard to whether this information was submitted or considered in the initial decision.

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

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

If the review results in a denial, Health Plan will notify the Member or the member’s Authorized Representative. The notification shall include:

a. the specific factual basis for the decision in clear understandable language;

b. references to any specific criteria or standards on including interpretive guidelines, on which the appeal decision was based (including reference to the specific plan provisions on which determination was based);

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. a description of the right of the Member to file an external appeal with the Bureau of Insurance, along with the forms for filing and a detailed explanation of how to file such an appeal. An external appeal must be filed within 120 days after the date of receipt of a notice of the right to an external review of a final adverse determination or an adverse determination if the internal appeal process has been deemed to be exhausted or waived, a covered person or his authorized representative may file a request for an external review in writing with the Commission, as described below; and

e. A statement of your rights under section 502(a) of ERISA.

f. If we send you a notice of an adverse decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least 10% of the population is literate only in the same federally mandated non-English language. You or your Authorized Representative may request translation of the notice by contacting Member Services.

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

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

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

1. You, your Authorized Representative, or your treating health care provider may initiate an Expedited Appeal by contacting Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.:
   (a) During Regular Business Hours
   Monday through Friday from 7:30am – 9:00pm – The Member should contact the Member Services Department.

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

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

   (b) During Non-Business Hours
   The Member should call the Advice/Appointment Line.

   Inside the Washington, D.C. Metropolitan area
   (703) 359-7878

   Outside the Washington, D.C. Metropolitan area
   (800) 777-7904

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

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

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

4. A decision with respect to such Expedited Appeal shall be rendered no later than:
   a. 72 hours after receipt of the claim, if we have all of the necessary information; or
   b. if the claim is for cancer pain medication, no later than 24 hours after receipt of the claim.

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

6. If Health Plan declines to review an appeal as an Expedited Appeal; or if the Expedited Appeal results in a denial, Health Plan shall immediately take the following actions:
   a. Notify you, your Authorized Representative, or the provider who requested the expedited review, by telephone, fax, or electronic mail that the Member is eligible for an Expedited Appeal to the Bureau of Insurance without the necessity of providing the justification required for a standard appeal; and
   b. Within 24 hours after the initial notice, provide a written notice to the provider and the Member clearly informing them of the right to appeal this decision to the Bureau of Insurance. The written notice will include the appropriate forms and instructions to file an appeal with the Bureau of Insurance, as described below.

The notification shall also include:
   a. the specific factual basis for the decision in clear understandable language;
   b. references to any specific criteria or standards, including interpretive guidelines, on which the decision was based (including reference to the specific plan provisions on which determination was based);
   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; and
d. A statement of your rights under section 502(a) of ERISA.

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

C. Bureau of Insurance Independent External Appeals

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

a. all of the Health Plan’s appeal procedures described above have been exhausted;
b. the Member requested an Expedited Appeal and the Health Plan determined that the standard appeal timeframes should apply; or
c. when an Expedited Appeal is reviewed and is denied.

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

a. an Adverse determinations was based on a determination that services are experimental/investigational may be expedited with written certification by the treating physician that services would be less effective if not initiated promptly;
b. an Expedited emergency review (ER) for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness denial may be requested simultaneously with an expedited internal review; the Independent Review Organization (IRO) will review and determine if internal appeal should be completed prior to ER;
c. the Health Plan fails to render a standard internal appeal determination within thirty (30) or sixty (60) days and you, your Authorized Representative or Health Care provider has not requested or agreed to a delay; or
d. the Health Plan waives the exhaustion requirement.

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

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

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

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

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

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

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Local: 1-804-371-9032
Toll Free: 1-877-310-6560
E-Mail: ombudsman@scc.virginia.gov

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

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

Complaint Hotline:
Local: 1-804-367-2106
Customer Satisfaction Procedure
In addition, Health Plan has established a procedure for hearing and resolving Complaints by Members. An oral Complaint may be made to any Health Plan employee or to any person who regularly provides health care services to Members. A written Complaint must be given or sent to a Membership Services Representative located at a Medical Office or by sending a letter to our Member Services Department at the following address:

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

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

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

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

State Corporation Commission
Bureau of Insurance
P O Box 1157
Richmond, VA 23218
Fax: (804) 371-9944
SECTION 6 – Termination of Membership

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

You will be billed at Non-Member Rates for any Services you receive after your membership terminates. Health Plan 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.

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.

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under “Who is Eligible” section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership terminates on the last day of that month unless your Group has an arrangement with us to terminate at a time other than the last day of the month. Please check with your Group’s benefits administrator to confirm your termination date.

Termination of Group Agreement

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

Termination for Cause

By sending written notice to the Subscriber at least 31 days before the termination date we may terminate your or your Dependent’s membership for cause if:

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

If the fraud or intentional misrepresentation was committed by the Subscriber, we may terminate the memberships of the Subscriber and all Dependents in the Family Unit.
- If the fraud or intentional misrepresentation was committed by a Dependent, we may terminate the membership of only that Dependent.

We may report any Member fraud to the authorities for prosecution.

Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Premium from your Group. If your Group fails to pay us the appropriate Premium for your Family Unit, your Group will be provided written or printed notice of termination due to nonpayment of premium, including a specific date, not less than 31 days from the mailing date of such notice, by which coverage will terminate if overdue premium is not paid. Coverage shall not be permitted to terminate for at least 31 days after such notice has been mailed. After those 31 days, 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, subject to Premium payment, in the following instance:

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

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

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

Limitation(s):

The “Extension of Benefits” section listed above does not apply to the following:

- Members’ whose coverage ends because of failure to pay Premium; or
- Members’ whose coverage ends because of fraud or material misrepresentation by 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 and/or your Dependents may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility. Members are eligible for COBRA continuation coverage even if they live in another Kaiser Foundation Health Plan Region or allied plan service area. Please contact your Group if you want to know whether you or your Dependents are eligible for COBRA coverage, how to elect COBRA coverage, or how much you will have to pay your Group for it.

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

- The application and payment for the extended coverage are made to the Group within 31 days after issuance of notification of your continued rights, but in no event beyond the 60 day period following the date of termination of eligibility;
- Each premium for the extended coverage is timely paid to the Group on a monthly basis for the 12 month period; and
- The premium for continuing the coverage shall be at the Health Plan’s current rate applicable to the Group Agreement plus any applicable administrative fee not to exceed 2.0% of the current rate.

