5. Bone mass measurement to determine risk for osteoporosis;
6. Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to men who are age 40 or older;
7. Colorectal cancer screening in accordance with screening guidelines issued by the American Cancer Society including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy;
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), 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 Screening (HPV) as recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;
11. Human immunodeficiency virus (HIV) tests and counseling;
12. TB tests;
13. Newborn hearing screenings that include follow up audiological examinations, as recommended by a physician or audiologist, and performed by a licensed audiologist to confirm the existence or absence of hearing loss when ordered by a Plan Provider; and
14. Associated preventive care radiological and lab 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 labs 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 lab test for people with heart disease
4. INR lab test for liver failure and bleeding disorders

Note: Refer to ***Diabetic Equipment, Supplies, and Self-Management Training*** for coverage of glucose monitoring equipment.

Note: Refer to ***Durable Medical Equipment*** for coverage of peak flow meters.

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

See the benefit-specific limitations immediately below for additional information.

Benefit-Specific Limitations:
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. Testing and diagnosis for specific diseases for which you have been determined to be at high risk for contracting, based on factors determined by national standards.
4. Services provided when you show signs or symptoms of a specific disease or disease process.
5. 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 Prosthetic Device. If we do not cover the Prosthetic Device, we will try to help you find facilities where you may obtain what you need at a reasonable price. Coverage is limited to the standard device that adequately meets your medical needs.

Internal Prosthetics

We cover Medically Necessary internal devices implanted during surgery, such as pacemakers, monofocal intraocular lens implants, artificial hips and joints, breast implants (see ***Reconstructive Surgery***) and cochlear implants, that are approved by the federal Food and Drug Administration 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 or misuse), and services to determine whether you need a Prosthetic or Orthotic Device.

Artificial Limbs and Eyes

We cover Medically Necessary Prosthetic Devices to replace, in whole or in part, a limb or eye, their repair, fitting, replacement and components.

As used in this provision:

"Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

"Component" means the materials and equipment needed to ensure the comfort and functioning of a Prosthetic Device.

Ostomy and Urological Supplies and Equipment

We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets the Health Plan's criteria for medical necessity. 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.

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

See the benefit-specific limitations and exclusions immediately below for additional information.

Benefit-Specific Limitations:

1. Coverage for mastectomy bras is limited to a maximum of four (4) per calendar 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. Therapeutic shoes and inserts are covered when deemed medically necessary by a Plan Provider and are limited to individuals who have diabetic foot disease with impaired sensation or altered peripheral circulation.

Benefit-Specific Exclusions:

1. Internally implanted breast prosthesis for cosmetic purposes.
2. Repair or replacement of prosthetic devices due to loss, misuse or theft.
3. Microprocessor and robotic-controlled external prosthetics that does not meet the Health Plan criteria as Medically Necessary.
4. Multifocal intraocular lens implants.
5. More than one piece of equipment or device for the same part of the body, except for replacements, spare devices or alternate use devices.
6. 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.
7. Hearing aids, except as specifically provided in this section, or as provided under a ***Hearing Services Rider***, if applicable.
8. Corrective lenses and eyeglasses, except as specifically provided in this section.
9. Orthopedic shoes or other supportive devices, unless the shoe is an integral part of a leg brace; or unless indicated above.
10. Non-rigid appliances and supplies, including but not limited to: jobst stockings; elastic garments and stockings; and garter belts.
11. Comfort, convenience, or luxury equipment or features.

Reconstructive Surgery

We cover reconstructive surgery. This shall include plastic, cosmetic and related procedures required 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.

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

See the benefit-specific exclusions immediately below for additional information.

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

1. Removal of moles or other benign skin growths for appearance only;
2. Chemical peels; and
3. Pierced earlobe repairs, except for the repair of an acute bleeding laceration.

Routine Foot Care

Coverage is provided for Medically Necessary routine foot care for patients with diabetes or other vascular disease.

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

Benefit-Specific Limitation:

1. Coverage is limited to Medically Necessary treatment of patients with diabetes or other vascular disease.

Benefit-Specific Exclusion:

1. Routine foot care is not provided to Members who do not meet the requirements of the limitations of this benefit.

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 exclusions immediately below for additional information.

Benefit-Specific Exclusions:

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 Benefits section when provided on a face-to-face basis.

Telemedicine Services is the delivery of healthcare Services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, treatment or providing remote patient monitoring Services as it pertains to the delivery of covered health care Services including mental health and substance use disorder Services.

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

Benefit-Specific Exclusion:

1. Services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions.

Therapy and Rehabilitation Services

Physical, Occupational, and Speech Therapy Services

If, in the judgment of a Plan Physician, significant improvement is 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 calendar year per injury, incident or condition; or
4. Via Video visits; or
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, significant improvement is 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 outpatient cardiac rehabilitation Services that is Medically Necessary 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; limited to one (1) program per lifetime.

See the benefit-specific limitations and exclusion immediately below for additional information.

Benefit-Specific Limitations:

1. Physical therapy is limited to treatment to restore physical function that was lost due to injury or illness. It is not covered to develop physical function, except as provided for under ***Early Intervention Services*** in this ***List of Benefits***.
2. Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
3. The limitations listed above for physical, occupational and speech therapy also apply to those Services when provided within a multidisciplinary program.

Benefit-Specific Exclusion:

1. Long-term rehabilitative therapy.

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, 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***.

We will not hold proton radiation therapy to a higher standard of clinical evidence for decisions regarding coverage under this Agreement than is applied for decisions regarding coverage of other types of radiation therapy treatment.

Transplants

We will not deny transplant Services based on physical, intellectual, developmental or other disability.
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. The 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.
5. We also provide coverage for Medically Necessary routine dental Services recommended prior to transplant.

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

Benefit-Specific Exclusion:

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 charges for Urgent Care Services received from Plan Providers and Plan Facilities within the Service Area. You will not incur any additional cost sharing for Urgent Care Services beyond that which is indicated in your Summary of Cost Shares.

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

If your Primary Care Plan Physician is located at a Plan Medical Center please 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 Kaiser Permanente identification card.

Outside of our Service Area

If you are injured or become ill while temporarily outside of the Service Area, we will cover charges for Urgent Care Services as defined in this section. You will not incur any additional cost sharing for Urgent Care Services beyond that which is indicated in your Summary of Cost Shares. All follow-up care must be provided by a Plan Provider or Plan Facility.

Bills for Urgent Care Services

If you are balance billed by an urgent care center for Urgent Care Services that were provided to you, simply mail a copy of the bill to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. Please mail your proof to us within one (1) year at the following address:

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

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

If you obtain prior approval from 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 Plan Medical Center in the Service Area, or in the nearest Kaiser Foundation Health Plan region for continuing or follow-up treatment.

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

Benefit-Specific Limitation:

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

Benefit-Specific Exclusion:

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

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 19:

1. One (1) routine eye exam per year, including:

a. Routine tests such as eye health and glaucoma tests; and
b. 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 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) for the first regular supply for that contact lens per year; 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. You will receive a discount on the purchase of eyeglass lenses and frames combined in lieu of the purchase of contact lenses.

