









guide to

YOUR 2026 BENEFITS AND SERVICES

kaiserpermanente.org

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

GROUP
EVIDENCE OF COVERAGE

MARYLAND

SIGNATURE CARE DELIVERY SYSTEM

This plan has accreditation from the NCQA
See 2026 NCQA Guide for more information on Accreditation

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
4000 Garden City Drive,
Hyattsville, MD 20785

KFHP-EOC COVER(01-23)MD

HMO

NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty Corporation (the Corporation) and the protection it provides for policyholders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

The Corporation was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Corporation are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 for basic hospital, medical, and surgical insurance or major medical insurance provided by health benefit plans
  - $300,000 for disability insurance
  - $300,000 for long-term care insurance
  - $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above
- Annuities
  - $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
  - With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values.
- The maximum amount of protection for each individual, regardless of the number of policies or contracts, is:
  - $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
  - $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

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

Maryland Life and Health
Insurance Guaranty Corporation
8817 Belair Road
Suite 208
Perry Hall, Maryland 21236
410-248-0407

Or,

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
1-800-492-6116, ext. 2170

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network and/or your plan does not cover out-of-network services.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than your in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit. Your health plan coverage may not cover out-of-network services when you agree (consent) to receive services from the out-of-network providers.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service. Providers and facilities are not balance billing you when they seek to collect cost sharing or another amount that you agreed to pay or are required to pay under your plan for the services that they provided.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

In some circumstances, you may be protected from balance billing under Maryland state law. For example, if you are enrolled in a fully-insured plan and are treated by a Maryland doctor in an emergency room, the law may protect you.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in- network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology,laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, or when an in-network provider is not available. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't**

balance bill you, unless you give written consent and give up your protections.

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

You are protected from balance billing under Maryland law given that most hospital services are subject to an All-Payor Model Agreement, which means that hospital bills are the same for all payers including consumers. Maryland law also provides protection from balance billing from out-of-network providers but the protection depends on whether you are enrolled in an HMO or PPO plan and, for PPO enrollees, whether the physician is on-call or hospital based.

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers and facilities.
    - Base what you owe the provider or facility (your cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or non-emergency services provided by certain out-of-network providers at an in-network facility toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed by a provider or facility, contact the federal government at: **1-800-985-3059** or the Maryland Insurance Administration at https://insurance.maryland.gov/Consumer/Pages/FileAComplaint.aspx or call **1-800-492- 6116.**

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law. Visit *https://insurance.maryland.gov/Consumer/Documents/publications/AssignmentofBenefitsFAQ.pdf* for more information about your rights under Maryland state law.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

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

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

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

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at:

Kaiser Permanente
Appeals and Correspondence Department
Attn: Kaiser Civil Rights Coordinator
4000 Garden City Drive
Hyattsville, MD 20785
Telephone Number: 1-800-777-7902

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
Telephone Number: 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/language-assistance/nondiscrimination-notice.

HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ትኩረት፡ እንግሊዘኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች ለእርስዎ ይገኛሉ። በ **1-800-777-7902** ይደውሉ (TTY: **711**)።

العربية (Arabic) تنبيه: إذا كنت تتحدث الإنجليزية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك وسائل المساعدة والخدمات المناسبة. اتصل بالرقم **1-800-777-7902** (TTY: **711**).

Bǎsɔ́ɔ̀ Wùɖù (Bassa) Mbi sog: nia maa Engilì, njàl mbom a ka maa njàng ndol ni mbom mi tsoŋ ni soŋ, niŋ ma kénŋɛn yé, mbi èyɛm. Wɔ nàŋ **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) মনোযোগ দিন: আপনি যদি ইংরেজিতে কথা বলেন, আপনি বিনামূল্যে, উপযুক্ত সহায়ক পরিষেবা ও সাহায্য সমেত ভাষা সহায়তা পরিষেবা পেতে পারেন। **1-800-777-7902** (TTY: **711**)-এ ফোন করুন।

中文 (Chinese) 注意事項：如果您說英語，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان انگلیسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با **1-800-777-7902** تماس بگیرید (TTY (تلفن متنی): **711**).

Français (French) ATTENTION : si vous parlez anglais, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Englisch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-777-7902** an (TTY: **711**).

ગુજરાતી (Gujarati) ધ્યાન આપો: જો તમે અંગ્રેજી બોલો છો, તો યોગ્ય સહાયક સહાય અને સેવાઓ સહિતની ભાષા સહાય સેવાઓ, તમારા માટે મફત ઉપલબ્ધ છે. **1-800-777-7902** (TTY: **711**) પર કૉલ કરો.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale angle, w ap jwenn sèvis asistans lang tankou èd ak sèvis konplemantè adapte gratis. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: अगर आप अंग्रेज़ी बोलते हैं, तो आपके लिए उपयुक्त सहायक उपकरण और सेवाओं सहित भाषा सहायता सेवाएँ मुफ़्त उपलब्ध हैं। **1-800-777-7902** पर कॉल करें (TTY: **711**).

Igbo (Igbo) TINYE UCHE: Ọ bụrụ na ị na-asụ bekee, Ọrụ enyemaka nke asụsụ gụnyere udi enyemaka na ọrụ kwesịrị ekwesị, n'efu, dị nye gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE. Se parla inglese, può usufruire gratuitamente dei servizi di assistenza linguistica compresi gli opportuni aiuti e servizi ausiliari. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (Japanese) 注意：英語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-777-7902** までお電話ください（TTY: **711**）。

한국어 (Korean) 주의: 영어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-777-7902** 로 전화해 주세요(TTY: **711**).

Naabeehó (Navajo) BAA NAANISH 'AGHA: Daa nihi t'aa 'aanii 'adishni Bilagaana bizaad, saad 'ahilka 'ana'alwo' biniit'aa da beeso ndinish'aah t'aala'I bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, bineesh'a bil hadlee' goo nihi. Bika 'adishni **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala inglês, temos à sua disposição serviços gratuitos de assistência linguística, incluindo serviços e materiais de apoio adequados. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-английски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: Si habla inglés, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng English, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาอังกฤษ ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) توجہ: اگر آپ انگریزی بولتے ہیں تو آپ مفت زبان کی معاونت کی خدمات حاصل کر سکتے ہیں، جیسے مناسب معاون امداد اور خدمات۔ کال کریں **1-800-777-7902** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Anh, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) ÀKÍYÈSÍ: Tí o bá ń sọ èdè Gẹ̀ẹ́sì, àwọn iṣẹ́ ìrànlọ́wọ́ èdè àwọn ohun èlò ìrànlọ́wọ́ àti àwọn iṣẹ́ láìsí ìdíyelé wà fún ọ. Pe **1-800-777-7902** (TTY: **711**).

TABLE OF CONTENTS

SECTION 1 – INTRODUCTION TO YOUR KAISER PERMANENTE HEALTH PLAN 1.1

Welcome to Kaiser Permanente 1.1
Our Commitment to Diversity and Nondiscrimination 1.1
About This Group Agreement 1.1
How Your Health Plan Works 1.2
Kaiser Permanente Signature℠ 1.3
Eligibility for This Plan 1.3
Disabled Dependent Certification 1.4
Rights and Responsibilities of Members: Our Commitment to Each Other 1.5
Payment of Premium 1.7
Payment of Copayments, Coinsurance and Deductibles 1.7
Open Enrollment 1.7
Enrollment Period and Effective Date of Coverage 1.8
Enrollment Due to Reemployment After Military Service 1.11
Genetic Testing 1.11

SECTION 2 – HOW TO GET THE CARE YOU NEED 2.1

Making and Cancelling Appointments and Who to Contact 2.1
Advance Directives to Direct Your Care While Incapacitated 2.2
Using Your Kaiser Permanente Identification Card 2.2
Choosing Your Primary Care Plan Physician 2.3
Getting a Referral 2.3
Continuing Care Patient 2.6
Continuity of Care for New Members 2.7
Getting Emergency, Non-Emergency and Urgent Care Services 2.8
Hospital Admissions 2.10
Getting Assistance from Our Advice Nurses 2.10
Getting a Second Opinion 2.10
Receiving Care in Another Kaiser Foundation Health Plan Service Area 2.10
Wellness Program 2.10
Payment Toward Your Cost Share and When You May Be Billed 2.13

SECTION 3 – BENEFITS, EXCLUSIONS AND LIMITATIONS 3.1

Your Benefits 3.1
List of Benefits 3.1
Exclusions 3.37
Limitations 3.39

SECTION 4 – SUBROGATION, REDUCTIONS AND COORDINATION OF BENEFITS 4.1

Subrogation and Reductions, Explained 4.1
When Illness or Injury is Caused by a Third Party 4.1
Workers' Compensation or Employer's Liability 4.3
Health Plan Not Liable for Illness or Injury to Others 4.3
Failure to Notify the Health Plan of Responsible Parties 4.3

Pursuit of Payment from Responsible Parties 4.4
Reductions Under Medicare and TRICARE Benefits 4.4
Coordination of Benefits 4.4
Order of Benefit Determination Rules 4.5
Military Service 4.8

SECTION 5 – HEALTH CARE SERVICE REVIEW, APPEALS AND GRIEVANCES 5.1

Important Definitions 5.1
Questions About Health Care Service Review, Appeals or Grievances 5.1
The Health Care Service Review Program 5.1
Notice of Claim 5.4
Filing for Payment or Reimbursement of a Covered Service or Post-Service Claim 5.4
The Health Education and Advocacy Unit, Office of the Attorney General 5.6
Maryland Insurance Commissioner 5.6
Our Internal Grievance Process 5.7
Our Internal Appeal Process 5.12
Filing Complaints About the Health Plan 5.14

SECTION 6 – TERMINATION OF MEMBERSHIP 6.1

Termination of Membership 6.1
Extension of Benefits 6.2
Discontinuation of a Product or All Products 6.2
Continuation of Group Coverage Under Federal Law 6.3
Continuation of Coverage Under State Law 6.3

SECTION 7 – OTHER IMPORTANT PROVISIONS OF YOUR PLAN 7.1

Applications and Statements 7.1
Assignment 7.1
Attorney Fees and Expenses 7.1
Certificates 7.1
Contestability 7.1
Contracts with Plan Providers 7.1
Governing Law 7.2
Legal Action 7.2
Mailed Notices 7.2
Notice of Non-Grandfathered Group Plan 7.3
Overpayment Recovery 7.3
Privacy Practices 7.3

APPENDICES DEF.1

Important Terms You Should Know DEF.1
Summary of Services and Cost Shares CS.1

Kaiser Permanente
Maryland Large Group Agreement and Evidence of Coverage

SECTION 1: Introduction to Your Kaiser Permanente Health Plan

Welcome to Kaiser Permanente

Thank you for choosing us as your partner in total health. Kaiser Permanente provides you with many resources to support your health and wellbeing. This Group Agreement and Evidence of Coverage (EOC) is one of them. It provides you with an overview of your Group Health Plan, including the benefits you are entitled to, how to get care, what services are covered and what part of the costs of your care you will have to pay.

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

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

Again, thank you for enrolling with Kaiser Permanente.

Our Commitment to Diversity and Nondiscrimination

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

About This Group Agreement

Once you are enrolled under this Group Agreement, you become a Member. A Member may be a Subscriber and/or any eligible Dependents, once properly enrolled. Members are sometimes referred to by the terms "you" and "your." Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., is sometimes referred to as "Health Plan," "we," "us," "our" and "Kaiser Permanente."

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

Important Terms

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

Purpose of this Group Agreement and EOC

This EOC, including the large Group Agreement and any attached applications, riders and amendments serves three important purposes. It:

1. Constitutes the entire contract between your Group and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2. Provides evidence of your health care coverage; and
3. Describes the Kaiser Permanente Signature℠ health care coverage provided under this contract.

Administration of this Group Agreement and EOC

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

Group Agreement and EOC Binding on All Members

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

Amendment of Group Agreement and EOC

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

No Waiver
Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, nor impair our right thereafter to require your strict performance of any provision.

Entire Contract
This Group Agreement replaces any earlier Group Agreement that may have been issued by us. The term of this EOC is based on your Group's contract year and your effective date of coverage. Your Group's benefits administrator can confirm that this EOC is still in effect.

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

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

Any change to this contract may not be valid until the:

1. Approval is endorsed by an executive officer of the Health Plan; and
2. Endorsement appears on, or is attached to the contract.

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



By: _____

Gracelyn McDermott
Vice President, Marketing, Sales & Business Development

How Your Health Plan Works

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

Under our contract with your Group, we have assumed the role of a named fiduciary, which is the party responsible for determining whether you are entitled to covered Services under this EOC and provides us with the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by reasonably interpreting the provisions of this EOC.

Relations Among Parties Affected By This Group Agreement and EOC
Kaiser Permanente is comprised of three entities: the Health Plan, Medical Group and Plan Hospitals. Please note that:

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

Additionally:

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

Patient Information Obtained by Affected Parties

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

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

Liability for Amounts Owed By the Health Plan

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

Kaiser Permanente Signature℠

Kaiser Permanente Signature℠ provides you with Health Care Services administered by Plan Providers at our Plan Medical Centers, which are located throughout our Service Area. At our Plan Medical Centers, integrated teams of Specialists, nurses and technicians work alongside your Primary Care Plan Physician to support your health and wellbeing. Pharmacy, optical, laboratory and X-ray facilities are also available at many Plan Medical Centers.

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

1. Emergency Services, as described in ***Section 3: Benefits, Exclusions and Limitations;***
2. Urgent Care Services outside of our Service Area, as described in ***Section 3: Benefits, Exclusions and Limitations;***
3. ***Continuity of Care for New Members,*** as described in ***Section 2: How to Get the Care You Need;***
4. Continuing Care Patients, as described in ***Section 2: How to Get the Care You Need;***
5. Receiving Care in Another Kaiser Foundation Health Plan Service Area, as described in ***Section 2: How to Get the Care You Need;***
6. Approved Referrals, as described in ***Section 2: How to Get the Care You Need*** under the ***Getting a Referral*** provision, including referrals for Clinical Trials, as described in ***Section 3: Benefits, Exclusions and Limitations***; and
7. Covered Services received in other Kaiser Permanente regions and Group Health Cooperative service areas;
8. Non-Emergency Services, including Ancillary Services, and Services for unforeseen urgent medical needs received by a non-Participating Provider at a Plan Hospital or a Plan Facility as described in ***Section 2: How to Get the Care You Need*** under the ***Non-Emergency Services & Urgent Care Services*** provision.

Eligibility for This Plan

Eligibility of a Member

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

1. Your Group's eligibility requirements that we have approved (your Group is required to inform Subscribers of the Group's eligibility requirements) and meet the Subscriber or Dependent eligibility requirements below.
2. You must reside, live, or work inside our Service Area to be eligible for this Plan. However, the Subscriber and their Spouse's, Domestic Partner's eligible children who live outside of our Service Area may be eligible to enroll if you are required to cover them pursuant to any court order, court-approved agreement or other testamentary appointment. A Dependent who attends school outside of our Service Area and meets the eligibility requirements listed below under ***Dependents*** is also eligible for enrollment. However, the only covered Services outside of our

Service Area are:

a. Emergency Services;
b. Urgent Care Services;
c. Continuity of Care for New Members;
d. Continuity of Care when a plan provider's contract is terminated;
e. Services as described in ***Section 2: How to Get the Care You Need*** under the ***Non -Emergency Services & Urgent Care Services*** provision;
f. Services received in connection with an approved referral, unless you elect to bring the Dependent within our Service Area to receive covered Services;
g. Approved Clinical Trials; and
h. Covered Services received in other Kaiser Permanente regions and Group Health Cooperative service areas.

3. **Subscribers**

You are eligible to enroll if you are employed by a Large Employer and that Large Employer offers you coverage under this Health Plan as an eligible employee, based on your Group's eligibility requirements, which we have previously approved (e.g., you are an employee of your Group who works at least the number of hours specified in those requirements). At the option of the Large Employer, an eligible employee may include:

a. Only Full-Time Employees; or
b. Both Full-Time Employees and Part-Time Employees.

4. **Dependents**

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

a. Your lawful Spouse or Domestic Partner;
b. You or your Spouse's or Domestic Partner's Dependent child who is under the age limit specified in the ***Summary of Services and Cost Shares*** and who is:
   i. A biological child, stepchild, grandchild or foster child;
   ii. A lawfully adopted child, or, from the date of placement, a child in the process of being adopted;
   iii. A grandchild under testamentary or court-appointed guardianship of the Subscriber or the Subscriber's Spouse or Domestic Partner;
   iv. A child for whom you or your Spouse or Domestic Partner have been granted legal custody (other than custody as a result of a guardianship); or
   v. A child for whom you or your Spouse or Domestic Partner have the legal obligation to provide coverage pursuant to a child support order or other court order or court-approved agreement or testamentary appointment.

An unmarried child who is covered as a Dependent when they reach the age limit specified in the ***Summary of Services and Cost Shares*** may be eligible for coverage as a disabled Dependent if they meet all of the following requirements:

1. They are incapable of self-sustaining employment because of a mental or physical incapacity that occurred prior to reaching the age limit for Dependents;
2. They are primarily dependent for their support and maintenance from you or your Spouse or Domestic Partner's; and
3. You provide us proof of their incapacity and dependency in accordance with the ***Disabled Dependent Certification*** requirements in this section.

Disabled Dependent Certification

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

1. If your Dependent is a Member and reaches the age limit specified in the ***Summary of Services and Cost Shares***, we will send you a notice of his or her membership termination due to loss of eligibility under this Plan at least ninety (90) days before the date that coverage will end. Your Dependent's membership will terminate as described in our notice unless you provide us with documentation of his or her incapacity and dependency. Once proof of incapacity and dependency are received, we will make a determination as to whether he or she is eligible as a disabled Dependent. If you provide proof of incapacity and dependency to us:
   a. Prior to the termination date in the notice and we do not make an eligibility determination before the termination date, the Dependent's coverage will continue until we make a determination.
   b. Within the sixty (60) days following the Dependent reaching the limiting age and we determine that your Dependent is eligible as a disabled Dependent, then there will be no lapse in coverage.
2. If we determine that your Dependent does not meet the eligibility requirements as a disabled Dependent, we will notify you that he or she is not eligible and advise you of the child's membership termination date.
3. Beginning two (2) years after your Dependent reaches the limiting age you are required to provide us with proof of his or her continued incapacity and dependency annually. Proof must be received within sixty (60) days of our request. Once received, we will determine whether he or she remains eligible as a disabled Dependent. We reserve the right to request proof of your Dependent's incapacity and dependency less frequently than once per year; however, proof still must be received within sixty (60) days of our request.

Rights and Responsibilities of Members: Our Commitment to Each Other

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

Rights of Members

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

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

the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. You or your Authorized Representative will be asked to provide written permission before a Member's records are released, unless otherwise permitted by law.

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

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

Responsibilities of Members

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

1. **Promote your own good health:**
   a. Be active in your health care and engage in healthy habits;
   b. Select a Primary Care Plan Physician. You may choose any participating primary care provider who practices in the specialty of Internal Medicine, Pediatrics, or Family Practice as your Primary Care Plan Physician. You may also choose a personal OB/GYN in addition to Primary Care Plan Physician;
   c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you;
   d. Work with us to help you understand your health problems and develop mutually agreed upon treatment goals;
   e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment;
   f. Do your best to improve your health by following the treatment plan and instructions your

Primary Care Plan Physician or health care professional recommends;

g. Schedule the health care appointments your Primary Care Plan Physician or health care professional recommends;
h. Keep scheduled appointments or cancel appointments with as much notice as possible.
i. Inform us if you no longer reside, live, or work within the Plan Service Area.

2. **Know and understand your Plan and benefits:**
   a. Read about your health care benefits in this contract and become familiar with them. Call us when you have questions or concerns;
   b. Pay your Plan Premium, and bring payment with you when your visit requires a Copayment, Coinsurance or Deductible;
   c. Let us know if you have any questions, concerns, problems or suggestions;
   d. Inform us if you have any other health insurance or prescription drug coverage; and
   e. Inform any network or non-Participating provider from whom you receive care that you are enrolled in our Plan.
3. **Promote respect and safety for others:**
   a. Extend the same courtesy and respect to others that you expect when seeking Health Care Services; and
   b. Assure a safe environment for other members, staff and physicians by not threatening or harming others.

Payment of Premium

Members are entitled to health care coverage only for the period for which the Health Plan has received the appropriate Premium from your Group. You are responsible to pay any required contribution to the Premium, as determined and required by your Group. Your Group will tell you the amount you owe and how you will pay it to your Group. For example: A payroll deduction.

Payment of Copayments, Coinsurance and Deductibles

In addition to your monthly Premium payment, you may also be required to pay a Cost Share when you receive certain covered Services. A Cost Share may consist of a Copayment, Coinsurance, Deductible or a combination of these. Copayments are due at the time you receive a Service. You will be billed for any Deductible and/or Coinsurance you owe.

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

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

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

Open Enrollment

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

1. Yourself, as a new Subscriber, along with any of your eligible Dependents; or

2. Eligible Dependents, if you are already an existing Subscriber.

Enrollment Period and Effective Date of Coverage

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

Your Group will let you know when the open enrollment period begins and ends. Your membership will be effective at 12 a.m. Eastern Time (the time at the location of the administrative office of carrier at 4000 Garden City Drive, Hyattsville, MD 20785) on the first day of the contract year.

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

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

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

1. Become eligible for a special enrollment period, as described in this section; or
2. Did not enroll in any coverage through your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling at a later time. The effective date of an enrollment resulting from this provision is no later than the 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 thirty-one (31) days after marriage, Domestic Partnership, birth, adoption or placement for adoption by submitting to your Group a Health Plan-approved enrollment application.

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

1. **For new Spouse** Domestic Partnership, no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber.
2. **For newborn children, the moment of birth.** If payment of additional Premium is required to provide coverage for the newborn child then, in order for coverage to continue beyond thirty-one (31) days from the date of birth, notification of birth and payment of additional Premium must be provided within thirty-one (31) days of the date of birth, otherwise coverage for the newborn will terminate thirty-one (31) days from the date of birth.
3. **For children, stepchildren, grandchildren, or adopted children who become eligible through Subscriber's marriage, the date of the marriage.** If payment of additional Premium is required to provide coverage for the child(ren) then, in order for coverage to continue beyond thirty-one (31) days from the date of eligibility, notification of eligibility and payment of additional Premium must be provided within thirty-one (31) days of the date of eligibility, otherwise coverage for the newly eligible child(ren) will terminate thirty-one (31) days from the date of eligibility.

4. **For children, stepchildren, grandchildren, or adopted children who become eligible through Subscriber's new Domestic Partner arrangement, the date of the signed Affidavit of Domestic Partnership.** If payment of additional Premium is required to provide coverage for the child(ren) then, in order for coverage to continue beyond thirty-one (31) days from the date of eligibility, notification of eligibility and payment of additional Premium must be provided within thirty-one (31) days of the date of eligibility, otherwise coverage for the newly eligible child(ren) will terminate thirty-one (31) days from the date of eligibility.
5. **For newly born, newly adopted children or newly adopted grandchildren (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 thirty-one (31) days from the date of adoption, notification of adoption and payment of additional Premium must be provided within thirty-one (31) days of the date of adoption, otherwise coverage for the newly adopted child will terminate thirty-one (31) days from the date of adoption.
6. **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 thirty-one (31) days of the date of the court ordered custody, otherwise coverage terminates thirty-one (31) days from the date of the court ordered custody.

Special Enrollment for Child Due to Order

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

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

If a child has health insurance coverage through an insuring parent, Health Plan shall:

(1) provide to the non-insuring parent membership cards, claims forms, and any other information necessary for the child to obtain benefits through the health insurance coverage; and

(2) process the claims forms and make appropriate payment to the non-insuring parent, health care provider, or Department of Health if the non-insuring parent incurs expenses for health care provided to the child.

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 thirty-one (31) days of enrollment of the child, otherwise, enrollment of the child will be void. Enrollment for such child will be allowed in accordance with Section 15-405(c) of the Insurance Article which provides for the following:

1. An insuring parent is allowed to enroll in family member's coverage and include the child in that coverage regardless of enrollment period restrictions;
2. A non-insuring parent, child support agency, or Maryland Department of Health (MDH) is allowed to apply for health insurance coverage on behalf of the child and include the child in the coverage regardless of enrollment period restrictions; and
3. The Health Plan may not terminate health insurance coverage for a child eligible under this

subsection unless written evidence is provided that the:

a. Order is no longer in effect;
b. Child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective termination date;
c. Employer has eliminated family member's coverage for all employees; or
d. Employer no longer employs the insuring parent, except the parent elects to enroll in COBRA, coverage shall be provided for the child consistent with the employer's plan for postemployment health insurance coverage for dependents under COBRA.