The Group Administrator shall provide you or other persons covered under this Group Agreement written notice of the availability of the option chosen and the procedures and timeframes for obtaining continuation of the Group Agreement. This notice shall be provided within 14 days of the Group Administrator’s knowledge of your or other your Dependent’s loss of eligibility under this Group Agreement.

**USERRA**
If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. Members are not ineligible for USERRA continuation coverage solely because they live in another Kaiser Foundation Health Plan Region or allied plan service area. You must submit a USERRA election form to your Group within 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.
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 and instructions, contact our Member Services Call Center.

Inside Washington, D.C., Metropolitan area (301) 468-6000, or in the Baltimore, Maryland TTY at 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
Except as provided below for ambulance Services, you may not assign this EOC or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

For ambulance Services, any person providing such Services to a Member under this EOC may receive reimbursement for such Services directly from us upon submission of assignment of benefits within 6 months from the date of Service.

If you receive a payment for covered Services received from a non-participating provider for which you have not already made payment, you are responsible for applying that Plan payment to the claim from that non-participating provider.

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

Contracts with Plan Providers
Health Plan and Plan Providers are independent contractors. Your Plan Providers are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee for service, and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please refer to your **Provider Directory** or call our Member Services Call Center 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 at 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 for Emergency Services or authorized referrals.

If our Contract with any Plan Provider terminates, for reasons unrelated to fraud, patient abuse, incompetence, or loss of licensure status, while you are under the care of that Plan Provider, you may continue to see that provider and we will retain financial responsibility for covered Services you receive, in excess of any applicable Copayments, Coinsurance or Deductibles for a period at least 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 law of the Commonwealth of Virginia and any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.
Notice of Non-Grandfathered Coverage

Health Plan believes this coverage is a “non-grandfathered health plan” under the Patient Protection and Affordable Care Act (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 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, gender identification, race, ethnicity, religion, disability, medical condition, national origin, educational background, reading skills, ability to speak or read English, or economic or health status, including any 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.

**MEMBER RESPONSIBILITIES**

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

1. **Promote your own good health:**
   a. Be active in your health care and engage in healthy habits.
   b. Select a Primary Care Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics, or Family Practice as your Primary Care Physician.
   c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you.
   d. Work with us to help you understand your health problems and develop mutually agreed upon treatment goals.
   e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment.
   f. Do your best to improve your health by following the treatment plan and instructions your physician or health care professional recommends.
   g. Schedule the health care appointments your physician or health care professional recommends.
   h. Keep scheduled appointments or cancel appointments with as much notice as possible.

2. **Know and understand your plan and benefits:**
   a. Read about your health care benefits in this EOC and become familiar with them. Call us when you have questions or concerns.
   b. Pay your plan premiums and bring payment with you when your visit requires a Copayment, Coinsurance or Deductible.

3. **Promote respect and safety for others:**
   a. Extend the same courtesy and respect to others that you expect when seeking health care Services.
   b. Assure a safe environment for other Members, staff, and physicians by not threatening or harming others.
   c. Let us know if you have any questions, concerns, problems or suggestions.

**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, gender identification, 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 care services you receive, or payment for your health care. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, health research and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give PHI to others, such as government agencies or in judicial actions. In addition, Member-identifiable health information is shared with your Group only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative’s) written authorization, except as described in our Notice of Privacy Practices (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our Notice of Privacy Practices, which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request. To request a copy, please call our Member Service Call Center (see below). You can also find the notice at your local Plan Facility or on our Web site at www.kp.org.

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

Outside the Washington, D.C. Metropolitan area
1-800-777-7902
SECTION 8. 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 contracted amount;
- the negotiated amount
- 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.

Coinsurance: The percentage of Allowable Charges 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.

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.

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

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

Deductible: The amount of Allowable Charges that must be incurred by an individual or a family per year before Health Plan begins payment. Please refer to the Summary of Services and Cost Shares section for the Services that are subject to Deductible and the amount of the Deductible.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements see “Who Is Eligible” in the “Eligibility and Enrollment” section.)

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: All of the following with respect to an Emergency Medical Condition:
- A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition.
- 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.

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.

Habilitative Services: Health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age.
These services may include physical and occupational therapy, speech-language pathology and other Services for people with disabilities in a variety of inpatient and/or outpatient settings, including, but not limited to applied behavioral analysis for the treatment of autism spectrum disorder.

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

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


**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 you 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 this Section 3) is Medically Necessary and our decision is final and conclusive subject to your right to appeal as set forth in Section 5.

**Medicare**: 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.”

**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 you 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 nurse practitioners and physician assistants employed by us to 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.

**Qualified Employee**: Any employee or former employee of a Qualified Employer who has been offered health insurance coverage by such Qualified Employer through the SHOP Exchange for himself or herself and, if the Qualified Employer offers dependent coverage through the SHOP Exchange, for his or her dependents.

**Qualified Employer**: Qualified employer means a small employer that elects to make, at a minimum, all full-time employees of such employer eligible for one or more QHPs in the small group market offered through a SHOP:

1. Has its principal place of business in the Commonwealth of Virginia and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or
2. Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in the Commonwealth of Virginia.
**Qualified Health Plan or QHP:** A health plan that has in effect a certification that it meets the standards recognized by the Exchange through which such plan is offered.

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

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

**SHOP:** A Small Business Health Options Program operated by an Exchange through which a qualified employer can provide its employees and their dependents with access to one or more qualified health plans.

**Skilled Nursing Facility:** A facility that provides inpatient skilled nursing care, rehabilitation Services, or other related health care Services and is certified by Medicare. The facility’s primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term “Skilled Nursing Facility” does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

**Small Employer:** An employer who employed an average of at least one but not more than 100 employees on business days during the preceding contract year and who employs at least one employee on the first day of the contract year.

**Spouse:** Your legal husband or wife.

**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” section).

**Totally Disabled:**

- **For Subscribers and Adult Dependents:** Dependents: In the judgment of a Medical Group Physician, a person is totally disabled by reason of injury or sickness if the Member is unable to perform each and every duty pertaining to his or her occupation during the first 52 weeks of the disability. After the first 52 weeks, a person is totally disabled if the Member is unable to perform each and every duty of any business or occupation for which the Member is reasonably fitted by education, training and experience.

- **For Dependent Children:** In the judgment of a Medical Group Physician, an illness or injury which makes the child unable to substantially engage in any of the normal activities of children in good health and like age.