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

Contact Lenses
We provide a discount on the initial fitting for contact lenses, in lieu of the discount on glasses 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 exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. Industrial and athletic safety frames.
2. Eyeglass lenses and contact lenses with no refractive value.
3. Sunglasses without corrective lenses unless Medically Necessary.
4. Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), and astigmatism (for example: radial keratotomy, photo-refractive keratectomy, and similar procedures).
5. Eye exercises.
6. Non-corrective contact lenses;
7. Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section.

8. Replacement of lost, broken, or damaged lenses frames and contact lenses.
9. Plano lenses.
10. Lens adornment, such as engraving, faceting or jewelling.
11. Non-prescription products, such as eyeglass holders, eyeglass cases and repair kits.
12. 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, including tests for specific genetic disorders such as preimplantation genetic disorder (PGD), for which genetic counseling is available;
3. Special procedures, such as:
   a. Electrocardiograms, and
   b. Electroencephalograms.
4. Sleep lab and sleep studies; and
5. Specialty imaging: including CT, MRI, PET Scans, and diagnostic Nuclear Medicine studies; and interventional radiology.

Note: Routine screening mammograms are covered, but not under this provision (see ***Preventive Health Care Services***)

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

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, unless otherwise covered under a Rider attached to this EOC.

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, licensing, or disability determinations; 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. Examples of cosmetic Services include but are not limited to cosmetic dermatology, cosmetic surgical Services and cosmetic dental Services.

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 Ectodermal Dysplasia*** 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 <u>any</u> 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.

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. **Routine Foot Care Services:** This exclusion does not exclude Services when you are under active treatment for a metabolic or peripheral vascular disease.
12. **Services for Members in the Custody of Law Enforcement Officers:** Non-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as Out-of-Plan Emergency Services.
13. **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.
14. **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.

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: Coordination of Benefits

This section provides information on how your benefits may be coordinated with other types of coverage.

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.

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, the Health Plan has rules. The following rules for the Health Plan are modeled after the rules recommended by the National Association of Insurance Commissioners. You will find the rules under ***Order of Benefit Determination Rule***s 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. A secondary Plan, the benefits or services provided under this Agreement will be coordinated with the primary plan so the total of benefits paid, or the reasonable cash value of the services provided, between the primary plan and the secondary plan(s) do not exceed 100 percent of the total Allowable 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. 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 Subscriber and Dependents

1. Subject to #2 (immediately below), a plan that covers a person as a Subscriber is primary to a plan that covers the person as a dependent.
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. If both parents have the same birthday, the plan that covered a parent longer is primary. If the aforementioned parental birthday rules do not apply to the rules provided in the other plan, then the rules in the other plan will be used to determine the order of benefits.
2. **Dependent child with separated or divorced parents:** If two (2) or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   a. First, the Plan of the parent with custody of the child;
   b. Then, the Plan of the spouse of the parent with custody of the child; and
   c. Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the Plan obligated to pay or provide the benefits of that parent has actual knowledge of those terms, that Plan is primary. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payer has that actual knowledge.

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).

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 provided 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. Or 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 thereon is made; exceeds Allowable Expenses in a Claim Determination Period.

In that case, the Health Plan benefits will be coordinated, or the reasonable cash value of any services provided by 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.

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 by the primary plan, then we may recover the excess or the reasonable cash value of the 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.

Medicare and TRICARE Benefits

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

Workers' Compensation or Employer's Liability

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
2101 East Jefferson Street, 4 East
Rockville, Maryland 20852

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 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.

SECTION 5: Filing Claims, Appeals and Grievances

Getting Assistance

Member Services representatives are available to assist you at most of our Plan Medical Centers and by phone Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY). Member Services representatives will answer any questions you have about your benefits, available services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace your Kaiser Permanente identification card. These representatives can also help you file a claim for Emergency Services and Urgent Care Services outside of our Service Area (see ***Post-Service Claims***) or to initiate an Appeal for any unresolved problem.

We want you to be satisfied with your health care. Please discuss any problems with your Primary Care Plan Provider or other health care professionals treating you. If you are not satisfied with your Primary Care Plan Provider, you can request a different Plan Provider by visiting our website **www.kp.org** or contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY) .

Who to Contact

If you have questions about how to file a claim, Appeal or Grievance with the Health Plan, please contact Member Relations Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

To contact us in writing, mail or fax your correspondence to:
Kaiser Permanente
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Rd NE
Atlanta, GA 30305
1(404) 949-5001 (FAX)

When you must file a claim (request for payment/reimbursement) for services inside or outside of the Plan's service area, please submit claims to the following address:
Kaiser Permanente
National Claims Administration - Mid-Atlantic States
Attention: Claims Department
P.O. Box 371860
Denver, CO 80237-9998

Paper forms can be obtained by visiting kp.org or by calling the Member Services Contact Center. You may also file a claim electronically by visiting kp.org.

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:

- Member/Patient Name and Medical/Health Record Number
- 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.

Procedure for Filing a Claim and Initial Claim Decisions

When receiving services outside of a Plan Medical Center, you will receive an Explanation of Benefits (EOB) within twenty-one (21) days of Proof of Loss. The EOB will describe the Services provided, whether the claim was paid or denied, the amount paid by Health Plan, your Cost Share, and the amounts accumulated toward meeting your Deductible (if applicable) and Out-of-Pocket Maximum. For Services furnished by Kaiser Permanente staff clinicians within a Plan Medical Center, EOBs will not be issued unless the Services provided are subject to a Deductible and/or Coinsurance.

The Health Plan will review claims that you make for Services or payment, and we may use medical experts to help us review claims and Appeals. You may file a claim or an Appeal on your own behalf or through an Authorized Representative. As used with respect to Pre-Service, Concurrent Care, or Post-Service Claims and Appeals related thereto, the term "Member" or "you" shall include an Authorized Representative, as defined in the section ***Important Terms You Should Know***.

The Health Plan will also process a request for a standard review of a decision that a drug is not covered by the Plan for you or your Authorized Representative or the prescribing physician (or other prescriber).

The initial response of the Health Plan may be to request additional information from the prescribing provider in order to make a determination. The Health Plan will make its utilization review decision no later than two (2) business days following receipt of all the information necessary to complete the review.

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

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

We do not charge you for filing claims or Appeals, but you must bear the cost of anyone you hire to represent or help you. You may also contact the Office of the Managed Care Ombudsman, for which contact information is contained within this section,) to obtain assistance.

Pre-Service Claims

Pre-Service Claims are requests that the Health Plan provide or pay for a Service that you have not yet received. Our clinical peer will decide if your claim involves an Urgent Medical Condition or not. If you receive any of the Services you are requesting before we make our decision, your claim or Appeal will become a Post-Service Claim with respect to those Services. If you have any questions about Pre-Service Claims, please contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY) .

Procedure for Making a Non-Urgent Pre-Service Claim

1. Tell Member Services that you want to make a claim for the Health Plan to provide or pay for a

Service you have not yet received. Your written or oral request and any related documents you give us constitute your claim. You may write or call us at the address and number listed above.