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.

Special Enrollment Due to Loss of Other Coverage

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

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

Note: If you are enrolling yourself as a Subscriber along with at least one (1) eligible Dependent, only one (1) of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Health Plan-approved enrollment or change of enrollment application to your Group within thirty (30) days after loss of other coverage, except that the timeframe for submitting the application is sixty (60) days if you are requesting enrollment due to loss of eligibility for Medicaid or CHIP coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the 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 Eligibility for Premium Assistance Under Medicaid or CHIP

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

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

Enrollment Due to Reemployment After Military Service

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

Genetic Testing

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

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

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

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

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

SECTION 2: How to Get the Care You Need

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

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

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

Making and Cancelling Appointments and Who to Contact

At Kaiser Permanente, we are available to assist you in getting the care you need. Should you experience a medical condition or require assistance from us, please contact the appropriate number below.

Medical Emergencies

- **Call 911, (where available), if you think you have a medical emergency.**

Medical Advice

- **Call us at 1-800-677-1112 if you are unsure of your condition and require immediate medical advice.** You should also call this number in the event that you have an emergency hospital admission. We require notice within 48 hours, or as soon as reasonably possible thereafter, of any emergency hospital admission.

Making or Canceling Appointments

To make or cancel an appointment, please visit us online at **www.kp.org**.

You may also make or cancel an appointment with a Primary Care Plan Physician in one of our Plan Medical Centers by phone. To do so, please have your Kaiser Permanente identification card with you and contact us at 1-800-777-7904 or 711 (TTY). We are available to assist you 24/7.

If your Primary Care Plan Physician is in our Network of Plan Providers, but not located in a Plan Medical Center, please contact his/her office directly for assistance making or canceling an appointment. The telephone number for their office is located on your Kaiser Permanente identification card.

Choosing or Changing Your Primary Care Plan Physician

We recommend that you choose a Primary Care Plan Physician if you have not done so already. For more information, see ***Choosing Your Primary Care Plan Physician*** in this section.

You may choose or change your Primary Care Plan Physician at any time, for any reason, by visiting **www.kp.org/doctor**. On the website, you can browse all doctor's profiles and select a doctor who matches your needs.

You may also choose or change your Primary Care Plan Physician by phone by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Customer Service

We want you to be satisfied with your health care. Member Services representatives are available to assist you with questions about your Plan Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Member Services representatives are also available at most of our Plan Medical Centers. You may also ask your Primary Care Plan Physician or other health care professionals about problems you may have.

Advance Directives to Direct Your Care While Incapacitated

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

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

For additional information about advance directives, including how to obtain forms and instructions, visit us online at **www.kp.org** or contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Using Your Kaiser Permanente Identification Card

Digital Kaiser Permanente Identification Card

Managing your health care is convenient with the Kaiser Permanente mobile app. The app gives you access to your digital Kaiser Permanente identification card, which allows you to check in for appointments, pick up prescriptions and provide your membership information, all from your smartphone. To access your digital Kaiser Permanente identification card:

1. Log into the Kaiser Permanente mobile app; and
2. Select “Member ID Card” from the menu options.

Note: Verify that the Kaiser Permanente mobile app is available on your smartphone and create your login before arriving at your appointment. Additionally, the availability of the digital Kaiser Permanente identification card is limited to certain types of Plans and does not replace the physical card. Each Member will also receive a physical Kaiser Permanente identification card.

Using Your Kaiser Permanente Identification Card

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

Your medical record number is used to identify your medical records and status as a Member. You should always have the same medical record number.

If you need to replace your Kaiser Permanente identification card, or if we ever issue you more than one (1) medical record number, please let us know by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Note: Allowing another person to use your ID card will result in forfeiture of your Kaiser Permanente identification card and may result in termination of your status as a Member.

Choosing Your Primary Care Plan Physician

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

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

Primary Care Plan Physicians are located within our Plan Medical Centers.

Our Provider Directory is available online at **www.kp.org** and updated daily. A listing of all Primary Care Plan Physicians is also provided to you on an annual basis.

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

Getting a Referral

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

If your Provider decides that you need covered Services from a Specialist, your Provider will request a referral for you. To check whether the referral is approved or denied, please call Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY). You will not be held liable if the provider does not obtain the referral.

In the event that the covered Services you need are not available from a Plan Provider, we may refer you to another provider. For more information, see ***Referrals to Non-Plan Specialists and Non-Physician Specialists*** below.

The Cost Shares for approved referral Services provided by a non-Plan Provider are the same as those required for Services provided by a Plan Provider.

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

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

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

Services that Do Not Require a Referral

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.

Except for Emergency Services, these Services include the following:

1. An initial consultation for treatment of mental illness, emotional disorders, and drug or alcohol abuse when provided by a Plan Provider. For continued treatment, you or your Plan Provider must contact the Behavioral Health Access Unit for assistance to arrange and schedule these covered Services. The Behavioral Health Access Unit may be reached at 1-866-530-8778;
2. OB/GYN Services provided by an OB/GYN, a certified nurse-midwife or any other Plan Provider authorized to provide OB/GYN Services, including the ordering of related, covered OB/GYN Services; and
3. Optometry Services.

Emergency Services do not require a referral from your Primary Care Plan Physician, regardless if the Emergency Services are received from a Plan Provider or a non-Participating Provider.

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

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

Prior Authorization for Prescription Drugs

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

Step-therapy is a process that requires a prescription drug or sequence of prescription drugs to be used by a Member before the Health Plan will cover a prescription drug prescribed by a prescriber.

For a step therapy exception request submitted electronically in accordance with a process established under §15-142(f) of the Maryland Insurance Article or a Prior Authorization request submitted electronically for pharmaceutical Services, a Health Plan shall make a determination:

1. in real time if:
    a. no additional information is needed by the Health Plan to process the request; and
    b. the request meets the private review agent's criteria for approval; or
2. if a request is not approved in real time under item #1 immediately listed above, within one (1) working day after the Health Plan receives all of the information necessary to make the determination.

If additional information is needed to make a determination after confirming through a complete review of the information already submitted by the Health Care Provider, the Health Plan shall request the

information promptly, but not later than three (3) calendar days after receipt of the initial request, by specifying:

1. the information, including any laboratory or diagnostic test or other medical information, that must be submitted to complete the request; and
2. the criteria and standards to support the need for the additional information.

If a Health Plan fails to make a determination within the required time limits, the request shall be deemed approved.

We will not require step-therapy if:

1. The step-therapy drug has not been approved by the U.S. Food & Drug Administration (FDA) for the medical condition being treated; or
2. A prescriber provides supporting medical information to us that a prescription drug we cover:
    a. Was ordered by the prescriber for the Member within the past 180 days; and
    b. Based on the professional judgement of the prescriber, was effective in treating the Member's disease or medical condition; or
3. A prescription drug was approved by the FDA; and
    a. Is insulin or an insulin analog used to treat the Member's Type 1, Type 2, or gestational diabetes; or
    b. Is used to treat a Member's stage four advanced metastatic cancer; and
    c. Use of the prescription drug is:
        i. Consistent with the FDA approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer; and
        ii. Supported by peer-reviewed medical literature; or
    d. Prescribed by a treating physician to treat a symptom of or a side effect from treatment of the Member's stage four advanced metastatic cancer; and
        i. Use of the prescription drug is consistent with best practices for the treatment of stage four advanced metastatic cancer, a condition associated with stage four advanced metastatic cancer, or a side effect associated with stage four advanced metastatic cancer treatment; and
        ii. Is supported by peer-review medical literature; and
        iii. Is covered under this Plan.

Supporting medical information means:

1. A paid claim from the Health Plan for a Member;
2. A pharmacy record that documents that a prescription has been filled and delivered to a Member or a representative of a Member; or
3. Other information mutually agreed on by the Health Plan and the prescriber.

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

Standing Referrals to Specialists

If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires

Specialty Services, your Primary Care Plan Physician may determine, in consultation with you and a Specialist, that you need continuing care from that Specialist. The Specialist has expertise in treating the life-threatening, degenerative, chronic, or disabling disease or condition; and is part of the Health Plan's provider panel. In such instances, your Primary Care Plan Physician will issue a standing referral to the Specialist.

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

Referrals to Non-Plan Specialists and Non-Physician Specialists

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

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

You must have an approved referral to the non-Plan Specialist or Non-Physician Specialist in order for us to cover the Services. Any additional radiology studies, laboratory Services or Services from any professional who is not named in the referral are not authorized and will not be reimbursed. If the non-Plan Provider recommends Services not indicated in the approved referral, your primary care Plan Physician will work with you to determine whether those Services can be provided by a Plan Provider. The Cost Shares for approved referral Services provided by non-Plan Providers are the same as those required for Services provided by a Plan Provider. The Member will not be liable for an amount that exceeds the Cost Sharing that would have applied to the Member if the provider was a Participating Provider. Services received for mental health or substance use disorders are provided at no greater cost to the Member than if the covered benefit were provided by a provider on Kaiser's provider panel.

Post-Referral Services Not Covered

Any additional Services not specifically listed, and/or that are provided by a professional not named in the referral, are not authorized and will not be reimbursed.

If a non-Plan Provider for whom you have received an authorized referral recommends additional Services that are not indicated in that approved referral, advise your Plan Provider. He or she will work with you to determine whether those Services can be provided by a Plan Provider. Additional services not specifically listed in the referral are not authorized and will not be reimbursed unless you have received a Prior Authorization for those Services.

Continuing Care Patient

A Continuing Care Patient, as defined in the section ***Important Terms You Should Know***, receiving care from a Participating Provider may elect to continue to receive transitional care from such provider if the provider's Participating Provider contract is terminated or non-renewed for reasons other than for failure to meet applicable quality standards or for fraud; or if the group contract terminates resulting in a loss of benefits with respect to such provider or facility. Health plan will notify each Member who is a Continuing Care Patient at the time of termination or non-renewal on a timely basis of such termination and the Member's right to elect transitional care.

When elected, benefits will be provided under the same terms and conditions as would have applied with respect to items and Services that would have been covered had termination not occurred, with respect to the course of treatment provided by such provider or facility relating to the Member's status as a Continuing Care Patient. Benefits will be provided during the period beginning on the date Health Plan notifies the Continuing Care Patient of the termination and ending on the earlier of: (i) 90 days after the date of such notice; or (ii) the date on which such member is no longer a Continuing Care Patient with respect to such provider or facility.

The member will not be liable for an amount that exceeds the cost-sharing that would have applied to the member had the termination not occurred.

Continuity of Care for New Members

At the request of a new Member, or a new Member's parent, guardian, designee or Health Care Provider, the Health Plan shall:

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

As described below, see ***Accepting Prior Authorization for Services*** in this section, the Health Plan will accept the Prior Authorization and allow a new Member to continue to receive Services from a non-Plan Provider for:

1. The course of treatment or ninety (90) days, whichever is less; and
2. Up to three (3) trimesters of a pregnancy and the initial postpartum Visit.

Transitioning to Our Services

At the end of the applicable time period immediately above under ***Continuity of Care for New Members*** in this section, we may elect to perform our own review to determine the need for continued treatment; and to authorize continued Services as described under ***Getting a Referral*** in this section.

Accepting Prior Authorization for Services

The Health Plan shall accept a Prior Authorization for the procedures, treatments, medications or other Services covered under this Agreement.

Health Plan shall accept Prior Authorization from a Member or their Health Care Provider from a prior carrier for at least the lesser of ninety (90) days or the length of the course of treatment; and the duration of the three trimesters of a pregnancy and the initial postpartum visit.

After receiving the consent of a Member, or the Member's parent, guardian or designee, we may request a copy of the Prior Authorization by following all the laws for confidentiality of medical records. The prior carrier, managed care organization or third-party administrator must provide a copy of the Prior Authorization within ten (10) days following receipt of our request.

Continuity of Care Limitation for Prior Authorization

With respect to any benefit or Service provided through the fee-for-services Maryland Medical Assistance Program, this subsection shall apply only to:

1. Enrollees transitioning from the Maryland Medical Assistance Program to the Health Plan; and
2. Behavioral health and dental benefits, to the extent they are authorized by a third-party administrator.

Continuity of Care for Existing Members

Health Plan shall approve a request for the Prior Authorization of a course of treatment, including for chronic conditions, rehabilitative Services, substance use disorders, and mental health conditions, that is for a period of time that is as long as necessary to avoid disruptions in care and determined in accordance with applicable coverage criteria, the Member's medical history, and the Health Care Provider's recommendation.

Health Plan will not disrupt or require reauthorization for an active course of treatment for covered Services for at least ninety (90) days after the date of enrollment; and the duration of the three trimesters of a pregnancy and the initial postpartum visit.

Services from Non-Plan Providers

The Health Plan shall allow a new Member to continue to receive covered health care Services being rendered by a non-Plan Provider at the time of the Member's transition to our plan for the following conditions:

1. Acute conditions;
2. Serious chronic conditions;
3. Pregnancy;
4. Mental health conditions and substance use disorders; and
5. Any other condition on which the non-Plan Provider and the Health Plan reach agreement.

Examples of acute and serious chronic conditions may include:

1. Bone fractures;
2. Joint replacements;
3. Heart attack;
4. Cancer;
5. HIV/AIDS; and
6. Organ transplants.

Health Plan shall allow a new Member to continue to receive these Services for at least the lesser of ninety (90) days or the length of the course of treatment; and the duration of the three trimesters of a pregnancy and the initial postpartum visit.

Getting Emergency, Non-Emergency and Urgent Care Services

Emergency Services

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

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

You will incur the same cost sharing (Deductible, Coinsurance and/or Copayment, as applicable) for Emergency Services furnished by non-Participating Providers as Participating Providers, or for Emergency Services furnished by non-Participating Emergency Facilities as Participating Emergency Facilities, and such Cost Sharing will be calculated based on the Recognized Amount in accordance with applicable law. Any Cost Share payments made by you will apply toward any in-network Deductible, if any, and in-network Out-of-Pocket Maximum, if any.

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

Bills for Emergency Services

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

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

Kaiser Permanente National Claims Administration - Mid-Atlantic States
PO Box 371860
Denver, CO 80237-9998
Website: **www.kp.org**

If you have already paid the bill, then please send proof of payment and a copy of the bill to the address or website listed above. Please remember to include your medical record number on your proof. For more information on the payment or reimbursement of covered services and how to file a claim, see ***Section 5: Health Care Service Review, Appeals and Grievances.***

Non-Emergency Services & Urgent Care Services

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

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

When a non-Participating Provider provides non-Emergency Services at a Plan Hospital or a Plan Facility, your Cost Share will be the same Cost Sharing amount for the same Service(s) from a Participating Provider unless the non-Participating Provider has satisfied the notice and consent requirements of 45 C.F.R. §149.420(c) through (i) with respect to those non-Emergency Services. Any Cost Sharing requirement for the items and Services will be calculated based on the Recognized Amount. Such Cost Share shall count toward your in-network Deductible, if any, and in-network Out-of-Pocket Maximum. You will not be liable for any additional payment other than your Cost Share for non-Emergency Services. We will make payment for the items and Services directly to the

non-Participating Provider. The payment amount will be equal to the amount by which the Out-of-Network Rate exceeds the Cost Sharing amount for the items and Services.

For covered Services rendered by a Health Care Provider for which payment is required under §19-710.1 of the Health-General Article, Ancillary Services, and items or Services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or Service is furnished, regardless of whether the non-Participating Provider satisfied the notice and consent criteria. The notice and consent criteria of 45 C.F.R. §149.420 (c) through (i) do not apply to non-Participating Providers. Additionally, when these Services are received by a non-Participating Provider they will always be subject to the conditions described in the above paragraph.

Hospital Admissions

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

Getting Assistance from Our Advice Nurses

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

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

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

Getting a Second Opinion

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

Receiving Care in Another Kaiser Foundation Health Plan Service Area

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

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

Wellness Program

The Wellness Program offers the opportunity to participate in ancillary promotional giveaways described in detail below. Kaiser Permanente rewards provide you with access to a software platform, either via the KP mobile application on your phone or KP internet site, or both, where you can earn rewards by completing health and wellness related activities designed to promote health or prevent disease.

The Wellness Program works by assigning reward values to each activity including points, as described below, up to a maximum total amount of rewards you can earn in a year. The maximum total rewards plus points that you can earn will not exceed 30% of the total cost of employee–only coverage under your health benefit plan for the year. When you complete the activity, you will be automatically awarded the value of the reward, which is paid as a deposit onto a reloadable payment card. This reloadable payment card can be used like a debit card to purchase eligible items at participating retail locations including grocery stores, pharmacies, and other merchants. The card can be used for health-related expenses, groceries, household items, and other everyday purchases. Restrictions apply: specifically, purchase of alcohol, tobacco, or firearms products is prohibited and the reloadable card will be declined for such purchases. The card cannot be used at ATMs to withdraw cash. You will receive instructions on how to activate and use your card when it is issued to you. In addition, you will earn one point equal to the dollar amount of the reward for each activity that can be converted into entries into promotional contests of chance, also called drawings or promotions, for an additional prize. Points are in addition to your rewards, which are earned solely by completing the activity, and no reward is awarded based on chance. Drawings will be held once per month, and you may participate in each monthly drawing based on the points you've earned. You may win multiple prizes throughout the year from different drawings. The potential prize value for each drawing is up to $100. Points earned for entries into promotional drawings are in addition to the Rewards you earn directly for completing activities.

Rewards vary by activity but range from $5 to $20 per activity. You can track your progress in the application, which clearly displays completion status of all activities and changes the graphic indicators to "COMPLETE" once an activity has been completed. Along with a running total of points, the platform will display reward dollars you have accumulated. Specific Rewards and Activities are listed below:

Step	**Action**	**Frequency**	**Reward**	**Promotions Entries Once member reaches $150 max**
Get Started	Activate Your Account	One-time	$10	--
	Set your 2026 health goals	One-time	$5	--
	Play Health Trivia	One-time	$5	--
	Complete the Total Health Assessment	One-time	$15	15
Fitness & Exercise	Members can choose one: 1. Step it Up: *Hit 200k steps this month* OR 2. Exercise moderately for 30 minutes or more per at least 5x a week	Monthly	$10 / month	10 / month
	Strengthen Your Body: *Strength train at least 8 times this month*	Monthly	$10 / month	10 / month
Self-care & Wellness	Meditate to Boost Your Wellness: *Meditate for 150 minutes this month*	Monthly	$10 / month	10 / month

	Rewardable activities rotate quarterly: Q1: Live a Life of Gratitude: Each day write down 3 things you are grateful for in your life and log 24 journal entries a month Q2: Volunteer your Time: Donate your time to an organization of your choice for at least one hour per month Q3: Turn off screens 90 minutes before bedtime 5 days a week (20 days per month) Q4: Maintain positive social connections: Connect with a friend who lifts your spirits once a week.	Monthly	$5 / month	5 / month
	Get Your Zzz's: Get at least 7 hours of sleep on 20+ nights per month	Monthly	$10 / month	10 / month
Healthy Eating	Rethink your drink: Reduce your consumption of sugar sweetened beverages. Aim to quench your thirst with water, black coffee or unsweetened tea in lieu of sugar sweetened beverages (soda, juice, energy drinks) 6 out of 7 days of the week (or 24 days of the month). Rewardable activities rotate quarterly: Q1: Go alcohol free for a month. Q2: Walk for at least 10 minutes after dinner 5x /week (20 days per month) Q3: Eat 1/3 cup of nuts or seeds five days a week (20 days per month) Q4: Eat the rainbow at least 2x/week: include leafy greens and red, orange, yellow and purple fruits and vegetables (8 days a month)	Monthly	$5 / month	5 / month
Sustain your Health	Start Your Wellness Coaching	One-time	$15	15
	Complete a KP virtual health class	One-time	$15	15
	Get Your Flu Vaccine	One-time	$20	20
Other	Complete Your Dental Exam: Complete 1 cleaning a year and be rewarded	One-time	$20	20
	Share Your Program Feedback	One-time	$5	5

The Wellness Program is designed to have many more activities to choose from than are required to reach the maximum reward level. This is intended to provide sufficient reasonable alternatives so that all

members enrolled in the Wellness Program can receive the same benefit.

Kaiser Permanente will provide a reasonable alternative standard for any member who is unable to satisfy the otherwise applicable standard because it is unreasonably difficult due to a medical condition, or for whom it is medically inadvisable to attempt to satisfy the otherwise applicable standard. If you cannot reasonably complete enough activities to reach the maximum amount of rewards, you can reach out to member support at 1-888-338-2120 who can provide you with instructions to submit written requests for reasonable alternatives. Kaiser Permanente may request verification, such as a statement from your health care provider, that a health factor makes it unreasonably difficult or medically inadvisable for you to satisfy or attempt to satisfy the otherwise applicable standard.

Once you reach the maximum number of total rewards for the year, completing an activity will not earn a reward; however, to encourage you to continue to engage in healthy behaviors, you will continue to receive points that can be used to participate in the drawings for each additional activity you complete. You will continue to receive the same number of points as the activity would have earned as a reward. The monetary value of each point is calculated as the total amount of the applicable prize divided by the number of points earned by all persons included in the drawing. For example, if the prize value is $300, and the total number of points awarded is 500,000, the value of each individual point is $0.0006. As noted above, the maximum total amount of rewards that you can earn plus the maximum amount of points you can earn, when combined, will not exceed 30% of the total cost of employee–only coverage under your health benefit plan for the year.

We may engage a third party to act as the administrator of the drawings under applicable laws. This third party will ensure all details are disclosed in official rules documents that are published on our website. This third party, and not Kaiser Permanente, is responsible for all aspects of the promotions. Additional conditions may apply to promotions, as explained by the administrator, including how to participate without internet access, eligible activity periods, contact information, and winners lists. Participation in any promotion is always free, and you are never required to make any purchase or provide any consideration, or exchange any item or thing of value, if you choose to voluntarily participate. Notwithstanding the foregoing, if it is necessary to replace the third party for any reason, Kaiser Permanente will ensure that the program remains available and will secure a new third party if needed.

Payment Toward Your Cost Share and When You May Be Billed

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

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

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

diagnostic Services.

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

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

SECTION 3: Benefits, Exclusions and Limitations

Your Benefits

The benefits described in this section are covered only when:

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

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

1. Emergency Services, as described in this section;
2. Urgent Care Services outside of our Service Area, as described in this section;
3. Continuity of Care for New Members, as described in ***Section 2: How to Get the Care You Need***;
4. Continuing Care Patients, as described in ***Section 2: How to Get the Care You Need***;
5. Receiving Care in Another Kaiser Foundation Health Plan Service Area, as described in ***Section 2: How to Get the Care You Need;***
6. Approved referrals, as described under ***Getting a Referral*** in ***Section 2: How to Get the Care You Need***, including referrals for clinical trials as described in this section; and
7. Non-Emergency Services, including Ancillary Services, and Services for unforeseen urgent medical needs received by a non-Participating Provider at a Plan Hospital or a Plan Facility as described in ***Section 2: How to Get the Care You Need*** under the ***Non-Emergency Services & Urgent Care Services*** provision.

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

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

List of Benefits

The following benefits are covered by the Health Plan. Benefits are listed alphabetically for your convenience. Some benefits are subject to benefit-specific limitations and/or exclusions, which are listed, when applicable, directly below each benefit. A broader list of exclusions that apply to all benefits,

regardless of whether they are Medically Necessary, is provided under ***Exclusions*** in this section.

Accidental Dental Injury Services

Medically Necessary dental services to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. Dental appliances required to diagnose or treat an accidental injury to the teeth, and the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face, are also covered. Coverage is provided when all of the following conditions have been satisfied:

1. The accident has been reported to your Primary Care Plan Physician within seventy-two (72) hours of the accident;
2. A Plan Provider provides the restorative dental Services;
3. 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;

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:

1. Have not been weakened by existing dental pathology such as decay or periodontal disease; or
2. Have not been previously restored by a crown, inlay, onlay, porcelain restoration or treatment by endodontics.