**Urgent Care Services:** Services required as the result of a sudden illness or injury, which require prompt attention, but are not of an emergent nature.
Outpatient Prescription Drug Benefit

Health Plan will provide coverage for prescription drugs as follows:

**DEFINITIONS**

**Allowable Charge:** Has the same meaning as defined in Definitions section in your Group Evidence of Coverage.

**Brand Name Drug:** A prescription drug that has been patented and is produced by only one manufacturer.

**Coinsurance:** A percentage of the Allowable Charge that you must pay for each prescription or prescription refill.

**Contraceptive drug:** A drug or device that is approved by the FDA for use as a contraceptive and requires a prescription.

**Copayment:** The specific dollar amount that you must pay for each prescription or prescription refill.

**FDA:** The United States Food and Drug Administration.

**Generic Drug:** A prescription drug that does not bear the trademark of a specific manufacturer. It is chemically the same as a Brand Name Drug.

**Limited Distribution Drug (LDD):** Prescription drug that is limited in distribution by the manufacturer or FDA.

**Mail Service Delivery Program:** A program operated by Health Plan that distributes prescription drugs to Members via mail. Certain drugs that require special handling are not provided through the mail-delivery service. This includes, but is not limited to, drugs that are time or temperature sensitive, drugs that cannot legally be sent by U.S. mail, and drugs that require professional administration or observation.

**Maintenance Medications:** A covered drug anticipated to be required for six months or more to treat a chronic condition.

**Medical Literature:** Scientific studies published in a peer-reviewed national professional medical journal.

**Non-Preferred Brand Drug:** A Brand Name Drug that is not on the Preferred Drug List.

**Plan Pharmacy:** A pharmacy that is owned and operated by Health Plan.

**Preferred Brand Drug:** A Brand Name Drug that is on the Preferred Drug List.

**Preferred Drug List:** A list of prescription drugs and compounded drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members. Our Pharmacy and Therapeutics Committee, which is comprised of Plan Physicians and other Plan Providers, selects prescription drugs for inclusion in the Preferred Drug List based on a number of factors, including but not limited to safety and effectiveness as determined from a review of Medical Literature, Standard Reference Compendia, and research.

**Specialty Drugs:** A class of prescription drugs as designated by Kaiser Permanente that are unique, high cost, injected, infused, oral or inhaled prescription drugs (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. A list of the drugs in our Preferred Drug List Formulary may be viewed on our website at www.kp.org. This list changes periodically. Please contact the Member Services Call Center to find out if a drug is covered under this benefit as a Specialty Drug.
**Standard Manufacturer’s Package Size:** The volume or quantity of a drug or medication that is placed in a receptacle by the maker/distributor of the drug or medication, and is intended by the maker/distributor to be distributed in that volume or quantity.

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

**Tobacco Cessation Drugs:** Over-the-Counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.

**Benefits**
Except as provided in the Limitations and Exclusions sections, we cover drugs described below when prescribed by a Plan physician, a non-Plan Physician to whom you have an approved referral, or a dentist. Each prescription refill is subject to the same conditions as the original prescription. A Plan Provider prescribes drugs in accordance with Health Plan’s Preferred Drug List. If the price of the drug is less than the Copayment, you will pay the price of the drug. You must obtain covered drugs from a Plan Pharmacy. You may also obtain prescription drugs using our Mail Service Delivery Program; ask for details at a Plan Pharmacy.

We cover the following prescription drugs:
- FDA-approved drugs for which a prescription is required by law.
- Compounded preparations that contain at least one ingredient requiring a prescription.
- Insulin.
- Injectable drugs and drugs administered in an outpatient setting, including injections administered at authorized pharmacies.
- Oral chemotherapy drugs.
- Drugs for the treatment of intractable cancer pain.
- Drugs that are FDA-approved for use as contraceptives and diaphragms at no cost. For coverage of other types of contraception, including contraceptive injections, implants and devices, refer to “Family Planning Services” in Section 3 - Benefits of this Group Evidence of Coverage.
- Off label use of drugs when a drug is recognized in Standard Reference Compendia or certain Medical Literature as appropriate in the treatment of the diagnosed condition.
- Non-prescription drugs when they are prescribed by a Plan Provider and are listed on the Preferred Drug List.
- Growth hormone therapy (GHT) for treatment of children under age 18 with a growth hormone deficiency; or when prescribed by a Plan Physician, pursuant to clinical guidelines for adults.
- Limited Distribution Drugs (LDD) Regardless of where they are purchased, LDD’s will be covered on the same basis as if they were purchased at a Plan Pharmacy.

In the following circumstances, you can obtain an additional 30-day supply from your pharmacist:
- You’ve lost your medication;
- Your medication was stolen; or
- Your physician increases the amount of your dosage.

The Health Plan Pharmacy and Therapeutics Committee sets dispensing limitations in accordance with therapeutic guidelines based on the Medical Literature and research. The Committee also meets periodically to consider adding and removing prescribed drugs on the Preferred Drug List. If you would like information about whether a particular drug is included in our Preferred Drug List, please visit us on line at www.kaiserpermanente.org/formulary, or call the Member Services Call Center at the phone numbers listed below:

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

**Outside the Washington, D.C. Metropolitan Area**
1-800-777-7902
WHERE TO PURCHASE COVERED DRUGS
We cover prescribed drugs when purchased at a Plan Pharmacy or through Health Plan’s Mail Service Delivery Program. Most non-refrigerated prescription medications ordered through the Health Plan’s Mail Service Delivery Program can be delivered anywhere in the United States.

Services of Non-Plan Pharmacies
Notwithstanding any provision in this Group Evidence of Coverage to the contrary, you have coverage for outpatient prescription drug services provided to you by a non-Plan Pharmacy that has previously notified Health Plan of its agreement to accept reimbursement for its services at rates applicable to our Health Plan Pharmacy network providers. This shall include any applicable copayment, coinsurance and/or deductible (if any) amounts as payment in full, to the same extent as coverage for outpatient prescription drug services provided to you by Plan Pharmacies participating in our pharmacy network. Note, however, that this paragraph shall not apply to any pharmacy which does not execute a participating pharmacy agreement with Health Plan or its designee within 30 days of being requested to do so in writing by Health Plan, unless and until the pharmacy executes and delivers the agreement.

