guide to

YOUR 2012 BENEFITS AND SERVICES

kaiserpermanente.org

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

GROUP
EVIDENCE OF COVERAGE

MARYLAND

SELECT CARE DELIVERY SYSTEM

This plan has Excellent accreditation from the NCQA
See 2012 NCQA Guide for more information on Accreditation

KAISER PERMANENTE®

Kaiser Foundation Health Plan
of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, Maryland 20849

KFHP-EOC COVER(01/10)MD DHMO

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APPENDICES

SECTION 1 – Introduction

This Evidence of Coverage (EOC) describes "Kaiser Permanente Select℠" health care coverage provided under the Agreement between Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and your Group. In this EOC, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. is sometimes referred to as "Health Plan," "we," or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this EOC, please see the "Definitions" section of this EOC for terms you should know.

The term of this EOC is based on your Group's contract year and your effective date of coverage. Your Group's benefits administrator can confirm that this EOC is still in effect.

Health Plan provides health care Services directly to its Members through an integrated medical care system, rather than reimburse expenses on a fee-for-service basis. The EOC should be read with this direct-service nature in mind. Under our Agreement with your Group, we have assumed the role of a "named fiduciary," a party responsible for determining whether you are entitled to benefits under this EOC. Also, as named fiduciary, we have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC.

Kaiser Permanente Select℠

Kaiser Permanente Select℠ provides health care Services to Members using Plan Providers located throughout our Service Area, which is described in the "Definitions" section of this EOC.

You must receive care from Plan Providers within our Service Area, except for:

- Emergency Services
- Urgent Care Services outside our Service Area
- Authorized Referrals
- Covered Services received in other Kaiser Permanente Regions or Group Health Cooperative Service Areas

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

Who is Eligible

General

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

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

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

However, you or your Spouse's or Domestic Partner's eligible children who live outside our Service Area may be eligible to enroll if you are required to cover them pursuant to any court order, court-approved agreement, or testamentary appointment. Please note that coverage is limited to only Emergency Services and Urgent Care Services provided outside of our Service Area, unless you elect to bring the Dependent within our Service Area to receive covered Services from Plan Providers.

C. Neither you nor any member of your family may enroll under this EOC if you or any dependent have ever had entitlement to Services through Health Plan terminated for:

(1) If you or any Dependent have ever had entitlement to receive Services through us terminated for any of the reasons listed under "Termination for Cause" in the "Termination of Membership" section, neither you nor any member of your family is eligible to enroll under this EOC.

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

a. failure of you or your Dependent to pay any amounts owed to us, Kaiser Foundation Hospitals, or Medical Group, or

b. failure to pay your Cost Share to any Plan Provider, or

c. failure to pay non-group Premium.

Subscribers

You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements that we have approved (for example, an employee of your Group who works at least the number of hours specified in those requirements).

Dependents

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

A. Your Spouse or Domestic Partner;

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

   (i) a natural child,

   (ii) a stepchild,

   (iii) an adopted child,

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

   (v) a child placed with the Subscriber or Subscriber's Spouse or Domestic Partner for legal adoption, or

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

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

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

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

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

Disabled Dependent Certification

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

A. If your Dependent is 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.

B. If we determine that your Dependent does not meet the eligibility requirements as a disabled Dependent, we will notify you that he or she is not eligible and let you know the membership termination date.

C. If we determine that your Dependent is eligible as a disabled Dependent, there will be no lapse in coverage. Also, two years after the date that your Dependent reached the age limit, you must provide us documentation of his or her incapacity and dependency annually within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled Dependent. Documentation of your Dependent's incapacity and dependency may be requested less than once per year; however, such documentation must be provided within 60 days after we request it.

Genetic Information

Note: We will not use, require or request a genetic test, the results of a genetic test, genetic information, or genetic services for the purpose of rejecting, limiting, canceling or refusing to renew a health insurance policy or contract. In addition, genetic information or the request for such information shall not be used to increase the rates of, affect the terms

or conditions of, or otherwise affect a Member's coverage.

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

Enrollment and Effective Date of Coverage

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

New Employees and Their Dependents

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible (you should check with your Group to see when new employees become eligible).

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

Special Enrollment

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

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

B. You did not enroll when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application from the Subscriber.

Special enrollment due to new Dependents

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

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

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

A. For newborn children, the moment of birth.

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

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

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

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

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

D. For newly adopted children (including children newly placed for adoption), the "date of adoption."

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

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

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

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

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

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

Special Enrollment due to court or administrative order

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

If you are not enrolled at the time we receive a court or administrative order to provide coverage for a Dependent child, we shall enroll both you and the child, without regard to any enrollment period restrictions, pursuant to the requirements and time periods specified by §15-405(f) and (g) of the Maryland Insurance Article.

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

If payment of additional Premium is required to provide coverage for the child, notification of the court or administrative order may be provided at any time but, payment of additional Premium must be provided within 31 days of enrollment of the child, otherwise, enrollment of the child will be void. Enrollment for such child will be allowed in accordance with Section 15- 405(c) of the Insurance Article, if applicable.

Special enrollment due to loss of other coverage

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

A. The Subscriber or at least one of the Dependents had other coverage when he or she previously declined Health Plan coverage

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

(1) exhaustion of COBRA coverage;

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

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

(4) loss of eligibility for Medicaid coverage or Child Health Insurance Program coverage, but not termination for cause; or

(5) reaching a lifetime maximum on all benefits

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

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of

enrollment application to your Group within 31 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for Medicaid or Child Health Insurance Program coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special enrollment due to reemployment after military service

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

Special enrollment due to eligibility for premium assistance under Medicaid or CHIP

You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, if the Subscriber or at least one of the enrolling Dependents becomes eligible to receive premium assistance under Medicaid or CHIP. To request enrollment, the Subscriber must submit a Health Plan-approved enrollment or change of enrollment application to your Group within 60 days after the Subscriber or Dependent is determined eligible for premium assistance. The effective date of an enrollment resulting from eligibility for the premium assistance under Medicaid or CHIP is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Open Enrollment

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

Premium

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

SECTION 2 – How to Obtain Services

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

As a Member, you are selecting our medical care system to provide your health care. You must receive all covered Services from Plan Providers inside our Service Area, except as described under the following headings:

- Emergency Services, in Section 3: "Benefits"
- Urgent Care Outside our Service Area, in Section 3: "Benefits"
- Getting a Referral, in this section
- Visiting Other Kaiser Permanente Regions or Group Health Cooperative Service Areas, in this section
- Visiting Member Services, in Section 3: "Benefits"

Your Primary Care Plan Physician

Your primary care Plan Physician plays an important role in coordinating your health care needs, including hospital stays and referrals to specialists. We encourage you to choose a primary care Plan Physician when you enroll. Each member of your family should have his or her own primary care Plan Physician. If you do not select a primary care Plan Physician upon enrollment, we will assign you one near your home.

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

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

www.kp.org

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

Inside the Washington, D.C., Metropolitan area
301-468-6000
TTY 301-879-6380

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

Our Member Services Representatives are available to assist you Monday through Friday from 7:30 a.m. until 5:30 p.m.

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, in consultation with you, that you require covered Services from a specialist, you will be referred to a Plan Provider in your provider network who is a specialist that can provide the care you need.

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

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

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

If your primary care Plan Physician decides that you require covered Services not available from us, he or she will refer you to a non-Plan Provider inside or outside our Service Area. You must have an approved written referral to the non-Plan Provider in order for us to cover the Services. Copayments, Coinsurance and Deductibles for approved referral Services are the same as those required for Services provided by a Plan Provider.

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 Health Access Unit may be reached at 1-866-530-8778.

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

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

Standing Referrals to Specialists

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

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

For a Member who is pregnant, after the Member receives a standing referral to an obstetrician, the obstetrician is responsible for the primary management of the Member's pregnancy, including the issuance of referrals in accordance with Health Plan's policies and procedures, through the postpartum period. A written treatment plan is not required for a standing referral to an Obstetrician.

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

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

(1) The Member has been diagnosed with a condition or disease that requires specialized medical care; and
(2) Health Plan does not have a Plan specialist or a Non-Physician Specialist with the professional training and expertise to treat or provide health care Services for the condition or disease; or
(3) Health Plan cannot provide reasonable access to a specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care Services for the condition or disease without unreasonable delay or travel.

You must have an approved written referral to the non-Plan specialist or non-Plan Non-Physician Specialist in order for us to cover the Services. Copayments, Coinsurance and Deductibles for approved referral Services are the same as those required for Services provided by a Plan Provider.

Second Opinions

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

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

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition we cover Emergency Services you receive from Plan Providers or Non-Plan Providers anywhere in the world, as long as the Services would have been covered under the "Benefits" section (subject to the "Exclusions, Limitations, and Reductions" section).

Emergency Services are available from Plan Hospital emergency departments 24 hours a day, seven days a week.

Getting Advice from our Advice Nurses

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

Inside the Washington, D.C. Metropolitan Area
703-359-7878
TTY 703-359-7616

Outside the Washington, D.C. Metropolitan Area
1-800-777-7904
TTY 1-800-700-4901

After office hours, call: 1-800-677-1112. You can

call this number from anywhere in the United States, Canada, Puerto Rico, or the Virgin Islands.

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

Making Appointments

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

Inside the Washington, D.C. Metropolitan Area
703-359-7878
TTY 703-359-7616

Outside the Washington, D.C. Metropolitan Area
1-800-777-7904
TTY at 1-800-700-4901

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

Missed Appointment Fee

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

Using Your Identification Card

Each Member has a Health Plan ID card with a Medical Record Number on it to use when you call for advice, make an appointment, or go to a Plan Provider for care. The Medical Record Number is used to identify your medical records and membership information. You should always have the same Medical Record Number. If you need to replace your card, or if we ever inadvertently issue you more than one Medical Record Number, please let us know by calling our Member Services Department in the Washington, D.C., Metropolitan area at 301-468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902. Our TYY is 301-879-6380.

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

Visiting Other Kaiser Permanente Regions or Group Health Cooperative Service Areas

If you visit a different Kaiser Permanente Region or Group Health Cooperative service area temporarily (not more than 90 days), 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. Also, except for Out-of-Plan Emergency Services, your right to receive covered Services in the visited service area ends after 90 days unless you receive prior written authorization from us to continue receiving covered Services in the visited service area. The 90-day limit on visiting member care does not apply to Members who attend an accredited college or accredited vocational school.

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
TYY 301-816-6344

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

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

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

Hospital Inpatient Care:

- Physician Services
- Room and board
- Necessary Services and supplies
- Maternity Services
- Prescription drugs

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

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

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

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

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

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

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

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

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
- Mental health hospital Services
- Residential facility admissions for chemical dependency
- Outpatient mental health or chemical dependency benefits

Visiting Member Service Exclusions
The following Services are not covered under your visiting member benefits. ("Services" include equipment and supplies.) However, some of these Services, such as Emergency Services, may be covered under your home Service Area benefits, and applicable Copayments, Coinsurance and/or Deductibles will apply. For coverage information, refer to the "Benefits" section of this EOC.
- Services that are not Medically Necessary
- Physical examinations and related Services for insurance, employment, or licensing
- Drugs for the treatment of sexual dysfunction disorders
- Dental care and dental X-rays
- Services to reverse voluntary infertility
- Infertility Services
- Services related to conception by artificial means, such as IVF and GIFT
- Experimental Services and all clinical trials
- Cosmetic surgery or other Services primarily to change appearance
- Custodial care and care provided in an intermediate care facility
- Services related to sexual reassignment
- Transplants and related care
- Complementary and alternative medicine Services, such as chiropractic Services
- Services received as a result of a written referral from a Plan provider in your home service area
- Emergency Services, including emergency ambulance Services
- Services that are excluded or limited in your home Service Area

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

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

SECTION 3 – Benefits

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

- You are a Member on the date the Services are rendered, except as provided for "Extension of Benefits" as described in Section 6 of this EOC;
- You have met any Deductible requirement described in the "Deductibles" section of the Summary of Cost Shares section of the Appendix.
- You have not met the maximum benefit for the Service, if any. A maximum benefit applies per Member per contract year.
- The Services are provided by a Plan Provider (unless the Service is to be provided by a non-Plan Provider subject to an approved referral as described in Section 2) in accordance with the terms and conditions of this EOC including but not limited to the requirements, if any, for prior approval (authorization);
- The Services are Medically Necessary; and
- You receive the Services from a Plan Provider except as specifically described in this EOC.