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

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

Benefit-Specific Exclusion(s):

1. Services provided by non-Plan Providers.
2. 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.

Allergy Services

We cover the following allergy Services:

1. Evaluations and treatment; and
2. Injection Visits and serum.

Ambulance Services

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

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

Coverage is also provided for Medically Necessary transportation or Services, including Medically Necessary air ambulance transport to the nearest hospital able to provide needed Services, rendered as the result of a 911 call. Your Cost Share will apply to each encounter, whether or not transport was required.

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

Coverage for Air Ambulance Services, as defined in the section ***Important Terms You Should Know***, when Services are received from a Non-Participating Provider of Air Ambulance Services:

1. The Cost Shares for Air Ambulance Services provided by a non-Participating Provider will not exceed that of Cost Shares for Air Ambulance Services provided by a Participating Provider and will apply toward your Deductible, if any, and Out-of-Pocket Maximum, if any;
2. Any cost-sharing requirement will be calculated based on the lesser of the Qualifying Payment Amount or the billed amount for the services;
3. Any cost-sharing payments made with respect to the Air Ambulance Service will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;
4. We will make payment for the Air Ambulance Services directly to the non-Participating Provider of ambulance services. The payment amount will be equal to the amount by which the Out-of-Network Rate exceeds the cost-sharing amount for Air Ambulance Services; and
5. The member will not be liable for an amount that exceeds the member's cost-sharing requirement.

We also cover medically appropriate ambulette (non-emergent transportation) Services provided by select transport carriers when ordered by a Plan Provider.

We will not cover emergency ambulance or ambulette (non-emergent transportation) Services in any other circumstances, even if no other transportation is available. We cover licensed ambulance and ambulette (non-emergent transportation) Services ordered by a Plan Provider only inside our Service Area, except as covered under ***Emergency Services***.

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

Benefit-Specific Exclusion(s):

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

Anesthesia for Dental Services

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

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

General anesthesia and associated hospital and ambulatory facility charges will be covered only for dental care that is provided by a fully accredited Specialist for whom hospital privileges have been granted.

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

Benefit-Specific Exclusion(s):

1. The dentist or Specialist's dental Services.

Blood, Blood Products and their Administration

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

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

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

Benefit-Specific Limitation(s):

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

Benefit-Specific Exclusion(s):

1. Directed blood donations.

Chemical Dependency and Mental Health Services

Mental Illness, Emotional Disorders, Drug and Alcohol Misuse Services

We cover the diagnosis and treatment of mental illnesses, emotional disorders, drug misuse and alcohol misuse for conditions that, in the opinion of a Plan Provider, would be Medically Necessary and treatable and follow the American Society of Addiction Medicine (ASAM) criteria. For the purposes of this benefit provision, drug and alcohol misuse means a disease that is characterized by a pattern of pathological use of a drug and/or alcohol with repeated attempts to control its use and with significant negative consequences in at least one the following areas of life: medical, legal, financial or psycho-social.

ASAM criteria means the most recent edition of the American Society of Addiction Medicine treatment criteria for addictive, substance related and co-occurring conditions that establish guidelines for placement, continued stay and transfer or discharge of Members with addiction and co-occurring conditions.

We cover inpatient in a licensed or certified facility or program, including hospital inpatient and a licensed or certified residential treatment center. Covered Services include all medical Services of physicians and other health professionals as performed, prescribed or directed by a physician including, but not limited to:

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

7. Appropriate hospital Services.

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

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

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

1. All office Visits;
2. Diagnostic evaluations;
3. Opioid treatment Services;
4. Crisis intervention;
5. Individual therapy;
6. Group therapy;
7. Medication evaluation and management Visits;
8. Psychological and neuropsychological testing for diagnostic purposes;
9. Medical treatment for withdrawal symptoms; and
10. Visits for the purpose of monitoring drug therapy.

Psychiatric Residential Crisis Services

We cover residential crisis Services that are:

1. 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;
2. Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay;
3. Provided out of the Member's residence on a short-term basis in a community-based residential setting; and
4. Provided by entities that are licensed by the Maryland Department of Health to provide residential crisis Services.

Note: Refer to the ***Wellness Services Rider***, if applicable, for additional Services.

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

Benefit-Specific Exclusion(s):

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

Necessary.

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.

Clinical Trials

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

1. The cost of an investigational drug or device, except as provided below for off-label use of a United States Food and Drug Administration (FDA) approved drug or device;
2. The cost of non-health care Services that may be required as a result of treatment in the clinical trial; or
3. Costs associated with managing the research for the clinical trial.

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

1. The Services would be covered if they were not related to a clinical trial;
2. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   a. A Plan Provider makes this determination;
   b. You, or your beneficiary, provide us with medical and scientific information establishing this determination;
3. If you participate in the clinical trial, the service area restrictions and requirements for non-Plan Providers will not be applied to the clinical trial benefit;
4. The clinical trial is a phase I, phase II, phase III or phase IV clinical trial related to the prevention, detection or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
   a. The study or investigation is conducted under an investigational new drug application reviewed by the FDA;
   b. The study or investigation is a drug trial that is exempt from having an investigational new drug application; or
   c. The study or investigation is approved or funded, including funding through in-kind contributions, by at least one (1) of the following:
      i. The National Institutes of Health;
      ii. The Centers for Disease Control and Prevention;
      iii. The Agency for Health Care Research and Quality;
      iv. The Centers for Medicare & Medicaid Services;
      v. A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs;
      vi. 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;
      vii. A qualified non-governmental research entity identified in the guidelines issued by

the National Institutes of Health for center support grants; or

viii. The Department of Veterans Affairs, Department of Defense or the Department of Energy; but only if the study or investigation has been reviewed and approved through a system of peer review that the United States Secretary of Health and Human Services determines meets all of the following requirements:

(a) It is comparable to the National Institutes of Health system of peer review of studies and investigations; and

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

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

Note: Coverage will not be restricted solely because the Member received the Service outside of 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.

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

Benefit-Specific Exclusion(s):

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

Diabetic Treatment, Equipment, Supplies and Self-Management Training

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

1. Insulin-using diabetes;
2. Insulin-dependent diabetes;
3. Non-insulin using diabetes;
4. Elevated or impaired blood glucose levels induced by pregnancy, including gestational diabetes; or
5. Consistent with the American Diabetes Association's standards, elevated or impaired blood glucose levels induced by prediabetes.

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

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

Benefit-Specific Limitation(s):

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

1. Was prescribed by a Plan Provider; and
2. There is no equivalent preferred equipment or supply available, or an equivalent preferred

equipment or supply has been ineffective in treating the disease or condition of the Member or has caused or is likely to cause an adverse reaction or other harm to the Member.

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

Dialysis Services

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

1. You satisfy all medical criteria developed by Medical Group and by the facility providing the dialysis; and
2. A Plan Physician provides a written referral for care at the facility.

We cover the following renal dialysis Services:

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

We cover the following self-dialysis Services:

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

We cover home dialysis, which includes:

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

Members traveling outside the Service Area may receive pre-planned dialysis Services for up to twenty-six (26) dialysis sessions per contract year. Prior authorization is required.

Note: If you have ESRD, you may be eligible to enroll, at your option, in Original Medicare Part B. which will reduce costs for dialysis Services related to ESRD. Original Medicare Part B has a ninety (90)-day waiting period after dialysis begins and will not cover any costs until after the waiting period has been satisfied. Upon enrollment in Original Medicare Part B, we will directly reimburse you for your Original Medicare Part B premiums, should you opt-in to this benefit. We will continue to reimburse you for these premiums as long as you are covered under this Plan and eligible for and enrolled in Original Medicare Part B due to ESRD.

Dialysis Services related to ESRD and covered under Original Medicare Part B will not be subject to any Cost Shares.

Dialysis Services related to ESRD and received during the ninety-(90) day waiting period will be subject to Cost Shares as described in the ***Summary of Services and Cost Shares*** form.

Dialysis Services not related to ESRD nor covered under Original Medicare Part B will be subject to Cost Shares as described in the ***Summary of Services and Cost Shares*** form.

If you do not choose to enroll in Original Medicare Part B, the applicable Cost Share under this Plan

will apply.

Drugs, Supplies and Supplements

We cover drugs, supplies and supplements during a covered stay in a Plan Hospital, Skilled Nursing Facility and outpatient settings, or if they require administration or observation by medical personnel and are administered to you in a Plan Medical Center or during a home health visit:

1. Oral, infused or injected drugs and radioactive materials used for therapeutic purposes, including chemotherapy. This includes off-label use of a drug when the drug is recognized in Standard Reference Compendia or certain medical literature as appropriate in the treatment of the diagnosed condition;
    a. **Note:** If a drug covered under this benefit meets the criteria for a Specialty Drug, in accordance with §15-847 of the Insurance Article, or is a prescription drug to treat diabetes, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS), as described in §15-847.1 of the Insurance Article, then the Member's cost for the drug will not exceed $150 for a 30-day supply. If this benefit is subject to the Deductible, as shown in the ***Summary of Services and Cost Shares***, the Deductible must be met first. For all insulin, the Member's cost will not exceed $30 for a 30-day supply, regardless of the amount or type of insulin needed to fill the member's prescription in accordance with §15-822.1 (b), of the Insurance Article. Insulin is not subject to the Deductible.
    b. **Note:** As permitted under §15-846 of the Insurance Article, oral chemotherapy drugs will be provided at the same or better level than intravenous or injectable chemotherapy drugs.
2. Injectable devices;
3. The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
4. Medical and surgical supplies including dressing, casts, hypodermic needles, syringes or any other Medically Necessary supplies provided at the time of treatment; and
5. Vaccines and immunizations approved for use by the FDA that are not considered part of routine preventive care.

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

Note: Prior authorization or step-therapy may be required for certain prescription drugs, supplies or supplements administered by medical personnel in an office Visit.

A list of drugs subject to utilization management is available to you upon request. You may contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY). For more information, see ***Getting a Referral*** in ***Section 2: How to Get the Care You Need***.

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

Benefit-Specific Exclusion(s):

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

Durable Medical Equipment (DME)

Durable Medical Equipment is defined as equipment that:

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

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 and Orthotic 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, misuse or theft. You must return the equipment to us or pay us the fair market value of the equipment when we are no longer covering it.

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

Supplemental Durable Medical Equipment

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

Oxygen and Equipment

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

Positive Airway Pressure Equipment

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

Apnea Monitors

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

Asthma Equipment

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

1. Spacers;
2. Peak-flow meters;
3. Home UV Lightbox; and
4. Nebulizers.

Bilirubin Lights

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

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

Benefits for International Normalized Ratio (INR) Home Testing Machines are available to the same extent as benefits provided for other similar Services.

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

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

Note: A "gradient compression garment" means a garment that is used for the treatment of lymphedema, requires a prescription, and is custom fit for the individual for whom the garment is prescribed.

Benefits for Lymphedema Equipment & Supplies are available to the same extent as benefits provided for other similar Services.

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

Benefit-Specific Exclusion(s):

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

Emergency Services

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

If you think you are experiencing an Emergency Medical Condition, you should call 911, (where available) 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 Kaiser Permanente identification card for immediate medical advice. You or your representative should notify the Health Plan as soon as possible, and not to exceed forty-eight (48) hours or the first business day, whichever is later, after you receive care at a hospital emergency room (ER) to ensure coverage, unless it was not reasonably possible to notify us within that time frame.

We cover Emergency Services as follows:

Inside our Service Area
We cover 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 (screening and

stabilization) Services required before you can, without medically harmful consequences, be transported to a Plan Hospital or your Primary Care Plan Physician's office.

Outside of our Service Area

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

We do not cover Services for conditions that, before leaving the Service Area, you should have known might require Services while you are away, such as, 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, (see ***Urgent Care*** Services in this ***List of Benefits***). 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

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.

Post-Stabilization Care

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

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

To request Prior Authorization, You, Your provider including Your non-Participating Provider (or someone else acting on your behalf) must call 1-800-225-8883 or the notification telephone number on

the reverse side of your ID card before you receive the care. We will discuss your condition with the non-Participating Provider. If we determine that you require post-stabilization care, we will authorize your care from the non-Participating Provider or arrange to have a Participating Provider (or other designated provider) provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated non-Participating Provider provide your care, we may authorize special transportation services that are non-Participating Providers. If you receive care from a non-Participating Provider that we have not authorized, you may have to pay the full cost of that care.

When you receive Emergency Services from non-Participating Providers, Post Stabilization Care may qualify as Emergency Services pursuant to federal law. We will not require Prior Authorization for such Post-Stabilization Care at a non-Participating Facility when your attending non-Participating Provider determines that, after You receive Emergency (screening and stabilization) Services, You are not able to travel using non-medical transportation or non-emergency medical transportation to an available Participating Provider located within a reasonable travel distance taking into account Your medical condition. Additionally, we will not require Prior Authorization for such Post-Stabilization Care at a non-Participating facility when you, or your Authorized Representative, are not in a condition to receive notice of nor provide informed consent to be treated by a non-Participating Provider.

Non-Participating Providers may provide notice and seek Your consent to provide Post-Stabilization Care Services or other covered Services as stated in the notice and consent criteria of 45 C.F.R. § 149.420(c) through (g). Such Services will not be covered when You do not obtain Prior Authorization as described herein. If you (or your Authorized Representative) consent to the furnishing of Services by non-Plan Providers, then You will be responsible for paying for such Services in the absence of any Prior Authorization. The cost of such Services will not accumulate to Your deductible, if any, or your maximum out-of-pocket costs.

Transport to a Service Area

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

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

Continued Care in Non-Plan Facility Limitation

If you are admitted to a non-Plan Hospital, you or someone on your behalf must notify us within the later of forty-eight (48) hours of any hospital admission, or on the first business day following the admission, unless it was not reasonably possible to notify us within that time. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us, 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 one (1) year of receipt of covered Services. Failure to submit such a request within one (1) year of receipt of the covered Services will not invalidate or reduce the amount of the claim, if it was not reasonably possible to submit the request within the aforementioned time frame. If it is not reasonably possible to submit the claim within one (1) year after the date of Service, it shall be sent to us no later than two (2) years from the time, proof is otherwise required. A Member's legal incapacity shall suspend the time to submit a claim. Such suspension period ends when legal capacity is regained.

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

Benefit-Specific Limitation(s):

1. **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 forty-eight (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.
2. **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 the Health Plan. We cover only the out-of-Plan Emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Permanente Region or Group Health Cooperative Service Area.
3. **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.

Family Planning Services

We cover the following:

1. Women's Preventive Services (WPS), including:
   a. Patient education and contraceptive method counseling for all women of reproductive capacity;
   b. Coverage for FDA-approved contraceptive drugs and devices, hormonal contraceptive methods, and the insertion or removal of contraceptive devices, including any Medically Necessary examination associated with the use of contraceptive drugs and devices;
   c. Female sterilization;
   Note: WPS are preventive care and are covered at no charge;
2. Family planning counseling (counseling does not include instruction for fertility awareness based methods), including pre-abortion and post-abortion care counseling; and
3. Male sterilization; and
4. Abortion care Services; as permitted under Maryland state law; and
5. Instruction by a licensed health care provider on fertility awareness–based methods, which are methods of identifying times of fertility and infertility by an individual to avoid pregnancy, including: cervical mucous methods, sympto-thermal or sympto-hormonal methods, the standard days methods, and the lactational amenorrhea method. **Note:** Copayments and/or Coinsurances will not be applied in-network or out-of-network for this benefit.

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

Note: Copayments and/or Coinsurances do not apply to male sterilization Services.

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

Fertility Services

We cover the following fertility Services:

1. Standard fertility preservation procedures performed on you or your dependent and that are Medically Necessary to preserve fertility for you or your dependent due to a need for medical treatment that may directly or indirectly cause iatrogenic infertility. These procedures include sperm and oocyte collection and cryopreservation, evaluations, laboratory assessments, medications, and treatments associated with sperm and oocyte collection and cryopreservation.

Note: The Member must contract with storage facility of his or her choice. Upon termination of Member's coverage under this EOC, Member assumes responsibility for all charges associated with cryopreserved tissues.

Definitions:

- **Iatrogenic infertility:** Impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting the reproductive organs or processes.
- **Medical treatment that may directly or indirectly cause iatrogenic infertility:** Medical treatment with a likely side effect of infertility as established by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologist, or the American Society of Clinical Oncology.
- **Standard fertility preservation procedures:** Procedures to preserve fertility that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.

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

Benefit-Specific Exclusion(s):

1. All charges associated with thawing and the storage of female Member's eggs (oocytes) and/or male Member's sperm.

Habilitative Services

We cover Medically Necessary Habilitative Services with no Visit limits for children up until end of the month in which they turn age nineteen (19). "Medically Necessary Habilitative Services" are those Services and devices, including occupational therapy, physical therapy, and speech therapy that help a child keep, learn, or improve skills and functioning for daily living.

Medical Necessary Services to treat autism and autism spectrum disorders shall include Applied Behavioral Analysis (ABA).

For adults age nineteen (19) and over we cover Medically Necessary Habilitative Services that are designed to enhance a Member's functional ability, without effecting a cure, for the treatment of autism or an autism spectrum disorder, "Medically Necessary Habilitative Services" include occupational therapy, physical therapy, speech therapy and Applied Behavioral Analysis (ABA). See the benefit-specific exclusion(s) immediately below for additional information.

Benefit-Specific Exclusion(s):

1. Services provided through federal, state or local early intervention programs, including school programs.
2. Services not preauthorized by the Health Plan.

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 of newborn hearing screenings.

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 adults, and is non-disposable. We cover hearing aid evaluations and diagnostic procedures to determine the hearing aid model which will best compensate for loss of hearing. We also cover Visits to verify that the hearing aid conforms to the prescription and Visits for fitting, counseling, adjustment, cleaning, and inspection.

We cover hearing aids when ordered, prescribed, fitted, and dispensed by a licensed audiologist or a licensed hearing aid dispenser.

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

Benefit -Specific Limitation(s):

1. Coverage is provided for one hearing aid for each hearing-impaired ear every 36 months.
2. You are not required to obtain hearing aids for both ears at the same time. Two (2) hearing aids are covered every thirty-six (36) months only if both are required to provide significant improvement that is not obtainable with one hearing aid, as determined by your Plan Provider. The thirty-six (36) month benefit period extends separately for each ear and commences at the initial point of sale for each ear.
3. The type of hearing aid is limited to the models provided by Kaiser Permanente or the Kaiser Permanente-designated hearing aid vendor.

Benefit-Specific Exclusion(s):

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

1. Hearing aids or tests to determine an appropriate hearing aid and its efficacy; except as specifically provided in this section.
2. Replacement parts and batteries.
3. Replacement of lost or broken hearing aids.
4. Comfort, convenience or luxury equipment or features.

Home Health Care Services

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

1. Skilled nursing care;
2. Home health aide Services; and
3. 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 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

We cover the cost of inpatient hospitalization Services for a minimum of forty-eight (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 forty-eight (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 forty-eight (48) hours of inpatient hospitalization following the surgery, we cover the following:

1. One home Visit scheduled to occur within twenty-four (24) hours following his or her discharge from the hospital or outpatient facility; and
2. 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.
Additional limitations may be stated in the ***Summary of Services and Cost Shares***.

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

Benefit-Specific Limitation(s):

1. Home Health Care Visits shall be limited to two (2) hours per Visit. Intermittent care shall not exceed three (3) Visits in one day.

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

Benefit-Specific Exclusion(s):

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

Hospice Care Services

Hospice Care Services are for terminally ill Members. If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice 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:

1. Nursing care;
2. Physical, occupational, speech and respiratory therapy;
3. Medical social Services;
4. Home health aide Services;
5. Homemaker Services;
6. Medical supplies, equipment and medication required to maintain the comfort and manage the pain of the terminally ill Member;
7. Palliative drugs in accordance with our drug formulary guidelines;
8. Physician care;
9. Inpatient care (unlimited days); including care for pain management and acute symptom management as Medically Necessary;
10. Respite Care for up to fourteen (14) days per contract year, limited to five (5) consecutive days for any one inpatient stay;
11. Counseling Services for the Member and their Family Members and the Member's caregiver, including dietary counseling for the Member; and bereavement counseling for the Member's Family or the Member's caregiver for a period of one (1) year after the Member's death; and
12. Services of hospice volunteers.

Hospital Inpatient Care

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

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

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

Note: Prior Authorization is not required for a transfer to a special pediatric hospital. A special pediatric hospital is a facility that provides nonacute medical, rehabilitation, therapy, and palliative Services to individuals:

1. Under the age of twenty-two (22) years; or
2. Who are at least two (2) years old and under the age of twenty-three (23) years and have co-occurring physical and behavioral health conditions.

Infertility Services

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

1. Artificial insemination;
2. In vitro fertilization (IVF), if:
   a. For a married Member whose Spouse is of the opposite sex, the married Member's oocytes are fertilized with the married Member's Spouse's sperm; unless:
      i. The Spouse is unable to produce and deliver functional sperm; and the inability to produce and deliver functional sperm does not result from:
         (a) A vasectomy; or
         (b) Another method of voluntary sterilization;
   b. The married Member and the married Member's Spouse have a history of involuntary infertility, which may be demonstrated by a history of:
      i. Intercourse of at least one (1) year duration failing to result in a successful pregnancy when the Member and the Member's Spouse are of opposite sexes; or
   c. For an unmarried Member or if the married Member and the married Member's Spouse are of the same sex, three (3) attempts of artificial insemination over the course of one (1) year failing to result in a successful pregnancy; or
   d. The infertility of the unmarried Member or of the married Member or the married Member's Spouse 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 (1) or both fallopian tubes (lateral or bilateral salpingectomy); or
      iv. Abnormal male factors, including oligospermia, contributing to the infertility;
   e. The unmarried Member or the married Member or the married Member's Spouse has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this EOC; and
   f. The in vitro fertilization (IVF) procedures are performed at medical facilities that conform to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine; and
3. Intracytoplasmic Sperm Injection (ICSI) if the Member meets medical guidelines.

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

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

Benefit-Specific Limitation(s):

1. Coverage for in vitro fertilization (IVF) embryo transfer cycles, including frozen embryo transfer (FET) procedure, is limited to three attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.

Benefit-Specific Exclusion(s):

1. Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member's eggs and/or male Member's sperm for future attempts.
2. Any charges associated with obtaining donor eggs, donor sperm or donor embryos.
3. Infertility Services, that does not meet the medical guidelines established by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or American Society of Clinical Oncology.
4. Services to reverse voluntary, surgically induced infertility.
5. Infertility Services when the infertility is the result of an elective male or female sterilization surgical procedure.
6. Assisted reproductive technologies and procedures, other than those described above: Gamete intrafallopian transfers (GIFT); zygote intrafallopian transfers (ZIFT); and prescription drugs related to such procedures.

Maternity Services

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

We cover obstetrical care, which includes:

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

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

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

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

Outpatient delivery and associated Services are covered, subject to the applicable Cost Share.

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

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

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

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

Benefit-Specific Exclusion(s):

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

Medical Foods

We cover 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:

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

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

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

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

Benefit-Specific Exclusion(s):

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

Medical Nutrition Therapy and Counseling

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

1. Nutritional history;
2. Current dietary intake;
3. Medication use; or

4. Chronic illness or condition.

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

Morbid Obesity Services

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

1. Recognized by the National Institutes of Health (NIH) as effective for long-term reversal of morbid obesity; and
2. Consistent with guidelines approved by the NIH.

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

Morbid obesity is defined as a Body Mass Index (BMI) that is:

1. Greater than forty (40) kilograms per meter squared; or
2. Equal to or greater than thirty-five (35) kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

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

Oral Surgery

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

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

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

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

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

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

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

Temporomandibular Joint Services

Coverage is provided for:

1. Orthognathic surgery, including inpatient and outpatient surgery to correct temporomandibular joint (TMJ) pain dysfunction syndrome and craniomandibular joint services, that are required because of a medical condition or injury that prevents normal function of the joint or bone and

is deemed Medically Necessary to attain functional capacity of the affected part;
2. Removable appliances for TMJ repositioning;
3. Therapeutic injections for TMJ.

The Health Plan provides coverage for cleft lip, cleft palate or both under a separate benefit. Please see ***Cleft Lip, Cleft Palate or Both***.