2. We will review your claim, and if we have all the information we need we will communicate our decision within two (2) working days after we receive your claim. If we cannot make a determination because we do not have all the information we need, we will ask you for more information within fifteen (15) days of receipt of your claim. We encourage you to send all the requested information at one time, so that we will be able to consider all of it when we make our decision. If we do not receive any of the requested information (including documents) within forty-five (45) days, we will then make a decision within fifteen (15) days of the due date or the receipt date, whichever is earlier, based on the information we have.
3. We will make a good faith attempt to obtain information from the treating provider before we make any Adverse Decision. At any time before we make our decision, the provider shall be entitled to review the issue of medical necessity with a physician advisor or peer of the treating provider. A physician reviewer will review the issue of medical necessity with the provider prior to making any Adverse Decision relating to cancer pain medication.
4. If we make an Adverse Decision regarding your claim, we will notify the treating provider:
   a. In writing within two (2) working days of the decision; or
   b. Orally by telephone within twenty-four (24) hours of the decision if the claim is for cancer pain medication.

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

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

Expedited Procedure for an Urgent Medical Condition

1. If you or your treating provider feels that you have an Urgent Medical Condition, you may request an expedited review of your Pre-Service Claim.
2. If our clinical peer determines your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Pre-Service Claim.
3. We will review your claim, and if we have all the information we need we will notify you of our decision as soon as possible taking into account your medical condition(s) but no later than seventy-two (72) hours after receiving your claim. We will send a written or electronic confirmation within three (3) days after making our decision. If we cannot make a decision because we do not have all the information we need, we will ask you for more information within twenty-four (24) hours of receipt of your claim. You will have forty-eight (48) hours from the time of notification by us to provide the missing information. We will make a decision forty-eight (48) hours after the earlier of:
   a. Our receipt of the requested information; or
   b. The end of the forty-eight (48)-hour period we have given you to provide the specified additional information.
4. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can Appeal.
5. When you or your Authorized Representative sends an Appeal, you or your Authorized Representative may also request simultaneous external review of our initial Adverse Decision. If

you or your Authorized Representative wants simultaneous external review, your or your Authorized Representative's Appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service Appeal qualifies as urgent. If you do not request simultaneous external review in your Appeal, then you or your Authorized Representative may be able to request external review after we make our decision regarding the Appeal. See ***Bureau of Insurance Independent External Appeals*** in this section for additional information about filing an external Appeal.

Concurrent Care Claims

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

1. Expire; or
2. Be shortened.

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

1. If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date of onset of services and the date of the next scheduled concurrent review of the case.
2. If we reduce or terminate coverage for an ongoing course of treatment that we already approved, we will notify the Member sufficiently in advance of the reduction or termination to allow the member to Appeal the decision as described below.

Concurrent Care Claims for an Urgent Medical Condition

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

If you filed a request for additional services at least twenty-four (24) hours before the end of an approved course of treatment, you may continue to receive those services during the time your claim is under consideration. If your claim is denied, you will be financially responsible for the entire cost of those services. Otherwise, if your request for additional services was not timely filed, 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 your claim was received.

1. If our clinical peer determines your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Concurrent Care Claim.
2. We will notify you of our decision orally or in writing within twenty-four (24) hours after we receive your claim. If we notify you orally, we will send you a written decision within three (3) days after that.
3. If we deny your claim or if we do not agree to continue approval of all the Services you requested, we will tell you in writing why we denied your claim and how you can Appeal.
4. When you or your Authorized Representative sends the Appeal, you or your Authorized Representative may also request simultaneous external review of our Adverse Decision. If you want simultaneous external review, you or your Authorized Representative's Appeal must tell us this. You or your Authorized Representative will be eligible for the simultaneous external review

only if your concurrent care claim qualifies as urgent. If you or your Authorized Representative do not request simultaneous external review in the Appeal, then you or your Authorized Representative may be able to request external review after we make our decision regarding the Appeal. See ***Bureau of Insurance Independent External Appeals*** in this section for additional information about filing an external Appeal.

Post-Service Claims

Post-Service claims are requests for payment for Services you already received, including claims for Emergency Services and Urgent Care Services rendered outside of our Service Area. If you have any questions about Post-Service claims or Appeals, please contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY) .

Procedure for Making a Post-Service Claim

Claims for Emergency Services or Urgent Care Services rendered outside of our Service Area or other Services received from non-Plan Providers must be filed on forms provided by the Health Plan; such forms may be obtained on our website, **www.kp.org** or by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

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

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

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

Reconsideration of an Adverse Decision

Reconsideration of an Adverse Decision is available only to the treating health care provider, to request the review of an Adverse Decision by the Health Plan, on behalf of a Member. A request for reconsideration is optional. The treating provider may choose to skip this step and the you or your Authorized Representative may file an Appeal as described below. If the provider does request reconsideration, the Member still has a right to Appeal.

The Health Plan will render its decision regarding the reconsideration request and provide the decision to the treating provider and the Member, in writing, within ten (10) working days of the date of receipt of the request. If we deny the claim, the notice will include the criteria used and the clinical reason for the Adverse Decision, the alternate length of treatment of any alternate treatment recommended, and the

Member's right to Appeal the decision as described below.

Appeals of Claim Decisions

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

Standard Appeal

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

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

Kaiser Permanente
Attention: Appeals Coordinator
Nine Piedmont Center
3495 Piedmont Rd NE
Atlanta, GA 30305
(404) 364-4743 (FAX)

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

Wherever the term "Member" or "you" or "your" is used in this section, it shall include the Member's Authorized Representative.

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

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

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

Standard Appeals will either be acknowledged within five (5) working days of the filing date of the written Appeal request. An acknowledgement letter will be sent as described immediately below.

Appeal of a Non-Urgent Pre-Service or Non-Urgent Concurrent Care Claim

If the Appeal is for a Service that the Member is requesting, the acknowledgment letter will:

1. Request additional information, if necessary;
2. Inform the Member when there will be a decision on their Appeal; and
3. State that written notice of the Appeal decision will be sent within thirty (30) days of the date the Appeal was received.

Appeal of a Post-Service Claim

If the Appeal is asking for payment for completed services, an acknowledgment letter is sent:

1. Requesting additional information, if necessary;
2. Informing the Member when a decision will be made;
3. That the Member will be notified of the decision within sixty (60) days of the date the Appeal was received.

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

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

In addition, you or your Authorized Representative, as applicable, may review (without charge) the information upon which the Health Plan made its decision. You or your Authorized Representative may also send additional information, including comments, documents, or additional medical records supporting the claim, to:

Kaiser Permanente
Attention: Appeals Coordinator
Nine Piedmont Center
3495 Piedmont Rd NE
Atlanta, GA 30305
(404) 364-4743 (FAX)

If the Health Plan asked for additional information before and you or your Authorized Representative did not provide it, you or your Authorized Representative may still submit the additional information with the Appeal. In addition, you or your Authorized Representative may also provide testimony by writing or by telephone. Written testimony may be sent along with the Appeal to the address above. To arrange to give testimony by telephone, you or your Authorized Representative may contact the Appeals and Complaints Resolution Department. The Health Plan will add all additional information to the claim file and review all new information without regard to whether this information was submitted or considered in the initial decision.