If you have a prescription filled at a Non-Plan Pharmacy, you must complete and submit a claim form. Reimbursement will be based on what a Plan Pharmacy would receive had the prescription been filled at a Plan Pharmacy. If you have questions or need a claim form, call Member Services or visit our website at www.kp.org.

GENERIC AND PREFERRED DRUG REQUIREMENTS
You may view our Preferred Drug List at:

https://healthy.kaiserpermanente.org/static/health/pdfs/formulary/mid/mid_exchange_formulary.pdf

Generic vs. Brand Name Drugs
Plan Pharmacies will substitute a generic equivalent for a Brand Name Drug when a generic equivalent is on our Preferred Drug List unless one of the following is met:

- The provider has prescribed a Brand Name Drug and has indicated “dispense as written” (DAW) on the prescription;
- The Brand Name Drug is listed on our Preferred Drug List;
- The Brand Name Drug is: (1) prescribed by a Plan physician, a non-Plan Physician to whom you have an approved referral, or a dentist; and (2) (a) there is no equivalent Generic Drug, or (b) an equivalent Generic Drug (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.

The Health Plan will treat the drug(s) obtained as prescribed above as an Essential Health Benefit, including by counting any Cost-Sharing towards the plan's annual limitation on Cost-Sharing.

If you request a Brand Name Drug for which none of the above conditions has been met, you will be responsible for the Non-Preferred Brand Drug Cost Share.

Preferred Brand vs. Non-Preferred Brand Drugs
Plan Pharmacies will dispense drugs from our Preferred Drug List unless the following criteria are met: (1) the Non-Preferred Brand Drug is prescribed by a Plan physician, a non-Plan Physician to whom you have a referral, or a dentist; and (2) (a) there is no equivalent drug in our Preferred Drug List, or (b) an equivalent Preferred Drug List drug (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.

The Health Plan will treat the drug(s) obtained as prescribed above as an Essential Health Benefit, including by counting any Cost-Sharing towards the plan's annual limitation on Cost-Sharing.

If you request a Non-Preferred Brand Drug the applicable drug Cost Share will apply.
**Dispensing Limitations**

Except for Maintenance Medications as described below, Members may obtain up to a 30-day supply and will be charged the applicable Copayment or Coinsurance based on: (a) the prescribed dosage, (b) Standard Manufacturers Package Size, and (c) specified dispensing limits.

Drugs that have a short shelf life may require dispensing in smaller quantities to assure that the quality is maintained. Such drugs will be limited to a 30-day supply. If a drug is dispensed in several smaller quantities (for example, three 10-day supplies), you will be charged only one Cost Share at the initial dispensing for each 30-day supply.

Except for Maintenance Medications as described below, injectable drugs that are self-administered and dispensed from the pharmacy are limited to a 30-day supply.

**Maintenance Medication Dispensing Limitations**

Members may obtain up to a 90-day supply of Maintenance Medications in a single prescription, when authorized by the prescribing Plan Provider or by a dentist or a referral physician. This does not apply to the first prescription or change in a prescription. Members will be charged two (2) times the amount of the applicable Copayment or Coinsurance for a 30-day supply. The day supply is based on: (a) the prescribed dosage; (b) Standard Manufacturer’s Package Size; and (c) specified dispensing limits.

**Prescriptions Covered Outside the Service Area; Obtaining Reimbursement**

The Health Plan covers drugs prescribed by non-Plan Providers and purchased at non-Plan Pharmacies when the drug was prescribed during the course of an emergency care visit or an urgent care visit (see “Emergency Services” and “Urgent Care Services” sections of the Group Evidence of Coverage), or associated with a covered, authorized referral inside or outside Health Plan’s Service Area. To obtain reimbursement, the Member must submit a copy of the itemized receipts for their prescriptions to Health Plan. We may require proof that urgent or emergency care Services were provided. Reimbursement will be made at the Allowable Charge less the applicable Copayment as shown below. Claims should be submitted to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.  
Attention: Claims Department  
P.O. Box 6233  
Rockville, Maryland 20849-6233

**Limitations and Exclusions**

**Limitations:**

Benefits are subject to the following limitations:

- For drugs prescribed by dentists, coverage is limited to antibiotics and pain relief drugs that are included on our Preferred Drug List and purchased at a Plan Pharmacy, unless the criteria for coverage of Non-Preferred Brand Drugs has been met. The Non-Preferred Brand Drugs coverage criteria is detailed in the subsection titled, “Preferred Brand vs. Non-Preferred Brand Drugs”.

- In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with the Health Plan’s emergency management department and/or our Pharmacy and Therapeutics Committee. If limited, the applicable Cost Share per prescription will apply. However, a Member may file a claim for the difference between the Cost Share for a full prescription and the pro-rata Cost Share for the actual amount received. Instructions for filing a claim can be found in Section 5 of your Group Evidence of Coverage. Claims should be submitted to:

  Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.  
  Attention: Claims Department  
P.O. Box 6233  
Rockville, Maryland 20849-6233
**Exclusions:**
The following are not covered under the Outpatient Prescription Drug Benefit. Please note that certain Services excluded below may be covered under other benefits in Section 3 of your Group Evidence of Coverage. Please refer to the applicable benefit to determine if drugs are covered:

- Drugs for which a prescription is not required by law, except for non-prescription drugs that are prescribed by a Plan Provider and are listed in our Preferred Drug List.
- Compounded preparations that do not contain at least one ingredient requiring a prescription and are not listed in our Preferred Drug List.
- Drugs obtained from a non-Plan Pharmacy, except when the drug is prescribed during an emergency or urgent care visit in which covered Services are rendered, or associated with a covered authorized referral outside the Service Area.
- Take home drugs received from a hospital, Skilled Nursing Facility, or other similar facility. Refer to “Hospital Inpatient Care” and “Skilled Nursing Facility Care” in Section 3 – Benefits of your Group Evidence of Coverage.
- Drugs that are not listed in our Preferred Drug List, except as described in this Outpatient Prescription Drug Benefit.
- Drugs that are considered to be experimental or investigational. Refer to “Clinical Trials” in Section 3 – Benefits of your Group Evidence of Coverage.
- Except as specifically covered under this Outpatient Prescription Drug Benefit, a drug (a) which can be obtained without a prescription, or (b) for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug.
- Drugs for which the Member is not legally obligated to pay, or for which no charge is made.
- Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes including but not limited to drugs used to retard or reverse the effects of skin aging or to treat nail fungus or hair loss.
- Medical foods. Refer to “Medical Foods” in Section 3 – Benefits of your Agreement.
- Drugs for the palliation and management of terminal illness if they are provided by a licensed hospice agency to a Member participating in our hospice care program. Refer to “Hospice Care Services” in Section 3 – Benefits of your Group Evidence of Coverage.
- Prescribed drugs and accessories that are necessary for Services that are excluded under this Agreement.
- Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from the Health Plan’s standard packaging for prescription drugs.
- Alternative formulations or delivery methods that are (1) different from the Health Plan’s standard formulation or delivery method for prescription drugs and (2) deemed not Medically Necessary.
- Drugs and devices that are provided during a covered stay in a hospital or Skilled Nursing Facility, or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits. This includes the equipment and supplies associated with the administration of a drug. Refer to “Drugs, Supplies, and Supplements” and “Home Health Services” in Section 3 – Benefits of your Group Evidence of Coverage.
- Bandages or dressings. Refer to “Drugs, Supplies, and Supplements” and “Home Health Services” in Section 3 – Benefits of your Group Evidence of Coverage.
- Diabetic equipment and supplies. Refer to “Diabetic Services” in Section 3 – Benefits of this Group Evidence of Coverage.
- Growth hormone therapy (GHT) for treatment of adults age 18 or older, except when prescribed by a Plan Physician, pursuant to clinical guidelines for adults.
- Immunizations and vaccinations solely for the purpose of travel. Refer to “Outpatient Care” in Section 3 – Benefits of your Group Evidence of Coverage.
- Any prescription drug product that is therapeutically equivalent to an over-the-counter drug, upon a review and determination by the Pharmacy and Therapeutics Committee.
- Drugs for weight management.
Drugs for treatment of sexual dysfunction disorder, such as erectile dysfunction.
SECTION B. ADULT DENTAL PLAN

Health Plan will provide coverage for adult dental coverage as follows:

DEFINITIONS

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

Covered Dental Services: A range of diagnostic, preventive, restorative, endodontic, periodontics, prosthetics, orthodontic and oral surgery services that are covered under this Agreement.

Covered Preventive Care Dental Services includes, but is not limited to oral evaluation, cleaning and certain diagnostic X-rays.

Dental Administrator means the entity that has entered into a Contract with Health Plan to provide or arrange for the provision of Covered Dental Services. The name and information about the Dental Administrator can be found under General Provisions, see Section II, Paragraph F below.

Dental Fee means the discounted fees that a Participating Dental Provider charges you for a Covered Dental Service. Dental Fees are reviewed annually and subject to change effective January 1st of each year.

Dental Specialist means a Participating Dental Provider that is a dental specialist.

General Dentist means a Participating Dental Provider that is a general dentist.

Participating Dental Provider means a licensed dentist who has entered into an agreement with Dental Administrator to provide Covered Preventive Care Dental Services and/or other dental services at negotiated contracted rates.

II. GENERAL PROVISIONS

A. Subject to the terms, conditions, limitations, and exclusions specified in the Agreement, you may receive Covered Preventive Care Dental and Covered Dental Services from Participating Dental Providers.

B. Health Plan has entered into an Agreement with Dental Administrator to provide Covered Preventive Care Dental Services and certain other Covered Dental Services through its Participating Dental Providers.

C. Attached is a list of Covered Preventive Care Dental Services and other Covered Dental Services and the associated Dental Fees that you will be charged for each Service. You will pay a fixed copayment for each preventive care office visit during which Covered Preventive Care Dental Services are provided. The fixed copayment does not apply to the following preventive services: additional cleaning beyond benefit limitation (D1110*), sealant (D1351), preventive resin restoration (D1352), space maintainer (D1510, D1515, D1520, D1525), and re-cementation of space maintainer (D1550). You will pay Dental Fees for certain other Covered Dental Services you receive from Participating Dental Providers. You will pay the applicable Dental Fee directly to the Participating Dental Provider at the time services are rendered. The Participating Dental Provider has agreed to accept that Dental Fee as payment in full of the Member’s responsibility for that procedure. Neither Health Plan nor Dental Administrator are responsible for payment of these fees or for any fees incurred as the result of receipt of non-Covered Dental Services or any other non-covered dental service.

D. You will receive a list of Participating Dental Providers from the Health Plan or from Dental Administrator. You should select a Participating Dental Provider, who is a “General Dentist”, from whom you and your covered family members will receive Covered Preventive Care Dental Services and other Covered Dental Services. Specialty care is also available should such care be required, however, you must be referred to a Dental Specialist by your General Dentist. Your Dental Fees are usually higher for care received by a Dental Specialist.

E. You may obtain a list of Participating Dental Providers, Covered Dental Services and Dental Fees by contacting Dental Administrator or the Health Plan’s Member Services Department at the following telephone numbers:
F. **Dental Administrator (Dominion Dental Services USA, Inc. or “Dominion”):** Health Plan has entered into an agreement with Dominion to provide Covered Dental Services as described in this Agreement. For assistance concerning dental coverage questions or for help finding a Participating Dental Provider, Dominion Member Services specialists are available Monday through Friday from 7:30 a.m. to 6:00 p.m. (Eastern Time), or you may call the following numbers:

Within the Washington DC Metropolitan Service Area: 703-518-5338
Outside the Washington DC Metropolitan Service Area (toll free): 1-888-518-5338
TTY Line: 711.

Hearing impaired members may also use the internet at [www.IP-RELAY.com](http://www.IP-RELAY.com)

Dominion’s Integrated Voice Response System is available 24 hours a day for information about Participating Dental Providers in your area, or to help you select a Participating Dental Provider. The most up-to-date list of Participating Dental Providers can be found at the following website:

DominionDental.com/kaiserdentists

DOMINION also provides many other secure features online at DominionDental.com

G. **Missed Appointment Fee:** Participating Dental Providers may charge you an administrative fee if you miss a scheduled dental appointment without giving 24 hours advance notice. The fee may vary depending on the Participating Dental Provider, however in no event shall the missed appointment fee exceed $30 for a single visit.

III. **SPECIALIST REFERRALS**

A. **Participating Specialist Referrals**

If, in the judgment of your General Dentist, you require the Services of a specialist, you may be referred to a Dental Specialist who will provide Covered Dental Services to you at the Dental Fee for each procedure rendered.