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

Benefit-Specific Exclusion(s):

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

Outpatient Care

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

1. 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);
2. Specialty care Visits. (Refer to ***Section 2: How to Get the Care You Need*** for information about referrals to Plan Specialists);
3. Consultations and immunizations for foreign travel;
4. Diagnostic testing for care or treatment of an illness, or to screen for a disease for which you have been determined to be at high risk for contracting, including, but limited not to:
    a. Diagnostic examinations, including digital rectal exams and prostate-specific antigen (PSA) tests provided:
        i. For men who are between 40 and 75 years of age;
        ii. When used for male patients who are at high risk for prostate cancer;
        iii. When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; or
        iv. When used for staging in determining the need for a bone scan in patients with prostate cancer.
    b. Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances, radiological imaging, for persons in accordance with the most recently published guidelines of the American Cancer Society. Your initial screening colonoscopy will be preventive;
    c. Bone mass measurement for the diagnosis and treatment of osteoporosis is provided when the bone mass measurement is requested by a health care provider for a qualified individual. A "qualified individual" means an individual:
        i. Who is estrogen deficient and at clinical risk for osteoporosis;
        ii. With a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
        iii. Receiving long-term glucocorticoid (steroid) therapy;
        iv. With primary hyperparathyroidism; or

v. Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

5. Outpatient surgery;
6. Anesthesia, including Services of an anesthesiologist;
7. Respiratory therapy;
8. Medical social Services;
9. House calls when care can best be provided in your home as determined by a Plan Provider;
10. After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to ***Urgent Care*** for covered Services;
11. Smoking cessation counseling programs; and
12. Lymphedema Services. Refer to ***Durable Medical Equipment*** for covered Services.

Note: As described here, diagnostic testing is not preventive care and may include an office visit, outpatient surgery, diagnostic imaging, or x-ray and laboratory. 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.

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

Pediatric Autoimmune Neuropsychiatric Disorders (PANDAS)

We cover Medically Necessary diagnosis, evaluation, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy.

Benefits are available to the same extent as benefits provided for other similar Services.

Preventive Health Care Services

We cover the following preventive Services based on your age, sex, or other factors, as determined by the Maryland Insurance Commissioner in accordance with §15-1A-10 of the Insurance Article 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:

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.
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.

The Health Plan shall update new recommendations to the preventive benefits, the preventive Services and limitations are determined by the Maryland Insurance Commissioner.

The Maryland Insurance Commissioner determines which recommendations and guidelines are

considered to be in effect and applicable, including whether and when subsequent updates and recommendations to the guidelines will apply in accordance with §15-1A-10 of the Insurance Article.

We cover medically appropriate preventive health care Services, health education and counseling without Cost Sharing requirements as described below.

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

1. Preventive care exams, including:
   a. Routine physical examinations and health screening tests appropriate to your age and sex;
   b. Well-woman examinations; and
   c. Well child care examinations.
2. Routine and necessary immunizations (travel immunizations are not preventive and are covered under ***Outpatient Care***) for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Maryland Insurance Commissioner;
3. An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
4. Breast cancer screening (for which the Deductible, if any, will not apply):
   a. In accordance with the latest screening guidelines issued by the American Cancer Society; and
   b. Digital tomosynthesis, commonly referred to as three-dimensional "3-D" mammography will be covered when the treating Plan physician determines that it is Medically Necessary.
5. Bone mass measurement to determine risk for osteoporosis;
6. Prostate Cancer screening. Medically recognized diagnostic examinations including prostate-specific antigen (PSA) tests and digital rectal examinations:
   a. For men who are between age forty (40) and seventy-five (75) years of age or older;
   b. When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;
   c. When used for tagging in determining the need for a bone scan for patients with prostate cancer; or
   d. When used for male Members who are at high risk for prostate cancer.
7. Colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society;
8. Cholesterol test (lipid profile);
9. Diabetes screening (fasting blood glucose test);
10. Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis and Human Papillomavirus (HPV) screening, subject to the following:
    a. Annual chlamydia screening is covered for:
       i. Women under age 20 if they are sexually active; and
       ii. Women age 20 or older, and men of any age, who have multiple risk factors, which include:
          a) Prior history of sexually transmitted diseases;
          b) New or multiple sex partners;

c) Inconsistent use of barrier contraceptives; or
d) Cervical ectopy;

b. Human Papillomavirus (HPV) Screening at the intervals recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists.

11. HIV tests;
12. TB tests;
13. Hearing loss screenings for newborns provided by a hospital prior to discharge;
14. Associated preventive care radiological and laboratory tests not listed above; and
15. BRCA counseling and genetic testing is covered at no Cost Share. Any follow up Medically Necessary treatment is covered at the applicable Cost Share based upon type and place of Service.

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

1. Retinopathy screening for diabetics
2. HbA1c for diabetics
3. Low density Lipoprotein laboratory test for people with heart disease
4. INR laboratory test for liver failure and bleeding disorders

For coverage of glucometers, see the ***Diabetic Treatment, Equipment, Supplies and Self-Management Training*** benefit in this ***List of Benefits***.

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

For coverage of diagnostic breast examinations, supplemental breast examinations, and follow-up diagnostic imaging to assist in the diagnosis of lung cancer, please see the ***X-Ray, Laboratory and Special Procedures*** benefit in this ***List of Benefits***.

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

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

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

1. Monitoring chronic disease.
2. Follow-up Services after you have been diagnosed with a disease.
3. Services provided when you show signs or symptoms of a specific disease or disease process.
4. Non-routine gynecological Visits.

Prosthetic and Orthotic Devices

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

Prosthesis means an artificial device to replace, in whole or in part, a leg, an arm, or an eye. Prosthesis includes a custom-designed, custom-fabricated, custom-fitted, or custom-modified device to treat partial or total limb loss for purposes of restoring physiological function. Coverage for prosthesis is provided when determined by a treating Health Care Provider to be Medically Necessary for completing activities of daily living, essential job-related activities, or performing physical activities including running, biking, swimming, strength training, and other activities to maximize the whole-body health and lower or upper limb function of the Member.

Internal Prosthetics

We cover Medically Necessary internal devices implanted during surgery, such as pacemakers, monofocal intraocular lens implants, artificial hips and joints, breast implants following mastectomy (see ***Reconstructive Surgery*** below), and cochlear implants, that are approved by the FDA for general use.

External Prosthetic & Orthotic Devices

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

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

Artificial Arms, Legs or Eyes

We cover:

1. Artificial devices to replace, in whole or in part, a leg, an arm or an eye;
2. Components of an artificial device to replace, in whole or in part, a leg, an arm or an eye; and
3. 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.

Coverage is provided once per contract year for:

1. Prostheses;
2. Components of prostheses;
3. Repairs to prostheses; and
4. Replacements of prostheses or prosthesis components if,

a. An ordering Health Care Provider determines that the provision of a replacement prosthesis or component of the prosthesis is necessary;
   i. Because of a change in the physiological condition of the Member;
   ii. Unless necessitated by misuse, because of an irreparable change in the condition of the prosthesis or a component of the prosthesis; or
   iii. Unless necessitated by misuse, because the condition of the prosthesis or the component of the prosthesis requires repairs, and the cost of the repairs would be more than 60% of the cost of replacing the prosthesis or the component of the prosthesis.

Ostomy and Urological Supplies and Equipment

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

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

Breast Prosthetics and Hair Prosthesis

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

We cover one (1) hair prosthesis required for a Member whose hair loss results from chemotherapy or radiation treatment for cancer.

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

Benefit-Specific Limitation(s):

1. Coverage for mastectomy bras is limited to a maximum of four (4) per contract year.
2. Coverage for hair prosthesis is limited to one (1) prosthesis per course of chemotherapy and/or radiation therapy not to exceed a maximum benefit of $350 per prosthesis.
3. Standard Devices: Coverage is limited to standard devices that adequately meet your medical needs.
4. Coverage is provided for Medically Necessary therapeutic shoes and inserts.

Benefit-Specific Exclusion(s):

1. Internally implanted breast prosthetics for cosmetic purposes.
2. Repair or replacement of prosthetics due to loss, misuse or theft.
3. Microprocessor and robotic-controlled external prosthetics not covered under the Medicare Coverage Database.
4. More than one piece of equipment or device for the same part of the body, except for replacements, spare devices or alternate use devices.
5. Dental prostheses, devices and appliances, except as specifically provided in this section, or the Oral Surgery section, or as provided under an ***Adult Dental Plan Rider*** or a ***Pediatric Dental Plan Rider***, if applicable.
6. Hearing aids, except as specifically provided in this section.
7. Corrective lenses and eyeglasses, except as specifically provided in this section.
8. Orthopedic shoes or other supportive devices, unless the shoe is an integral part of a leg brace; or unless indicated above.
9. Non-rigid appliances and supplies, including jobst stockings, elastic garments and stockings, and garter belts except when Medically Necessary for the treatment of lymphedema.
10. Comfort, convenience, or luxury equipment or features.

Reconstructive Surgery

We cover reconstructive surgery to:

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

Breast augmentation is covered only if determined to be Medically Necessary. Following mastectomy, we cover reconstructive breast surgery and all stages of reconstruction of the non-diseased breast to produce a symmetrical appearance, and treatment of physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Mastectomy is the surgical removal of all or part of a breast. Reconstructive breast surgery is surgery performed as a result of a mastectomy to reestablish symmetry between both breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

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

Benefit-Specific Exclusion(s):

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 or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.

Routine Foot Care

Coverage is provided for Medically Necessary routine foot care.

Benefit-Specific Exclusion(s):

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

Skilled Nursing Facility Care

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

We cover the following Services:

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

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

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

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

Benefit-Specific Exclusion(s):

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

Telemedicine Services

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

Telemedicine Services means the delivery of healthcare Services through the use of audio-only telephone conversation and interactive audio, video or other telecommunications or electronic media used for the purpose of diagnosis, consultation or treatment as it pertains to the delivery of covered Health Care Services. We cover an audio-only telephone conversation if it results in the delivery of a billable, covered health care service.

Note: We cover telehealth Services regardless of the location of the patient at the time the telehealth Services are provided.

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

Benefit-Specific Exclusion(s):

1. Services delivered through, electronic mail messages or facsimile transmissions. Not all medical services are conducive to telemedicine, as such the provider will make a determination whether the Member should instead be seen in a face-to-face medical office setting.

Therapy and Rehabilitation Services

Physical, Occupational and Speech Therapy Services

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

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

Refer to the ***Summary of Services and Cost Shares*** for Visit limitations for Physical, Occupational, and Speech Therapy Services. The limits do not apply to necessary treatment of cleft lip or cleft palate.

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

Multidisciplinary Rehabilitation Services

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

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

Cardiac Rehabilitation Services

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

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

Pulmonary Rehabilitation Services

We cover pulmonary rehabilitation Services that are Medically Necessary.

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

Benefit-Specific Limitation(s):

1. Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living, except as provided in ***Habilitative Services*** in this ***List of Benefits***.
2. Physical therapy is limited to the restoration of an existing physical function, except as provided in ***Habilitative Services*** in this ***List of Benefits***.

Benefit-Specific Exclusion(s):

1. 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 three (3) month period.
2. Long-term therapy and rehabilitation Services.

Therapy: Radiation, Chemotherapy and Infusion Therapy

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

We cover Services for infusion therapy, which is treatment by placing therapeutic agents into the vein (including therapeutic nuclear medicine), and parenteral administration of medication and nutrients. Infusion Services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These Services include coverage of all medications administered intravenously

and/or parentally.

Infusion Services may be received at multiple sites of Service, including facilities, professional provider offices and ambulatory infusion centers and from home infusion providers. The Cost Share amount will apply based on the place and type of Service provided.

Coverage is also provided for oral chemotherapy drugs. For additional information on this benefit, see ***Drugs, Supplies and Supplements*** in this ***List of Benefits***.

Note: If a drug covered under this benefit meets the criteria for a Specialty Drug, in accordance with §15-847 of the Insurance Article, or is a prescription drug to treat diabetes, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS), as described in §15-847.1 of the Insurance Article, then the Member's cost for the drug will not exceed $150 for up to a 30-day supply. In addition, insulin; may not exceed a maximum of $30 per 30-day supply, regardless of the amount or type of insulin needed to fill the member's prescription pursuant to §15–822.1 (b), of the Insurance Article. If this benefit is subject to the Deductible, as shown in the ***Summary of Services and Cost Shares***, the Deductible must be met first.

Transplants

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

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

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

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

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

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

Benefit-Specific Exclusion(s):

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

Urgent Care

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

Urgent Care Services are defined as Services required as the result of a sudden illness or injury, which

requires prompt attention, but is not of an emergent nature.

Inside our Service Area

We will cover 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:

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

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

Outside of our Service Area

If you are injured or become ill while temporarily outside the Service Area, we will cover 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 the Health Plan, covered benefits include the cost of necessary ambulance or other special transportation Services medically required to transport you to a Plan Hospital or 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, direct, 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:

1. Medically Necessary;
2. Directly related to the condition for which the surgical procedure was performed; and
3. 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.

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

Benefit-Specific Limitation(s):

1. 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 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.

Benefit-Specific Exclusion(s):

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

Vision Services

Medical Treatment

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

Eye Exams for Adults

We cover routine and necessary eye exams, including:

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

Pediatric Eye Exams

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

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

Pediatric Lenses and Frames

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

1. One (1) pair of lenses per year;
2. One (1) pair of frames per year from a select group of frames;
3. Regular contact lenses (in lieu of lenses and frames) (based on standard packaging for type purchased); or
4. Medically Necessary contact lenses up to two (2) pair per eye per year.

In addition, we cover the following Services:

Eyeglass Lenses

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

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 frame and subsequent adjustment.

Contact Lenses

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

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

You will also receive a discount on your initial purchase of contact lenses, if you choose to purchase them at the same time.

Note: Additional contact lens Services are available without the discount from any Kaiser Permanente Optical Shop.

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

Benefit-Specific Exclusion(s):

1. Sunglasses without corrective lenses unless Medically Necessary.
2. 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).
3. Eye exercises.
4. Non-corrective contact lenses.
5. Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section.
6. Replacement of lost or broken lenses or frames.
7. Orthoptic (eye training) therapy.

X-Ray, Laboratory and Special Procedures

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

1. Diagnostic imaging including x-ray, diagnostic mammograms, and ultrasounds;
2. Laboratory tests, such as:
   a. Calcium score testing in accordance with the most recent guidelines issued by the American College of Cardiology that expand the scope of preventive care services for the benefit of consumers; and
   b. Tests for specific genetic disorders such as preimplantation genetic testing (PGT), PGT for Monogenic/single gene defects (PGT-M) or PGT for inherited structural chromosome rearrangements (PGT-SR) for which genetic counseling is available;
3. Special procedures, such as:
   a. Electrocardiograms,
   b. Electroencephalograms; and
   c. Intracytoplasmic Sperm Injection (ICSI) in conjunction with preimplantation genetic testing (PGT), (PGT-M) or (PGT-SR) if the Member meets medical guidelines.
4. Sleep laboratory and sleep studies;
5. Specialty imaging, including computerized Tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET) scans, diagnostic Nuclear Medicine studies and interventional radiology; and
6. Biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition that is supported by medical and scientific evidence including testing:
   a. Cleared or approved by the U.S. Food and Drug Administration;
   b. Required or recommended for a drug approved by the U.S. Food and Drug Administration to ensure a Member is a good candidate for the drug treatment;
   c. Required or recommended through a warning or precaution for a drug approved by the U.S. Food and Drug Administration to identify whether a Member will have an adverse reaction

to the drug treatment or dosage;

d. Covered under a Centers for Medicare and Medicaid Services National Coverage Determination or Medicare Administrative Contractor Local Coverage Determination; or
e. Supported by nationally recognized clinical practice guidelines that are:
   (i) developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and that have a conflict of interest policy; and
   (ii) established standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

Biomarker means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention including known gene-drug interactions for medications being considered for use or already being administered and includes gene mutations, characteristics of genes, or protein expressions.

Biomarker testing is the analysis of a Member's tissue, blood, or other biospecimen for the presence of a biomarker, the results of which provide:

- information that may be used in the formulation of a treatment or monitoring strategy that informs a patient's outcomes and impacts the clinical decision; and
- include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.

Biomarker testing also includes single-analyte tests, multi-plex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing.

Benefits for biomarker testing are available to the same extent as benefits provided for other similar Services.

We cover diagnostic breast examinations and supplemental breast examinations, including image-guided biopsies, and lung cancer screening at no charge. For HDHP plans, if coverage for diagnostic breast examinations and supplemental breast examinations, including image-guided biopsies, is subject to the Deductible, as shown in the Summary of Services and Cost Shares, the Deductible must be met first.

Diagnostic breast examination means Medically Necessary and appropriate examination of the breast that is used to evaluate an abnormality that is:

1. Seen or suspected from a prior screening examination for breast cancer; or
2. Detected by another means of prior examination and includes
   a. An examination using diagnostic mammography, breast MRI, or breast ultrasound.

Supplemental breast examination means a Medically Necessary examination of the breast that is used to screen for breast cancer when:

1. There is no abnormality seen or suspected from a prior examination; and
2. There is a personal or family medical history or additional factors that may increase a Member's risk of breast cancer and includes:
   a. An examination using breast MRI, breast ultrasound, or image-guided breast biopsy.

We cover lung cancer screening, including recommended follow-up diagnostic imaging, such as diagnostic ultrasound, MRI, CT, and image-guided biopsy, to assist in the diagnosis of lung cancer for individuals for which lung cancer screening or follow-up diagnostic imaging is recommended by the United States Preventive Services Task Force (USPSTF). For HDHP plans, if coverage for recommended follow-up diagnostic imaging to assist in the diagnosis of lung cancer is subject to the Deductible, as shown in the ***Summary of Services and Cost Shares***, the Deductible must be met first.

Note: Refer to ***Preventive Health Care Services*** for coverage of preventive care tests and screening Services such as routine screening mammograms.

Exclusions

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

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

When a Service is not covered, all Services, drugs, or supplies related to the non-covered Service are excluded from coverage, except Services we would otherwise cover to treat serious complications of the non-covered Service:

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

The following Services are excluded from coverage:

1. **Alternative Medical Services:** Chiropractic and acupuncture Services and any other Services of a Chiropractor, Acupuncturist, Naturopath and/or Massage Therapist, except as specifically provided in the ***List of Benefits***, or as provided under a Rider attached to this EOC, if applicable.
2. **Certain Exams and Services:** Physical examinations and other Services:
   a. Required for obtaining or maintaining employment or participation in employee programs;
   b. Required for insurance or licensing; or
   c. On court-order or required for parole or probation, except for Medically Necessary Services covered in the ***List of Benefits*** in this section.
3. **Cosmetic Services:** Cosmetic Services, including surgery or related Services and other Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies. Cosmetic contact lenses do not apply to this exclusion when they are covered under ***Vision Services*** in the ***List of Benefits*** in this section.
4. **Custodial Care:** Custodial care means assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.
5. **Dental Care:** Dental care and dental X-rays, including dental appliances, dental implants, orthodontia, shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, 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 ***List of Benefits*** in this section.

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

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

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

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

   In making determinations whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:
   a. Your medical records;
   b. Written protocols or other documents pursuant to which the Service has been or will be provided;
   c. Any consent documents you or your representative has executed or will be asked to execute, to receive the Service;
   d. Files and records of the IRB or a similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;
   e. Published authoritative medical or scientific literature regarding the Service, as applied to your illness or injury; and
   f. Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

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

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

11. **Services for Incarcerated 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 and Out-of-Plan Urgent Care.

12. **Travel and Lodging Expenses:** Travel and lodging expenses except that in some situations, if a Plan Physician refers you to a non-Plan Provider outside our Service Area as described under ***Getting a Referral*** in ***Section 2: How to Get the Care You Need,*** we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines.
13. **Vision Services:** Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia or astigmatism (for example: radial keratotomy, photo-refractive keratectomy and similar procedures).
14. **Worker's Compensation:** Charges made for the following are not covered by the Health Plan. Services for injuries or diseases related to a Member's job to the extent the Member is required to be covered by a worker's compensation law.

Limitations

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

1. A major disaster;
2. An epidemic;
3. War;
4. Riot;
5. Civil insurrection;
6. Disability of a large share of personnel of a Plan Hospital or Plan Medical Center; and/or
7. Complete or partial destruction of facilities.

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

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

SECTION 4: Subrogation, Reductions and Coordination of Benefits

There may be occasions when we will seek reimbursement of the Health Plan's costs of providing care to you, or your benefits are reduced as the result of the existence of other types of health benefit coverage. This section provides information on these types of situations, and what to do when you encounter them.

Subrogation

There may be occasions when we require reimbursement of the Health Plan's costs of providing care to you. This occurs when there is a responsible party for an illness you acquire or injury you receive. This process is called subrogation. For example, if you were involved in a slip-and-fall incident at a store because of a spill, and the store was found liable for associated injuries you receive, they may become responsible for payment of the costs of your care for those associated injuries. For more information, see ***When Illness or Injury is Caused by a Third Party*** in this section.

Reductions

In addition, there may be occasions when your benefits are reduced as the result of the existence of other types of health benefit coverage available to you. For example, if you have coverage under your spouse's health plan in addition to this coverage, the costs of care may be divided between the available health benefit plans. For more information, see the ***Reductions Under Medicare and TRICARE Benefits and Coordination of Benefits*** provisions in this section.

The above scenarios are a couple of examples of when:

1. We would seek the right to recover the costs of the care we provided to you; or
2. We would reduce the payment of claims.

The remainder of this section will provide you with information on what to do when you encounter these situations.

When Illness or Injury is Caused by a Third Party

If the Health Plan provides coverage under this Agreement when another party is alleged to be responsible to pay for treatment you receive, we have the right to recover the costs of covered Services provided or arranged by Health Plan under this Agreement. To secure our rights, the Health Plan will have a lien on the proceeds of any judgment you obtain against, or settlement you receive from a third party for medical expenses for covered Services provided or arranged by Health Plan under this Agreement.

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. However, you will not have to pay Health Plan more than what you received from or on behalf of the third party for covered Services.

Notifying the Health Plan of Claims and/or Legal Action

Within thirty (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 us at the following address:

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

Attention: Patient Financial Services

4000 Garden City Drive

Hyattsville, Maryland 20785

When notifying us, please include the third party's liability insurance company name, policy and claim numbers, business address and telephone number and, if known, the name of the handler of the claim.

If you are represented by an attorney in relation to the loss for which you have brought legal action against a third party, please ensure that you provide your attorney's name and contact information, including their business address and telephone number. If you change attorneys during the legal process, you are required to inform the Health Plan of your change in representation.

The Health Plan's Right to Recover Payments

In order for the Health Plan to determine the existence of any rights we may have, and to satisfy those rights, you must complete and send the 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 reimburse the Health Plan directly. You may not take any action that is prejudicial to our rights.

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

The Health Plan's recovery shall be limited to the extent that the Health Plan provided benefits or made payments for benefits as a result of the occurrence that gave rise to the cause of action.

Except for any benefits that would be payable under either Personal Injury Protection coverage; and/or any capitation agreement the Health Plan has with a participating provider:

1. If you become ill or injured through the fault of a third party and you collect any money from the third party or their insurance company for medical expenses; or
2. When you recover for medical expenses in a cause of action, the 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, medical payments coverage under any premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage or other source of coverage for monetary damages, compensation or indemnification on account of the injury or illness allegedly caused by the third party:
    a. The Health Plan will be subrogated for any Service provided by or arranged for as:
        i. A result of the occurrence that gave rise to the cause of action; or
        ii. At the time it mails or delivers a written notice of its intent to exercise this option to you or to your attorney, should you be represented by one, as follows:
            a) Per the Health Plan's fee schedule for Services provided or arranged by the Medical Group; or
            b) Any actual expenses that were made for Services provided by contracted providers.

When applicable, any amount returned to the Health Plan will be reduced by a pro rata share of the court costs and legal fees incurred by the Member that are applicable to the portion of the settlement returned to the Health Plan.

Medicare

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

Workers' Compensation or Employer's Liability

If benefits are paid by the Health Plan and the Health Plan determines you received Workers' Compensation benefits for the same incident, the Health Plan has the right to recover as described under the section "**When Illness or Injury is Caused by a Third Party**". The Health Plan will exercise its right to recover against you.

The Recovery Rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily injury or illness was sustained in the course of or resulted from your employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation Carrier;
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this policy, you will notify the Health Plan of any Workers' Compensation claim you make, and that you agree to reimburse the Health Plan as described above. If benefits are paid under this policy and you or your covered dependent recover from a responsible party by settlement, award or otherwise, the Health Plan has a right to recover from you or your covered dependent an amount equal to the amount the Health Plan paid.