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

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

If the review results in a denial, the Health Plan will notify you or your Authorized Representative. The

notification shall include:

1. The specific factual basis for the decision in clear understandable language;
2. References to any specific criteria or standards on including interpretive guidelines, on which the Appeal Decision was based (including reference to the specific plan provisions on which determination was based);
3. A statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request. In addition, you or your Authorized representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of your or your Authorized representative's claim.
4. A description of the right of the Member to file an external Appeal with the Bureau of Insurance, along with the forms for filing and a detailed explanation of how to file such an Appeal. An external Appeal must be filed within one-hundred twenty (120) days after the date of receipt of a notice of the right to an external review of a final Adverse Decision or an Adverse Decision if the internal Appeal process has been deemed to be exhausted or waived, a Member or their Authorized Representative may file a request for an external review in writing with the Commission of the date of the Health Plan's final Adverse Decision, as described below; and
5. A statement of your rights under section 502(a) of ERISA.

If we send you a notice of an Adverse Decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least 10 percent of the population is literate only in the same federally mandated non-English language. You or your Authorized Representative may request translation of the notice by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

If the Health Plan fails to make an Appeal decision for a non-urgent pre-service Appeal within thirty (30) days or within sixty (60) days for a post-service Appeal, the Member may file a complaint with the Bureau of Insurance.

Expedited Appeal

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

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

You, your Authorized Representative, or your treating health care provider may initiate an Expedited Appeal by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY) or faxing the request to (404) 364-4743 during regular business hours.

During non-business hours, please contact the Advice and Appointment Line at 703-359-7878.

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

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

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

A decision with respect to such Expedited Appeal shall be rendered no later than:

1. Seventy-two (72) hours after receipt of the claim, if we have all of the necessary information; or
2. If the claim is for cancer pain medication, no later than twenty-four (24) hours after receipt of the claim.

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

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

1. Notify you, your Authorized Representative, or the provider who requested the expedited review, by telephone, fax, or electronic mail that the Member is eligible for an Expedited Appeal to the Bureau of Insurance without the necessity of providing the justification required for a standard Appeal; and
2. Within twenty-four (24) hours after the initial notice, provide a written notice to the provider and the Member clearly informing them of the right to Appeal this decision to the Bureau of Insurance. The written notice will include the appropriate forms and instructions to file an Appeal with the Bureau of Insurance, as described below.

The notification shall also include:

1. The specific factual basis for the decision in clear understandable language;
2. References to any specific criteria or standards, including interpretive guidelines, on which the decision was based (including reference to the specific plan provisions on which determination was based);
3. A statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request; and
4. A statement of your rights under section 502(a) of ERISA.

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

Bureau of Insurance Independent External Appeals

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

1. If all of the Health Plan's Appeal procedures described above have been exhausted; or
2. If the Member's Adverse Decision involves cancer treatment or a medical condition where the timeframe for completion of an expedited internal appeal of an Adverse Decision would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function; or
3. If the Member requested an Expedited Appeal and the Health Plan determined that the standard Appeal timeframes should apply; or
4. When an Expedited Appeal is reviewed and is denied.

A Member may request an expedited emergency review prior to exhausting our internal Appeal process if:

1. An Adverse Decision that was based on a determination that services are experimental/investigational may be expedited with written certification by the treating physician that services would be less effective if not initiated promptly;
2. The Health Plan fails to render a standard internal Appeal determination within thirty (30) or sixty (60) days and you, your Authorized Representative or Health Care Provider has not requested or agreed to a delay; or
3. The Health Plan waives the exhaustion requirement.

An Expedited emergency review for denials due to medical necessity, appropriateness, healthcare setting, level of care or effectiveness may be requested simultaneously with an expedited internal review; the Independent Review Organization will review and determine if internal Appeal should be completed prior to expedited emergency review.

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

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

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

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

to the same extent to which we would have been bound by a judgment entered in an action of law or in equity, with respect to those issues which the external review entity may review regarding a final Adverse Decision of the Health Plan.

Office of the Managed Care Ombudsman

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

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

Bureau of Insurance
Attention: Office of the Managed Care Ombudsman
P.O. Box 1157
Richmond, VA 23218
804-371-9032 (Phone)
1-877-310-6560 (Toll-free)
ombudsman@scc.virginia.gov (Email)

The Office of Licensure and Certification

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

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

Complaint Hotline:
804-367-2106 (Phone)
1-800-955-1819 (Toll-free)
1-804-527-4503 (FAX)

www.vdh.virginia.gov (Website)
mchip@vdh.Virginia.gov (Email)

Customer Satisfaction Procedure

In addition, the Health Plan has established a procedure for hearing and resolving Complaints by Members. An oral Complaint may be made to any Health Plan employee or to any person who regularly provides health care Services to Members. A written Complaint must be given or sent to a Membership Services Representative located at a Medical Office or by sending a letter to the following address:

Kaiser Permanente
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Rd NE
Atlanta, GA 30305

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

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

For information visit the Bureau of Insurance's website at **www.scc.virginia.gov** or call the Life and Health Consumer Services Section at 804-371-9691 or toll-free at 1-877-310-6560, to discuss your complaint or receive assistance on how to file a complaint. Written complaints may be mailed to:

Bureau of Insurance
Attention: State Corporation Commission
P.O. Box 1157
Richmond, VA 23218
804-371-9944 (FAX)

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 2101 East Jefferson Street, Rockville, Maryland 20852) 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

Except as expressly provided in this section, all rights to Services and other benefits hereunder terminate as of the effective date of termination.

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 of 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 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

We may terminate the memberships of the Subscriber and all Dependents in your Family Unit by sending written notice to the Subscriber at least thirty-one (31) days before the termination date if anyone in your Family Unit commits one of the following acts:

1. You knowingly:
   a. Misrepresent membership status;
   b. Present an invalid prescription or physician order;
   c. Misuse (or let someone else misuse) a Member ID card; or
   d. Commit other types of fraud in connection with your membership;
2. You knowingly furnish incorrect or incomplete information to us or fail to notify us of changes in your family status that may affect your eligibility or benefits;
3. You no longer live or work within the Health Plan's Service Area; or
4. Your behavior with respect to the Health Plan staff or Medical Group providers is:

a. Disruptive;
b. Unruly;
c. Abusive; or
d. Uncooperative, to the extent that your continued enrollment under this EOC seriously impairs the Health Plan's ability to furnish Services to you or to other Health Plan members.

Termination for Nonpayment

Nonpayment of Premium

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

Nonpayment of any other charges

We may terminate the memberships of a Subscriber and all Dependents in your Family Unit if any one of you fails to pay any amount he or she owes to the Health Plan or Medical Group, or fails to pay the applicable Cost Share to any Plan Provider. We will send written notice of the termination to the Subscriber at least thirty-one (31) days before the termination date.

Extension of Benefits

In those instances when coverage with us has terminated for you and/or your covered Dependent(s), we will extend benefits for covered Services, subject to Premium payment, in the following instance:

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

To assist us, if you believe you and/or your covered Dependent(s) qualify under this provision, you must notify us in writing.

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

Limitations to Extension of Benefits

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

1. Members whose coverage ends because of failure to pay Premium; or
2. Members whose coverage ends because of fraud or material misrepresentation by the Member.