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

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

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

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

A. Outpatient Care

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

- Primary care visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics and gynecology Services (refer to "Preventive Health Care Services" for coverage of preventive care Services);
- Specialty care visits (refer Section 2 "How to Obtain Services" for information about referrals to Plan specialists);
- Consultations and immunizations for foreign travel (refer to the "Outpatient Prescription Drugs Rider," attached to this EOC, for coverage of self-administered travel vaccines);
- Diagnostic testing for care or treatment of an illness, or to screen for a disease for which you have been determined to be at high risk for contracting, including, but limited not to:
  - Diagnostic examinations, including digital rectal exams and prostate antigen (PSA) tests provided:
    - for men who are between 40 and 75 years of age;
    - when used for male patients who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society;
    - when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; or
    - when used for staging in determining the need for a bone scan in patients with prostate cancer;
  - Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiological imaging, for persons, who are at high risk of cancer, in accordance with the most recently published guidelines of the American Cancer Society;
  - Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis when the bone mass measurement is requested by a Plan Provider for individuals determined to be at high risk for osteoporosis

  Note: As described here, diagnostic testing is not preventive care and may include an office visit, outpatient surgery, diagnostic imaging, or x-ray and lab. The applicable Cost Share will apply based on the place and type of Service provided.

(Refer to "Preventive Health Care Services" for coverage of preventive care tests and screening Services);
- Outpatient surgery;
- Anesthesia;
- Chemotherapy and radiation therapy;
- Respiratory therapy;
- Medical social services;
- House calls when care can best be provided in your home as determined by a Plan Provider; and
- After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to the Urgent Care provision for covered Services.

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

B. Hospital Inpatient Care

We cover the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by an acute care general hospital in our Service Area:
- Room and board, including private room when deemed medically necessary;
- Specialized care and critical care units;
- General and special nursing care;
- Operating and recovery room;
- Plan Physicians' and surgeons' Services, including consultation and treatment by specialists;
- Anesthesia;
- Medical supplies;
- Chemotherapy and radiation therapy;
- Respiratory therapy; and
- Medical social Services and discharge planning.

Hospitalization and Home Health Visits Following Mastectomy

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

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

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

C. Accidental Dental Injury Services

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

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

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

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

D. Allergy Services

We cover the following allergy Services:

- Evaluations and treatment
- Injection visits and serum

E. Ambulance Services

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

We will not cover ambulance transportation Services in any other circumstances, even if no other transportation is available. We cover ambulance Services only inside our Service Area, except as covered under the "Emergency Services" provision in this section of the EOC.

Ambulance Services Exclusions:

- Transportation by car, taxi, bus, gurney van, wheelchair van, 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.

F. Anesthesia for Dental Services

We cover general anesthesia and associated hospital or ambulatory facility Services for dental care provided to Members:

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

General anesthesia and associated hospital and ambulatory facility charges will be covered only for dental care that is provided by:

- A fully accredited specialist in pediatric dentistry; or
- A fully accredited specialist in oral and maxillofacial surgery; and
- For whom hospital privileges have been granted.

Anesthesia for Dental Services Exclusions:

- The dentist or specialist's professional Services.
- Anesthesia and associated facility charges for dental care for temporomandibular joint (TMJ) disorders.

G. Blood, Blood Products and their Administration

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

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

Blood, Blood Products and their Administration Limitations:

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

Blood, Blood Products and their Administration Exclusions:

- Directed blood donations.

H. Chemical Dependency and Mental Health Services

Mental Illness, Emotional Disorders, Drug and Alcohol Abuse Services

We cover the treatment of mental illnesses, emotional disorders, drug abuse and alcohol abuse for conditions that in the opinion of a Plan Provider would be medically necessary and treatable. For the

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

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

- Individual therapy
- Group therapy
- Shock therapy
- Drug therapy
- Education
- Psychiatric nursing care
- Appropriate Hospital Services

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

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

In an outpatient setting, we cover all necessary Services of physicians and other health care professionals to treat mental illness, emotional disorders, drug abuse and alcohol abuse, as performed, prescribed, or directed by a physician including, but not limited to:

- Evaluations
- Crisis intervention
- Individual therapy
- Group therapy
- Psychological and neuropsychological testing for diagnostic purposes
- Medical treatment for withdrawal symptoms
- Visits for the purpose of monitoring drug therapy

Chemical Dependency and Mental Health Services Exclusions:

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

Psychiatric Residential Crisis Services

We cover residential crisis Services that are:

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

Psychiatric Residential Crisis Services Exclusion:

- Long-term residential treatment Services

I. Cleft Lip, Cleft Palate or Both

We cover inpatient and outpatient Services arising from orthodontics, oral surgery and otologic, audiological and speech/language treatment as the result of the congenital defect known as cleft lip, cleft palate, or both.

J. Clinical Trials

We cover the patient costs you incur for clinical trials provided on an inpatient and an outpatient basis as the result of: (i) treatment for a life-threatening condition; or (ii) prevention, early detection, and treatment studies on cancer. "Patient costs" mean the cost of a medically necessary Service that is incurred as a result of the treatment being provided to the member for purposes of the clinical trial. "Patient costs" do not include:

(a) The cost of an investigational drug or device, except as provided below for off-label use of an FDA-approved drug or device;
(b) The cost of non-health care services that may be required as a result of treatment in the clinical trial; or
(c) Costs associated with managing the research for the clinical trial.

We cover the patient costs incurred for clinical trials if:

(a) the treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer or any other life-threatening condition;
(b) the treatment is being provided in a clinical trial approved by:
- one of the National Institutes of Health (NIH);
- an NIH cooperative group or an NIH center;
- the FDA in the form of an investigational new drug application;
- the Federal Department of Veterans Affairs; or
- an institutional review board of an institution in the state which has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the National Institutes of Health;

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

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

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

K. Diabetic Equipment, Supplies, and Self-Management

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

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

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

Diabetic Equipment, Supplies, and Self-Management Limitation:
Diabetic equipment and supplies are limited to Health Plan preferred equipment and supplies unless the equipment or supply: (1) was prescribed by a Plan Provider; and (2) (a) there is no equivalent preferred equipment or supply available, or (b) an equivalent preferred equipment or supply (i) has been ineffective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member. "Health Plan preferred equipment and supplies" are those purchased from a Plan preferred vendor. To obtain information about Plan preferred vendors, you may call our Member Services Department:

Inside the Washington, D.C. Metropolitan Area
(301) 468-6000
TYY (301) 816-6344

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

L. Dialysis

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

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

We cover the following renal dialysis services:

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

We cover the following self-dialysis services:

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

We cover home dialysis, which includes:

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

M. Drugs, Supplies and Supplements

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

- Oral, infused or injected drugs, and radioactive materials used for therapeutic purposes, including chemotherapy;
- Injectable devices;
- The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
- Dressings and casts;
- Vaccines and immunizations approved for use by the federal Food and Drug Administration (FDA) that are not considered part of routine preventive care.

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

Drugs, Supplies and Supplements Exclusions

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

N. Durable Medical Equipment

Durable Medical Equipment is defined as equipment that: (a) is intended for repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) is generally not useful to a person in the absence of illness or injury; and (d) meets Health Plan criteria for medical necessity.

Durable Medical Equipment does not include coverage for prosthetic devices, such as artificial eyes or legs, or orthotic devices, such as braces or therapeutic shoes. Refer to "Prosthetic Devices" for coverage of prosthetic and orthotic devices.

Basic Durable Medical Equipment

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

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

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

Supplemental Durable Medical Equipment

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

1. Oxygen and Equipment

We cover oxygen and equipment when prescribed by a Plan Provider and your medical condition meets Health Plan's criteria for medical necessity. A Plan Provider must certify the continued medical need for oxygen and equipment every 30 days.

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

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

4. Asthma Equipment
We cover the following asthma equipment for pediatric and adult asthmatics when purchased from a Plan Provider:

- Spacers
- Peak-flow meters
- Nebulizers

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

Durable Medical Equipment Exclusions:

- Comfort, convenience, or luxury equipment or features.
- Exercise or hygiene equipment.
- Non-medical items such as sauna baths or elevators.
- Modifications to your home or car.
- Devices for testing blood or other body substances (except as covered under "Diabetes Equipment, Supplies and Self Management").
- Electronic monitors of the heart or lungs, except infant apnea monitors.
- Services not preauthorized by Health Plan.

O. Emergency Services

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

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

We cover Emergency Services as follows:

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

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

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

Continuing Treatment Following Emergency Services

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

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

Outside our Service Area
Except for Emergency Services received for emergency surgery described below, all other continuing or follow-up care for Emergency Services received outside our Service Area must be authorized by us, until you can safely return to the Service Area.

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

who performed the surgical procedure for follow-up care that is:

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

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

Transport to a Service Area
If you obtain prior approval from us, or from the nearest Kaiser Foundation Health Plan 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 "Ambulance Services" benefit in this section.

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

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

Emergency Services Limitations:

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

  If possible, we urge you or your authorized representative to notify us of any emergency room visits to assist you in coordinating any necessary follow-up care.

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

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

P. Family Planning Services

We cover the following:

- Family planning counseling, including pre-abortion and post-abortion counseling and information on birth control
- Insertion and removal, and any medically necessary examination associated with the use of contraceptive drugs and devices. Contraceptive devices (other than diaphragms) and implantable contraceptive drugs are supplied by the provider, and are covered under this benefit. Contraceptive drug and diaphragms are covered only under an "Outpatient Prescription Drug Rider," if applicable.
- Tubal ligations
- Vasectomies
- Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (i) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (ii) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.

Voluntary termination of pregnancy limitations:

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

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

Q. Habilitative Services

We cover medically necessary speech therapy, occupational therapy and physical therapy, for children under the age of 19 years with a congenital or genetic birth defect, to enhance the child's ability to function. Medically necessary habilitative services are those services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, and shall include services that enhance functional ability without effecting a cure. Congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. Congenital or genetic birth defect includes, but is not limited to (1) autism or an autism spectrum disorder and (2) cerebral palsy.

Habilitative Services Exclusions:

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

R. Hearing Services

Hearing Exams

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

Hearing Aids for Children under Age 18.

We cover one hearing aid for each hearing impaired ear every 36 months for children through the age of 17 if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist. We cover up to $1,400 per hearing aid. You may choose a hearing aid that is priced higher than the benefit and pay the difference between the price of the hearing aid and $1400, without financial or contractual penalty to the provider of the hearing aid. (Note: If a single hearing aid device provides hearing aid to both ears, we will cover the single device, up to $2,800 every 36 months, in lieu of two hearing aids.)