If you have an active workers' compensation claim for injuries sustained while conducting the duties of your occupation, you must send written notice of the claim to us within thirty (30) days at the following address:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Patient Financial Services
4000 Garden City Drive
Hyattsville, Maryland 20785

When notifying us, please include the workers' compensation insurance company or third-party administrator (TPA) name, policy and claim numbers, business address and telephone number and, if known, the name of the handler of the claim.

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

Health Plan Not Liable for Illness or Injury to Others

Who is eligible for coverage under this Agreement is stated in ***Section 1: Introduction to Your Kaiser Permanente Health Plan.*** Neither the Health Plan, Plan Hospitals nor the Medical Group provide benefits or health care Services to others due to your liabilities. If you are responsible for illness or injury caused to another person, coverage will not be provided under this Agreement unless they are a Member.

Failure to Notify the Health Plan of Responsible Parties

Note: This provision does not apply to payments made to a covered person under personal injury protection (see §19-713.1(e) of the Maryland Health General Article.)

It is a requirement under this Agreement to notify the Health Plan of any third party who is responsible for an action that causes illness or injury to you.

Failure to notify the Health Plan of your pursuit of claims against a third party due to their negligence is a violation of this Agreement. If a member dually recovers compensation by obtaining benefits from the Health Plan and compensation for the same loss from a responsible third party, the Health Plan reserves the right to directly pursue reimbursement of its expenses from the Member who received the settlement as compensation.

No Member, nor the legal representative they appoint, may take any action that would prejudice or prevent the Health Plan's right to recover the costs associated with providing care to any Member covered under this Agreement.

Pursuit of Payment from Responsible Parties

The Health Plan may use the services of another company to handle the pursuit of subrogation against a responsible third party. When we use these services, the Health Plan may need to release information that does not require Member consent, including, but not limited to, your name, medical record number, the date of loss, policy and claim numbers (including those of the insurance carrier for a third party), attorney information and copies of bills.

In the event that medical records or other protected information that requires your consent to be released is requested from us, we will notify you to obtain your consent and you must provide such consent in a timely manner.

Reductions Under Medicare and TRICARE Benefits

If you are enrolled in Medicare Part A and/or Part B, your benefits are reduced by any benefits for which you are enrolled and receive under Medicare; except for Members whose Medicare benefits are secondary by law.

TRICARE benefits are secondary by law.

Coordination of Benefits

Coordination of Benefits Overview

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

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

Right to Obtain and Release Needed Information

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

Primary and Secondary Plan Determination

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

The plan that pays benefits second, which is known as the secondary plan, coordinates its benefits with the primary plan, and pays the difference between what the primary plan paid, or the value of any benefit

or Service provided, but not more than 100 percent of the total Allowable Expenses, and not to exceed the maximum liability of the secondary plan. The secondary plan is never liable for more expenses than it would cover if it had been primary.

Coordination of Benefits Rules

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

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

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

Assistance with Questions about the Coordination of Your Benefits

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

Order of Benefit Determination Rules

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

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

Rules for a Non Dependent and Dependents

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

Rules for a Dependent Child/Parent

1. **Dependent child with parents who are not separated or divorced:** When the Health Plan and another plan cover the same child as a Dependent of different persons, called “parents,” who are married or are living together, whether or not they have ever been married, then the plan of the parent whose birthday falls earlier in the year is primary to the plan of the parent whose birthday falls later in the year. When both parents have the same birthday, the plan that covered a parent longer is primary, this is known as the "Birthday Rule". If the Birthday Rules does not apply by the terms of the other plan, then the applicable rule in the other plan will be used to determine the order of benefits.

2. **Dependent child with separated or divorced parents:** If two (2) or more plans cover a person as a dependent child, and that child's parents are divorced, separated or are not living together, whether or not they have ever been married the following rules apply. If a court decree states that:
   a. One (1) of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision; or
   b. Both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph #1 of this provision: ***Dependent Child with Parents Who Are Not Separated or Divorced***, shall determine the order of benefits; or
   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph #1 of this provision: ***Dependent Child with Parents Who Are Not Separated or Divorced***, shall determine the order of benefits; or
      i. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         a) The plan covering the custodial parent;
         b) The plan covering the custodial parent's spouse;
         c) The plan covering the non-custodial parent; and then
         d) The plan covering the non-custodial parent's spouse.

Dependent Child Covered Under the Plans of Non-Parent(s)

1. For a dependent child covered under more than one (1) plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the dependent child provisions above, as if those individuals were parents of the child.

Dependent Child Who Has Their Own Coverage

1. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in this provision for ***Longer or Shorter Length of Coverage*** applies.
2. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the "Birthday Rule".

Active/Inactive Employee Coverage

1. A plan that covers a person as an employee who is neither laid off nor retired (or that employee's dependent) is primary to a plan that covers that person as a laid off or retired employee (or a laid off or retired employee's dependent).
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the rules in #1. and #2. under the provision ***Rules for a Non-Dependent and Dependents*** above can determine the order of benefits.

COBRA or State Continuation Coverage

1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person

as an employee, member, subscriber or retiree, or that covers the person as a dependent of an employee, member, subscriber or retiree, is the primary plan and the Plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the rules in #1. and #2. under the provision ***Rules for a Non-Dependent and Dependents*** above can determine the order of benefits.

Longer/Shorter Length of Coverage

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

Effect of Coordination of Benefits on the Benefits of this Plan

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

Coordination with the Health Plan's Benefits

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

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

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

If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

Facility of Payment

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

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

Right of Recovery of Payments Made Under Coordination of Benefits

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

Military Service

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

SECTION 5: Health Care Service Review, Appeals and Grievances

This section provides you with information on how to file claims, Appeals and Grievances with the Health Plan and receive support with these processes.

Important Definitions

Please see the ***Important Terms You Should Know*** section for an explanation of important, capitalized terms used within this section.

Questions About Health Care Service Review, Appeals or Grievances

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

The Health Care Service Review Program

Pre-Service Reviews

If you do not have an Emergency Case and you have not received the health care Service or course of treatment you are requesting, including pharmaceutical Services not submitted electronically, then within two (2) working days of receiving all necessary information, Health Plan will promptly notify the Health Care Provider of the determination.

After receipt of the initial request for health care Services and confirming through a complete review of information already submitted by the Health Care Provider, if Health Plan determines we do not have sufficient information to make a determination, Health Plan shall promptly, but not later than three (3) calendar days after receipt of the initial request, inform the Health Care Provider that additional information must be provided by specifying:

i. the information, including any laboratory or diagnostic test or other medical information, that must be submitted to complete the request; and
ii. the criteria and standards to support the need for additional information.

Once the necessary information has been received, the Health Plan will make its determination within two (2) working days.

We must receive the information requested by the notice, within forty-five (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 Health Plan fails to make a determination within the required time limits listed above, the request shall be deemed approved.

If an admission, procedure or Service has Prior Authorization, the Health Plan will:

1. Notify the provider by telephone within one (1) working day of Prior Authorization; and
2. Confirm the Prior Authorization with you and the provider in writing within five (5) working days of our decision.

If Prior Authorization is denied or an alternate treatment or Service is recommended, the Health Plan will:

1. Notify the provider promptly by telephone within one (1) working day of making the denial or alternate treatment or Service recommendation; and
2. Confirm the denial decision with you, your Authorized Representative and the Health Care Provider acting on behalf of the Member in writing within five (5) working days of making our decision.

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

Emergency Expedited Pre-Service Reviews

Health Plan will make initial determinations on whether to authorize or certify an emergency course of treatment or healthcare Service for a Member within twenty-four (24) hours after the initial request after receipt of the information necessary to make the determination. If Health Plan determines that additional information is needed after confirming through a complete review of the information already submitted by the Health Care provider, the Health Plan shall:

1. promptly request the specific information needed, including any laboratory or diagnostic test or other medical information; and
2. promptly, but not later than two (2) hours after receipt of the information, notify the Health Care Provider of an authorization or certification determination when made by Health Plan.

If additional information is requested, your Health Care Provider will have only 48 hours to submit the requested information. Decision regarding pre-Service review will be communicated to you, your Authorized Representative and Health Care provider by telephone within 24 hours of the request. Such decisions will be confirmed in writing to you, your Authorized Representative, and the Health Care Provider acting on behalf of the Member, within one (1) calendar day after a decision has been orally communicated to you, your Authorized Representative, and your Health Care Provider.

Health Plan shall initiate the expedited procedure for an Emergency Case if you, your Authorized Representative requests, or the Health Care Provider attests that the Services are necessary to treat a condition or illness that, without immediate medical attention, would:

1. seriously jeopardize the life or health of you or your ability to regain maximum functions;
2. cause you to be in danger to self or others; or
3. cause you to continue using intoxicating substances in an imminently dangerous manner.

If Health Plan fails to make a determination within the required time limits listed above, the request shall be deemed approved.

Concurrent Reviews

When you make a request for, an extended stay in a health care facility, additional health care Services, or a request for additional Visits or days of care submitted as part of an existing course of treatment or treatment plan that is about to end, when we had previously approved a course of treatment or treatment plan that is about to end the Health Plan will make concurrent review determinations within one (1) working day of receiving the request or within one (1) working day of obtaining all the necessary information. If you have an Emergency Case, then a request for concurrent review will be handled like any other pre-Service request for review when an Emergency Case is involved, except that our decision will be made within twenty-four (24) hours of the request. Health Plan will promptly notify the Health Care Provider of the determination.

After receipt of the initial request for health care Services and confirming through a complete review of information already submitted by the Health Care Provider, if Health Plan determines that Health Plan does not have sufficient information to make a determination, Health Plan shall promptly, but not later than three (3) calendar days after receipt of the initial request, inform the Health Care Provider that additional information must be provided by specifying:

i. the information, including any laboratory or diagnostic test or other medical information, that must be submitted to complete the request; and
ii. the criteria and standards to support the need for additional information.

If Health Plan fails to make a determination within the required time limits listed above, the request shall

be deemed approved.

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

1. Promptly notify the Health Care Provider of the determination;
2. Notify the provider by telephone within one (1) working day after receipt of the information necessary to make the determination; and.
3. Confirm the authorization in writing with you or your Authorized Representative within five (5) working days after the decision was made. 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, the Health Plan will:

1. Notify the provider promptly by telephone or with the affirmative consent from you, your Authorized Representative, and your Health care Provider acting on your behalf, by text, facsimile, e-mail, an online portal, or other expedited means of the denial within one (1) working day after receipt of the information necessary to make the determination; and
2. Confirm the denial in writing with you, your Authorized Representative and your Health Care Provider within five (5) working days after the telephone notification. Coverage will continue for Health Care Services until you, 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 in this section. If you filed a request for additional Services 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, the Health Plan will decide your request for review within a reasonable period of time appropriate to the circumstances but in no event later than thirty (30) calendar days from the date on which the Appeal or Grievance was received.

Step-therapy Exception

Prior Authorization or step-therapy may be required for certain prescription drugs, supplies or supplements administered by medical personnel in an office Visit. For an electronically submitted step-therapy exception, Health Plan shall make a determination:

1. in real time if:
   a. No additional information is needed by Health Plan to process the request; and
   b. The request meets the Health Plan's criteria for approval; or
2. If a request is not approved in real time, as described in item #1 immediately listed above, within one (1) working day after Health Plan receives all of the information necessary to make the determination.

If additional information is needed to make a determination after confirming through a complete review of the information already submitted by the Health Care Provider, Health Plan will request the information promptly, but not later than three (3) calendar days after receipt of the initial request, inform the Health Care Provider that additional information must be provided by specifying:

1. the information, including any laboratory or diagnostic test or other medical information, that must be submitted to complete the request; and
2. the criteria and standards to support the need for additional information.

If Health Plan fails to make a determination within the required time limits listed above, the request shall be deemed approved.

Reconsiderations

If an initial determination is made by Health Plan to not authorize or certify a health care Service and the Health Care Provider believes the determination warrants an immediate reconsideration, the Health Plan shall provide the opportunity to the Health Care Provider to speak with the physician that rendered the determination, by telephone on an expedited basis, within a period of time not to exceed twenty-four (24) hours of the Health Care Provider seeking the reconsideration. If the physician is unable to immediately speak with the Health Care Provider seeking the reconsideration, the physician shall provide the Health Care Provider with the following contact information for the Health Care Provider to use to contact the physician:

1. a direct telephone number that is not the general customer call number; or
2. a monitored e-mail address that is dedicated to communication related to utilization review.

Post-Service Claim Reviews

The Health Plan will make its determination on post-service review within thirty (30) days of receiving a claim. If Health Plan approves the claim, benefits payable under your contract will be paid within thirty (30) days of receiving the receipt of written proof of loss. If we determine we cannot reimburse the claim because of the:

1. Legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary; or
2. Claim is not clean and, therefore, we need more information to process the claim.

We will notify you of the extension within the initial thirty (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 forty-five (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:

1. The claim was paid; or
2. The claim is being denied in whole or in part; or
3. Additional information is needed to determine if all or part of the claim will be reimbursed and what specific information must be submitted; or
4. The claim is incomplete and/or unclean and what information is needed to make the claim complete and/or clean.

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

Notice of Claim

We do not require a written notice of claim. Additionally, Members are not required to use a claim form to notify us of a claim.

Filing for Payment or Reimbursement of a Covered Service or Post-Service Claim

Notice of Claim and Proof of Loss Requirements

When the Health Plan receives a notice of claim, we will provide you with the appropriate forms for filing proof of loss. If we do not provide you with claim forms within fifteen (15) days of your notice to us, then

you will be considered to have complied with the proof of loss requirements of this Agreement after you have submitted written proof that details the occurrence and the character and extent of the loss for which you have made a claim.

We consider an itemized bill or 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 to be sufficient proof of the covered Service you received or your post-service claim. Simply mail or submit online a proof of payment and a copy of the bill to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. Please mail or submit online your proof to us within one (1) year at the following address:

Kaiser Permanente National Claims Administration - Mid-Atlantic States
PO Box 371860
Denver, CO 80237-9998
Website: www.kp.org

Failure to submit such proof within one (1) year will not invalidate or reduce the amount of your claim if it was not reasonably possible to submit the request within that time frame. If it is not reasonably possible to submit the proof within one (1) year after the date of Service, we ask that you ensure that it is sent to us no later than two (2) years from the date of Service. A Member's legal incapacity shall suspend the time restrictions regarding the submission of proof; however, any suspension period will end when legal capacity is regained.

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

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

- Member/Patient Name and Medical Record Number (MRN)
- The date you received the Services
- Where you received the Services
- Who provided the Services
- Why you think we should pay for the Services
- A copy of the bill, your medical record(s) for these Services, and your receipt if you paid for the Services.

Paper forms, supporting documentation, and any other information can be mailed or submitted online to:

Kaiser Permanente National Claims Administration - Mid-Atlantic States
PO Box 371860
Denver, CO 80237-9998
Website: www.kp.org

Each Member claiming reimbursement under this contract shall complete and submit any consents, releases, assignments and/or other documents to the Health Plan that we may reasonably request for the purpose of acting upon a claim.

The Health Care Provider has a minimum of one-hundred and eighty (180) days from the date a covered Service is rendered to submit a claim for reimbursement for the Service.

The Health Education and Advocacy Unit, Office of the Attorney General

The Health Education and Advocacy Unit is available to assist you or your Authorized Representative:

1. With filing an Appeal or Grievance under the Health Plan's internal Appeal and Grievance processes, however:
   a. The Health Education and Advocacy Unit is not available to represent or accompany you or your Authorized Representative during any associated proceedings; and
2. In mediating a resolution of the Adverse Decision or Coverage Decision with the Health Plan.
   a. You or your Authorized Representative may file an Appeal or Grievance; and
   b. You, your Authorized Representative or a Health Care Provider acting on your behalf may file a Complaint with the Commissioner, without first filing a Grievance with the Health Plan and receiving a final decision on the Grievance, if:
      i. The Health Plan waives the requirement that our internal Grievance process must be exhausted before filing a Complaint with the Commissioner;
      ii. The Health Plan has failed to comply with any of the requirements of the internal Grievance process as described below in Our Internal Grievance Process; or
      iii. You, your Authorized Representative or a Health Care Provider acting on your behalf provides sufficient information and supporting documentation in the Complaint that demonstrated a compelling reason to do so; or
   c. In the case of a Coverage Decision, you, your Authorized Representative or a Health Care Provider acting on your behalf may file a Complaint with the Commissioner without first filing an Appeal if the Coverage Decision involves an Urgent Medical Condition for which the health care Service has not yet been rendered.

The Health Education and Advocacy Unit may be contacted at:

Office of the Attorney General
Consumer Protection Division
Attention: Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840
Toll-free: 1-877-261-8807
Fax: 1-410-576-6571
Website: **www.oag.state.md.us**
Email: mailto:consumer@oag.state.md.us

Maryland Insurance Commissioner

You or your Authorized Representative must exhaust our internal Appeal or Grievance process as described in this section prior to filing a Complaint with the Insurance Commissioner except when:

1. You or your Authorized Representative, or your Health Care Provider provides sufficient information or 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 Service could result in loss of life, serious impairment to a bodily function, or serious dysfunction to a bodily organ or part, or the Member remaining seriously mentally ill or using intoxicating substance with symptoms that cause the Member to be a danger to him/herself or others, or the Member continuing to experience severe withdrawal symptoms. A Member is considered to be in danger to self or others if the Member is unable to function in activities of daily living or care for self without imminent dangerous consequences;
2. We failed to make a Grievance Decision for a pre-service Grievance within thirty (30) working days after the Filing Date, or forty-five (45) working days after the Filing Date for a post-service Grievance;
3. We or our representative failed to make a Grievance Decision for an expedited Grievance for an Emergency Case within twenty-four (24) hours after you or your Authorized Representative filed the Grievance;
4. We have waived the requirement that our internal Grievance process must be exhausted before filing a Complaint with the Commissioner; or
5. We have failed to comply with any of the requirements of our internal Grievance process.

Maryland Insurance Commissioner may be contacted at:

Maryland Insurance Administration
Attention: Consumer Complaint Investigation
Life and Health/Appeal and Grievance
200 St. Paul Place
Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000
Toll free/out-of-area: 1-800-492-6116
TTY: 1-800-735-2258
Fax: 1-410-468-2260 or 1-410-468-2270

Our Internal Grievance Process

This process applies to a utilization review determination made by us that a proposed or delivered health care Service is or 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 file a Grievance by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY) or by submitting a written request. All supporting documentation that relates to the Grievance should be mailed to:

Kaiser Permanente
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Rd NE
Atlanta, GA 30305
Fax: 1-404-949-5001

A Grievance must be filed within one-hundred eighty (180) calendar days from the date of receipt of the Adverse Decision notice. If the Grievance is filed after one-hundred eighty (180) calendar days, we will send a letter denying any further review due to lack of timely filing.

After confirming through a complete review of any information already submitted by your Health Care Provider, if we need additional information to complete our internal Grievance process within five (5) working days after you or your Authorized Representative file a Grievance, we will notify you, your Authorized Representative, or Health Care Provider that we cannot proceed with review of the Grievance unless we receive the additional information, request the specific information, including any laboratory or diagnostic test or other medical information that must be submitted to complete the internal Grievance process, and provide the specific reference, language, or requirements from the criteria and standards used by us to support the need for the additional information. If you, your Authorized Representative, or Health Care Provider require assistance, we will assist you to gather necessary additional information without further delay.

Grievance Acknowledgment
We will acknowledge receipt of your Grievance within five (5) calendar days after the date your written Grievance was received by us.

Pre-service Grievance
If you have a Grievance about a health care Service that has not yet been rendered, an acknowledgment letter will be sent requesting any additional information that may be necessary within five (5) working days after the Filing Date. We will also inform you or your Authorized Representative that a decision regarding the Grievance will be made and provided in writing. Such written notice will be sent within thirty (30) working days of the Filing Date of the Grievance or within five (5) working days of the decision whichever comes first.

Post-service Grievance
If the Grievance requests payment for health care Services already rendered to you, an acknowledgment letter will be sent requesting additional information that may be necessary within five (5) working days after the Filing Date. We will also inform you or your Authorized Representative that a decision regarding the Grievance will be made and provided in writing. Such written notice will be sent within forty-five (45) working days of the Filing Date of the Grievance or within five (5) working days of the decision whichever comes first.

For both pre-service and post-service Grievances, we will send you or your Authorized Representative, or your Health Care Provider a letter requesting an extension if we anticipate that there will be a delay in our concluding the Grievance within the designated period. The requested extension period shall not exceed more than thirty (30) working days. If you or your Authorized Representative, or your Health Care Provider do not agree to the extension, then the Grievance will be completed in the originally designated time frame. 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 or your Authorized Representative, or your Health Care Provider confirming the approval. If the Grievance was filed by you or your Authorized Representative, or your Health Care Provider then a letter confirming the Grievance Decision will also be sent to you.

In the case of an agreed upon extension, we will communicate our decision to you or your Authorized Representative or your Health Care Provider and provide written notice of the decision by no later than the end of the extension period or within five (5) working days from the date of the decision, whichever comes first.

Grievance Decision Time Periods and Complaints to the Commissioner

For pre-service Grievances, if you or your Authorized Representative does not receive a Grievance Decision from us on or before the later of the:

1. 30th working day from the date the Grievance was filed; or
2. End of an extension period to which was agreed, then:
   a. You or your Authorized Representative, or your Health Care Provider may file a Complaint with the Commissioner without waiting to hear from us.

For post-service Grievances, if you or your Authorized Representative does not receive a post-service Grievance Decision from us on or before the later of the:

1. 45th working day from the date the Grievance was filed; or
2. End of an extension period that to which was agreed, then:
   a. You or your Authorized Representative may file a Complaint with the Commissioner without waiting to hear from us.

Note: In cases in which a Complaint is filed with the Commissioner, you or your Authorized Representative must authorize the release of medical records to the Commissioner to assist with reaching a decision in the Complaint.

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 for this section. An expedited review of an Emergency Case may be initiated by calling Member Services 1-800-777-7902 or 711 (TTY).

The expedited review will be initiated if the Member or Member's representative requests the expedited review or if the Member or Member's representative or Health Care Provider attests that:

1. the Adverse Decision was rendered for Health Care Services that are proposed but have not been provided; and
2. the Services are necessary to treat a condition or illness that, without immediate medical attention, would:
   a. seriously jeopardize the life or health of you or your ability to regain maximum functions;
   b. cause you to be in danger to yourself or others; or
   c. cause you to continue using intoxicating substances in an imminently dangerous manner.

Within twenty-four (24) hours of the Filing Date of the expedited review request, we will verbally notify you or your Authorized Representative of our decision. We will send written notification within one (1) calendar day following verbal communication of the decision to you or your Authorized Representative, or your Health Care Provider. If approval is granted, then we will assist the Member in arranging the authorized treatment or benefit. If the expedited review results in a denial, we will notify you or your Authorized Representative in writing within one (1) calendar day following verbal communication of the decision.

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.

Notice of an Adverse Decision

If our review of your request for a Service (including expedited) results in an Adverse Decision, we will provide you, your Authorized Representative, or your Health Care Provider acting on your behalf communication of our Adverse Decision orally by telephone, or with the affirmative consent from you, your Authorized Representative, or your Health Care Provider acting on your behalf, by text, facsimile, e-mail, an online portal, or other expedited means. Within five (5) business days after the Adverse Decision has made for a non-Emergency Case or within one (1) day after a decision has been orally communicated for expedited cases, we will provide you, your Authorized Representative, or your Health Care Provider acting on your behalf written notice of the Adverse Decision. This written notice shall state at the top in prominent bold print that the notice is a denial of a requested Health Care Service, that the Member may file an Appeal, the telephone number and email address required to be available under § 15–10B–05(E) of this title, and that the notice includes additional information on how to file and receive assistance for filing a Complaint. This written notice shall include:

1. States in detail in clear understandable language the specific factual basis for our decision and the reasoning used to determine that the Health Care Service is not Medically Necessary and did not meet our criteria and standards used in conducting the utilization review;
2. Provides the specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines, on which the decision was based, and may not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "Service included under another procedure", or "not Medically Necessary" or language directing the Member to review the additional coverage criteria in your Evidence of Coverage;
3. A statement that you, your Authorized Representative, or Health Care Provider acting on your behalf, as applicable, are 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.
4. A unique identifier for and the name, business address, and business telephone number of the medical director or associate medical director who made the decision, as follows:

   Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
   Attention: Office of the Medical Director
   4000 Garden City Drive
   Hyattsville, MD 20785
   Phone: 301-816-6482

   The business telephone number will be a dedicated number for Adverse Decisions and will not be the Health Plan's general customer call number. Your provider may contact the utilization management physician at 1-800-810-4766 to discuss your Adverse Decision.