B. **Non-Participating Specialist Referrals**

Benefits may be provided for referrals to non-Participating Dental Provider specialists when:

1. You have been diagnosed by your General Dentist with a condition or disease that requires care from a dental specialist; and
2. Health Plan and Dental Administrator do not have a Participating Dental Provider specialist who possesses the professional training and expertise required to treat the condition or disease; or
3. Health Plan and Dental Administrator cannot provide reasonable access to a Dental Specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

The Member’s cost share will be calculated as if the provider rendering the Covered Dental Services was a Participating Dental Provider.

C. **Standing Referrals to Dental Specialists**

1. If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires specialized care, your General Dentist may determine, in consultation with you and the Dental Specialist that you would be best served through the continued care of a Dental Specialist. In such instances, the General Dentist will issue a standing referral to the Dental Specialist.
2. The standing referral will be made in accordance with a written treatment plan developed by the General Dentist, Dental Specialist, and you. The treatment plan may limit the number of visits to the Dental Specialist or the period of time in which visits to the Dental Specialist are authorized. Health Plan retains the right to require the Dental Specialist to provide the General Dentist with ongoing communication regarding your treatment and dental health status.

IV. EXTENSION OF BENEFITS

A. In those instances when your coverage with Health Plan has terminated, we will extend Covered Dental Services, without payment of Premium Payments, in the following instances:

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

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

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

A. Extension of Benefit Limitations:

The “Extension of Benefits” section listed above does not apply to the following:

1. Coverage ends because of your failure to pay Premiums;

2. Coverage ends as the result of you committing fraud or material misrepresentation;

3. When coverage is provided by a succeeding health plan and that health plan’s coverage:
   a. is provided at a cost to you that is less than or equal to the cost to you of the extended benefit available under this Pediatric Dental Plan; and
   b. will not result in an interruption of the Covered Dental Services you are receiving.

V. DENTAL EMERGENCIES OUTSIDE THE SERVICE AREA

When a dental emergency occurs outside the Service Area, Dental Administrator will reimburse you for the reasonable charges for Covered Dental Services that may be provided, less any discounted fee, upon proof of payment, not to exceed $50 per incident. Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. You must receive all post-emergency care from your Participating Dental Provider.

VI. EXCLUSIONS AND LIMITATIONS

A. Exclusions

The following services are not covered under this Agreement:

1. Services which are covered under worker’s compensation or employer’s liability laws.

2. Services which, in the opinion of the attending dentist, are not necessary for the patient’s dental health.

3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth.

4. Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan which is described in Section 3 of the Agreement.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism or development malformations, except as may be otherwise covered in your medical plan as described in Section 3 of the Agreement.
6. Dispensing of drugs, except as may be otherwise covered in your medical plan this is described in the Agreement.
8. Treatment required for conditions resulting from major disaster, epidemic, war or acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Procedures not listed as a Covered Dental Service.
11. Services provided by a non-Participating Dental Provider or not pre-authorized by Dental Administrator (with the exception of out-of-area emergency dental services).
12. Services related to procedures that are of such a degree of complexity as to not be normally performed by a Participating Dental Provider, unless referred by your General Dentist to a Dental Specialist who will provide Covered Dental Services at the Dental Free for each procedure rendered.
13. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
14. The Invisalign system and similar specialized braces are not a covered benefit. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient’s responsibility.
15. Services which are provided without cost to Member by any federal, state, municipal, county, or other political subdivision (with the exception of Medicaid).
17. Procedures relating to the change and maintenance of vertical dimension or major restoration of occlusion, or to alter the occlusion (bite) through full mouth adjustment/grinding of the teeth. This does not exclude minor occlusal adjustments on individual teeth to remove high spots or smooth out rough or sharp areas.
18. Dental expenses incurred in connection with any dental procedure that was started prior to your effective date of coverage. Examples include orthodontic work in progress, teeth prepared for crowns, and root canal therapy in progress.
19. Lab Fees for excisions and biopsies, except as may be otherwise covered in your medical plan that is described in the Agreement.
20. Treatment of Coverage.
21. Experimental procedures, implantations, or pharmacological regimens.
22. Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
23. Charges for second opinions, unless pre-authorized.
24. Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
25. Occlusal guards, except for the purpose of controlling habitual grinding.
26. Dental services for children up until the end of the month that they turn age 19.

B. Limitations
Covered Dental Services are subject to the following limitations:
1. Two (2) evaluations are covered per contract year including a maximum of one (1) comprehensive evaluation.
2. One (1) problem focused exam is covered per contract year.
3. Coverage for periodic oral exams, prophylaxes (cleanings) and fluoride applications is limited to two times per contract year. One additional cleaning is covered during pregnancy and for diabetic patients.
4. One (1) topical fluoride or fluoride varnish is covered per contract year.
5. Two (2) bitewing x-rays are covered per contract year.
6. One (1) set of full mouth x-rays or panoramic film is covered every three (3) years.
7. One (1) sealant or preventive resin restoration per tooth is covered per lifetime, up to age 16 (limited to the permanent 1st and 2nd molars).
8. Replacement of a filling is covered if it is more than two (2) years from the original date of placement.
9. Replacement of a bridge, crown or denture is covered if it is more than seven (7) years from the date of original placement.
10. Crown and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider’s Usual, Customary, and Reasonable (UCR) fee, minus 25%.
11. Relining and rebasing of dentures is limited to once every 24 months.
12. Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
13. Root planing or scaling is covered once every 24 months per quadrant.
14. Full mouth debridement is limited to once per lifetime.
15. Procedure code D4381 is limited to one (1) benefit per tooth for three (3) teeth per quadrant or a total of 12 teeth for all four (4) quadrants per 12 months. Must have pocket depths of five (5) millimeters or greater.
16. Periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site.
17. Periodontal maintenance after active therapy is covered twice per contract year, within 24 months after definitive periodontal therapy.
SECTION C. PEDIATRIC DENTAL PLAN

The following dental Services are covered for Members under age 19, through the date that is the end of the month in which the Member attains age 19. The Member shall be covered under the Adult Dental Plan on the first day of the month following attainment of age 19.

This Pediatric Dental Plan for Members under age 19, is effective as of the date of your Kaiser Permanente for Individuals and Families Membership Agreement (Agreement) and shall terminate as of the date your Agreement terminates.

The following dental Services shall be included in the Kaiser Permanente Membership Agreement.

I. DEFINITIONS

The following terms, when capitalized and used in any part of this Pediatric Dental Plan, mean:

**Covered Dental Services**: A range of diagnostic, preventive, restorative, endodontic, periodontic, prosthetics, orthodontic and oral surgery Services that are covered under this Pediatric Dental Plan and listed in the Pediatric Dental Plan Schedule of Dental Fees attached to this Agreement.