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

Note: Any benefit maximums shown in the "Summary of Services and Cost Shares" in the appendix, that apply on a contract year, do not apply to hearing aids for children under age 18.

Hearing Services Exclusions:

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

- Tests to determine an appropriate hearing aid.
- Hearing aids or tests to determine their efficacy.
- Replacement parts and batteries.
- Replacement of lost or broken hearing aids.
- Comfort, convenience, or luxury equipment or features.

S. Home Health Care

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

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

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

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

Home Health Visits Following Mastectomy or Removal of Testicle

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

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

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

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

Home Health Care Limitations:

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

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

- Additional limitations may be stated in the "Summary of Services and Cost Share."

Home Health Care Exclusions:

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

T. Hospice Care Services

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

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

- Nursing care;
- Physical, occupational, speech, and respiratory therapy;
- Medical social Services;
- Home health aide Services;
- Homemaker Services;
- Medical supplies and appliances;
- Palliative drugs in accord with our drug formulary guidelines;
- Physician care;
- At least 30 days of short-term inpatient care; including care for pain management and acute symptom management;
- Respite Care that may be limited to 5 consecutive days for any one inpatient stay, but not less than 14 days per 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 for a period of one year after the Member's death; and
- Services of hospice volunteers.

Definitions:

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

Hospice Care Services mean a coordinated, inter-disciplinary program of hospice care Services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement to (a) individuals who have no reasonable prospect of cure as estimated by a physician; and (b) Family Members and Caregivers of those individuals.

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

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

U. Infertility Services

We cover the following:

- Services for diagnosis and treatment of involuntary infertility for females and males; and
- Artificial insemination; and
- In vitro fertilization, if:
  (a) the Member's oocytes are fertilized with the Member's spouse's sperm; and
  (b) the Member's and the Member's spouse have a history of infertility of at least 2 years duration; or the infertility is associated with any of the following:
    (i) endometriosis;
    (ii) exposure in utero to diethylstilbestrol, commonly known as DES;
    (iii) blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
    (iv) abnormal male factors, including oligospermia, contributing to the infertility;
  (c) the Member has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this EOC; and
  (d) the in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or the American Fertility Society minimal standards for programs of in vitro fertilization.

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

Infertility Limitations:

- Coverage for in vitro fertilization is limited to three attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.

Infertility Exclusions:

- Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member's eggs and/or male Member's sperm for future attempts.
- Assisted reproductive procedures and any related testing or service that includes the use of donor sperm, donor eggs or donor embryos.
- Any charges associated with donor eggs, donor sperm or donor embryos.
- Infertility Services, except for covered Services for in vitro fertilization, when the member does not meet medical guidelines established by the American College of Obstetricians and Gynecologists.
- Services to reverse voluntary, surgically induced infertility.
- Infertility Services when the infertility is the result of an elective male or female surgical procedure.
- Assisted reproductive technologies and procedures other than those described above, including, but not limited to: gamete intrafallopian transfers (GIFT); zygote intrafallopian transfers (ZIFT); intracytoplasmic sperm injection (ICSI); assisted hatching; preimplantation genetic diagnosis (PGD); and prescription drugs related to such procedures.

V. Maternity Services

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

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

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

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

We cover inpatient hospitalization Services for you and your newborn child for a minimum stay of at least 48 hours following an uncomplicated vaginal delivery; and at least 96 hours following an uncomplicated cesarean section. We also cover postpartum home care visits upon release, when prescribed by the attending provider.

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

Up to 4 days of additional hospitalization for the newborn is covered if the enrolled mother is required

to remain hospitalized after childbirth for medical reasons.

W. Medical Foods

We cover medical foods and low protein modified food products for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry including a disease for which the State screens newborn babies. Coverage is provided if the medical foods and low protein food products are prescribed as medically necessary for the therapeutic treatment of inherited metabolic diseases, and are administered under the direction of a Plan Provider.

Medical foods are intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and are formulated to be consumed or administered enterally (i.e., by tube directly into the stomach or small intestines) under the direction of a Plan Provider.

Low protein modified foods are food products that are (a) specially formulated to have less than one gram of protein per serving, and (b) intended to be used under the direction of a Plan Provider for the dietary treatment of an inherited metabolic disease.

Medical Foods Exclusions:

- Medical food for treatment of any conditions other than an inherited metabolic disease.

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

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

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

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

Amino Acid Based Elemental Formula Exclusions:

Amino-acid based elemental formula for treatment of any condition other than those listed above.

X. Morbid Obesity Services

We cover diagnosis and surgical treatment of morbid obesity that is:

- recognized by the National Institutes of Health as effective for long-term reversal of morbid obesity; and
- consistent with guidelines approved by the National Institutes of Health.

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

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

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

Y. Oral Surgery

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

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

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

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

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

- evidenced through documented medical records showing significant impairment in speech or a nutritional deficit; and
- based on examination of the Member by a Plan Provider.

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

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

Oral Surgery Exclusions:

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

Z. Preventive Health Care Services

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

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

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

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

(d) With respect to women, such additional preventive care and screenings, not described in paragraph (a) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (To see the current guidelines, visit HRSA at http://mchb.hrsa.gov).

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

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

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

- Preventive care exams, including:
  - routine physical examinations and health screening tests appropriate to your age and sex;
  - well-woman examinations; and
  - well child care examinations;
- Routine and necessary immunizations (excluding travel immunizations) for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health.
- An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
- Breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society. The Deductible, if any, will not apply to this provision;
- Bone mass measurement to determine risk for osteoporosis;
- Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to men who are age 40 or older;
- Colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society;
- Cholesterol test (lipid profile);

- Diabetes screening (fasting blood glucose test);
- Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis and HPS), subject to the following:
  - Annual chlamydia screening is covered for (1) women under the age of 20, if they are sexually active; and (2) women 20 years of age or older, and men of any age, who have multiple risk factors, which include: (i) a prior history of sexually transmitted diseases; (ii) new or multiple sex partners; (iii) inconsistent use of barrier contraceptives; or (iv) cervical ectopy;
  - Human Papillomavirus Screening (HPS) at the intervals recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;
- HIV tests;
- TB tests;
- Hearing loss screenings for newborns provided by a hospital prior to discharge; and
- Associated preventive care radiological and lab tests not listed above.

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

- Monitoring chronic disease,
- Follow-up Services after you have been diagnosed with a disease,
- Testing and diagnosis for specific diseases for which you have been determined to be at high risk for contracting,
- Services provided when you show signs or symptoms of a specific disease or disease process,
- Non-routine gynecological visits.

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

AA. Prosthetic Devices

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

Internally Implanted Devices

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

Artificial Arms, Legs or Eyes

We cover:

- Artificial devices to replace, in whole or in part, a leg, an arm, or an eye;
- Components of an artificial device to replace, in whole or in part, a leg, an arm, or an eye; and
- Repairs to an artificial device to replace, in whole or in part, a leg, an arm, or an eye.

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

Ostomy and Urological Supplies

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 and Hair Prosthesis

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

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

Prosthetic Device Limitations:

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

Prosthetic Device Exclusions:

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

BB. Reconstructive Surgery

We cover reconstructive surgery (a) to correct significant disfigurement resulting from an injury or medically necessary surgery, (b) to correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function, and (c) to treat congenital hemangioma known as port wine stains on the face for Members age 18 or younger.

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

- Removal of moles or other benign skin growths for appearance only
- Chemical peels
- Pierced earlobe repairs, except for the repair of an acute bleeding laceration

CC. Skilled Nursing Facility Care

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

We cover the following Services:

- Room and board;
- Physician and nursing care;
- Medical social services;
- Medical and biological supplies; and
- Respiratory therapy.

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

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

Skilled Nursing Facility Care Exclusions:

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

DD. Therapy and Rehabilitation Services

Physical, Occupational and Speech Therapy Services

If, in the judgment of a Plan Physician, significant improvement is achievable within a two-month period, we cover physical, occupational and speech therapy:

1. while you are confined in Plan Hospital; and
2. for up to 30 visits of physical therapy, or 90 consecutive days of occupational or speech therapy per contract year per injury, incident or condition in a Plan Medical Center, a Plan Provider's medical office, or a Skilled Nursing Facility, or as part of home health care. These limits do not apply to necessary treatment of cleft lip or cleft palate.

Physical, Occupational and Speech Therapy Limitations:

- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Speech therapy is limited to treatment for speech impairments due to injury or illness.

- Physical therapy is limited to the restoration of an existing physical function, except as provided in the "Habilitative Services" section of this benefit.

Multidisciplinary Rehabilitation Services

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

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

Cardiac Rehabilitation Services

We cover medically necessary cardiac rehabilitation Services following coronary surgery or a myocardial infarction for up to 12 weeks, or 36 sessions, whichever occurs first.

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

Therapy and Rehabilitation Services Exclusions:

- Except as provided for cardiac rehabilitation Services, no coverage is provided for any therapy that the Plan Physician determines cannot achieve measurable improvement in function within a two-month period.

EE. Transplants

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

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

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

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

Transplant Exclusions:

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

FF. Urgent Care

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

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

Inside our Service Area:

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

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

1) If your primary care Plan Physician is located at a Plan Medical Office please call:

   Inside the Washington, D.C. Metropolitan Area
   703-359-7878
   TTY at 703-359-7616

   Outside the Washington, D.C. Metropolitan Area
   1-800-777-7904
   TTY at 1-800-700-4901

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

Outside our Service Area:

If you are injured or become ill while temporarily outside the Service Area, we will cover reasonable charges for Urgent Care Services as defined in this section. Except as provided for emergency surgery

below, all follow-up care must be provided by a Plan Provider or Plan Facility.

If you obtain prior approval from Health Plan, covered benefits include the cost of necessary ambulance or other special transportation Services medically required to transport you to a Plan Hospital or Medical Center in the Service Area, or in the nearest Kaiser Foundation Health Plan Region, for continuing or follow-up treatment.

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

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

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

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

Urgent Care Exclusions:

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

GG. 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.

We cover the following Services:

Eye Exams
We cover refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses. Exams performed in an Optometry Department will be subject to the Primary Care Copayment. 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.

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

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

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

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

Vision Exclusions:

- Sunglasses without corrective lenses unless medically necessary;
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures;
- Eye exercises;
- Non-corrective contact lenses;

- Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section;
- Replacement of lost or broken lenses or frames; and
- Orthoptic (eye training) therapy.

HH. Visiting Member Services

We cover the same medically necessary Services that are covered under this plan in our Service Area, and your Cost Share will b e the same, when you are temporarily (not more than 90 days) a visiting Member in a different Kaiser Permanente Region or Group Health Cooperative service area.

To receive more information about visiting member Services, including facility locations across the United States, yo u may call our Mem ber Services Department:

Inside the Washington, D.C. Metropolitan Area
301-468-6000
TTY 301-816-6344

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

Service areas an d facilities where you may o btain visiting member care may change at any time.

Visiting Member Services Limitations:

- Access to Services in the visited service area will be subject to availability at the time you request the Service. Services m ay be unavailable due to temporary capacity constraints, inability to provide the Service generally, or o ther restrictions. If the Service is not available in the visited service area, you m ust call us for authorization to receive the Service.
- Except for Emergency Services, your right to receive covered Services in the visited service area ends after 90 days unles s you receive prior written authorization from us to continue receiving covered Services in the visited service area. The 90-day limit on vi siting member care does not apply to any Member who is a student attending an accredited college or acc redited vocational school.