Continuation of Coverage

A member whose eligibility for coverage terminates under this group contract has the opportunity to continue coverage at their own expense under the group contract for a period no shorter than twelve (12) months. The continuation coverage period begins immediately after the member's termination date of eligibility for coverage under this group contract.

1. Continuation coverage is to be provided without additional evidence of insurability, and is subject to the following requirements:
   a. The application and payment for continued coverage is made to the group contract holder within thirty-one (31) days following issuance of the written notice required in number 3 of this section (below), but not beyond the sixty (60)-day period following the member's termination date, as indicated in the written notice provided by the group contract holder;
   b. Each premium payment for continued coverage is paid timely to the group contract holder on a monthly basis during the twelve (12)-month continuation coverage period (or longer, if offered by the group); and
   c. The premium for continuation coverage shall be at the Health Plan's current rate, as applicable to similarly situated individuals under the group contract, plus any applicable administrative fee not to exceed 2 percent of the current rate.
2. Continuation coverage is not required to be made available by the group when the enrollee:
   a. Is covered by or eligible for Medicare;
   b. Is covered by substantially the same level of benefits under any policy, contract or plan for individuals in a group;
   c. Has not been continuously covered during the three (3)-month period immediately preceding the enrollee's termination of coverage;
   d. Was terminated by the Health Plan or coverage was rescinded for:
      i. Failure to pay the premium required by the contract as shown in the contract or EOC; and/or
      ii. The policyholder or contract holder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage.
   e. Was terminated from a plan administered by the Department of Medical Assistance Services that provided benefits pursuant to Title XIX or XXI of the Social Security Act (42 USC § 1396 et seq. or § 1397aa et seq.).
3. The group contract holder shall provide each enrollee or other person covered under the group contract with written notice of the procedures and timeframes for obtaining continuation of coverage under the group contract. This notice shall be provided within fourteen (14) days of the group contract holder's knowledge of the enrollee's or other covered person's loss of eligibility under the group contract.

Note: This continuation coverage provision is not applicable when a group contract holder is required by federal law to provide Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits under its group health plan.

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 live in another Kaiser Foundation Health Plan or allied plan service area. You must submit a USERRA election form to your Group within sixty (60) days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

Coverage Available on Termination

For information about non-group plans available through us with no waiting period or pre-existing condition limitations, contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY) or online at **www.kp.org**.

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 rights, interests, claims for money due, benefits or obligations hereunder without our prior written consent.

Attorney Fees and Expenses

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

The Health Plan may void this Agreement and/or deny any claim made hereunder on the basis of any statement or representation made by a Subscriber for a period of two years from the effective date of this Agreement. After this two-year period, Health Plan may void this Agreement and/or deny any claim made hereunder only on the basis of a statement that was material to the risk and contained in a written application or in the existence of fraud.

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. 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.

Governing Law

Except as preempted by federal law, this EOC will be covered in accordance with the law of the Commonwealth of Virginia. Any provision that is required to be in this EOC by state or federal law shall bind Members and the Health Plan whether or not it is set forth in this EOC.

Legal Action

No legal action may be brought to recover on this Agreement:

1. Before the expiration of sixty (60) days after you have provided us with proof of loss in accordance with the terms of this Agreement; 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. The Subscriber is 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. 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.
P.O. Box 6831
2101 East Jefferson Street
Rockville, MD 20852-4908

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. 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**.

Surrogacy Arrangements

A surrogacy/gestational carrier arrangement is an arrangement between a Member who becomes a surrogate mother/gestational carrier and another person or persons. In a surrogacy arrangement, you agree to become pregnant, then surrender the baby (or babies) to another person or persons who intend to raise the child (or children).

You must pay us charges for Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with a surrogacy arrangement (Surrogacy Health Services). Your obligation to pay us for Surrogacy Health Services is limited to the compensation you are entitled to receive under the surrogacy arrangement.

Note: This "Surrogacy Arrangements/Gestational Carrier" section does not affect your obligation to pay your Deductible, Copayment, Coinsurance, or other amounts you are required to pay for these Services. After you surrender a baby (or babies) to the legal parents, you are not obligated to pay charges for any Services that the baby (or babies) receive(s) (the legal parents are financially responsible for any Services that the baby receives).

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

Within thirty (30) days of entering into a surrogacy arrangement, you must send written notice of the arrangement, including all of the following information:

1. Names, addresses, and telephone numbers of the other parties to the arrangement;
2. Names, addresses, and telephone numbers of any escrow agent or trustee;
3. Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receive;
4. A signed copy of any contracts and other documents explaining the arrangement; and
5. Any other information we request in order to satisfy our rights

You must send this information to:

Kaiser Permanente

Attn: Patient Financial Services Surrogacy Coordinator

2101 E. Jefferson St., 4 East

Rockville, MD 20852

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

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

Kaiser Permanente
Virginia 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: Any determination by Health Plan that:

1. An admission, availability of care, continued stay, or other Service is or is not a covered benefit; or if it is a covered benefit, that such service has been reviewed and does not meet the Health Plan's requirements for medical necessity, appropriateness, health care settings, level of care or effectiveness, and therefore payment is not provided or made by the Health Plan, for the service, thereby making the Member responsible in whole, or in part; or
2. Cancels or terminates a Member's membership retroactively for a reason other than a failure to pay premiums or contributions toward the cost of coverage.

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.

Allowable Charges: Means either for:

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, the "Member Standard Value" which means the cost of the item calculated on a discounted wholesale price plus a dispensing fee;
3. 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. Stated in the fee schedule that providers have agreed to accept as payment for those Services; or
    d. That the Health Plan pays for those Services.
4. Covered Services for emergency Services performed by a non-Plan provider in a non-Plan Facility and for non-emergency surgical and ancillary Services provided by a non-Plan provider at a Plan Facility :
    a. The allowed and median billed charge amounts shall base payments for the same or similar Services provided in a similar geographic area.
    b. You will not be balance billed for (i) emergency services provided or (ii) nonemergency Services provided at a Plan Facility the non-emergency Services involve surgical or ancillary Services provided by a non-Plan provider.

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. This means that an expense or healthcare service or a portion of an expense or health care service that is not covered by any of the Plans is not an Allowable Expense. For example, if a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room usually is not an Allowable Expense. Allowable Expense does not include coverage for dental care except as provided under ***Accidental Dental Injury Services*** in ***Section 3: Benefits, Exclusions and Limitations***.

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

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

Appellant: An appellant is a person eligible to file an Independent External Appeal. The Member or the following persons may be considered an Appellant:

1. An Authorized Representative; or
2. The member's spouse, parent, committee, legal guardian or other individual authorized by law to act on the Member's behalf if the Member is not a minor but is incompetent or incapacitated.

Applied Behavior Analysis: The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Authorized Representative: An individual authorized by the Member in writing or otherwise authorized by state law to act on the Member's behalf to file claims and to submit Appeals or Grievances to 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 Calendar Year. However, it does not include any part of a year during which a person has no Health Plan coverage, or any part of a year before the date a Coordination of Benefits provision or a similar provision takes effect.

Coinsurance: After you have met your Deductible, a percentage of Allowable Charges that you must pay when you receive a covered Service.