**Covered Preventive Care Dental Services** includes, but is not limited to, oral evaluation, cleaning and certain diagnostic X-rays.

**Dental Administrator** means the entity that has entered into a Contract with Health Plan to provide or arrange for the provision of Covered Dental Services. The name and information about the Dental Administrator can be found under General Provisions, see Section II, Paragraph F below.

**Dental Fee** means the discounted fees that a Participating Dental Provider charges you for a Covered Dental Service. Dental Fees are reviewed annually and subject to change effective January 1st of each year.

**Dental Specialist** means a Participating Dental Provider that is a dental specialist.

**General Dentist** means a Participating Dental Provider that is a general dentist.

**Medically Necessary Orthodontia** means orthodontic services related to the treatment of a severe, dysfunctional, Handicapping malocclusion or as otherwise determined by the Plan.

**Participating Dental Provider** means a licensed dentist who has entered into an agreement with Dental Administrator to provide Covered Preventive Care Dental Services, Covered Dental Services and/or other dental Services at negotiated contracted rates.

II. GENERAL PROVISIONS

A. Subject to the terms, conditions, limitations, and exclusions specified in this Pediatric Dental Plan, you may receive Covered Preventive Care Dental and Covered Dental Services from Participating Dental Providers. You may receive Covered Dental Services from a non-Participating Dental Provider for emergencies, urgent care received outside Health Plan’s Service Area, and Services obtained pursuant to a referral to a non-participating specialist.

B. Health Plan has entered into an agreement with Dental Administrator to provide Covered Preventive Care Dental Services and certain other Covered Dental Services through its Participating Dental Providers.

C. Attached is a list of Covered Preventive Care Dental Services and other Covered Dental Services and the associated Dental Fees that you will be charged for each Service. You will pay a fixed copayment for each office visit. The fixed copayment does not apply to certain preventive Services. You will pay Dental Fees for certain other Covered Dental Services you receive from Participating Dental Providers. You will pay the applicable Dental Fee directly to the Participating Dental Provider at the time Services are rendered. The Participating Dental Provider has agreed to accept that Dental Fee as payment in full of the Member’s responsibility for that procedure. Neither Health Plan nor Dental Administrator are responsible for payment of these fees or for any fees incurred as the result of receipt of non-Covered Dental Services or
any other non-covered dental service. Covered Dental Services are not subject to a Deductible. Copayments and Dental Fees set forth in the attached Pediatric Dental Plan Schedule of Dental Fees apply toward the Out-of-Pocket Maximum in Summary of Copayments and Coinsurance of this Agreement.

D. You will receive a list of Participating Dental Providers from the Health Plan or from Dental Administrator. You should select a Participating Dental Provider, who is a “General Dentist”, from whom you and your covered family members will receive Covered Preventive Care Dental Services and other Covered Dental Services. Specialty care is also available should such care be required, however, you must be referred to a Dental Specialist by your General Dentist.

E. You may also obtain a list of Participating Dental Providers by contacting the Dental Administrator or the Health Plan’s Member Services Department at the following telephone numbers:

Within the Washington DC Metropolitan Area: 301-468-6000
Outside the Washington DC metropolitan area: 800-777-7902
TTY number is: 711

F. Dental Administrator (Dominion Dental Services USA, Inc. or “Dominion”): Health Plan has entered into an agreement with Dominion to provide Covered Dental Services as described in this Pediatric Dental Plan. For assistance concerning dental coverage questions or for help finding a Participating Dental Provider, Dominion Member Services specialists are available Monday through Friday from 7:30 a.m. to 6:00 p.m. (Eastern Time), or you may call the following numbers:

Within the Washington DC Metropolitan Service Area: 703-518-5338
Outside the Washington DC Metropolitan Service Area (toll free): 1-888-518-5338
TTY Line: 711

Hearing impaired members may also use the internet at www.IP-RELAY.com

Dominion’s Integrated Voice Response System is available 24 hours a day for information about Participating Dental Providers in your area, or to help you select a Participating Dental Provider. The most up-to-date list of Participating Dental Providers can be found at the following website:
DominionDental.com/kaiserdentists

DOMINION also provides many other secure features online at DominionDental.com

G. Missed Appointment Fee: Participating Dental Providers may charge you an administrative fee if you miss a scheduled dental appointment without giving 24 hours advance notice. The fee may vary depending on the Participating Dental Provider, however in no event shall the missed appointment fee exceed $30 for a single visit.

III. SPECIALIST REFERRALS

A. Participating Specialist Referrals
If, in the judgment of your General Dentist, you require the Services of a specialist, you may be referred to a Dental Specialist who will provide Covered Dental Services to you at the Dental Fee for each procedure rendered. Please note that a referral is not required to receive Covered Dental Services from a participating pediatric dentist.

B. Non-Participating Specialist Referrals
Benefits may be provided for referrals to non-Participating Dental Provider specialists when:

1. You have been diagnosed by your General Dentist with a condition or disease that requires care from a dental specialist; and

2. Health Plan and Dental Administrator do not have a Participating Dental Provider specialist who possesses the professional training and expertise required to treat the
condition or disease; or
3. Health Plan and Dental Administrator cannot provide reasonable access to a Dental Specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

The Member’s cost share will be calculated as if the provider rendering the Covered Dental Services was a Participating Dental Provider.

C. **Standing Referrals to Dental Specialists**
   1. If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires specialized care, your General Dentist may determine, in consultation with you and the Dental Specialist that you would be best served through the continued care of a Dental Specialist. In such instances, the General Dentist will issue a standing referral to the Dental Specialist.

   2. The standing referral will be made in accordance with a written treatment plan developed by the General Dentist, Dental Specialist, and you. The treatment plan may limit the number of visits to the Dental Specialist or the period of time in which visits to the Dental Specialist are authorized. Health Plan retains the right to require the Dental Specialist to provide the General Dentist with ongoing communication regarding your treatment and dental health status.