Visiting Member Service Exclusions

- All the terms and conditions, exclusions and limitations that apply to covered Services in o ur Service Area, will apply to Services received as a visiting Member in a d ifferent Kaiser Permanente Region or Group Health Cooperative service area.

II. X-ray, Laboratory, and Special Procedures

We cover t he 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 co vered for outpatient Services only to the extent the outpatient Services are covered under "Outpatient Care"):

- Diagnostic imaging and interventional diagnostic tests;
- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
- Special procedures, such as:
  - Electrocardiograms;
  - Electroencephalograms; and
  - Bone mass measurement for the diag nosis, and treatment of osteoporosis for a qualified individual when a Pl an Provider requires the bone mass measurement. A "q ualified individual" means:
    - an estrogen deficient indivi dual at cli nical risk for osteoporosis;
    - an individual with a specific sign suggestive of spinal osteoporosis, including roentgeno-graphic osteopenia or roe ntgenographic evidence suggestive of c ollapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candi date for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
    - an individual receiving long-term gluco-corticoid (steroid) therapy;
    - an individual with primary hyper-parathyroidism; or
    - an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

  Note: Refer to "Preventive Health Services" for coverage of preventive ca re tests and sc reening Services.
- Sleep lab and sleep studies; and
- Specialty imaging, including CT, MRI, PET Scans, and Nuclear Medicine studies.

SECTION 4 – Exclusions, Limitations, and Reductions

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

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

Exclusions

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

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

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

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

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

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

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

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

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

Experimental or Investigational Services
Except as covered under "Clinical Trials" section of the "Benefits" section, a Service is experimental or investigational for your condition if any of the following statements apply to it as of the time the Service is or will be provided to you:

- It cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or
- It is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or
- It is subject to the approval or review of an Institutional Review Board ("IRB") of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
- It is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

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

- your medical records,
- the written protocols or other documents pursuant to which the Service has been or will be provided,
- any consent documents you or your representative has executed or will be asked to execute, to receive the Service,
- the files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
- the published authoritative medical or scientific literature regarding the service, as applied to your illness or injury, and
- regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

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

External Prosthetic and Orthotic Devices
Services and supplies for external prosthetic and orthotic devices, except as specifically covered under the "Benefits" section of this EOC, or unless otherwise covered under a Rider attached to this EOC.

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

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

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

Sexual Reassignment
All Services related to sexual reassignment (also referred to as "sexual transformation").

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

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

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

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

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

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

Travel and Lodging Expenses
Travel and lodging expenses, except that in some situations, if a Plan Physician refers you to a non-Plan Provider outside our Service Area as described

under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines.

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

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

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

Limitations

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

Reductions

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

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

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

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

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

In order for Health Plan to determine the existence of any rights we may have and to satisfy those rights,

you must complete and send Health Plan all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay Health Plan directly. You must not take any action prejudicial to Health Plan's rights.

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

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

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

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

1. The Primary Plan then provides benefits as 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 301-816-6344

Order of Benefit Determination Rules

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

1. The Order of Benefit Determination Rules will be used to determine which Plan is the Primary Plan. The other Plans will be Secondary Plan(s).
2. If the Health Plan is the Primary Plan, it will provide or pay its benefits without considering the other Plan(s) benefits.
3. If the Health Plan is a Secondary Plan, the benefits or services provided under this Agreement will be coordinated with the Primary Plan so the total of benefits paid, or the reasonable cash value of the services provided, between the Primary Plan and the Secondary Plan(s) do not exceed 100% of the total Allowable Expenses.

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

"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 calendar year. However, it does not include any part of a year during which a person has no Health Plan coverage, or any part of a year before the date 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 calendar year. A Member may request detailed information concerning the Benefits Reserve Account from Health Plan's Patient Accounting Department.

Military Services

For any Services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such Services we may recover the value of the Services from the Department of Veterans Affairs.

SECTION 5 – Getting Assistance; Health Care Service Review; and the Grievance and Appeal Process

Getting Assistance

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

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

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

Outside the Washington, D.C. Metropolitan area
1-800-777-7902
TDD 301-816-6344

Definitions:

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

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

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

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

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

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

Commissioner: The Maryland Insurance Commissioner.

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

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

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

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

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

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

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

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

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

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

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

The Health Care Service Review Program

Pre-Service Reviews

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

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

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

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

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

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

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

Expedited Pre-Service Reviews

If you have an Urgent Medical Condition and you have not received the Health Care Service for which you are requesting review, then within 24 hours of your request, we will notify you if we need additional information to make a decision, or if you or your Authorized Representative failed to follow proper procedures which would result in a denial decision. If additional information is requested, you will have only 48 hours in which to submit the requested information. We will make a decision for this type of claim within 48 hours following the earlier of (1) receipt of the information from you; or (2) the end of the period for submitting the requested information.

Decision regarding pre-service review if you have an urgent Medical Condition will be communicated to you by telephone within 24 hours. Such decisions will be confirmed in writing within three calendar days of our decision.

Concurrent Reviews

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

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

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

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

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

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

Filing for Payment/Reimbursement of a Post Service Claim

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

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

You must notify us within the later of 48 hours of any hospital admission or on the first working day following the admission unless it was not reasonably possible to notify us within that time.

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

Post-Service Claim Reviews

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

requests for additional information within 45 calendar days or we will make our decision based upon the information we have available to us at that time.

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

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

Internal Grievance and Appeal Processes

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

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

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

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

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

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

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

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

2. Maryland Insurance Commissioner

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

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

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

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

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

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

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

(g) The member, member's Authorized Representative or the health care provider provides sufficient information and documentation in the complaint that demonstrates a compelling reason to do so.

The Maryland Insurance Commissioner may be contacted at:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeals and Grievance
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Telephone: 410-468-2000 or 1-800-492-6116
TTY: 1-800-735-2258
Fax: 410-468-2270 or 410-468-2260

3. Internal Grievance Process

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

Initiating a Grievance

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

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

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

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

Grievance Acknowledgment

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

(a) **Pre-service Grievance**

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

(b) **Post-service Grievance**

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

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

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

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

filing or no later than the last day of the extension period for a post-service Grievance.

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

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

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

4. Expedited Grievances for Emergency Cases

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

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

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

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

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

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

5. Notice of Adverse Grievance Decision

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

(a) the specific factual basis for the decision in clear understandable language;
(b) references to any specific criteria or standards on which the decision was based, including but not limited to interpretive guidelines used by us;
(c) a statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request;
(d) the name, business address, and business telephone number of the medical director who made the Grievance Decision;

(e) a description of your or your Authorized Representative's right to file a complaint with the Commissioner within 4 months after receipt of our Grievance Decision;
(f) the Commissioner's address, telephone number and facsimile number;

(g) a statement that the Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a complaint about the Health Plan with the Commissioner; and

(h) the Health Education and Advocacy Unit's address, telephone number, facsimile number, and electronic mail address.

6. Internal Appeal Process

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

Initiating an Appeal
You or your Authorized Representative must file an Appeal within 180 calendar days from the date of receipt of the Coverage Decision. The Appeal should be sent to us at the address shown at the beginning of this section.

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

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

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

In addition, the Member or the Member's Authorized Representative may request an internal appeal by contacting the Member Services Department. The Member or the Member's Authorized Representative, as applicable, may review the Health Plan's appeal file and provide evidence and testimony to support the appeal request.

Member Service Representatives are available by telephone each day during business hours to describe how internal appeals are processed and resolved and to assist with filing an internal appeal. The Member Service Representative can be contacted Monday through Friday from 7:30 AM to 5:30 PM at 301-468-6000, if calling within the local area, or 301-816-6344 TTY (Telephonic Device for the Deaf).

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

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

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

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

(a) the specific factual basis for the decision in clear understandable language;
(b) reference to the specific plan provision on which determination was based;
(c) a description of your right to file a C omplaint with the Commissioner within 4 months after receipt of our Appeals Decision;
(d) the Commissioner's address, telephone number and facsimile number.;

(e) a statement that the Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a complaint about the Health Plan with the Commissioner; and

(f) the Health E ducation and Advocacy Unit's address, telephone number, facsimile number, and electronic mail address.

Filing Complaints About Health Plan

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

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Telephone: 410-468-2000 or 1-800-492-6116
TTY: 1-800-735-2258
Fax: 410-468-2260

SECTION 6 – Termination of Membership

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

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

If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. You will be billed the applicable fee for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Extension of Benefits" in this "Termination of Membership" section.

Termination of Group Agreement

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

The Subscriber's group is required to inform the Subscriber of the date your coverage terminates.

Termination Due to Loss of Eligibility

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

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

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

Termination for Cause

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

We may terminate your membership, by sending written notice to you at least 30 days before the termination, if you commit any of the following acts:

- You present an invalid prescription or physician order, or you sell your prescriptions;
- You misuse (or let someone else misuse) a Member ID card; or
- You commit any other type of fraud in connection with your membership.
- Your behavior with respect to Health Plan staff or Medical Group providers is disruptive, unruly, abusive or uncooperative to the extent that your continued enrollment under this EOC seriously impairs Health Plan's ability to furnish services to you or to other Health Plan members.

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

Termination for Nonpayment

Nonpayment of Premium

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

Nonpayment of any other charges

We may terminate your membership if you fail to pay any amount you owe to Health Plan or Medical Group, or you fail to pay the applicable Cost Share to any Plan Provider. We will send written notice of the termination to the Subscriber at least 30 days before the termination date.

Extension of Benefits

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

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

provide benefits for covered eyeglasses or contact lenses received within 30 days following the date you placed the order.

- If you are in the midst of a course of covered dental treatment at the time your coverage ends, we will continue to provide benefits, in accordance with the EOC in effect at the time your coverage ended, for a period of 90 days following the date your coverage ended.
- If you are in the midst of a course of covered orthodontic treatment at the time your coverage ends, we will continue to provide benefits, in accordance with the EOC in effect at the time your coverage ended, for a period of:
  - 60 days following the date your coverage ended if the orthodontist has agreed to or is receiving monthly payments; or
  - until the latter of 60 days following the date your coverage ended, or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

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

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

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

Discontinuation of a Product or All Products

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

Continuation of Group Coverage under Federal Law

COBRA

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

USERRA

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

Continuation of Coverage under State Law

Death of the Subscriber

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

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

- Group coverage under this section continues, for those Dependents who are eligible for state continuation coverage, only upon payment of applicable monthly charges, which may include an allowable reasonable administrative fee, not to exceed 2% of the entire cost to the employer, to your Group's Premium charge at the time specified by Group, and terminates on the earliest of:
  - Termination of this Agreement; or
  - Eligibility of the Member under any other group health plan or entitlement to Medicare benefits; or

- Acceptance of covera ge under any non-group health insurance plan or healt h maintenance organization; or
- Ceasing to qualify as a dependent child; or
- Expiration of 18 cal endar months after the death of the Subscriber.

Divorce of the Subscriber and his/her Spouse

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

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

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

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

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

- Coverage under this section continues only upon payment of a pplicable monthly charges, which may include an allowable rea sonable administrative fee not to exceed 2% of the entire cost to the employer, to your Group's Premium charge at the time sp ecified by Group, and terminates on the earliest of:
  - Termination of this Agreement; or
  - Eligibility of the Subscriber under any other group health plan or entitlement to Medicare benefits; or
  - The Subscriber's acce ptance of c overage under any non-group health plan or health maintenance organization; or
  - Ceasing to qualify as a dependent; or
  - Expiration of 18 cal endar months after the termination of Subscriber's employment.