5. Written details of our Internal Grievance Process.
6. A description of your, your Authorized Representative's, or, acting on your behalf, our Health Care Provider's right to file a Complaint with the Commissioner within four (4) months following receipt of our Grievance Decision;
7. A description that you, your Authorized Representative, or your Health Care Provider acting on your behalf may file a Complaint without first filing a grievance if you, your Authorized Representative, or your Health Care Provider acting on your behalf can demonstrate a compelling reason to do so, as determined by the Commissioner;
8. Commissioner's address and telephone and facsimile number;
9. A statement that the Health Education and Advocacy Unit is available to assist you or your Authorized Representative in both mediating and filing a Grievance under our internal Grievance

process; and

10. The Health Education and Advocacy Unit's address, telephone and facsimile numbers and email address.

Note: The Health Plan must provide notice of an Adverse Decision in a non-English language if certain thresholds are met for the number of people who are literate in the same non-English language. A threshold language applies to a county if at least 10 percent of the population is literate only in the same foreign language that is identified as a federally mandated non-English language. If we send you a notice of an Appeal decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. You or your Authorized Representative may request translation of the notice by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Notice of Adverse Grievance Decision

If our review of a Grievance (including an expedited Grievance) results in denial, we will provide you, or your Authorized Representative, and your Health Care Provider acting on your behalf communication of our Grievance Decision orally. Within five (5) business days after the Grievance Decision has been made for a non-Emergency Case, or within one (1) day after a Grievance Decision has been orally communicated for expedited Grievances, we will provide you, your Authorized Representative, and your Health Care Provider acting on your behalf written notice of our Grievance Decision. This written notice shall state at the top in prominent bold print that the notice is a denial of a requested Health Care Service, that the Member may file a complaint with the Maryland Insurance Commissioner, the telephone number and email address required to be available under § 15–10b–05(E) of this title, and that the notice includes additional information on how to file and receive assistance for filing an Appeal. This written notice shall include:

1. The specific factual basis for the decision will be stated in detail in clear and understandable language and the reasoning used to determine that the Health Care Service is not Medically Necessary and did not meet our criteria and standards used in conducting the utilization review;
2. The specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines used by the Health Plan, on which the decision was based, and may not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "Service included under another procedure", or "not Medically Necessary" or language directing the member to review the additional coverage criteria in your Evidence of Coverage;
3. A statement that you, your Authorized Representative, or Health Care Provider acting on your behalf, as applicable, are 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.
4. A unique identifier for and the name, business address and business telephone number of the medical director and associate medical director who made the Grievance Decision:

   Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
   Attention: Office of the Medical Director
   4000 Garden City Drive
   Hyattsville, MD 20785
   Phone: 301-816-6482

   The business telephone number will be a dedicated number for Grievance Decisions and will not be the Health Plan's general customer call number.
5. A description of your or your Authorized Representative's right to file a Complaint with the

Commissioner within four (4) months following receipt of our Grievance Decision;A description of your or your Authorized Representative's right to file a Complaint with the Commissioner within four (4) months following receipt of our Grievance Decision;

6. The Commissioner's address and telephone and facsimile numbers;
7. A statement 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
8. The Health Education and Advocacy Unit's address, telephone and facsimile numbers and email address.

Notice of Coverage Decision

Within thirty (30) calendar days after a Coverage Decision has been made, we will send a written notice of the Coverage Decision to you, your Authorized Representative, and your Health Care Provider notice of the Coverage Decision. This written notice shall include:

1. state in detail, in clear, understandable language, the specific factual basis for our decisions; and
2. include the following information:
   a. that you, your Authorized Representative, or your Health Care Provider acting on your behalf has a right to file an appeal with us;
   b. that you, your Authorized Representative, or your Health Care Provider acting on your behalf may file a Complaint with the Commissioner without first filing an appeal if the Coverage Decision involves an urgent medical condition for which has not been rendered;
   c. the Commissioner's address, telephone number, and fax number;
   d. a statement that the Health Advocacy Unit is available to assist the Member in filing a Complaint with the Commissioner; and
   e. the address, telephone number, fax number, and email address of the Health Advocacy Unit.

Our Internal Appeal Process

The Health Plan's internal Appeal process must be exhausted prior to filing a Complaint with the Commissioner, except if our Coverage Decision involves an Urgent Medical Condition. For Urgent Medical Conditions, a complaint may be filed with the Commissioner without first exhausting our internal Appeal process for pre-service decisions only, meaning that Services have not yet been rendered.

Initiating an Appeal

These internal Appeal procedures are designed by the 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 the Health Plan, in regard to any aspect of coverage for a Health Care Service. You or your Authorized Representative must file an Appeal within one-hundred eighty (180) calendar days from the date of receipt of the Coverage Decision. The Appeal should be sent to us at the following address:s:

Kaiser Permanente
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305-1736
Fax: 1-(404) 949-5001

You or your Authorized Representative may also request an Appeal by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Member Services Representatives are also available to describe how Appeals are processed and resolved.

You or your Authorized Representative, as applicable, may review the Health Plan's Appeal file and provide evidence and testimony to support the Appeal request.

Along with an Appeal, you or your Authorized Representative may also send additional information including comments, documents or additional medical records that are believed to support the claim. If the Health Plan requested additional information before and you or your Authorized Representative did not provide it, the additional information may still be submitted with the Appeal. Additionally, testimony may be given in writing or by telephone. Written testimony may be sent with the Appeal to the address listed above. To arrange to provide testimony by telephone, contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY). The Health Plan will add all additional information to the claim file and will review all new information regardless of whether this information was submitted and/or considered while making the initial decision.

Prior to rendering its final decision, the Health Plan will provide you or your Authorized Representative with any new or additional evidence considered, relied upon or generated by (or at the direction of) the Health Plan in connection with the Appeal, at no charge. If during the Health Plan's review of the Appeal, we determine that an adverse coverage decision can be made based on a new or additional rationale, then we will provide you or your Authorized Representative with this new information prior to issuing our final coverage decision and will explain how you or your Authorized Representative can respond to the information, if desired. The additional information will be provided to you or your Authorized Representative as soon as possible, and sufficiently before the deadline to provide a reasonable opportunity to respond to the new information.

After the Health Plan receives the Appeal, we will respond to you, your Authorized Representative, and Health Care provider acting on behalf of the Member in writing within:

1. Thirty (30) working days for a pre-service claim; or
2. Sixty (60) working days for a post-service claim.

We will notify you, your Authorized Representative, and Health Care provider in writing within five (5) working days after the Appeal Decision has been verbally communicated. Written notice of the appeal decision will be sent no more than 30 calendar days after the decision has been made. This written notice will include:

1. The specific factual basis for the decision in detail in clear and understandable language;
2. Reference to the specific plan provision on which determination was based. Additionally, you or your Authorized Representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of the associated claim;
3. A description of your or your Authorized Representative's right to file a complaint with the Commissioner within four (4) months following receipt of our Appeal Decision;
4. The Commissioner's address and telephone and facsimile numbers;
5. A statement 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
6. The Health Education and Advocacy Unit's address, telephone and facsimile numbers and email address.

Note: The Health Plan must provide notice of an Appeal Decision in a non-English language if certain thresholds are met for the number of people who are literate in the same non-English language. A threshold language applies to a county if at least 10 percent of the population is literate only in the same foreign language that is identified as a federally mandated non-English language. If we send you a notice of an Appeal decision to an address in a county where a federally mandated threshold language applies,

then you or your Authorized Representative may request translation of that notice into the applicable threshold language. You or your Authorized Representative may request translation of the notice by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Filing Complaints About the Health Plan

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

Maryland Insurance Administration
Attention: Consumer Complaint Investigation
Life and Health
200 St. Paul Place
Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000
Toll-free/out-of-area: 1-800-492-6116
TTY: 1-800-735-2258
Fax: 1-410-468-2260 or 1-410-468-2270

SECTION 6: Termination of Membership

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

If a Subscriber's membership ends, both the Subscriber's and any applicable Dependents memberships will end at the same time. We will inform you of the date your coverage terminates and the reason for the termination. This termination notice will be provided at least thirty (30) days before the termination date. If your membership terminates, all rights to benefits end at 11:59 p.m. Eastern Time (the time at the location of the administrative office of Health Plan at 4000 Garden City Drive, Hyattsville, Maryland 20785) on the termination date. The Health Plan and Plan Providers have no further responsibility under this contract after a membership terminates, except as provided under ***Extension of Benefits*** in this section.

Termination of Membership

Termination of Your Group Agreement

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

Termination Due to Loss of Eligibility

Your membership will terminate if you no longer meet the conditions under which you became eligible to be enrolled, as described in ***Eligibility for This Plan*** in ***Section 1: Introduction to Your Kaiser Permanente Health Plan.***

If you are eligible on the 1st day of a month, but later in that month you no longer meet those eligibility requirements, your membership terminates on the last day of that month unless your Group has an arrangement with us to terminate at a time other than the last day of the month. Please check with the Group's benefits administrator to confirm your termination date.

Termination Due to Change of Residence

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

Termination for Cause

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

1. Knowingly perform an act, practice or omission that constitutes fraud, which under certain circumstances may include, but is not limited to, presenting a fraudulent prescription or physician order, selling your prescription or allowing someone else to obtain Services using your Kaiser Permanente identification card; or
2. Make an intentional misrepresentation of material fact.

Additionally, if the fraud or intentional misrepresentation was committed by:

1. The Subscriber, we may terminate the memberships of the Subscriber and all Dependents in the Family Unit.
2. A Dependent, we may terminate the membership of only that Dependent.

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

Termination for Nonpayment

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

Extension of Benefits

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

1. 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 twelve (12) months from the date your coverage ends, whichever comes first.
2. 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 thirty (30) days following the date you placed the order.
3. 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 ninety (90) days following the date your coverage ended.
4. 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:
    a. Sixty (60) days following the date your coverage ended if the orthodontist has agreed to or is receiving monthly payments; or
    b. Until the latter of sixty (60) days following the date your coverage ended, or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

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

Limitations to Extension of Benefits

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

1. Failure to pay Premium by the Member;
2. Members whose coverage ends because of fraud or material misrepresentation by the Member;
3. When coverage is provided by a succeeding health plan and that health plan's coverage:
    a. 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
    b. 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 provide ninety (90) days' prior written notice to the Subscriber. If we discontinue offering all products to groups in a market, we will give one-hundred eighty (180) days' prior written notice to the Subscriber.

Continuation of Group Coverage Under Federal Law

COBRA

You or your Dependents may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility. Members are eligible for COBRA continuation coverage even if they live in another Kaiser Foundation Health Plan or allied plan service area. Please contact your Group if you want to know whether you or your Dependents are eligible for COBRA coverage, how to elect COBRA coverage, or how much you will have to pay your Group for it.

USERRA

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. Members are not ineligible for USERRA continuation coverage solely because they move or live outside our Service Area. For Members who serve in the military, you must submit a USERRA election form to your Group within sixty (60) days following 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

Upon the Subscriber's death, the spouse of the Subscriber and any Dependent children of the Subscriber (including any of the Subscriber's children born after the Subscriber's death), may continue uninterrupted coverage hereunder, upon arrangement with the Group in compliance with applicable Maryland law.

The election period for such coverage provided under Maryland law shall begin with the date on which there has been an applicable change in status and end no sooner than forty-five (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 two percent 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:

1. Termination of this Agreement;
2. Eligibility of the Member for hospital, medical or surgical benefits under an insured or self-insured group health benefit program or plan, other than the group contract, that is written on an expense-incurred basis or is with a health maintenance organization;
3. Entitlement of the Member to benefits under Title XVIII of the Social Security Act;
4. Acceptance by the Member of any hospital, medical or surgical coverage under a non-group contract or policy that is written on an expense-incurred basis or is with a health maintenance organization;
5. Ceasing to qualify as a Dependent child (in which case only the coverage of the affected formerly Dependent child would be impacted); or
6. The expiration of eighteen (18) calendar months following the death of the Subscriber.

Divorce of the Subscriber and His/Her Spouse

If a Member would otherwise lose coverage due to divorce from the Subscriber, the former spouse of the Subscriber and any Dependent children of the Subscriber (including any of the Subscriber's children born after the divorce), 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 sixty (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:

1. Termination of this Agreement;
2. Eligibility of the Member for hospital, medical or surgical benefits under an insured or self-insured group health benefit program or plan, other than the group contract, that is written on an expense-incurred basis or is with a health maintenance organization;
3. Entitlement of the Member to benefits under Title XVIII of the Social Security Act;
4. Acceptance by the Member of any hospital, medical or surgical coverage under a non-group contract or policy that is written on an expense-incurred basis or is with a health maintenance organization;
5. Ceasing to qualify as a Dependent child (in which case only the coverage of the affected formerly Dependent child would be impacted); or
6. Remarriage of the Member who is the divorced former spouse of the Subscriber (in which case only the coverage of the divorced former spouse of the Subscriber would be impacted).

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

If you would otherwise lose coverage due to the voluntary or involuntary termination of the Subscriber's employment, for any reason other than for cause, the Subscriber's spouse and any Dependent children who were covered under this contract before the change in employment status of the Subscriber, may continue uninterrupted coverage hereunder, upon arrangement with Group in compliance with applicable Maryland law, if the Subscriber resides in Maryland.

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 two percent 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:

1. Termination of this Agreement; or
2. Eligibility of the Member for hospital, medical or surgical benefits under an insured or self-insured group health benefit program or plan, other than the group contract, that is written on a expense-incurred basis or is with a health maintenance organization;
3. Entitlement of the Member to benefits under Title XVIII of the Social Security Act;
4. Acceptance by the Member of any hospital, medical or surgical coverage under a non-group contract or policy that is written on an expense-incurred basis or is with a health maintenance organization;
5. Ceasing to qualify as a Dependent (in which case only the coverage of the affected formerly Dependent child would be impacted); or
6. The expiration of eighteen (18) calendar months after the termination of the Subscriber's employment.

Coverage Under the Continuation Provision of Group's Prior Plan

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

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

Unless otherwise agreed to by your Group, subject to these provisions, a person who is a Member hereunder on the 1st day of a month is covered for the entire month.

SECTION 7: Other Important Provisions of Your Plan

This section contains additional special provisions that apply to this EOC.

Applications and Statements

Any applications, forms or statements specified in this EOC, or that we request in our normal course of business, must be completed by you or your Authorized Representative.

Assignment

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

Attorney Fees and Expenses

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

Certificates

A certificate is a statement that summarizes the benefits and rights that pertain to each Member under this contract. We will provide you with a certificate, which will be delivered either:

1. Directly to each Subscriber, as only one statement per Family will be issued when Dependents are enrolled under this Plan; or
2. To your Group, for distribution to each Subscriber of the Group.

Contestability

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

A statement made by a Member in relation to insurability may not be used to contest the validity of their coverage if the statement was made after coverage was in force for a period of two (2) years before the contest.

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

1. The statement is documented in writing and signed by the applicant, employer or Member; and
2. A copy of the statement is provided to the applicant, employer or Member.

Contracts with Plan Providers

Plan Provider Relationship and Compensation

The Health Plan and Plan Providers are independent contractors. Your Plan Providers are paid in various ways, including salary, capitation, per diem rates, case rates, fee for service and incentive payments. If you would like additional information about the way Plan Providers are paid to provide or arrange medical and hospital Services for members, please refer to your Provider Directory or contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Plan Provider Termination

If our contract with any Plan Provider terminates for reasons unrelated to fraud, patient abuse, incompetence, or loss of licensure status while you are under the care of that Plan Provider, you may continue to see that provider and we will retain financial responsibility for covered Services you receive in excess of any applicable Cost Sharing for a period not to exceed ninety (90) days from the date we

have notified you of the Plan Provider's termination.

Primary Care Plan Physician Termination

If our contract with your Primary Care Plan Physician terminates for reasons unrelated to fraud, patient abuse, incompetence, or loss of licensure status while you are under the care of that Primary Care Plan Physician, you may continue to see that provider and we will retain financial responsibility for covered Services you receive in excess of any applicable Cost Sharing, for a period not to exceed ninety (90) days from the date we have notified you of the Plan Physician's termination, or until you have chosen a new Primary Care Plan Physician, whichever occurs first.

Provider Directory Information Requirements

If a Member is furnished, by a non-Participating Provider, an item or Service that would otherwise be covered if provided by a Participating Provider, and the Member relied on a database, provider directory, or information regarding the provider's network status provided by Health Plan through a telephone call or electronic, web-based, or Internet-based means which incorrectly indicated that the provider was a Participating Provider for the furnishing of such item or Service, then the following apply:

1. The Copayment, Coinsurance, and/or other Cost Sharing requirement for such item or Service furnished by a non-Participating Provider is the same as the Copayment, Coinsurance, and/or other Cost Sharing requirement listed in the EOC for the item or Service when provided by a Participating Provider; and
2. Any Cost Sharing payments made with respect to the item or Service will be counted toward any applicable Deductible and Out-of-Pocket Maximum.
3. The Member will not be liable for an amount that exceeds the Cost Sharing that would have applied to the Member if the provider was a Participating Provider.

Governing Law

This contract will be administered under the laws of the State of Maryland, except when preempted by federal law. Any provision that is required to be in this contract by state or federal law shall bind both Members and the Health Plan, regardless of whether or not set forth in this contract.

Legal Action

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

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

Mailed Notices

Our notices to you will be sent to the most recent address we have on file for the Subscriber. You are responsible for notifying us of any change in address. Subscribers who move should contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

You may mail a change of address notice to the Health Plan by postage prepaid U.S. Mail to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
4000 Garden City Drive
Hyattsville, MD 20785

Notice of Non-Grandfathered Group Plan

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. believes that your Plan is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA).

Overpayment Recovery

We may recover any overpayment we make for covered Services from:

1. Anyone who receives an overpayment; or
2. Any person or organization obligated to pay for the Services.

In the event of an overpayment to a health care provider, we may only retroactively deny reimbursement to that health care provider during the six (6)-month period following the date we paid a claim submitted by that health care provider.

Privacy Practices

Kaiser Permanente will protect the privacy of your Protected Health Information (PHI). We also require contracting providers to protect your PHI. Your PHI is individually identifiable information about your health, the health care Services you receive, and payment for your health care. You may generally:

1. See and receive copies of your PHI;
2. Correct or update your PHI; and
3. Ask us for an account of certain disclosures of your PHI.

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

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices*, which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request. To request a copy, contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY). You can also find the notice at your local Plan Facility or online at **www.kp.org**.

Kaiser Permanente
Maryland Large Group Agreement and Evidence of Coverage

Important Terms You Should Know

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

A

Adverse Decision: means:

1. A utilization review decision made by a private review agent, Health Plan, or a Health Care Provider 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.
2. A denial by a carrier of a request by a member for an alternative standard or a waiver of a standard to satisfy the requirements of a wellness program.

An Adverse Decision includes a utilization review determination based on a Prior Authorization or step-therapy requirement.

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

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

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

Allowable Charges (AC): means:

1. Services provided by the Health Plan or Medical Group: The amount in the Health Plan's schedule of Medical Group and the Health Plan charges for Services provided to Members;
2. Items obtained at a Plan Pharmacy: For items covered under the ***Outpatient Prescription Drug Rider*** and
   a. Obtained at a pharmacy owned and operated by Health Plan, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item. This amount is an estimate of the cost of acquiring, storing and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente Pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan.
   b. Obtained at a Plan Pharmacy other than a pharmacy owned and operated by Health Plan, the cost of the item calculated on a discounted wholesale price plus a dispensing fee;
3. Emergency Services from a non-Participating Provider (including Post-Stabilization Care that constitutes Emergency Services under federal law): the amount by which the Out-of-Network Rate exceeds the Cost Sharing amount for Services.
4. For Services received from Participating Providers, the amount the Participating Provider has agreed to accept as payment.
5. All other Services, the amount:
   a. The provider has contracted or otherwise agreed to accept;
   b. The provider has negotiated with the Health Plan;
   c. Health Plan must pay the non-Participating Provider pursuant to state law, when it is applicable, or federal law, including the amount by which the Out-of-Network Rate exceeds

the Cost Sharing amount for Services, or in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the provider and us;

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

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

Allowable Expense: A health care Service or expense, including Deductibles, Coinsurance or Copayments, that is covered in full or in part by any of the Plans covering the Member. When the Plans provide benefits in the form of Services, the reasonable cash value of each Service will be considered an Allowable Expense and a benefit paid. An expense or health care 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. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member 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 is not an Allowable Expense, unless one of the plans provides coverage for private hospital room expenses. If a Member is covered by two (2) or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

If a Member is covered by two (2) or more Plans that provide benefits or Services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

If a Member is covered by one (1) Plan that calculates its benefits and Services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits and Services on the basis of negotiated fees, the primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the secondary Plan to provide the benefit or Service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable Expense used for the secondary Plan to determine its benefits.

The amount of any benefit reduction by the primary Plan because a Member failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, Prior Authorization of admissions, and preferred provider arrangements.

Allowable Expense does not include coverage for dental care except as provided under "Accidental Dental Injuries" in ***Section 3: Benefits, Exclusions and Limitations***.

Ancillary Service: Services that are:

1. Items and Services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner;
2. Items and Services provided by assistant surgeons, hospitalists, and intensivists;
3. Diagnostic Services, including radiology and laboratory Services; and
4. Items and Services provided by a non-Participating Provider if there is no Participating Provider who can furnish such item or Service at such facility.

Appeal: A protest filed by a Member or his or her Authorized representative, or a Health Care Provider with the Health Plan under its internal appeal process regarding a Coverage Decision concerning a Member.

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

Authorized Representative: An individual authorized under state law to provide consent on behalf of a Member provided that the individual is not a provider affiliated with the facility or employee of the facility unless such provider or employee is a family member of the patient.

Authorized Representative: (For use in relation to ***Section 5: Health Care Service Review, Appeals and Grievances):*** An individual authorized by the Member or Parent/Guardian, as applicable, or otherwise authorized by state law to act on the Member's behalf to file claims or Complaints and to submit Appeals or Grievances to the Health Plan. A Health Care Provider (as defined below) may act on behalf of a Member with the Member's express consent, or without such consent in an Emergency Case.

C

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

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

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.

Commissioner: The Maryland Insurance Commissioner.

Complaint: A protest filed with the Commissioner involving a Coverage Decision, Adverse Decision or Grievance Decision.

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

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

Complex or Chronic Medical Condition includes, but is not limited to: Multiple Sclerosis, Hepatitis C, and Rheumatoid Arthritis.

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

1. Is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;
2. Is undergoing a course of institutional or inpatient care from the provider or facility;
3. Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
4. Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. Is or was determined to be terminally ill, as determined under section 1861(dd)(3)(A) of the Social Security Act, and is receiving treatment for such illness from such provider or facility.

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

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

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

D

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

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

1. Are at least age 18;
2. Are not related to each other by blood or marriage within four (4) degrees of consanguinity under civil law rule;
3. Are not married or in a civil union or domestic partnership with another individual;
4. Have been financially interdependent for at least six (6) consecutive months prior to application in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely; and
5. Share a common primary residence.

E

Emergency Case: Health Plan shall initiate the expedited procedure for an Emergency Case if the Member or the Member's representative requests the expedited review or the Health Care Provider or the Member or the Member's representative attests that:

1. an Adverse Decision was rendered pertaining to Health Care Services which have yet to be delivered; and
2. such Health Care Services are necessary to treat a condition or illness that, without immediate 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; or
    c. Cause the Member to continue using intoxicating substances in an imminently dangerous manner.