IV. **EXTENSION OF BENEFITS**

A. In those instances when your coverage with Health Plan has terminated, we will extend Covered Dental Services, without payment of Premiums, in the following instances:

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

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

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

B. **Extension of Benefit Limitations:**

   The “Extension of Benefits” section listed above does not apply to the following:

   3. Coverage ends because of your failure to pay Premiums;

   4. Coverage ends as the result of you committing fraud or material misrepresentation;

   3. When coverage is provided by a succeeding health plan and that health plan’s coverage:
      c. is provided at a cost to you that is less than or equal to the cost to you of the extended benefit available under this Pediatric Dental Plan; and
      d. will not result in an interruption of the Covered Dental Services you are receiving.
V. DENTAL EMERGENCIES OUTSIDE THE SERVICE AREA

When a dental emergency occurs outside the Service Area, Dental Administrator will reimburse you for the reasonable charges for Covered Dental Services that may be provided, less any discounted fee, upon proof of payment, not to exceed $50.00 per incident. Proof of payment must be submitted to Dental Administrator within ninety (90) days of treatment or as soon as reasonably possible. Proof of payment should be mailed to: Dominion Dental Services USA, Inc., 115 South Union Street, Suite 300, Alexandria, Virginia 22314, ATTN: Accounting Dept. Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. You must receive all post-emergency care from your Participating Dental Provider.

VI. PRE-AUTHORIZATION FOR MEDICALLY NECESSARY ORTHODONTIA

The Dental Administrator requires the treating orthodontist to submit a treatment plan prior to initiating Services. The Dental Administrator may request x-rays or other dental records prior to issuing the pre-authorization. The proposed Services will be reviewed and a pre-authorization will be issued to you or the orthodontist, specifying coverage. The pre-authorization is not a guarantee of coverage and is considered valid for 180 days.

VII. EXCLUSIONS AND LIMITATIONS

A. Exclusions

The following Services are not covered under this Pediatric Dental Plan:

1. Services which are covered under worker’s compensation or employer’s liability laws.
2. Services which are not necessary for the patient’s dental health as determined by the Plan.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where, in the opinion of the Plan, such services should not be performed in a dental office.
6. Dispensing of drugs.
8. Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Procedures not listed as covered benefits under this Plan.
11. Services obtained outside of the dental office in which enrolled and that are not preauthorized by such office or the Plan (with the exception of out-of-area emergency dental services).
12. Services related to the treatment of TMD (Temporomandibular Disorder) except if TMD is caused by severe, dysfunctional, handicapping malocclusion that requires Medically Necessary Orthodontia services.
13. Services performed by a Participating Special without a referral from a Participating General Dentist (with the exception of Orthodontics). Participating dentists should refer to Specialty Care Referral Guidelines.
14. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by the Plan. The prophylactic removal of these teeth for Medically Necessary Orthodontia services may be covered subject to review.
15. Non-Medically Necessary Orthodontia are not covered benefits under this policy. Discounts are provided to members through the Plan’s agreements with its participating orthodontists. The provider agreements create no liability for payment by the Plan, and payments by the member for these services do not contribute to the Out-of-Pocket Maximum. The Invisalign system and similar specialized braces are not a covered benefit. See limitation #23 concerning Medically Necessary Orthodontia.
B. **Limitations**

Covered Dental Services are subject to the following limitations:

1. One (1) evaluation (D0120, D0145 or D0150) per six (6) months, per patient.
2. One (1) teeth cleaning (D1110 or D1120) per six (6) months, per patient.
3. One (1) fluoride treatment is covered per six (6) months, per patient.
4. Bitewing x-rays are covered once per 12 months, per provider or location.
5. One (1) full mouth x-ray or panoramic film per 60 months, per patient, starting at age six (6). No more than one (1) set of x-rays are covered per provider/location.
6. One (1) sealant per tooth, per lifetime, per patient (limited to occlusal surfaces of posterior permanent teeth without restorations or decay).
7. One (1) space maintainer (D1515 or D1525) is covered per 12 months, per arch, per patient (D1510, or D1520) is covered per 24 months, per patient, per quadrant.
8. Replacement of a filling is covered if it is more than 12 months from the date of original placement.
9. Replacement of a crown, denture or labial veneer is covered if it is more than five (5) years from the date of original placement.
10. Replacement of a primary stainless steel crown is covered if it is more than three (3) years from the date of original placement, per tooth, per patient.
11. Crown and bridge fees apply to treatment involving five or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider’s Usual, Customary, and Reasonable (UCR) fee, minus 25%.
12. Relining and rebasing of dentures is covered once per 24 months, per patient, only after six (6) months of initial placement.
13. Root canal treatment is covered once per tooth, per lifetime, per patient. Retreatment of previous root canal therapy is covered once per tooth, per lifetime, per patient, not within 24 months when done by same provider/location.
14. Periodontal scaling and root planing (D4341 or D4342), osseous surgery (D4260 or D4261) and gingivectomy or gingivoplasty (D4210 or D4211) are limited to one (1) per 24 months, per quadrant, per patient.
15. Full mouth debridement is covered once per 12 months, per patient.
16. Procedure Code D4381 is limited to one (1) benefit per tooth for three (3) teeth per quadrant; or a total of 12 teeth for all four (4) quadrants per twelve (12) months, per patient. Must have pocket depths of five (5) millimeters or greater.
17. Periodontal surgery of any type, including any associated material, is covered once every 24 months, per quadrant or surgical site, per patient.
18. Periodontal maintenance after active therapy is covered four (4) times per 12 months, per patient.
19. All dental services that are to be rendered in a hospital setting require coordination and approval from both the dental insurer and the medical insurer before services can be rendered. Services delivered to the patient on the date of service are documented separately using applicable procedure codes.
20. Anesthesia requires a narrative of medical necessity be maintained in patient records. A maximum of 60 minutes of services are allowed for general anesthesia and intravenous or non-intravenous conscious sedation. General anesthesia is not covered with procedure codes D9230, D9241 or D9242. Intravenous conscious sedation is not covered with procedure codes D9220, D9221 or D9230. Non-intravenous conscious sedation is not covered with procedure codes D9220, D9221 or D9230. Analgesia (nitrous oxide) is not covered with procedure codes D9220, D9221, D9241 or D9242.
21. Occlusal guard with covered surgery, by report, once per patient, per lifetime.
22. Apexification, apicoectomy and clinical crown lengthening are each covered once per patient, per lifetime.
23. Orthodontics is only covered if Medically Necessary as determined by the Plan. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient’s responsibility. Medically necessary pediatric orthodontia exists when there is a severe, dysfunctional, handicapping malocclusion.

Only current ADA CDT codes are considered valid by the Dental Administrator.

*Current Dental Terminology © American Dental Association.*