Coverage Under the Continuation Provision of Group's Prior Plan

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

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

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

Conversion of Membership

If your membership terminates for any reason, other than the reasons listed below, you may be eligible to convert to a non-group plan. However, you may not convert to a non-group plan if:

- You continue to be eligible for coverage through your Group;
- You live outside the Health Plan Service Area; or
- We terminated your me mbership under "Termination for Cause" or "Termination for Nonpayment" in this "Termination of Membership" section.

You must apply to convert your membership to a non-group plan within the later of: (1) 31 days after your Group coverage ends; or (2) 31 days from the date we notify you of your conversion rights. During this period, no medical review is required, and your non-group coverage begins when your Group coverage ends. You will have to pay premium, and the benefits and c opayments under the non-group coverage may differ from those under this EOC.

If we fail to notify you of your conversion option, or we are late in n otifying you, th en you will have 90

days from such t ermination date to exercise your conversion option.

For information about converting your membership or about other non-group plans, call o ur Member Services Call Center.

Inside the Washington, D.C., Metropolitan Area
301-468-6000
TTY 301-816-6344

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

SECTION 7 – Miscellaneous Provisions

Administration of Agreement

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

Advance Directives

The following legal forms help you control the kind of health care you will receive if you become very ill or unconscious:

- *Durable Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your views on life support and other treatments.
- *A Living Will* and the *Natural Death Act Declaration to Physicians* lets you write down your wishes about receiving life support and other treatment.

For additional information about Advance Directives, including how to obtain forms, including the information sheet developed by the Maryland Department of Health and Mental Hygiene and the Attorney General, and instructions, visit our website at kp.org or contact our Member Services Call Center.

Inside Washington, D.C., Metropolitan area
301-468-6000, or in the Baltimore, Maryland
TTY 301-816-6344

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

Amendment of Agreement

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

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

Assignment

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

Attorney Fees and Expenses

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

Contestability

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

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

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

a. the statement is contained in a written instrument signed by the applicant, employer, or Member; and
b. a copy of the statement is provided to the applicant, employer or Member.

Contracts with Plan Providers

Health Plan and Plan Providers are independent contractors. Your Plan Providers are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee for service, and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call our Member Services Call Center in the Washington, D.C., Metropolitan area at 301-468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902. Our TTY is 301-816-6344.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or

Services you obtain from Non-Plan Providers, except as provided in this EOC for:

- Emergency Services;
- Urgent Care outside our Service Area;
- Authorized referrals; or
- Care in other Health Plan Regions.

If our contract with any Plan Provider terminates, for reasons unrelated to fraud, patient abuse, incompetence, or loss of licensure status, while you are under the care of that Plan Provider, you may continue to see that provider and we will retain financial responsibility for covered Services you receive, in excess of any applicable Copayments, Coinsurance or Deductibles for a period not to exceed 90 days from the date we have notified you of the Plan Provider's termination.

Governing Law

Except as preempted by federal law, this EOC will be covered in accord with the State of Maryland law and any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

Notice of Non-Grandfathered Coverage

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. believes that your Plan is a "non-grandfathered health plan" under the PPACA.

Groups and Members not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

Member Rights and Responsibilities

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

MEMBER RIGHTS

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

1. **Receive information that empowers you to be involved in health care decision making. This includes your right to:**
   a. Actively participate in discussions and decisions regarding your health care options.
   b. Receive and be helped to understand information related to the nature of your health status or condition, including all appropriate treatment and non-treatment options for your condition and the risks involved - no matter what the cost is or what your benefits are.
   c. Receive relevant information and education that helps promote your safety in the course of treatment.
   d. Receive information about the outcomes of health care you have received, including unanticipated outcomes. When appropriate, family members or others you have designated will receive such information.
   e. Refuse treatment, providing you accept the responsibility and consequences of your decision.
   f. Give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself by completing and giving us an Advance Directive, a durable power of attorney for health, living will, or other health care treatment directive. You can rescind or modify these documents at any time.
   g. Receive information about research projects that may affect your health care or treatment. You have the right to choose to participate in research projects.
   h. Receive access to your medical records and any information that pertains to you, except as prohibited by law. This includes the right to ask us to make additions or corrections to your medical record. We will review your request based on HIPAA criteria to determine if the requested additions are appropriate. If we approve your request, we will make the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. You, or your Authorized Representative, will be asked to provide written permission before your records are released, unless otherwise permitted by law.
2. **Receive information about Kaiser Permanente and your plan. This includes your right to:**
   a. Receive the information you need to choose or change your primary care Plan Physician, including the name, professional level, and

credentials of the doctors assisting or treating you.

b. Receive information about Kaiser Permanente, our Services, our practitioners and providers, and the rights and responsibilities you have as a Member. You also can make recommendations regarding Kaiser Permanente's member rights and responsibility policies.

c. Receive information about financial arrangements with physicians that could affect the use of Services you might need.

d. Receive Emergency Services when you, as a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

e. Receive covered urgently needed Services when traveling outside Kaiser Permanente's Service Area.

f. Receive information about what Services are covered and what you will have to pay and to examine an explanation of any bills for Services that are not covered.

g. File a complaint, grievance or appeal about Kaiser Permanente or the care you received without fear of retribution or discrimination, expect problems to be fairly examined, and receive an acknowledgement and a resolution in a timely manner.

3. Receive professional care and service. This includes your right to:

a. See Plan Providers, get covered health care Services and get your prescriptions filled within a reasonable period of time and in an efficient, prompt, caring, and professional manner.

b. Have your medical care, medical records and protected health information handled confidentially and in a way that respects your privacy.

c. Be treated with respect and dignity.

d. Request that a staff member be present as a chaperone during medical appointments or tests.

e. Receive and exercise your rights and responsibilities without any discrimination based on age, gender, sexual orientation, race, ethnicity, religion, disability, medical condition, national origin, educational background, reading skills, ability to speak or read English, or economic or health status including any mental or physical disability you may have.

f. Request interpreter Services in your primary language at no charge.

g. Receive health care in facilities that are environmentally safe and accessible to all.

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 Plan Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics, or Family Practice as your primary care Plan Physician.

c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you.

d. Work with us to help you understand your health problems and develop mutually agreed upon treatment goals.

e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment.

f. Do your best to improve your health by following the treatment plan and instructions your physician or health care professional recommends.

g. Schedule the health care appointments your physician or health care professional recommends.

h. Keep scheduled appointments or cancel appointments with as much notice as possible.

2. Know and understand your plan and benefits:

a. Read about your health care benefits in this EOC and become familiar with them. Call us when you have questions or concerns.

b. Pay your plan premiums and bring payment with you when your visit requires a Copayment, Coinsurance or Deductible.

c. Let us know if you have any questions, concerns, problems or suggestions.

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

Named Fiduciary

Under our Agreement with your Group, we have assumed the role of a "named fiduciary," a party responsible for determining whether you are entitled to benefits under this EOC. Also, as a named fiduciary, we have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC.

No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Nondiscrimination

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

Notices

Our notices to you will be sent to the most recent address we have on file for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Services Call Center in the Washington, D.C., Metropolitan area at 301-468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902 as soon as possible to give us their new address. Our TTY is 301-816-6344.

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services, to the extent that if we have made payment to a health care provider, we may only retroactively deny reimbursement to the health care provider during the 6-month period after the date we paid the claim submitted by the health care provider.

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. Your PHI is individually identifiable information about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

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

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

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

By: _____

Ruben J. Burnett
Vice President, Marketing, Sales & Business Development

APPENDICES

Definitions

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

Allowable Charges (AC): means either:

- For Services provided by Health Plan or Medical Group, the amount in the Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members;
- For items obtained at a Plan Pharmacy, the "Member Standard Value" which means the cost of the item calculated on a discounted wholesale price plus a dispensing fee;
- For all other Services,
  - the amount the provider has contracted to accept;
  - the amount the provider has negotiated with the Health Plan;
  - the amount stated in the fee schedule that providers have agreed to accept as payment for those Services; or,
  - the amount that the Health Plan pays for those Services.

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

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 of the Appendix.

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

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

Deductible: The Deductible is an amount of Allowable Charges you must incur during a contract year for certain covered Services before we will provide benefits for those Services.. Please refer to the Summary of Services and Cost Shares section of the Appendix, 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 Section 1, Introduction).

Domestic Partner: An individual in a relationship with another individual of the same or opposite sex, provided both individuals:

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

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
  Serious dysfunction of any bodily organ or part

Emergency Services: With respect to an Emergency Medical Condition, as defined above:

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

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

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

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

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

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

Medically Necessary: Medically Necessary means that the Service is all of the following: (i) medically required to prevent, diagnose or treat your condition or clinical symptoms; (ii) in accordance with generally accepted standards of medical practice; (iii) not solely for the convenience of you, your family and /or your provider; and (iv) the most appropriate level of Service which can safely be provided to you. For purposes of this definition, "generally accepted standards of medical practice" means (a) standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; (b) physician specialty society recommendations; (c) the view of physicians practicing in the Kaiser Permanente Medical Care Program; and/or (d) any other relevant factors reasonably determined by us. Unless otherwise required by law, we decide if a Service (described in Section 3) is Medically Necessary and our decision is final and conclusive subject to your right to appeal as set forth in Section 5.

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

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

Non-Physician Specialist: A health care provider who:

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

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

Plan: Kaiser Permanente.

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

Plan Hospital: Any hospital in our Service Area where you receive hospital care pursuant to our arrangements made by a Plan Physician.

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

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

Plan Physician: Any licensed physician who is an employee of Medical Group, or any licensed physician who contracts with us to provide Services and supplies to Members.

Plan Provider: A Plan Hospital, Plan Physician, or other health care provider, including Non-Physician Specialists, that contracts with us to provide Services to Members.

Premium: Periodic membership charges paid by Group.

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

Services: Health care Services or items.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation Services,

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

Spouse: 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" in Section 1, Introduction).

Totally Disabled:

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

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

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

Summary of Services and Cost Shares

This summary does not describe benefits. For the description of a benefit, including any limitations or exclusions, please refer to the identical heading in the "Benefits" section (also refer to the "Exclusions, Limitations and Reductions" section, which applies to all benefits). **Note:** Additional benefits may also be covered under Riders attached to this EOC, and which follow this Summary of Services and Cost Shares.

DEPENDENT AGE LIMIT
Eligible Dependent children are covered from birth to age 26.

MEMBER COST-SHARE

Your Cost Share is the amount of the Allowable Charge for a covered Service that you must pay through Deductibles, Copayments and Coinsurance. The Cost Share, if any, is listed for each Service in this "Summary of Services and Cost Shares." Allowable Charge means:

- For Services provided by Health Plan or Medical Group, the amount in the Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members;
- For items obtained at a Plan Pharmacy, the "Member Standard Value" which means the cost of the item calculated on a discounted wholesale price plus a dispensing fee;
- For all other Services,
  - the amount the provider has contracted to accept;
  - the amount the provider has negotiated with the Health Plan;
  - the amount stated in the fee schedule that providers have agreed to accept as payment for those Services; or,
  - the amount that the Health Plan pays for those Services.

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

In addition to the monthly premium, you may be required to pay a Cost Share for some Services. You are responsible for payment of all Cost Shares. Copayments are due at the time you receive a Service. You will be billed for any Deductible and Coinsurance you owe. Failure to pay your Cost Shares may result in termination of your Membership (refer to Section 6, Termination for Nonpayment).

DEDUCTIBLE

The Deductible is the amount of Allowable Charges you must incur during a contract year for certain covered Services before Health Plan will provide benefits for those Services. The Deductible applies to the Services shown in the schedule below that have a Coinsurance. Other Services may have a Copayment. Copayments do not apply toward the Deductible.