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

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 Conditions include, but are not limited to: Multiple Sclerosis, Hepatitis C, and Rheumatoid Arthritis.

Copayment: A specific dollar amount that you must pay when you receive certain covered Services.

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

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 unmarried sex adult who resides with the Subscriber and the Subscriber and the individual meet the following requirements:

1. The individual has lived with the Subscriber in a committed relationship for at least six

consecutive months prior to eligibility for this coverage;

2. The individual must not have any blood relation to Subscriber;
3. The individual and the Subscriber must be at least 18 years of age;
4. Neither the Subscriber or the individual can be married, nor a member of another domestic partnership;
5. The individual and the Subscriber must agree to be jointly responsible for one another's basic living expenses and overall welfare;
6. Both the Subscriber and the individual must be mentally capable of consenting to the domestic partnership; and
7. The individual and the Subscriber must attest to the above in an Affidavit of Domestic Partnership provided by Health Plan.

E

Emergency Case: A case in which an Adverse Decision was rendered pertaining to health care Services which have yet to be delivered and such health care Services are necessary to treat a condition or illness that, without immediate medical attention would:

1. Seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function; or
2. Cause the Member to be in danger to self or others.

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

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

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

1. A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, or a freestanding emergency department including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and,
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, or a freestanding emergency department as are required under the Emergency Medical Treatment and Active Labor Act.

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.

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

of health and medicine. An Expedited Appeal is also an appeal involving:

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

Explanation of Benefits (EOB): Any form provided by an insurer, health services plan or health maintenance organization which explains the amounts covered under a policy or Plan or shows the amounts payable by a Member to a health care provider.

F

Family Coverage: Any coverage other than Self-Only Coverage.

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

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.

G

Grievance: A protest filed by a Member or parent/guardian, as applicable, or by a provider or other Authorized Representative on behalf of the Member, with the 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

Health Care Provider:

1. An individual who is: licensed or otherwise authorized in this State to provide health care services in the ordinary course of business or practice of a profession and is the treating provider of the Member; or
2. A hospital.

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., providing Services or benefits for health care. 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.

Hospital: Any hospital:

1. In the Service Area to which a Member is admitted to receive Hospital Services pursuant to arrangements made by a physician; or
2. Outside of the Service Area for clinical trials, Emergency or Urgent Care Services or upon receiving an approved referral.

I

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

K

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

M

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

Medically Necessary/Medical Necessity: 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; and/or
   c. The view of physicians practicing in the Kaiser Permanente Medical Care Program.

Note: 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: Filing Claims, Appeals and Grievances***.

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

Member: A person who is eligible and enrolled under this Agreement as a Subscriber or a Dependent, and for whom we have received applicable Premium. Members are sometimes referred to as "you" within this Agreement.

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.

O

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.

P

Plan: The health benefit Plan described in this Agreement.

Plan: (For use in relation to ***Coordination of Benefits*** provisions only, which are located in ***Section 4: 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 Virginia 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 including licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings that are:

1. Operated by us or contracts to provide Services and supplies to Members; and
2. Included in your Signature provider network.

Plan Hospital: A hospital that:

1. Contracts to provide inpatient and/or outpatient Services to Members; and

2. Is included in your Signature provider network.

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

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

Plan Physician: Any licensed physician who is an employee of Medical Group, or any licensed physician (except for those physicians who contract only to provide Services upon referral) who:

1. Contracts to provide Services and supplies to Members; and
2. Is included in your Signature provider network.

Plan Provider: A Plan Physician, or other health care provider including but not limited to a Non-Physician Specialist, and Plan Facility that:

1. Is employed by or operated by an entity that participates in the Kaiser Permanente Medical Care Program; or
2. Contracts with an entity that participates in the Kaiser Permanente Medical Care Program.

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

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

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).

Proof of Loss: All necessary documentation reasonably required by the Health Plan to make a determination of benefit or coverage.

Prosthetic Device: An artificial substitute for a missing body part used for functional reasons.

R

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.

Service: A health care diagnosis, procedure, treatment or item.

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.

Spouse: Your legal husband or wife.

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

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber. (For Subscriber eligibility requirements, see the ***Eligibility for This Plan*** provision in ***Section 1: Introduction to Your Kaiser Permanente Health Plan).***

T

Totally Disabled:

For Subscribers and Adult Dependents: In the judgment of a Medical Group Physician, a person is totally disabled by reason of injury or sickness if the Member is unable to perform each and every duty pertaining to his or her occupation during the first 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 Medical Group Physician, an illness or injury which makes the child unable to substantially engage in any of the normal activities of children in good health and like age.

U

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

Urgent Medical Condition: As used in ***Section 5: Filing Claims, 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.

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.

Kaiser Permanente
Virginia 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 are due at the time you receive a Service. You will be billed for any Coinsurance Cost Shares you owe. Failure to pay your Cost Shares may result in termination of your Membership (refer to ***Section 6: Termination of Membership***).

Copayments and Coinsurance

Covered Service	You Pay
Outpatient Care Office visits (for other than preventive health care Services)	
Primary care office visits For adults	$15 per visit
For children under 5 years of age	No charge
For children 5 years of age or older	No charge
Specialty care office visits	$20 per visit
Consultations and immunizations for foreign travel	$15 per visit
Outpatient surgery • Outpatient surgery facility fee	$20 per visit
• Outpatient surgery physician Services	No charge
Anesthesia	No charge
Respiratory therapy	$20 per visit
House calls	No charge
Hospital Inpatient Care All charges incurred during a covered stay as an inpatient in a hospital	No charge
Accidental Dental Injury Services	Applicable Cost Shares will apply based on type and place of Service
Dental Service Office Visit	$20 per visit

Copayments and Coinsurance	
Covered Service	**You Pay**
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)	$50 per encounter
Ambulette (Non-emergent transportation Service ordered by a Plan Provider)	No charge
Anesthesia for Dental Services	
Anesthesia and associated hospital or ambulatory Services for certain individuals only	No charge
Autism Spectrum Disorder Services	
Physical, Occupational or Speech Therapy	$15 per visit
Applied Behavioral Analysis (ABA)	$15 per visit
Blood, Blood Products and their Administration	No charge
Chemical Dependency and Mental Health Services	
Inpatient treatment in a hospital or residential treatment center	No charge
Partial hospitalization	$15 per visit
Outpatient office visits	
• Individual therapy	$15 per visit
• Group therapy	$7 per visit
• Intensive Outpatient Treatment	$15 per visit
• Medication management visits	$15 per visit
All other outpatient Services	
• Crisis intervention	$15 per visit
• Electroconvulsive Therapy (ECT)	$15 per visit
• Psychological and neuropsychological testing (for diagnostic purposes)	$15 per visit
Cleft Lip, Cleft Palate or Ectodermal Dysplasia	Applicable Cost Shares will apply based on type and place of Service

Copayments and Coinsurance

Covered Service	You Pay
Clinical Trials	Applicable Cost Shares will apply based on type and place of Service
Diabetic Equipment, Supplies and Self-Management Training	
Diabetic equipment and supplies	No charge
Self-management training	Applicable Cost Shares will apply based on type and place of Service
Dialysis	
Inpatient care	Applicable inpatient Cost Shares will apply
Outpatient Care	$20 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- Outpatient	
Outpatient Basic Durable Medical Equipment	No charge
Outpatient Supplemental Durable Medical Equipment	
• Oxygen and Equipment	No charge for 1st 3 months; 50% of AC* each month thereafter
• Positive Airway Pressure Equipment	No charge
• Apnea Monitors (Infants under 3, not to exceed a period of 6 months)	No charge
• Asthma Equipment	No charge
○ Peak-flow meters	No charge
○ Home UV Light Box	No charge
• Bilirubin Lights (Infants under 3, not to exceed a period of 6 months)	No charge
Early Intervention Services (From birth to age 3)	$20 per visit
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.	