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

1. Placing the health of the Member or, with respect to a pregnant person, the health of the pregnant person or their unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

1. An appropriate medical screening examination, including those that are provided in specialized facilities that are staffed by behavioral health providers trained to provide crisis Services, (as required under the federal Emergency Medical Treatment and Active Labor Act (EMTALA), section 1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a hospital, or of an Independent Freestanding Emergency Department, as applicable including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition;
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment, required under EMTALA or would be required under EMTALA if EMTALA applied to an Independent Freestanding Emergency Department to Stabilize the patient regardless of the department of the hospital in which such further examination or treatment is furnished; and
3. Except as further described in paragraph 3.a., covered Services, also referred to as Post-Stabilization Care, that are furnished by a non-Participating Provider or non-Participating Emergency Facility after you are Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Visit in which the Emergency Services are furnished:
   a. When, under applicable federal law, the covered Services described in item #3 are not included as Emergency Services if all of the following conditions are met:
      i. The attending emergency physician or Treating Provider determines that the Member is able to travel using non-medical transportation or non-emergency medical transportation to an available Participating Facility, or Participating Provider located within a reasonable travel distance, taking into account the Member's medical condition;
      ii. The provider or facility furnishing such additional covered Services satisfies the notice and consent requirements set forth in federal regulation 45 C.F.R § 149.420(c) through (g) with respect to such covered Services, provided that the written notice additionally (1) in the case of Participating Emergency Facility and a non-Participating Provider, the written notice must also include a list of any Participating Providers at the facility who are able to furnish such items and Services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a Participating Provider and (2) in the case of a non-Participating Emergency Facility, the written notice must include a good faith estimate of the charges for covered Services to be furnished at a non-Participating Emergency Facility or by non-Participating Providers during the Visit, (including any item or Service that is reasonably expected to be furnished by the non-Participating Emergency Facility or non-Participating providers in conjunction with such items or Services);
      iii. The Member, or an Authorized Representative of such Member, is in a condition to receive the information in the consent as described in item #3(a)(ii), as determined by the attending emergency physician or Treating Provider using appropriate medical judgment, and to provide informed consent in accordance with applicable State law; and
   b. When the covered Services are not rendered by a Health Care Provider who is subject to state law prohibiting balance billing (§19-710(p) of the Health-General Article).

Essential Health Benefits: Has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health

and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder Services, including behavioral health treatment; prescription drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric Services, including oral and vision care.

F

Family Caregiver: A relative by blood, marriage, domestic partnership or adoption of the terminally ill Member.

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

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

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

Filing Date: The earlier of five (5) days after the date of mailing or the date of receipt by the Health Plan when you mail information to us.

G

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

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

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

H

Habilitative Services: Services and devices, including occupational therapy, physical therapy, and speech therapy that help a child and adult keep, learn, or improve skills and functioning for daily living.

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 licensed under the Health Occupations Article to provide health care Services in the ordinary course of business or practice of a profession and is a treating provider of the Member or hospital as defined in Health General Article, §19-301, Annotated Code of Maryland.

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

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

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

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

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

I

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

K

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

L

Legal Partner/Legal Partnership: Any same-sex relationship, other than marriage, that is recognized as valid by any other jurisdiction, such as a domestic partnership or civil union.

M

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

Medically Necessary: Medically Necessary means that the Service is all of the following:

1. Medically required to prevent, diagnose or treat the Member's condition or clinical symptoms;
2. In accordance with generally accepted standards of medical practice;
3. Not solely for the convenience of the Member, the Member's family and/or the Member's provider; and
4. The most appropriate level of Service which can safely be provided to the Member. For purposes of this definition, "generally accepted standards of medical practice" means:
    a. Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
    b. Physician specialty society recommendations;
    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: Benefits, Exclusions and Limitations***) is Medically Necessary and our decision is final and conclusive subject to the Member's right to appeal, or go to court, as set forth in ***Section 5: Health Care Service Review, Appeals and Grievances.***

Medicare: A federal health insurance program for people age 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 Members as "you" or "your."

N

Non-Physician Specialist: A health care provider who:

1. Is not a physician;

2. Is licensed or certified under the Health Occupations Article; and
3. Is certified or trained to treat or provide Health Care Services for a specified condition or disease in a manner that is within the scope of the license or certification of the Health Care Provider; or
4. Is licensed as a Behavioral Health Program under §7.5-401 of the Maryland Health-General Article.

O

Out-of-Network Rate: With respect to an item or Service furnished by a non-Participating Provider, non-Participating Emergency Facility, or non-Participating Provider of Air Ambulance Services, means:

1. In a State that has an All-Payor Model Agreement under section 1115A of the Social Security Act that applies to the Plan or carrier, non-Participating Provider or non-Participating Emergency Facility, and item or Service, the amount Health Plan is required to pay under the All-Payer Model Agreement for such item or Service. For certain Services billed by Maryland hospitals, this is the amount for the item or Service under the All-Payer Model Agreement as approved by the Health Services Cost Review Commission (HSCRC).
2. If there is no such All-Payer Model Agreement amount applicable to the covered item or Service, then under Maryland law, the amount Health Plan is required to pay pursuant to §19-710.1 of the Maryland Health-General Article.
3. If no All-Payer Model Agreement or State law amount as described in items #1 and # 2 above applies to the covered item or Service, an amount agreed upon by Health Plan and the non-Participating Provider or non-Participating Emergency Facility.
4. If items #1, #2, and #3 above does not apply, then an amount determined by a certified independent dispute resolution (IDR) entity under the federal IDR process, as described in section 2799A–1(c) or 2799A–2(b) of the federal Public Health Service Act, as applicable.

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

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

P

Participating Emergency Facility: Any Emergency Facility that has contracted directly with health plan or an entity contracting on behalf of Health Plan to provide Health Care Services to Health Plan's Members. A single case agreement between an Emergency Facility and Health Plan that is used to address unique situations in which a Member requires Services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Participating Facility: A Health Care Facility that has contracted directly with Health Plan or an entity contracting on behalf of Health Plan to provide Health Care Services to Health Plan's Members. A single case agreement between a health care facility and Health Plan that is used to address unique situations in which a Member requires Services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement. Additionally, for purposes of this definition and in the context of non-Emergency Services, "Health Care Facility" is limited to a hospital, as defined in section 1861(e) of the Social Security Act; a hospital outpatient department; a critical access hospital, as defined in section 1861(mm)(1) of the Social Security Act; and an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Participating Network Pharmacy: Any pharmacy with whom we have entered into an agreement to

provide pharmaceutical Services to Members.

Participating Provider: A physician or other Health Care Provider that has contracted directly with Health Plan or an entity contracting on behalf of Health Plan to provide health care Services to Health Plan's Members.

Plan: Kaiser Permanente.

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

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

Plan Facility: A Plan Medical Center, a Plan Hospital or another freestanding facility that is:

1. Operated by us or contracts, directly or indirectly to provide Services to Members; and
2. Included in your Signature care delivery system.

A single case agreement between a Health Care Facility and Health Plan that is used to address unique situations in which a Member requires Services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement. Additionally, for purposes of this definition and in the context of non-Emergency Services, 'Health Care Facility' is limited to a hospital (as defined in section 1861(e) of the Social Security Act); a hospital outpatient department; a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Plan Hospital: A hospital that:

1. Contracts, directly or indirectly, to provide inpatient and/or outpatient Services to Members; and
2. Is included in your Signature care delivery system.

A single case agreement between an emergency facility and Health Plan that is used to address unique situations in which a Member requires Services that typically occur out-of-network constitutes a

contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

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

Plan Pharmacy: Any pharmacy that:

1. Is located at a Plan Medical Center.
2. Contracts, directly or indirectly, to provide Services to Members, and is included in the Signature care delivery system.

Plan Physician: Any licensed physician who is an employee of Medical Group, or any licensed physician (except for those physicians who contract only, directly or indirectly, to provide Services upon referral) who:

1. Contracts, directly or indirectly, to provide Services to Members; and
2. Is included in the Signature care delivery system.

Plan Provider: A Plan Physician, or other health care provider including but not limited to a non-physician specialist, and Plan Facility that:

1. Is employed by or operated by an entity that participates in the Kaiser Permanente Medical Care Program; or
2. Contracts, directly or indirectly with an entity that participates in the Kaiser Permanente Medical Care Program.

Post Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive after your attending emergency physician or Treating Provider determines that Your Emergency Medical Condition is Stabilized. We cover Post-Stabilization Care only when (1) it is considered to be Emergency Services under federal law, without Prior Authorization, or, (2) we determine that such Services are Medically Necessary pursuant to a request for Prior Authorization for the Service(s).

Premium: Periodic membership charges paid by Group.

Primary Care: Services rendered by a Health Care Practitioner in the following disciplines:

1. General internal medicine;
2. Family practice medicine;
3. Pediatrics; or
4. Obstetrics/gynecology (OB/GYN).

Prior Authorization: Our determination that a proposed Service is covered and Medically Necessary pursuant to Our Quality Resource Management Program in advance of your receipt of the Service.

R

Rare Medical Condition: A disease or condition that affects less than 200,000 individuals in the United States or approximately 1 in 1,500 individuals worldwide. Rare Medical Condition includes, but is not limited to: Cystic Fibrosis, Hemophilia, and Multiple Myeloma.

Recognized Amount: With respect to an item or Service furnished by a non-Participating Provider or non-Participating Emergency Facility, means an amount that is determined as follows:

1. In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to the Plan or carrier, non-Participating Provider or non-Participating Emergency Facility, and item or Service, the amount Health Plan is required to pay under the All-Payer Model Agreement for such Service. For certain Services billed by Maryland hospitals, this is the amount for the Service under the All-Payer Model Agreement as approved by the HSCRC.
2. If there is no such All-Payer Model Agreement applicable to the Service, then under Maryland law, the amount that Health Plan is required to pay pursuant to §19-710.1 of the Maryland Health-General Article.
3. If no All-Payer Model Agreement or State law amount, as described in items #1 and #2 above, applies to the covered Service, then the lesser of the amount billed by the non-Participating Provider or non-Participating Emergency Facility, or the Qualifying Payment Amount.

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

S

Self-Only Coverage: Coverage for a Subscriber only, with no Dependents covered under this Plan.

Serious or Complex Condition: In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm or, in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time.

Service: A health care item or service that is covered under this Agreement and Medically Necessary to prevent, diagnose, or treat a medical condition.

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

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

Specialist: A licensed health care professional that includes physicians and non-physicians who is trained to treat or provide health care Services for a specified condition or disease in a manner that is within the scope of their license or certification. Specialist physicians shall be board-eligible or board-certified.

Specialty Drugs: A prescription drug that:

1. Is prescribed for an individual with a Complex or Chronic Medical Condition, or a Rare Medical Condition;
2. Costs $600 or more for up to a 30-day supply;
3. Is not typically stocked at retail pharmacies; and
4. Requires a difficult or unusual process of delivery to the Member in the preparation, handling, storage, inventory, or distribution of the drug; or requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after

administration of the drug.

Specialty Drugs do not include prescription drugs to treat diabetes, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS).

Spouse: Your legal husband or wife. The person to whom you are legally married to under applicable law.

Stabilize: To provide the medical treatment for an 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 them to another hospital before delivery (or the transfer may pose a threat to the health or safety of the person 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 ***Eligibility for This Plan*** in ***Section 1: Introduction to your Kaiser Permanente Health Plan***).

T

Totally Disabled:

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

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

Treating Provider: A physician or other health care provider who has evaluated the Member's Emergency Medical Condition.

U

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

Urgent Medical Condition: As used in ***Section 5: "Health Care Service Review, Appeals and Grievances"*** a condition that satisfies either of the following:

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

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

V

Visit: The instance of going to or staying at a health care facility, and, with respect to Services furnished to a Member at a Health Care Facility, includes, in addition to Services furnished by a provider at the health care facility, equipment and devices, telemedicine Services, imaging Services, laboratory Services, and preoperative and postoperative Services, regardless of whether the provider furnishing such Services is at the health care facility.

Kaiser Permanente
Maryland Large Group Agreement and Evidence of Coverage
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 ***Section 3: Benefits, Exclusions and Limitations***. **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, as defined by your Group and approved by Health Plan.

MEMBER COST-SHARE
Your Cost Share is the amount of the Allowable Charge for a covered Service that you must pay through Copayments and Coinsurance. †The Cost Share, if any, is listed for each Service in this "Summary of Services and Cost Shares." Allowable Charge is defined under ***Important Terms You Should Know.***

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, if applicable, are due at the time you receive a Service. You will be billed for any Coinsurance you owe. Failure to pay your Cost Shares may result in termination of your Membership (refer to ***Section 6: Termination of Membership)***.

†When a non-Participating Provider provides non-Emergency Services at a Plan Hospital or a Plan Facility, your Cost Share will be the same Cost Sharing amount for the same Service(s) from a Participating Provider unless the non-Participating Provider has satisfied the notice and consent requirements of 45 C.F.R §149.420(c) through (i) with respect to those non-Emergency Services. Any Cost Sharing requirement for the items and Services will be calculated based on the Recognized Amount. Such Cost Share shall count toward your Deductible, if any, and Out-of-Pocket Maximum. You will not be liable for any additional payment other than your Cost Share for non-Emergency Services. We will make payment for the items and Services directly to the non-Participating Provider. The payment amount will be equal to the amount by which the Out-of-Network Rate exceeds the Cost Sharing amount for the items and Services. The Member will not be liable for an amount that exceeds the Cost Sharing that would have applied to the Member if the provider was a Participating Provider.

For covered Services rendered by a Health Care Provider for which payment is required under §19-710.1 of the Health-General Article, Ancillary Services, and items or Services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or Service is furnished, regardless of whether the non-Participating Provider satisfied the notice and consent criteria, the notice and consent criteria of 45 C.F.R. §149.420 (c) through (i) do not apply to non-Participating Providers. Additionally, when these Services are received by a non-Participating Provider they will always be subject to the conditions described in the above paragraph.

Copayments and Coinsurance

Covered Service	You Pay
Outpatient Care	
Office Visits (for other than preventive health care Services required by the Maryland Insurance Commissioner)	
Primary care office Visits	
For adults	$15 per visit
For children under 5 years of age	$15 per visit
For children 5 years of age or older	$15 per visit
Specialty care office Visits	$15 per visit
Consultations and immunizations for foreign travel	$15 per visit
Outpatient surgery	
• Outpatient surgery facility fee	No charge

Copayments and Coinsurance	
Covered Service	**You Pay**
• Outpatient surgery physician Services	No charge
Diagnostic testing (not preventive screening) as described under Outpatient Care in Section 3	Applicable Cost Shares will apply based on type and place of Service
Anesthesia	No charge
Respiratory therapy	$15 per visit
Medical social Services	$15 per visit
House calls	No charge
Smoking cessation counseling program	No charge
Hospital Inpatient Care All charges incurred during a covered stay as an inpatient in a hospital	No charge
Accidental Dental Injury Services	
Dental Service Office Visit	$15 per visit
All Other Services	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
Serum Injections (without a provider Visit)	Applicable Cost Shares will apply based on type and place of Service, not to exceed the cost of the serum plus administration
Ambulance Services Ambulance (Emergency transport by a licensed ambulance Service, per encounter)	No charge
Ambulette (Non-emergent transportation Services ordered by a Plan Provider)	No charge
Anesthesia for Dental Services Anesthesia and associated hospital or ambulatory Services for certain individuals only	No charge
Blood, Blood Products and Their Administration	No charge
Chemical Dependency and Mental Health Services	
Treatment of mental illness, emotional disorders, drug and alcohol abuse described in Section 3	
Inpatient treatment in a hospital or residential treatment center	No charge

Copayments and Coinsurance	
Covered Service	**You Pay**
Partial hospitalization	No charge
Outpatient office Visits	
• Diagnostic evaluation	$15 per visit
• Individual therapy	$15 per visit
• Group therapy	$7 per visit
• Intensive Outpatient Treatment	$15 per visit
• Medication evaluation and management visits	$15 per visit
• Methadone treatment	$15 per week
• All other outpatient Services (Office)	$15 per visit
All other outpatient Services (Non-Office)	
• Crisis intervention	No charge
• Electroconvulsive Therapy (ECT)	No charge
• Psychological and neuropsychological testing (for diagnostic purposes)	No charge
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 Treatment, Equipment, Supplies and Self-Management Training **Note:** Copayments and/or Coinsurance do not apply to diabetic test strips.	
Diabetic test strips	No charge
Diabetic equipment and supplies	No charge
Self-management training	Applicable Cost Shares will apply based on type and place of Service
Dialysis Services	
Inpatient care	Applicable inpatient Cost Shares will apply
Outpatient Care	$15 per visit
Drugs, Supplies and Supplements Administered by or under the supervision of a Plan Provider	Applicable Cost Shares will apply based on type and place of Service
Durable Medical Equipment (DME) **Note:** Applicable inpatient hospital cost shares will apply to equipment provided while you are confined as an inpatient.	

Copayments and Coinsurance

Covered Service	You Pay
Basic Durable Medical Equipment (DME)	No charge
Supplemental Durable Medical Equipment (DME)	
• Oxygen and Equipment	No charge for 1st 3 months; 50% of AC* each month thereafter
• Positive Airway Pressure Equipment	No charge
• Apnea Monitors (Not to exceed a period of 6 months)	No charge
• Asthma Equipment	No charge
o Peak-flow meters	No charge
o Home UV Light Box	No charge
• Bilirubin Lights (Not to exceed a period of 6 months)	No charge
Emergency Services	
Emergency Room Visits	
• Inside the Service Area	$50 per visit; Copayment waived if immediately admitted
• Outside of the Service Area	$50 per visit; Copayment waived if immediately admitted
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. **Note:** Your Cost Share will be the same Copayment, or Coinsurance, as applicable, for Emergency Services provided by Plan Providers and non-Plan Providers. Calculation of the Cost Share will be in accordance with the requirements of state law or, in the event that state law is inapplicable, then federal law.	
Family Planning Services Women's Preventive Services, including all Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity are required by the Maryland Insurance Commissioner to be covered under Preventive Care at no charge.	
Office Visits	$15 per visit
Abortion Care Services	No charge
Male sterilization	No charge

Copayments and Coinsurance	
Covered Service	**You Pay**
Fertility Services	
Standard fertility preservation Visit and procedure for iatrogenic infertility	$15 per visit
All other covered Services	Applicable Cost Share will apply based on type and place of Service
Habilitative Services	
Physical, Occupational or Speech therapy	$15 per visit
Applied Behavioral Analysis (ABA)	$15 per visit
Assistive Devices	Applicable DME/P & O Cost Share will apply
Hearing Services	
Hearing exam (newborn hearing screening tests are covered under preventive health care Services)	Applicable Cost Shares will apply based on type and place of Service
Hearing aids	
• Hearing aid tests	Applicable office visit Cost Share will apply
• Hearing aids (Limited to a hearing aid per ear, every 36 months.)	No charge per hearing aid
Home Health Care Services	No charge
Hospice Care Services	No charge
Infertility Services	
Office Visits	50% of AC*
Inpatient Hospital Care	50% of AC*
All other Services for treatment of infertility	50% of AC*
Note: Coverage for in vitro fertilization (IVF) is limited to a maximum of three attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.	
Maternity Services	
Inpatient and Birthing Centers Delivery and all inpatient Services	No charge
Outpatient delivery and all Services	Applicable Cost Shares will apply based on type and place of Service
Prenatal care and the first post-natal Visit	No charge
Postpartum home Visits	No charge

Copayments and Coinsurance	
Covered Service	**You Pay**
Breast Pumps **Note:** Only maternity Services that are determined to be preventive care Services by the Maryland Insurance Commissioner are covered under Preventive Care Services at no charge.	No charge
Medical Foods (including Amino Acid-based Elemental Formula)	25% of AC*
Medical Nutrition Therapy & Counseling	$15 per visit
Morbid Obesity Services	Applicable Cost Shares will apply based on type and place of Service
Oral Surgery	Applicable Cost Shares will apply based on type and place of Service
Temporomandibular Joint (TMJ) Services	Applicable Cost Shares will apply based on type and place of Service
TMJ Appliances	Applicable DME Cost Share will apply
Pediatric Autoimmune Neuropsychiatric Disorders (PANDAS)	Applicable Cost Shares will apply based on type and place of Service
Preventive Health Care Services (The Deductible, Copayment or Coinsurance does not apply to Prostate-specific cancer screening.)	No charge
Prosthetic and Orthotic Devices	
External Orthotics	
• Rigid and semi-rigid orthotic devices (Limited to standard devices)	No charge
• Therapeutic shoes and inserts (when medically necessary)	No charge
External Prosthetics	
• Artificial eyes, legs, and arms	No charge
• Breast prosthesis following a Medically Necessary mastectomy	No charge
• Ostomy and urological supplies	No charge
• Hair prostheses (Limited to one (1) prosthesis per course of chemotherapy and/or radiation therapy, not to exceed a maximum benefit of $350 per prosthesis)	No charge
Internal Prosthetics	No charge
Reconstructive Surgery	Applicable Cost Shares will apply based on type and place of Service
Routine Foot Care	$15 per visit

Copayments and Coinsurance	
Covered Service	**You Pay**
Skilled Nursing Facility Care Limited to a maximum benefit of 100 days per contract year	No charge
Telemedicine Services	No charge
Therapy and Rehabilitation Services	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	
• Physical Therapy; 30 visits per contract year per injury/incident/condition	$15 per visit
• Speech Therapy; 30 visits per contract year per injury/incident/condition	$15 per visit
• Occupational Therapy; 30 visits per contract year per injury/incident/condition	$15 per visit
• Cardiac Rehabilitation	$15 per visit
• Multidisciplinary Rehabilitation	$15 per visit
Note: All Services received in one day for multidisciplinary rehabilitation Services at a day treatment program will be considered one Visit.	
Therapy: Radiation/Chemotherapy/Infusion Therapy	
Chemotherapy and Radiation Therapy	$15 per visit
Infusion Therapy	Applicable Cost Shares will apply based on type and place of Service
Transplants	Applicable Cost Shares will apply based on type and place of Service
Pre-Transplant Dental Services	
• Dental Services office Visit	$15 per visit
• All other related Services	Applicable Cost Shares will apply based on type and place of Service
Urgent Care	
Office Visit during regular office hours	Applicable office visit Cost Shares will apply
After-Hours Urgent Care or Urgent Care Center	$15 per visit
Vision Services **Adult Vision** (for adults age 19 or older)	
Routine eye exams and Eye Care (Medical Treatment) - Optometry Services	$15 per visit
Eye Care (Medical Treatment) - Ophthalmology Services	$15 per visit

Copayments and Coinsurance	
Covered Service	**You Pay**
Eyeglass lenses and frames	You receive a $75 discount off retail price** for eyeglass lenses and for eyeglass frames, combined, once per plan year
Contact lenses	You receive a $25 discount off retail price** on initial pair of contact lenses, once per plan year.
Pediatric Vision (for children under age 19) **Note:** A child is covered until the end of the month in which the child attains age 19.	
Routine eye exams and Eye Care (Medical Treatment) - Optometry Services	$15 per visit
Eye Care (Medical Treatment) - Ophthalmology Services	$15 per visit
Eyeglass lenses and frames (Limited to one pair of lenses and frames per year from a select group. Lenses limited to single vision or bifocal lenses (ST28) in polycarbonate or plastic. Glasses not available if contacts are substituted for glasses.)	No charge for one pair per plan year
Contact lenses (Includes fitting fee and initial supply (based on standard packaging for type purchased) from a select group. Regular contacts may be substituted for pediatric lenses/frames once per plan year.)	No charge for initial fit and first purchase per plan year
Medically necessary contact lenses (Limited to two pairs per eye per year from a select group)	No charge
Low Vision Aids (Unlimited from available supply)	No charge
Note: A child may select any pair of glasses in lieu of, or in addition to, the eyeglasses or contact lenses available at no charge under Vision Services for children and receive the discount at any Plan Vision Center.	
X-ray, Laboratory and Special Procedures Diagnostic imaging, and laboratory tests including Biomarker Testing	
Inpatient Services	Applicable inpatient Cost Share will apply
Outpatient diagnostic imaging	No charge
Outpatient laboratory tests	No charge

Copayments and Coinsurance	
Covered Service	**You Pay**
Specialty Imaging (including CT, MRI, PET Scans and diagnostic Nuclear Medicine); Interventional Radiology and Special Procedures	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	No charge
Sleep laboratory	No charge
Sleep studies	$15 per visit
Note: Charges for covered outpatient diagnostic and laboratory tests performed in a Plan Physician's office are included in the office Visit Copayment.	

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the maximum amount of Copayments and Coinsurance that an individual or family is obligated to pay for covered Services per contract year. 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 Services that are subject to the out-of-pocket maximum for the rest of the contract year.