For covered Services that are subject to a Deductible, you must pay the full charge for the Services when you receive them, until you meet your Deductible. The only amounts that count toward your Deductible are the Allowable Charges you incur for Services that are subject to the Deductible, but only if the Service would otherwise be covered. After you meet the Deductible, you pay the applicable Coinsurance for these Service.

Family Deductible. After two or more Members of a Family Unit combined have met the family Deductible, the Deductible will be met for all Members of the Family Unit for the rest of the contract year.

Keep Your Receipts. When you pay an amount toward your Deductible, we will give you a receipt. Keep your receipts. If you have met your Deductible, and we have not received and processed all of your claims, you can use your receipts to prove that you have met your Deductible. You can also obtain a statement of the amounts that have been applied toward your Deductible from our Member Services Department.

Missed Appointment Fee	
The amount you may be required to pay if you fail to keep a scheduled appointment and you do not notify us at least one day prior to the appointment.	$25 per missed appointment

Deductible

The amount you must pay each contract year for the Services indicated below before we provide benefits for those Services	**Individual Deductible** $500 per individual per contract year **Family Deductible** $1,000 per Family Unit per contract year

Copayments and Coinsurance

Covered Service	You Pay
Outpatient Care	
Office visits (for other than preventive health care Services)	
Primary care office visits	
For adults	10% of AC*
For children under 5 years of age	No charge
For children 5 years of age or older	10% of AC*
Specialty care office visits	10% of AC*
Consultations and immunizations for foreign travel	10% of AC*
Outpatient surgery	10% of AC* after Deductible
Diagnostic testing (not preventive screening) as described under Outpatient Care in Section 3	Applicable Cost Shares will apply based on place and type of Service
Anesthesia	No charge
Chemotherapy and radiation therapy	10% of AC*
Respiratory therapy	10% of AC*
Medical social Services	10% of AC*
House calls	No charge
Hospital Inpatient Care All charges incurred during a covered stay as an inpatient in a hospital	10% of AC*
Accidental Dental Injury Services Limited to a maximum benefit of $2,000 per contract year.	Applicable Cost Shares will apply, based on type and place of Service
Allergy Services	
Evaluations and treatment	Applicable Cost Shares will apply, based on type and place of Service
Injection visits and serum	Applicable Cost Shares will apply, based on type and place of Service, not to exceed the cost of the serum plus administration
Ambulance Services By a licensed ambulance Service, per encounter	10% of AC*
Anesthesia for Dental Services Anesthesia and associated hospital or ambulatory Services for certain individuals only.	Applicable Cost Shares will apply, based on type and place of Service

Copayments and Coinsurance

Covered Service	You Pay
Blood, Blood Products and Their Administration	10% of AC*
Chemical Dependency and Mental Health Services Treatment of mental illness, emotional disorders, drug and alcohol abuse described in the "Benefits" section	
Inpatient psychiatric and substance abuse care, including detoxification	Applicable inpatient Cost Shares will apply
Partial hospitalization	10% of AC*
Outpatient psychiatric and substance abuse care • Individual therapy	10% of AC*
• Group therapy	10% of AC*
Medication management visits	10% of AC*
Methadone treatment	10% of AC* per week, but not to exceed 50% of the daily cost of the treatment
Psychiatric Residential Crisis Services	10% of AC* after Deductible
Cleft Lip, Cleft Palate, or Both	Applicable Cost Shares will apply, based on type and place of Service
Clinical Trials	Applicable Cost Shares will apply, based on type and place of Service
Diabetic Equipment, Supplies and Self-Management Training	
Diabetic equipment and supplies	10% of AC*
Self-management training	Applicable Cost Shares will apply, based on place of Service
Dialysis	
Inpatient care	Applicable inpatient care Cost Shares will apply
Outpatient Care	10% of AC*
Drugs, Supplies, and Supplements Administered by or under the supervision of a Plan Provider	No charge
Durable Medical Equipment Applicable inpatient hospital cost shares will apply to equipment provided while you are confined as an inpatient.	
Basic Durable Medical Equipment	10% of AC*
Supplemental Durable Medical Equipment • Oxygen and Equipment (Must be certified every 30 days)	10% of AC*

Copayments and Coinsurance	
Covered Service	**You Pay**
• Positive Airway Pressure Equipment (Must be certified every 30 days)	10% of AC*
• Apnea Monitors (under age 3, not to exceed a period of 6 months)	10% of AC*
• Asthma Equipment	10% of AC*
• Bilirubin Lights (under age 3, not to exceed a period of 6 months)	10% of AC*
Emergency Services	
Emergency Room Visits	
• Inside the Service Area	$100 per visit; Copayment waived if immediately admitted as an inpatient
• Outside the Service Area	$100 per visit; Copayment waived if immediately admitted as an inpatient
Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit Copayment will not be waived.	
Family Planning	
Office visits	10% of AC*
Tubal ligation, Vasectomy, Voluntary termination of pregnancy	Applicable Cost Share will apply based on place of Service
Habilitative Services For children under age 19 **Note:** applicable Inpatient Hospital Cost Shares will also apply for Services provided in a Hospital.	10% of AC*
Hearing Services	
Hearing tests (newborn hearing screening tests are covered under preventive health care Services)	Applicable office visit Cost Share will apply based on place of service
Hearing aids for children under age 18.	
• Hearing aid tests	Applicable office visit Cost Share will apply
• Hearing aids (Limited to a maximum benefit of $1400 per hearing aid per ear, or to $2800 for a single hearing device that provides hearing aid to both ears, every 36 months.)	No charge up to Health Plan maximum payment.
Home Health Care See Section 3 for benefit limitations The visit maximum does not apply to home visits following mastectomy or testicle removal; and home visits following mastectomy or testicle removal do not count toward the maximum visits.	No charge
Hospice Care	No charge
Infertility Services	
Office visits	50% of AC*
Inpatient Hospital Care	50% of AC*

Copayments and Coinsurance	
Covered Service	**You Pay**
All other Services for treatment of infertility Note: Coverage for in vitro fertilization is limited to a maximum of three attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.	50% of AC*
Maternity Services	
Routine prenatal global maternity care (after confirmation of pregnancy)	No charge
Non-routine obstetrical care	10% of AC*
Inpatient Services	10% of AC*
Postpartum home visits (as described in Section 3)	No Charge
Medical Foods (including Amino Acid-based Elemental Formula)	10% of AC*
Morbid Obesity Services	Applicable Cost Shares will apply based on type and place of Service
Oral Surgery **Note:** applicable inpatient Cost Shares will also apply for Services provided in a hospital or other inpatient facility.	10% of AC*
Preventive Health Care Services	No charge
Prosthetic Devices	
Internally implanted devices	10% of AC*
Replacements for legs, arms or eyes and their components and repair	10% of AC*
Ostomy and urological supplies	10% of AC*
Breast prosthetics	10% of AC*
Hair Prosthesis (Limited to a maximum of $350 per course of chemotherapy and/or radiation therapy)	No charge
Reconstructive Surgery	Applicable Cost Shares will apply based on place and type of Service.
Skilled Nursing Facility Care Limited to a maximum benefit of 100 days per contract year	10% of AC* after Deductible
Therapy and Rehabilitation Services (Refer to Section 3 for benefit maximums)	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services **Note:** All Services received in one day for multidisciplinary rehabilitation Services at a day treatment program will be considered one visit.	10% of AC*

Copayments and Coinsurance	
Covered Service	**You Pay**
Transplants	Applicable Cost Shares will apply based on place and type of Service
Urgent Care	
Office visit during regular office hours	Applicable office visit Cost Share will apply
After-Hours Urgent Care or Urgent Care Center	10% of AC*
Vision Services	
Eye exams	
• by an Optometrist	10% of AC*
• by an Ophthalmologist	10% of AC*
Eyeglass lenses and frames	You receive a 25% discount off retail price** for eyeglass lenses and for eyeglass frames once per contract year
Contact lenses	You receive a 15% discount off retail price** on initial pair of contact lenses
X-ray, Laboratory and Special Procedures	
Diagnostic Imaging, interventional diagnostic and laboratory tests	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	10% of AC* after Deductible
Specialty Imaging (including CT, MRI, PET Scans, Nuclear Medicine) and Special Procedures Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	10% of AC* after Deductible
Sleep lab and sleep studies	10% of AC*

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the limit to the total amount of Deductible, Copayments and Coinsurance you must pay in a contract year for the Basic Health Services covered under this EOC as shown below. Once you or your Family Unit have met your Out-of-Pocket Maximum, you will not be required to pay any additional Cost Shares for Basic Health Services for the rest of the contract year.

Family Out-of-Pocket Maximum with an Individual Out-of-Pocket Maximum. If you have one or more Dependents covered under this plan, all Family Unit medical expenses together apply toward the family Out-of-Pocket Maximum shown below; however no one family member's medical expenses may contribute more than the individual Out-of-Pocket Maximum shown below.

Except as excluded below, the following Services are considered "Basic Health Services" that apply toward the Out-of-Pocket Maximum:

- Inpatient and outpatient physician Services
- Inpatient hospital Services
- Outpatient medical Services
- Preventive health care Services
- Emergency Services
- X-ray, laboratory and special procedures
- Inpatient and outpatient chemical dependency and mental health Services

Out-of-Pocket Maximum Exclusions:
The following Services, if covered, are ***not*** considered "Basic Health Services" and ***do not*** apply toward your Out-of-Pocket Maximum:

- Outpatient drugs, supplies and supplements, including blood, blood products, and medical foods
- Outpatient durable medical equipment and prosthetic and orthotic devices
- Inpatient and outpatient infertility Services
- Eyeglass lenses and frames, contact lenses

Keep Your Receipts. When you pay a Cost Share, we will give you a receipt. Keep your receipts. If you have met your Out-of-Pocket Maximum, and we have not received and processed all of your claims, you can use your receipts to prove that you have met your Out-of-Pocket Maximum. You can also obtain a statement of the amounts that have been applied toward your Out-of-Pocket Maximum from our Member Services Department.

Notice of Out-of-Pocket Maximum. We will also keep accurate records of your Out-of-Pocket expenses and will notify you when you have reached the maximum. We will send you written notice no later than 30 days after we have received and processed your claims that the Out-of-Pocket maximum is reached. If you have exceeded your Out-of-Pocket Maximum, we will promptly refund to you any Copayments or Coinsurance charged after the maximum was reached.

Annual Out-of-Pocket Maximum	
Combined total of Deductible and allowable Copayments and Coinsurance	**Individual Out-of-Pocket Maximum** **$3,000** per individual per contract year **Family Out-of-Pocket Maximum** **$6,000** per Family Unit per contract year

*AC means Allowable Charge

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

2101 East Jefferson Street
Rockville, Maryland 20852
301-816-2424

OUTPATIENT PRESCRIPTION DRUG RIDER

GROUP EVIDENCE OF COVERAGE

This Outpatient Prescription Drug Rider (Rider) is effective as of the date of your Group Agreement and Group Evidence of Coverage (EOC) and shall terminate as of the date your Group Agreement and Group Evidence of Coverage (EOC) terminate.

The following benefit, limitations, and exclusions are hereby added to the "Benefits" Section of your EOC in consideration of the application and payment of the additional Premium for such Services.

A. Definitions:

Allowable Charge: Has the same meaning as defined in your EOC. See "Appendices -Definitions."

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

Contraceptive drug: A drug or device that is approved by the United States Food and Drug Administration (FDA) for use as a contraceptive and requires a prescription.