Copayments and Coinsurance

Covered Service	You Pay
Family Planning Services Women's Preventive Services, including all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity are covered under Preventive Care at no charge.	
Office visits	$20 per visit
Voluntary termination of pregnancy	Applicable Cost Share will apply based on type and place of service
Male sterilization (i.e., vasectomies)	Applicable Cost Share will apply based on type and place of service
Hearing Services Hearing tests (newborn hearing screening tests are covered under preventive health care Services at no charge)	Applicable Cost Share will apply based on type and place of Service
Home Health Care	No charge
Hospice Care Services	No charge
Infertility Services **Note:** In Vitro Fertilization (IVF) is not covered under this Infertility Services benefit without the purchase of the Extended Infertility Services Rider.	
Office visits	50% of AC*
Inpatient Hospital Care	50% of AC*
All other Services for treatment of infertility	50% of AC*
Maternity Services Inpatient and Birthing Center 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
Breast Pumps	No charge
Note: Maternity Services that are required by the Affordable Care Act are covered under Preventive Care Services at no charge.	
Medical Foods	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

Copayments and Coinsurance	
Covered Service	**You Pay**
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
Preventive Health Care Services Routine physical exams for adults	No charge
Routine preventive tests for adults	No charge
Well child care visits	No charge
Routine immunizations for children and adults (No additional charge for immunization agent)	No charge
Routine Preventive Care Screenings conducted in a Lab or Radiology	No charge
Prosthetic and Orthotic Devices External Orthotics • Rigid and semi-rigid orthotic devices (Limited to standard devices)	No charge
• Therapeutic shoes and inserts (Limited to individuals who have diabetic foot disease with impaired sensation or altered peripheral circulation)	No charge
External Prosthetics • Artificial limbs	No charge
• Breast prosthesis following a Medically Necessary mastectomy	No charge
• Ostomy and urological supplies	No charge
• Hair prostheses (Limited to one 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 place and type of Service
Skilled Nursing Facility Care Limited to a maximum benefit of 100 days per calendar year	No charge
Telemedicine Services	No charge
Therapy and Rehabilitation Services	
Inpatient Services	Applicable inpatient Cost Shares will apply

Copayments and Coinsurance	
Covered Service	**You Pay**
Outpatient Services	
• Physical Therapy; 30 visits per calendar year per injury/incident/condition	$20 per visit
• Speech Therapy; 30 visits per calendar year per injury/incident/condition	$20 per visit
• Occupational Therapy; 30 visits per calendar year per injury/incident/condition	$20 per visit
• Cardiac Rehabilitation	$20 per visit
• Multidisciplinary Rehabilitation	$20 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	$20 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	$20 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 Cost Shares will apply based on type and place of Service
After-Hours Urgent Care or Urgent Care Center	$20 per visit
Vision Services	
Adult Vision (for adults age 19 or older)	
Routine eye exams/refractions - Optometry Services	$15 per visit
Eye Care (Medical Treatment) - Ophthalmology Services	$20 per visit
Eyeglass lenses and frames	You receive a $75 discount off retail price** for eyeglass lenses and for eyeglass frames, combined, in lieu of the discount on contact lenses once per calendar year.
Contact lenses	You receive a $25 discount off retail price**on initial pair of contact lenses, in lieu of the discount on glasses, once per calender year.

Copayments and Coinsurance

Covered Service	You Pay
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 below and receive the discount at any Plan Vision Center.	
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/refractions - Optometry Services	$15 per visit
Eye Care (Medical Treatment) - Ophthalmology Services	$20 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 calendar year
Contact lenses (in lieu of eyeglass lenses and frames) (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 calendar year.)	No charge for initial fit and first purchase per calendar year
Medically necessary contact lenses (in lieu of eyeglass lenses and frames) (Limited to a select group)	No charge
Low Vision Aids (Unlimited from available supply)	No charge
X-ray, Laboratory and Special Procedures Diagnostic imaging and laboratory tests	
Inpatient Services	Applicable inpatient Cost Shares will apply
• Outpatient diagnostic imaging	No charge
• Outpatient laboratory tests	No charge
Specialty Imaging (including CT, MRI, PET Scans, and Nuclear Medicine); Interventional Radiology	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	$50 per test
Sleep lab	$50 per visit
Sleep studies	$20 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.	

*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 or contacts at the Kaiser Permanente Vision Care Center on the day purchased.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the limit to the total amount of Copayments and Coinsurance you must pay in a calendar year. Once you or your Family Unit have met your Out-of-Pocket Maximum, you will not be required to pay any Cost Shares for most Services for the rest of the calendar year.

Self-Only Coverage Out-of-Pocket Maximum. If you are covered as a Subscriber, and you do not have any Dependents covered under this EOC, 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 calendar 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 calendar 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.
- Adult routine eye exams;
- Hearing aids, if included by Rider attached to this plan;
- Acupuncture Services, if included by Rider attached to this plan;
- In vitro fertilization if included by Rider attached; and
- Inpatient and outpatient infertility Services.

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 calendar year
Family Out-of-Pocket Maximum	$4,500 per Family Unit per calendar year

KAISER PERMANENTE®
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 E. Jefferson Street, Rockville, MD 20852
301-816-2424

OUTPATIENT PRESCRIPTION DRUG RIDER

GROUP EVIDENCE OF COVERAGE

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

The following benefit, limitations, and exclusions are hereby added to ***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.

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.

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

FDA: The United States Food and Drug Administration.

Formulary: A list of prescription drugs covered by this Plan.

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

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.

Non-Preferred Drug: A Brand Name drug that is not in the Formulary.

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

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

Preferred Brand Drugs: A Brand Name Drug that is on the Formulary in Tier 1 and Tier 2

Formulary: A list of prescription drugs and compounded drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members. Our Pharmacy and Therapeutics Committee, which is comprised of Plan Physicians and other Plan Providers, selects prescription drugs for inclusion in the Formulary based on a number of factors, including but not limited to safety and effectiveness as determined from a review of Medical Literature, Standard Reference Compendia, and research. Preferred drugs are listed on Tier 1 and Tier 2.

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.

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.

Standard Manufacturer's Package Size: The volume or quantity of a drug or medication that is placed in a receptacle by the maker/distributor of the drug or medication and is intended by the maker/distributor to be distributed in that volume or quantity.