Self-Only Coverage Out-of-Pocket Maximum. If you are covered as a Subscriber, and you do not have any Dependents covered under the plan, your medical expenses apply toward the Self-Only Out-of-Pocket Maximum shown below.

Family Coverage Out-of-Pocket Maximum. If you have one or more Dependents covered under this EOC, the covered medical expenses incurred by all Members of the Family Unit 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. After one member of a Family Unit has met the Individual Out-of-Pocket Maximum shown below, his or her Out-of-Pocket Maximum will be met for the rest of the contract year. Other family Members will continue to pay applicable Cost Shares until the Family Out-of-Pocket Maximum is met. After all Members of the Family Unit combined have met the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be met for all Members of the Family Unit for the rest of the contract year.

Out-of-Pocket Maximum Exclusions:
The following Services do not apply toward your Out-of-Pocket Maximum:

- Adult eyeglass lenses and frames; contact lenses that are available with a discount only;
- Adult dental Services, if included by Rider attached to this plan; and
- Behavioral health Services, if included in the Wellness rider attached to this plan.

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 may 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 allowable Copayments and Coinsurance	
Self-Only Out-of-Pocket Maximum	$2,250 per individual per contract year
Family Out-of-Pocket Maximum	$4,500 per Family Unit per contract year

*Allowable Charge (AC) is defined under ***Important Terms You Should Know.***
**"Retail price" means the price that would otherwise be charged for the lenses, frames and contacts at the Kaiser Permanente Vision Care Center on the day purchased.
†Cost-Sharing for Non-Emergency Services Performed by Non-Participating Providers at Participating Facilities, including Ancillary Services and Services for Unforeseen Urgent Medical Needs.

KAISER PERMANENTE®
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
4000 Garden City Drive, Hyattsville, Maryland 20785
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 EOC terminate.

The following benefit, limitations, and exclusions are hereby added to the ***Section 3: Benefits, Exclusions and Limitations*** 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 ***Important Terms You Should Know***.

Biosimilar: FDA-approved biologics that are highly similar to a brand biologic product.

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

Cancer Chemotherapy Drugs: A prescription drug that is prescribed by a licensed physician to kill or slow the group of cancer cells.

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

Complex or Chronic Medical Condition: A physical, behavioral, or developmental condition that: (1) may have no known cure; (2) is progressive; or (3) can be debilitating or fatal if left untreated or undertreated. Complex or Chronic Medical Condition includes, but is not limited to: Multiple Sclerosis, Hepatitis C, and Rheumatoid Arthritis**.**

Contraceptive Drug: A drug or device that is approved by the United States Food and Drug Administration (FDA) for use as a contraceptive with or without a prescription.

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

Food & Drug Administration/FDA: The United States Food and Drug Administration.

Formulary: A list of Generic and Brand Name prescription drugs that are covered under this Plan, organized into cost-sharing tiers based on clinical efficacy, safety, and cost-effectiveness.

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 or arranged by Health Plan that distributes prescription drugs to Members via mail. Some medications are not eligible for the Mail Service Delivery Program. These may include, but are not limited to, drugs that are time or temperature sensitive, drugs that cannot legally be sent by U.S. mail, and drugs that require professional administration or observation. The Mail Service Delivery Program can mail to addresses in MD, VA, DC and certain locations outside the service area.

Maintenance Medications: A covered drug anticipated to be required for six (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**.**

Non-Formulary Drug: Generic or Brand Name, that is listed on Tier 3 and may require additional clinical review or higher cost sharing. These drugs are covered only when specific medical criteria are met, such as failure or intolerance to Formulary Drugs.

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.

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.

Rare Medical Condition: A disease or condition that affects less than 200,000 individuals in the United States or approximately 1 in 1,500 individuals worldwide. Rare Medical Condition includes, but is not limited to: Cystic Fibrosis, Hemophilia, and Multiple Myeloma**.**

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

Specialty Drugs: A prescription drug that: (1) is prescribed for an individual with a Complex or Chronic Medical Condition, or a Rare Medical Condition; (2) costs $600 or more for up to a 30-day supply; (3) is not typically stocked at retail pharmacies; and (4) requires a difficult or unusual process of delivery to the Member in the preparation, handling, storage, inventory, or distribution of the drug; or requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug.

Note: Specialty Drugs do not include prescription drugs to treat diabetes, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS).

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. BENEFITS

Except as provided in the Limitations and Exclusions sections of this Rider, we cover drugs as described in this Section, in accordance with our Formulary guidelines, when prescribed by a Plan Physician, a non-Plan Physician to whom you have an approved referral, a non-Plan Physician consulted due to an emergency or for out-of-area urgent care, physician assistant, nurse practitioner, or a dentist, or any licensed psychiatrist, whether or not the psychiatrist is a Plan Physician. Each prescription refill is subject to the same conditions as the original prescription. Plan Providers prescribe drugs in accordance with Health Plan's Formulary. If the retail price of the drug is less than the Rx Copayment you will pay the retail price of the drug. 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.

We cover the following:

1. FDA-approved drugs for which a prescription is required by law.
2. Compounded preparations containing at least one ingredient requiring a prescription and the ingredient is listed in our Formulary.
3. Insulin - Insulin; will not exceed a maximum of $30 per 30-day supply, regardless of the amount or type of insulin needed to fill the member's prescription pursuant to § 15–822.1 (b), of the Insurance Article.
4. Drugs that are FDA-approved for use as contraceptives and diaphragms available by prescription or over-the-counter without a prescription. For coverage of other types of contraception, including contraceptive injections, implants and devices, refer to ***Family Planning Services*** in Section 3.
5. Nicotine Replacement Therapy, including over-the counter Nicotine Replacement Therapy when prescribed by a Plan Provider, for up to two 90-day courses of treatment per contract year.
6. Smoking Cessation Drugs that are approved by the FDA for the treatment of tobacco dependence, including over-the-counter Smoking Cessation Drugs when prescribed by a Plan Provider.
7. 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.
8. Growth hormone therapy (GHT).
9. Non-prescription drugs when they are prescribed by a Plan Provider and are listed on the Formulary with the exception of over-the-counter contraceptives, which are available without a prescription and do not require authorization by a Plan Provider.
10. Prescription eye drops and refills in accordance with guidance for early refills of topical ophthalmic products provided by the Centers for Medicare and Medicaid Services if the:
    a. Original prescription indicates additional quantities are needed; and
    b. Refill requested does not exceed the number of refills indicated on the original prescription.
11. Specialty Drugs received from Plan Pharmacies and Participating Network Pharmacies, as described below in ***Section F. Copayments and Coinsurance***. We also cover Specialty Drugs required to be received from a specialty pharmacy.

Additionally, we cover Specialty Drugs administered or dispensed by a provider under §12–102 of the Health Occupations Article if we determine that:

a. The provider that administers or dispenses the covered Specialty Drug:
    i. Is a Plan Provider of covered oncology Services; and
    ii. Complies with state regulations for the administering and dispensing of Specialty Drugs; and
b. The covered Specialty Drug is:
    i. Auto-injected or an oral targeted immune modular; or
    ii. An oral medication that:
        a. Requires complex dosing based on clinical presentation; or
        b. Is used concomitantly with other infusion or radiation therapies.

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 Formulary.

Certain covered outpatient prescription drugs may be subject to utilization management such as prior authorization and step therapy. A list of drugs subject to utilization management is available to you upon request.

If you would like information about whether a particular drug or accessory is included in our Formulary, please visit us online at www.kp.org, or call the Member Services Call Center Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST) at 1-800-777-7902 or 711 (TTY).

Step-Therapy Exception and Prior Authorization Requests

For a step therapy request submitted electronically or a prior authorization request submitted electronically for pharmaceutical services, Health Plan shall make a determination:

1. in real time if:
    a. No additional information is needed by Health Plan to process the request; and
    b. The request meets the Health Plan's criteria for approval; or
2. If a request is not approved in real time, as described in item #1 immediately listed above, within one (1) working day after Health Plan receives all of the information necessary to make the determination.

If additional information is needed to make a determination after confirming through a complete review of the information already submitted by the Health Care Provider, Health Plan will request the information promptly, but not later than three (3) calendar days after receipt of the initial request, inform the Health Care Provider that additional information must be provided by specifying:

1. the information, including any laboratory or diagnostic test or other medical information, that must be submitted to complete the request; and
2. the criteria and standards to support the need for additional information.

If Health Plan fails to make a determination within the required time limits listed above, the request shall be deemed approved.

Prior Authorization for Services

If the Health Plan requires a Prior Authorization for a prescription drug, the Prior Authorization request shall allow a Health Care Provider to indicate whether a prescription drug is to be used to treat a chronic condition.

If the Health Care Provider indicates the prescription drug is to treat a chronic condition, the Health Plan may not request a reauthorization for a repeat prescription for the prescription drug for one (1) year or for

the standard course of treatment for the chronic condition being treated, whichever is less.

Health Plan shall accept Prior Authorization from a Member or their Health Care Provider for a prescription drug from the prior health insurance carrier for at least the lesser of ninety (90) days or the length of the course of treatment. During the applicable time period, Health Plan may perform its own review to grant a Prior Authorization for the prescription drug.

Health Plan will accept Prior Authorization when a member changes from a Kaiser Plan to another Kaiser Plan and may not require a Health Care Provider to submit a request for another prior authorization for a prescription drug if:

1. The prescription drug is a covered benefit under the current Kaiser Plan; or
2. The dosage for the approved prescription drug changes and the change is consistent with Federal Food and Drug Administration labeled dosages.

If the Health Plan requires a Prior Authorization for a prescription drug, we shall provide notice of the new requirement, including that the Member may remain on the prescription drug at the time of reauthorization, at least sixty (60) days before the requirement of the new Prior Authorization:

1. in writing to any Member who is prescribed the prescription drug; and
2. either in writing or electronically to all contracted Health Care Providers.

Health Plan does not require more than one Prior Authorization if two (2) or more tablets of different dosage strengths of the same prescription drug are:

a. prescribed at the same time as part of an insured's treatment plan; and
b. manufactured by the same manufacturer.

Health Plan will not issue an Adverse Decision on a reauthorization for the same prescription drug or request additional documentation from the prescriber for the reauthorization request if:

1. The prescription drug is:
   a. an immune globulin (human) as defined in 21 C.F.R. §640.100; or
   b. is used for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association;
2. Health Plan previously approved a Prior Authorization for the prescription drug for the Member;
3. The Member has been treated with the prescription drug without interruption since the initial approval of the Prior Authorization; and
4. The prescriber attests that, based on their professional judgment, the prescription drug continue to be necessary to effectively treat the Member's condition.

If the prescription drug that is being requested has been removed from the Formulary or has been moved to a higher Cost Sharing, Health Plan will provide the Member and the Member's Health Care Provider a thirty (30)-day notice prior to its removal or movement to a higher tier or Cost Share.

Where to Purchase Covered Drugs

Except for Emergency Services and Urgent Care Services, you must obtain prescribed drugs from a Plan Pharmacy, a Participating Network Pharmacy, or through Health Plan's Mail Service Delivery Program subject to the Cost Shares listed below under "Copayment/Coinsurance" Most non-refrigerated prescription medications ordered through the Health Plan's Mail Service Delivery Program can be delivered to addresses in MD, VA, DC and certain locations outside the service area.

Formulary Generic and Brand Name Drug Requirements

Generic vs. Brand Name Drugs

Plan Pharmacies, Participating Network Pharmacies and our Mail Service Delivery Program will substitute a generic equivalent for a Brand Name Drug or device when a generic equivalent is listed as a Formulary Drug unless one of the following conditions is met:

1. The Plan Provider has prescribed a Brand Name Drug and has indicated "dispense as written" (DAW) on the prescription; or
2. The Brand Name Drug or device is listed on our Formulary Drug list, or
3. There is no equivalent prescription generic drug or device, or (a) an equivalent prescription generic drug or device (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; or a contraceptive prescription drug or device that is not on our Formulary is Medically Necessary for the Member to adhere to appropriate use of the prescription drug or device**.**

If the above conditions in item #3(a)(i) and(ii) are met and a Brand Name Drug or device is moved to a higher cost share, we will continue, upon Member or prescriber's request, the same cost share received when that Brand Name Drug or device was available on a lower tier (if the above criteria are met).

If a Member requests a Brand Name Drug for which there is a generic equivalent and plan provider has not indicated "dispense as written" (DAW) on the prescription, the brand name drug or device is not listed on the formulary drug list or 3(a)(i) or 3(a)(ii) have not been met, the Member will be responsible for the full Allowable Charge for the Brand Name Drug.

We will provide coverage for prescription drugs or devices not on the Formulary or if a prescription drug or device is removed from the Formulary (if the above criteria are met). If a prescription drug or device on the Formulary is moved to a higher tier resulting in a higher cost share, we will continue, upon Member or prescriber's request, the same cost share received when the prescription drug or device was available on a lower tier (if the above criteria are met). For plans with one or two tiers, a non-formulary drug which meets the formulary exception criteria will be covered on the plan's highest tier. For plans with three or four tiers, these drugs will be covered on tier three. If a drug or accessory is added or removed from the Formulary, or moved to a higher cost-sharing tier, a 30-day notice will be provided to you prior to its removal or movement to a higher tier or cost share.

Formulary vs. Non-Formulary Drugs

Plan Pharmacies, Participating Network Pharmacies and our Mail Service Delivery Program will dispense Formulary Drugs unless the following criteria are met, if in the judgment of an authorized prescriber: (1) there is no equivalent drug or device in our Formulary in a lower tier; (2) an equivalent Formulary drug or device in a lower tier (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; or (3) a contraceptive prescription drug or device that is not on our Formulary is Medically Necessary for the Member to adhere to appropriate use of the prescription drug or device**.**

For non-Formulary drugs, if the criteria are met, the applicable Tier Cost Share will apply based on the Formulary. If the Member requests a Non-Formulary drug and the criteria are not met, the Member will be responsible for the full Allowable Charge.

We will provide coverage for prescription drugs or devices not on the Formulary or if a prescription drug or device is removed from the Formulary (if the above criteria are met). If a prescription drug or device on the Formulary is moved to a higher tier resulting in a higher cost share, we will continue, upon Member or prescribers request, the same cost share received when the prescription drug or device was

available on a lower tier (if the above criteria are met). For plans with one or two tiers, a non-formulary drug which meets the formulary exception criteria will be covered on the plan's highest tier. For plans with three or four tiers, these drugs will be covered on tier three. If a drug or accessory is added or removed from the Formulary, or moved to a higher cost-sharing tier, a 30-day notice will be provided to you prior to its removal or movement to a higher tier or cost share.

Dispensing Limitations

Except for Maintenance Medications and Contraceptive Drugs as described below, Members may obtain up to a 30 day supply and will be charged the applicable 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 and Contraceptive Drugs as described below, injectable drugs that are self-administered and dispensed from the pharmacy are limited to a 30-day supply.

If a drug covered under this benefit meets the criteria for a Specialty Drug, in accordance with §15-847 of the Insurance Article, or is a prescription drug to treat diabetes, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS), as described in §15-847.1 of the Insurance Article, then the Member's cost for the drug will not exceed $150 for up to a 30-day supply.

For prescribed Contraceptive Drugs, Members may obtain up to a 12-month supply at one time.

Members may obtain a partial supply of a prescription drug and will be charged a prorated daily copayment or coinsurance, if the following conditions are met:

- the prescriber or the pharmacist determines dispensing a partial supply of a prescription drug to be in the best interest of the Member;
- the prescription drug is anticipated to be required for more than three (3) months;
- the Member requests or agrees to a partial supply for the purpose of synchronizing the dispensing of the Member's prescription drugs;
- the prescription drug is not a Schedule II controlled dangerous substance; and
- the supply and dispensing of the prescription drug meets all prior authorization and utilization management requirements specific to the prescription drug at the time of the synchronized dispensing.(Refer to ***Prior Authorization for Services*** in this Section of the EOC).

Maintenance Medication Dispensing Limitations

Members may obtain up to a 90-day supply of Maintenance Medications in a single prescription, if authorized by an authorized prescriber, 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 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*** in Section 3 of the EOC), or associated with a covered, authorized referral inside or outside Health Plan's Service Area. To obtain reimbursement, the Member must submit a copy of the itemized receipts for 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. Claims should be submitted online or mailed to:

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

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 Formulary and purchased at a Plan Pharmacy or a Participating Network Pharmacy, unless the criteria for coverage of non-Formulary drugs under Section B. Formulary vs. Non-Formulary 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. If a Member receives a partial supply of prescription drugs in accordance with the Dispensing Limitations section, those drugs will be subject to a prorated cost share as described in that section.

   Instructions for filing a claim can be found in Section 5 of the EOC to which this Rider is attached. Claims should be submitted online or mailed to:

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

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 Formulary and over-the-counter contraceptives, which are available without a prescription and do not require authorization by a Plan Provider or when the drug is approved by the FDA for treatment of tobacco dependence.
2. Compounded preparations that do not contain at least one ingredient requiring a prescription or only contain ingredients that are excluded from coverage.
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.
5. Drugs that are considered to be experimental or investigational. Refer to ***Clinical Trials*** in Section 3.
6. A drug (a) which can be obtained without a prescription (except over-the-counter contraceptives), 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. Item b will not be excluded if, in the judgment of the authorized prescriber: (1) there is no equivalent prescription drug or device in the entity's formulary; (2) an equivalent prescription drug or device in the entity's formulary: (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 or (3) contraceptive prescription drug or device that is not on our Formulary which is Medically Necessary for the Member to adhere to appropriate use of the prescription drug or device**.**
7. Drugs for which the Member is not legally obligated to pay, or for which no charge is made.
8. Blood or blood products. Refer to ***Blood, Blood Products and their Administration*** in Section 3.
9. Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes, including drugs used to retard or reverse the effects of skin aging or to treat nail fungus or hair loss.
10. Medical foods. Refer to ***Medical Foods*** in Section 3.
11. 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.
12. Replacement prescriptions necessitated by damage, theft or loss.
13. Prescribed drugs and accessories that are necessary for Services that are excluded under your EOC.
14. 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.
15. 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.

16. 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 (DME)*** and ***Prosthetic and Orthotic Devices*** in Section 3.
17. 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.
18. Bandages or dressings. Refer to ***Drugs, Supplies and Supplements*** and ***Home Health Care*** in Section 3.
19. Diabetic equipment and supplies except for insulin. Refer to ***Diabetic Treatment, Equipment, Supplies and Self-Management Training*** in Section 3.
20. Immunizations and vaccinations solely for the purpose of travel. Refer to ***Outpatient Care*** in Section 3.
21. 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, unless in the judgment of the authorized prescriber: (1) there is no equivalent prescription drug or device in the entity's formulary; or (2) an equivalent prescription drug or device in the entity's formulary: (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; or (3) a contraceptive prescription drug or device that is not on our Formulary which is Medically Necessary for the Member to adhere to appropriate use of the prescription drug or device.

    If the conditions in items #1, #2(i) and #2(ii) are met, the covered drug will be subject to the appropriate cost share.
22. Drugs for the treatment of sexual dysfunction disorders, such as erectile dysfunction.
23. Drugs solely for weight management.

F. COPAYMENTS AND COINSURANCE

Covered drugs are provided upon payment of the Rx Copayment or Rx Coinsurance per prescription or refill, set forth below. If the price of the drug is less than the Copayment, you will pay the price of the drug:

For outpatient prescription drugs and/or items that are covered under this Outpatient Prescription Drug Benefit appendix and obtained at a pharmacy owned and operated by Health Plan, you may be able to use manufacturer coupons as payment for the Cost Sharing that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of your Cost Sharing for your prescription. When you use an approved coupon, financial assistance payment, product voucher, or any discount or other out-of-pocket expense for payment of your Cost Sharing, the coupon, financial assistance payment, product voucher, or any discount or other out-of-pocket expense amounts, and any additional payment that you make, is used in the calculation of your Coinsurance and Copayment and will accumulate to your Out-of-Pocket Maximum. We will include any discount, financial assistance payment, product voucher, or any discount or other out-of-pocket expense amounts made by or on behalf of you for a covered prescription drug that either:

1. does not have an AB-rated generic equivalent drug or an interchangeable biological product preferred under the plan's formulary; or
2. has an AB-rated generic equivalent drug or an interchangeable biological product preferred under the plan's formulary, and for which the enrollee originally obtained coverage through prior authorization, a step therapy protocol, or an exception or appeal process. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at Drug Manufacturer Coupons (kaiserpermanente.org).

Tier 1 Drugs: Includes commonly prescribed Generic Drugs on the Formulary list.

Tier 2 Drugs: Includes commonly prescribed Brand Name Drugs and commonly prescribed higher-cost Generic Drugs on the Formulary list.

Tier 3 Drugs: Includes all other Generic and Brand Name Drugs that are not on the Formulary list (if the above criteria are met).

Tier 4 Drugs: Includes Specialty Drugs as defined above in the ***Definitions*** section within this ***Outpatient Prescription Drug Benefit Rider***.

Note: Drugs that meet the criteria of Specialty Drugs or is a prescription drug to treat diabetes, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS), as described in §15-847.1 of the Insurance Article, then the Member's cost for the drug will not exceed $150 for up to a 30-day supply.

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

30-Day Supply	Plan Pharmacy	Plan Pharmacy Mail Delivery	Participating Network Pharmacy (Retail or Mail Delivery)
Tier 1 Drugs	$7	$7	$10
Tier 2 Drugs	$15	$15	$20

Tier 3 Drugs	$30	$30	$35
Tier 4 Drugs	Refer to the applicable Tier 1, Tier 2, Tier 3 Drugs Cost Share above	Refer to the applicable Tier 1, Tier 2, Tier 3 Drugs Cost Share above	Refer to the applicable Tier 1, Tier 2, Tier 3 Drugs Cost Share above

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

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

Nicotine Replacement Therapy drugs for no charge.

Orally administered Cancer Chemotherapy Drugs for no charge.

Contraceptive Drugs (available by prescription or over-the-counter without a prescription) and preventive care drugs required to be covered by the Maryland Insurance Commissioner without Cost Sharing, including over-the-counter medications when prescribed by a Plan Provider, and obtained at a Plan Pharmacy, a Participating Network Pharmacy, or through the Mail Service Delivery Program are covered for no charge. This includes Smoking Cessation and Nicotine Replacement Therapy drugs. Please visit the following websites for a list of these drugs:

Mid and Large Size Employer Group Formulary (kaiserpermanente.org)

Summary of preventive services (kaiserpermanente.org)

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. OUT-OF-POCKET MAXIMUM

Cost Shares set forth in this Rider 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.

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.

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



By: _____

Gracelyn McDermott
Vice President, Marketing, Sales & Business Development

KAISER PERMANENTE®
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
4000 Garden City Drive, Hyattsville, MD 20785
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 ***Section 3: Benefits, Exclusions and Limitations*** of the Group Evidence of Coverage (herein referred to as the Group EOC), in consideration of the Group application and payment of the additional Premium for the services pursuant to this Rider.

Definitions

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

Benefits

We cover Acupuncture Services for chronic pain management or chronic illness management for Members when deemed Medically Necessary and prescribed by a Plan Provider as outlined under "Getting a Referral" in Section 2: How to Get the Care You Need.

We cover Chiropractic Services in accordance with Health Plan coverage guidelines when you are a Member on the date that you receive the Services or under the conditions outlined under "Extension of Benefits" in ***Section 6: Termination of Membership***. You must receive the Services from a Plan Provider as outlined under "Getting a Referral" in ***Section 2: How to Get the Care You Need***.

Limitations

The number of visits needed for the Member to reach the maximum level of recovery will be determined by the Plan Provider. The Member will receive 20 visits per condition per contract year for chiropractic Services. The Member will receive 20 visits per condition per contract year for acupuncture Services.

Exclusions

- Services requested by the Member that are not deemed Medically Necessary (as defined in the Group EOC to which this Rider is attached) for Acupuncture Services, by the Plan Provider
- Any Services not provided by a Plan Provider or for which a Referral is not obtained.

Your Cost Share

Covered Services under this Rider for Acupuncture Services apply toward the Out-of-Pocket Maximum shown in the Summary of Services and Cost Shares in the Group EOC.

Covered Services under this Rider for Chiropractic Services apply toward the Out-of-Pocket Maximum shown in the ***Summary of Services and Cost Shares*** in the Group EOC. You pay the following Cost Share for each visit.

- You pay $15 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: 

Gracelyn McDermott
Vice President, Marketing, Sales & Business Development

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