Cost Share: Has the same meaning as defined in your EOC.

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.

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 (6) months or more to treat a chronic condition.

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

Nicotine Replacement Therapy: A product that:
(a) is used to deliver nicotine to an individual attempting to cease the use of tobacco products;
(b) can be obtained only by a written prescription.

Nicotine Replacement Therapy does not include any over-the-counter products that may be obtained without a prescription.

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

Participating Network Pharmacy: Any pharmacy that has entered into an agreement with Health Plan or the Health Plan's agent to provide pharmacy Services to its Members.

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

Preferred Brand Drugs: 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.

Prescription Drug ("Rx") Coinsurance: A percentage of the Allowable Charge that you must pay for each prescription or prescription refill.

Prescription Drug ("Rx") Copayment: The specific dollar amount that you must pay for each prescription or prescription refill.

Prescription Drug ("Rx") Deductible: The amount you must pay in a contract year for covered outpatient prescription drugs before we will cover such drugs in that contract year.

Prescription Drug ("Rx") Out-of-Pocket Maximum: The maximum amount of Rx Copayments and Rx Coinsurance you are required to pay for covered outpatient prescription drugs during a contract year. Amounts in excess of Allowable Charge, payments for drugs not covered under this Rider, or any amounts other than a Rx Copayment and Rx Coinsurance shall not be counted towards the Rx Out-of-Pocket Maximum. Once the Rx Out-of-Pocket Maximum is met, you do not have to pay any additional Rx Copayments or Rx Coinsurance for covered outpatient prescription drugs.

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.

B. Benefit:

Except as provided in the Limitations and Exclusions sections of this Rider, we cover drugs as described in this Section, in accordance with our Preferred Drug List guidelines, when prescribed by a Plan physician or by a dentist. Each prescription refill is subject to the same conditions as the original prescription. Plan Providers prescribe drugs in accordance with Health Plan's Preferred Drug List. If the Allowable Charge of the drug is less than the Rx Copayment, the Member will pay the lesser amount. You must obtain these drugs from a Plan Pharmacy or a Participating Network Pharmacy. It may be possible for you to receive prescription drugs and refills using our Mail Service Delivery Program; ask for details at a Plan Pharmacy.

- FDA-approved drugs for which a prescription is required by law.
- Compounded preparations with at least one ingredient requiring a prescription and are listed in our Preferred Drug List.
- Insulin
- Contraceptive drugs, including contraceptive devices that are approved by the United States Food and Drug Administration (FDA) for use as contraceptives.
- Nicotine Replacement Therapy, for up to two 90-day courses of treatment per contract year and drugs that are approved by the FDA as an aid for the cessation of the use of tobacco products.
- 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.
- Growth hormone therapy (GHT) for treatment of children under age 18 with a growth hormone deficiency.
- Non-prescription drugs when they are prescribed by a Plan Provider and are listed on the Preferred Drug List.

The 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 and accessories on the Preferred Drug List. If you would like information about whether a particular drug or accessory is included in our Preferred Drug List, please visit us on line at www.kp.org, or call the Member Services Call Center at:

Inside the Washington, D.C. Metropolitan Area
(301) 468-6000
TTY (301) 879-6380

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

Where to Purchase Covered Drugs
We cover prescribed drugs only when purchased at a Plan Pharmacy, a Participating Network 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.

Generic and Preferred Drug Requirements
Generic vs. Brand Name Drugs

Plan Pharmacies and Participating Network Pharmacies will substitute a generic equivalent for a Brand Name Drug when a generic equivalent is on our formulary unless one of the following conditions is met:

- The provider has prescribed a Brand Name Drug and has indicated "dispense as written" (DAW) on the prescription; or
- The Brand Name Drug is listed on our Preferred Drug List or
- The Brand Name Drug is (1) prescribed by a Plan physician or by a dentist or a referral physician; 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.

If a Member requests a Brand Name Drug for which none of the above conditions has been met, the Member will be responsible for the full Allowable Charge for that Brand Name drug.

Preferred vs. Non-Preferred Drugs

Plan Pharmacies and Participating Network Pharmacies will dispense Preferred Drugs unless the following criteria are met:

(1) the Non-Preferred Drugs is prescribed by a Plan physician or by a dentist or a referral physician; and (2) (a) there is no equivalent drug in our Preferred Drug List, or (b) an equivalent Preferred 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.

If the criteria are met, the applicable Non-Preferred drug Cost Share will apply. If the Member requests a Non-Preferred drug and the criteria are not met, the Member will be responsible for the full Allowable Charge.

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

Members may obtain early refills of topical ophthalmic products at 70% of the predicted days of use or earlier if authorized by a Plan physician.

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), the Member 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. The day supply is based on (a) the prescribed dosage, (b) Standard Manufacturer's Package Size, and (c) specified dispensing limits.

C. 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 outside Health Plan's Service Area. To obtain reimbursement, the Member must submit a copy of the itemized receipts for the 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 Rx Copayment or Rx Coinsurance, set forth in the Summary of Services and Cost Shares in the EOC to which this Rider is attached. 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

D. Limitations:

Benefits are subject to the following limitations:

1. For drugs prescribed by a dentist, coverage is limited to antibiotics and pain relief drugs that are included on our Preferred Drug List and purchased at a Plan Pharmacy or a Participating Network Pharmacy, unless the criteria for coverage of non-Preferred drugs under Section B. Preferred vs. Non-Preferred Drugs has been met.

2. 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 the EOC to which this Rider is attached. 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

3. If the $100,000 benefit limit for in vitro fertilization has been met by a Member under Section 3 of the EOC, drugs for the treatment of in vitro fertilization are no longer covered under this Rider for that Member.

E. Exclusions:

The following are not covered under the Outpatient Prescription Drug Rider (Please note that certain Services excluded below may be covered under other benefits of your Group EOC. Please refer to the applicable benefit to determine if drugs are covered.):

1. 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.

2. Compounded preparations that do not contain at least one ingredient requiring a prescription and are not listed in our Preferred Drug List.

3. Drugs obtained from a non-Plan or non-Network 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.

4. 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 EOC.

5. Drugs that are not listed in our Preferred Drug List, except as described in this Rider.

6. Drugs that are considered to be experimental or investigational. Refer to "Clinical Trials" in Section 3 – Benefits of your EOC.

7. Except as specifically covered under this Outpatient Prescription Drug Rider, 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.

8. Drugs for which the Member is not legally obligated to pay, or for which no charge is made.

9. Blood or blood products. Refer to "Blood, Blood Products and their Administration" in Section 3 – Benefits of your EOC.

10. 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.

11. Medical foods. Refer to "Medical Foods" in Section 3 – Benefits of your EOC.

12. 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 EOC.

13. Replacement prescriptions necessitated by damage, theft or loss.

14. Prescribed drugs and accessories that are necessary for Services that are excluded under your EOC.

15. 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.

16. 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.

17. Durable medical equipment, prosthetic or orthotic devices, and their supplies, including: peak flow meters, nebulizers, and spacers; and ostomy and urological supplies. Refer to "Durable Medical Equipment" and "Prosthetic Devices" in Section 3 – Benefits of your EOC.

18. Drugs and devices 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 Care" in Section 3 – Benefits of your EOC.

19. Bandages or dressings. Refer to "Drugs, Supplies, and Supplements" and "Home Health Care" in Section 3 – Benefits of your EOC.

20. Diabetic equipment and supplies. Refer to "Diabetic Equipment, Supplies, and Self-Management" in Section 3 – Benefits of your EOC.

21. Growth hormone therapy (GHT) for treatment of adults age 18 or older.

22. Immunizations and vaccinations solely for the purpose of travel. Refer to "Outpatient Care" in Section 3 – Benefits of your EOC.

23. 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.

24. Drugs for the treatment of sexual dysfunction disorders.

F. Copayments/Coinsurance:

Covered drugs are provided upon payment of the Rx Copayment or Rx Coinsurance per prescription or refill set forth below:

Payment amounts for a Plan Pharmacy also apply to the Health Plan's Mail Service Delivery Program.

30 day supply	**Plan Pharmacy and Mail Delivery**	**Participating Network Pharmacy**
Generic Drugs	$10	$20
Preferred Brand Drugs	$20	$40
Non-Preferred Brand Drugs	$40	$55

	Mail Delivery, Plan Pharmacy and Participating Network Pharmacy
90-day Supply of Maintenance Medication	2 Rx Copayment(s) shown above

Weight management drugs for 50% of the Allowable Charge

Drugs for the treatment of infertility for 50% of the Allowable Charge.

If the Cost Share for the prescription drug is greater than the Allowable Charge for the prescription drug, the Member will only be responsible for the Allowable Charge for the prescription drug.

G. Deductible:
No Rx Deductible

Benefits set forth in this Rider are not subject to the Deductible set forth in the Summary of Services and Cost Shares in the EOC to which this Rider is attached.

H. Out-of-Pocket Maximum:
No Rx Out-of-Pocket Maximum

Cost Shares set forth in this Rider do not apply toward the Out-of-Pocket Maximum set forth in the Summary of Services and Cost Shares in your EOC to which this Rider is attached. The Rx Copayment and Rx Coinsurance set forth above will continue to apply even after the Out-of-Pocket Maximum in your EOC has been met.

This Outpatient Prescription Drug Rider is subject to all the terms and conditions of the Group Agreement and Group Evidence of Coverage to which this Rider is attached. This Rider does not change any of those terms and conditions, unless specifically stated in this Rider.

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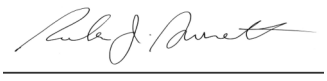
By: 

Ruben J. Burnett
Vice President, Marketing, Sales & Business Development

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

2101 East Jefferson St., Rockville, MD 20849
301-816-2424

EXTERNAL PROSTHETIC AND ORTHOTIC DEVICES RIDER

GROUP EVIDENCE OF COVERAGE

This External Prosthetic and Orthotic Devices Rider (herein called "Rider") is effective as of the date of your Group Agreement and Group Evidence of Coverage, and shall terminate as of the date your Group Agreement and Group Evidence of Coverage terminates.

The following benefits, limitations, and exclusions for External Prosthetic and Orthotic Devices are hereby added to the Benefits Section of the Group Evidence of Coverage (herein referred to as the Group EOC), in consideration of the application and payment of the additional Premium for such services.

External Prosthetic and Orthotic Devices

A. ***Definitions***

Allowable Charge (AC): As defined in your Group Evidence of Coverage.

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

Prosthetic Device: An artificial substitute for a missing body part used for functional reasons. As used in this Rider, "Prosthetic Device" does not include any prosthetic device that is covered under the Benefits Section of your Group EOC.

B. ***Benefits***

External Prosthetic and Orthotic Devices are covered when prescribed by a Plan Provider as follows, subject to the Cost Share shown below. Note: The benefit described in this Rider is in addition to the Prosthetic Device benefit provided in the Group EOC.

We select the provider or vendor that will furnish the covered device. Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and services to determine whether you need a Prosthetic or Orthotic Device. If we do not cover the device, we will try to help you find facilities where you may obtain what you need at a reasonable price.

External Prosthetic Devices
We cover external Prosthetic Devices (other than dental) that replace all or part of the function of a permanently inoperative or malfunctioning body part.

Orthotic Devices
We cover rigid and semi-rigid external Orthotic Devices that are used for the purpose of supporting a weak or deformed body member, or for restricting or eliminating motion in a diseased or injured part of the body. Examples of covered Orthotic Devices include, but are not limited to, leg, arm, back and neck braces. This benefit includes coverage of therapeutic shoes and inserts for individuals with severe diabetic foot disease only.

C. ***Limitations***

- Standard Devices: Coverage is limited to standard devices that adequately meet your medical needs.

D. ***Exclusions***

- More than one piece of equipment or device for the same part of the body, except for replacements; spare devices or alternate use devices.
- Dental prostheses, devices and appliances, except as specifically covered under the Group EOC.
- Hearing aids, except as specifically covered under the Group EOC.
- Corrective lenses and eyeglasses, except as specifically covered under the Group EOC.
- Repair or replacement due to misuse or loss.
- Orthopedic shoes or other supportive devices, unless the shoe is an integral part of a leg brace, unless indicated above.
- Non-rigid appliances and supplies, including but not limited to: jobst stockings, elastic garments and stockings, and garter belts.
- Comfort, convenience, or luxury equipment or features.

E. ***Your Cost Share***

Covered Services under this Rider are not subject to the Deductible and the Out-of-Pocket Maximum in the Group EOC to which this Rider is attached. You pay the following copayment or coinsurance for each Service:

- 10% of AC*

This External Prosthetic and Orthotic Devices Rider is subject to all the terms and conditions of the Group Evidence of Coverage to which this Rider is attached. This Rider does not change any of those terms and conditions, unless specifically stated in this Rider.

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

By: _____

Ruben J. Burnett
Vice President, Marketing, Sales & Business Development

KAISER FOUNDATION HEALTH PLAN
OF THE MID-ATLANTIC STATES, INC.
2101 East Jefferson St., Rockville, MD 20852
301-816-2424

COMPLEMENTARY ALTERNATIVE MEDICINE SERVICES RIDER

GROUP EVIDENCE OF COVERAGE

This Complementary Alternative Medicine Services Rider (herein called "Rider") is effective as of the date of your Group Agreement and Group Evidence of Coverage and shall terminate as of the date that your Group Agreement and Group Evidence of Coverage terminate.

The following benefits, limitations, and exclusions are hereby added to the "Benefits" Section of the Group Evidence of Coverage, in consideration of the Group application and payment of the additional Premium for the Services pursuant to this Rider.

Complementary Alternative Medicine Services

A. ***Definitions***
Allowable Charge (AC): As defined in your Group Evidence of Coverage.

B. ***Benefits:***
We cover the following complementary alternative medicine Services when deemed Medically Necessary and prescribed by a primary care Plan Physician in consultation with Kaiser Permanente's Complementary Alternative Medicine Department for chronic pain management or chronic illness management:

- Acupuncture Services
- Chiropractic Services

C. ***Limitations:***
The number of visits needed for the Member to reach a maximum level of recovery will be determined by the Plan Provider and shall not exceed a total of **20** visits per **contract** year.

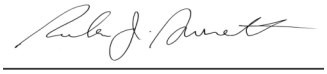
D. ***Exclusions:***
- Services requested by the Member that are deemed not Medically Necessary by the primary care Plan Physician in consultation with the Kaiser Permanente Complementary Alternative Medicine Department; and
- Services requested when the Member's medical condition does not satisfy Health Plan's clinical guidelines established for alternative care.

E. ***Your Cost Share:***
Covered Services under this Rider are not subject to the Deductible of the Group EOC to which this Rider is attached. You pay the following copayment or coinsurance for each visit:

- You pay **10% of AC*** per visit.

This Rider is subject to all the terms and conditions of the Group Agreement, and Group Evidence of Coverage to which this Rider is attached. This Rider does not change any of those terms and conditions, unless specifically stated in this Rider.

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

By: 

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KAISER PERMANENTE®

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

2010 AMENDMENT

This Amendment is effective as of the date of your Large Group Agreement and Evidence of Coverage, or July 1, 2010, whichever is later, and shall terminate on the date your Large Group Agreement and Large Group Evidence of Coverage terminates.

Coverage for Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas

The Pre-Authorization Required for Certain Services provision in SECTION 2 are hereby removed and replaced with the following provision:

Pre-Authorization Required for Certain Services
The following Services require preauthorization from your home Service Area while you are visiting another Health Plan or allied plan service area:

- Inpatient physical rehabilitation
- Mental health hospital services
- Residential facility admissions for chemical dependency
- Outpatient mental health or chemical dependency benefits

This Amendment is subject to all the terms and conditions of the Large Group Agreement and Evidence of Coverage to which this Amendment is attached. This Amendment does not change any of those terms and conditions, unless specifically stated in this Amendment.

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

By: _____

Ruben J. Burnett
Vice President, Marketing, Sales & Business Development

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.
AMENDMENT RIDER TO GROUP AGREEMENT AND EVIDENCE OF COVERAGE

(Non-Grandfathered Group Plan)

The Group Agreement and Evidence of Coverage (hereinafter severally and collectively referred to as the "Agreement") to which this amendment rider is attached are amended as described below.

Definitions

Capitalized terms shall have the meaning ascribed to them in the Agreement unless defined in this amendment rider. The following definitions have the following meanings in this amendment rider:

"Emergency Services" means, with respect to an Emergency Medical Condition (as that term is defined herein): (1) a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and, (2) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

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

"Essential Health Benefits" has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act (PPACA)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.

Notice of Non-Grandfathered Group Plan

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. believes that your Plan is "a non-grandfathered health plan" under the PPACA.

Children's Coverage to Age 26

The provisions of the Agreement that define a "child" or that describe the eligibility requirements or causes of termination of a child's coverage are revised as follows to comply with 45 CFR Parts 144, 146, and 147:

Eligibility

Any provision of the Agreement that indicates that a child's eligibility for coverage is based on any factor other than the relationship between the child and an individual covered under the Agreement is deleted. Any requirement that the child be financially dependent on an individual covered under the Agreement, that the child share a residence with an individual covered under the Agreement, that the child meet certain student status requirements, that the child be unmarried, that the child not be eligible for other coverage, or that the child not be employed is deleted.

Termination

Any provision of the Agreement that indicates that a child's coverage will terminate when the child marries, ceases to be financially dependent on an individual covered under the Agreement, ceases to share a residence with an individual covered under the Agreement, ceases to be a full-time or part-time student, is eligible for other coverage, becomes employed full-time or part-time, or reaches the child's 25th birthday is deleted.

The Agreement is revised to provide that the coverage of a child will terminate on the date the child reaches his or her 26th birthday. The limiting age will not apply to a child, who at the time of reaching the limiting age, is incapable of self-support because of mental or physical incapacity that started before the child attained the limiting age, provided the incapacitated child is unmarried and dependent on an individual covered under the Agreement. Coverage of the incapacitated child will continue for as long as the child remains incapable of self-support because of a mental or physical incapacity, unmarried, and dependent on an individual covered under the Agreement.

Definition of Child

Any provision of the Agreement that defines or describes which children can be covered under the Agreement is revised to include a child who has not attained the child's 26th birthday irrespective of the child's:

(1) Financial dependency on an individual covered under the Agreement;
(2) Marital status;
(3) Residency with an individual covered under the Agreement;
(4) Student status;
(5) Employment; or,
(6) Satisfaction of any combination of the above factors.

Transition for Children Previously Denied Enrollment or Who Terminated Coverage Due to Attaining Limiting Age

The Agreement is amended to provide coverage from the first day of the first contract year occurring on or after September 23, 2010, if the child meets both of the following:

(1) The child was terminated from coverage previously due to failure to satisfy the child definition of the Agreement or the child was prohibited from enrolling under the Agreement due to failure to meet the child definition in the Agreement; and
(2) The child enrolls during the first 30 days of the first contract year occurring on or after September 23, 2010.

Annual Dollar Limits

Any annual dollar limit on any Essential Health Benefits in the Agreement is amended to be the greater of (1) the annual dollar limit permitted under 45 CFR 147.126; and (2) the annual dollar limit described in the Agreement.

Rescissions

Any provision of the Agreement that describes the right of Health Plan to rescind or void the Agreement or to rescind the coverage of an individual under the Agreement is amended to permit Health Plan to rescind or void the entire Agreement or the coverage of a Member only if (1) the Member (or a person seeking coverage on behalf of the Member) performs an act, practice, or omission that constitutes fraud; or (2) the Member (or a person seeking coverage on behalf of the Member) makes an intentional misrepresentation of material fact.

Any provision of the Agreement that describes notice of rescission of coverage and that provides less than 30-days advance written notice of rescission is amended to provide 30-days advance written notice of any rescission of coverage.

Preventive 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:

(1) Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
(2) Immunizations that have in effect a recommendation from the Advisory

Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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

Prohibition on Pre-Existing Conditions for Children

The following provisions of the Agreement shall not apply to any child who is under the age of 19:

(1) Any provision that describes a pre-existing condition exclusion or limitation;

(2) Any provision that indicates that a pre-existing condition exclusion or limitation is applicable;

(3) Any provision that indicates that benefits are contingent on an injury occurring or a sickness first manifesting itself while the child is covered under the Agreement; and

(4) Any provision of the Agreement that describes possible denial or rejection of coverage due to underwriting.

Choice of Provider

Any provision of the Agreement that indicates that a Member is required to designate or provide for the designation of a primary care Plan Physician is amended to permit the Member to select any Plan Provider who is a primary care Plan Physician and is available to accept the Member.

Any provision of the Agreement that indicates that a primary care Plan Physician is required to be designated for a child Member, is amended to permit the designation of any Plan Physician (allopathic or osteopathic) who specializes in pediatrics as the child Member's primary care Plan Physician, if the provider is available to accept the child Member.

Any provision of the Agreement that requires a female Member to receive a referral or authorization from the primary care Plan Physician before receiving obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecological care is deleted. The Agreement is also amended to provide that the obstetrical and gynecological care received from a Plan Provider who specializes in obstetrics or gynecological care without the referral or authorization from the primary care Plan Physician includes the ordering of related obstetrical and gynecological Services that are covered under the Agreement.

Emergency Services

Any provision of the Agreement that provides benefits with respect to Services in an emergency

department of a hospital is amended to provide Emergency Services:

(1) Without the need for any prior authorization determination, even if the Emergency Services are provided by a non-Plan Provider;

(2) Without regard to whether the health care provider furnishing the Emergency Services is a Plan Provider with respect to the Services; and

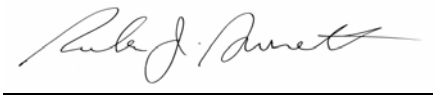
(3) If the Emergency Services are provided by a non-Plan Provider, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency Services received from Plan Providers.

Cost-Sharing Requirements for Emergency Services

If any Copayment amount or Coinsurance percentage described in the Agreement for Emergency Services is different for a Service received from a Plan Provider than a non-Plan Provider, the Copayment amount and Coinsurance percentage for Emergency Services provided by a non-Plan Provider is amended to be identical to the Copayment amount and Coinsurance percentage listed in the Agreement for Emergency Services provided by a Plan Provider.

Any other provision of the Agreement that describes cost-sharing for services received from non-Plan Providers, other than Copayment amounts or Coinsurance responsibilities, continue to apply to Emergency Services received from non-Plan Providers. Examples of these cost-sharing requirements include Deductibles and Out-of-Pocket Maximums. Any Out-of-Pocket Maximum described in the Agreement that generally applies to Services received from non-Plan Providers is applicable to Emergency Services received from non-Plan Providers.

This amendment rider shall be effective the first day of the first Contract Year on or after September 23, 2010.



Ruben J. Burnett
Vice President, Marketing, Sales & Business Development

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