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

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

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 or by a dentist. Each prescription refill is subject to the same conditions as the original prescription. Plan Providers prescribe drugs in accordance with Health Plan's Formulary. If the price of the drug is less than the Rx Copayment, the Member will pay the lesser amount. You must obtain these drugs from a Plan Pharmacy or a Participating Network Pharmacy. It may be possible for you to receive 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, when the drug is listed in our Formulary.
2. Compounded preparations that contain at least one ingredient requiring a prescription and are listed in our Formulary, if: (1) there is no medically appropriate alternative in our Formulary; and (2) the compound is prescribed for an appropriate FDA-approved indication.
3. Insulin. Insulin; will not exceed a maximum of $50 per 30-day supply and $150 per 90-day supply, in accordance with § 38.2-3407.15:5 of the Code of Virginia.
4. Drugs that are FDA-approved for use as contraceptives and diaphragms, including over-the-counter contraceptives for women when prescribed by a Plan Provider, and diaphragms. 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 ninety (90)-day courses of treatment per calendar year.
6. Tobacco cessation drugs that are approved by the FDA for the treatment of tobacco dependence, including over-the-counter tobacco cessation drugs when prescribed by a Plan Provider. 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.
7. For a patient with intractable cancer pain, any drug approved by the FDA for cancer pain in excess of the recommended dosage when the excess dosage is determined to be Medically Necessary by a Plan Provider.
8. Growth hormone therapy (GHT) for treatment of children under age 18 with a growth hormone deficiency.
9. Non-prescription drugs when they are prescribed by a Plan Provider and are listed on the Preferred Drug List or when the drug is approved by the FDA for treatment of tobacco dependence.

The Pharmacy and Therapeutics Committee sets dispensing limitations in accordance with therapeutic guidelines based on the Medical Literature and research. The Committee also meets monthly to consider adding and removing prescribed drugs and accessories on the Formulary. If a change is implemented to our Formulary, a 30-day notice will be provided to you.

Certain covered outpatient prescription drugs may be subject to utilization management such as prior authorization, step therapy and other requirements. A list of drugs subject to utilization management is available to you upon request.

If you would like information about whether a particular drug or accessory is included in our Formulary, please visit us online at

https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/mas/marketplace-formulary-mas-en.pdf

You may also call the Member Services Call Center Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

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.

Generic and Preferred Drug Requirements

Generic vs. Brand Name Drugs

Plan Pharmacies and Participating Network Pharmacies will substitute a generic equivalent for a Brand Name Drug unless the prescribing provider indicates "dispense as written" (DAW) on the prescription.

Brand Name Drugs will be covered following the formulary exception process, provided they are prescribed by:

1. A Plan physician,
2. A Non-Plan Physician to whom you have a referral, or a Non-Plan physician consulted due to an emergency or out-of-area urgent care; or
3. A Dentist; and
    a. There is no equivalent Generic Drug, or
    b. An equivalent Generic Drug
        i. Has not been effective in treating the disease or condition of the Member; or
        ii. Has caused or is likely to cause an adverse reaction or other harm to the Member.

The applicable Cost Share for the Brand Name Drug will apply.

If a Member requests a Brand Name Drug, for which the prescribing provider has determined it does not meet one of the above criteria of the exception process, the Member will be responsible for the full Allowable Charge for that Brand Name Drug.

Formulary Exception Process

If you or your Plan Physician asks for an exception, you may give us a doctor's statement supporting your request. Generally, we must make our decision within 72 hours of getting your request for a coverage decision if we have your doctor's statement. If waiting up to 72 hours could be harmful to your health, either you, your Kaiser Permanente Plan Physician, or Plan Provider can ask for an expedited (fast) exception. If the fast request is approved, we'll make a decision within 24 hours of getting your doctor's supporting statement.

Step-Therapy override exception requests will be processed following the formulary exception process. You may appeal any step-therapy exception request denial following the appeals process as described in ***Section 5. Filing Claims, Appeals and Grievances of EOC.***

If you would like detailed information on the formulary exception process; please visit us at www.kp.org, or call the Member Services Call Center Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Preferred vs. Non-Preferred-Drugs

Plan Pharmacies and Participating Network Pharmacies will dispense Preferred drugs unless the prescribing provider indicates "dispense as written" (DAW) on the prescription.

Non-Preferred Drugs will be covered following the formulary exception process when: (1) prescribed by a:

1. Plan physician,

2. A Non-Plan Physician to whom you have a referral, or a Non-Plan physician consulted due to an emergency or out-of-area urgent care; or
3. Dentist; and
    c. There is no equivalent Generic Drug, or
    d. An equivalent Generic Drug
        i. Has not been effective in treating the disease or condition of the Member; or
        ii. Has caused or is likely to cause an adverse reaction or other harm to the Member.

The applicable Non-Preferred Drug Cost Share will apply.

The Health Plan, upon consultation with the prescribing provider, shall act on urgent requests within one business day of receipt of the request.

If a Member requests a Non-Preferred Drug, for which the provider has determined it does not meet one of the above criteria of the exception process, the Member will be responsible for the full cost of that drug.

Dispensing Limitations

Except for Maintenance Medications as described below, Members may obtain up to a 30 day supply and will be charged the applicable Rx Copayment or Rx Coinsurance based on: (1) the place of purchase, (2) the prescribed dosage, (3) Standard Manufacturers Package Size, and (4) specified dispensing limits. For contraceptive drugs, Members may obtain up to a 12-month supply at one time.

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

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

Maintenance Medication Dispensing Limitations

Members may obtain up to a 90-day supply of Maintenance Medications in a single prescription, when authorized by the prescribing Plan Provider or by a dentist or a referral physician. This does not apply to the first prescription or change in a prescription. The day supply is based on (1) the prescribed dosage, (2) Standard Manufacturer's Package Size, and (3) specified dispensing limits.

Partial Dispensing of Medication

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:

1. The prescribing physician or pharmacist determines dispensing a partial supply of a prescription drug to be in the best interest of the member; and
2. The Member requests or agrees to a partial supply for the purpose of synchronizing the dispensing of the Member's prescription drugs.

C. PRESCRIPTIONS COVERED OUTSIDE THE SERVICE AREA; OBTAINING REIMBURSEMENT

The Health Plan covers drugs prescribed by non-Plan Providers and purchased at non-Plan Pharmacies when the drug was prescribed during the course of an emergency care visit or an urgent care visit (see Emergency Services and Urgent Care Services in Section 3 of the EOC), or associated with a covered, authorized referral outside Health Plan's Service Area. To get reimbursed, you must submit a copy of the itemized receipts for the prescriptions to the Health Plan. We may require proof that Urgent Care or Emergency Services were provided. We will reimburse you at the Allowable Charge less the applicable Rx Copayment or Rx Coinsurance, set forth in the ***Summary of Services and Cost Shares*** in the EOC to which this Rider is attached. Claims should be submitted to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Claims Department
P.O. Box 371860
Denver, CO 80237-9998

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.
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.

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 when the drug is listed in our Formulary.
2. Compounded preparations that do not contain at least one ingredient requiring a prescription and are not listed in our (Formulary; or for which: (1) there is a medically appropriate alternative in our Formulary; or (2) the compound was not prescribed for an appropriate FDA-approved indication.
3. Except as provided for in the "Where to Purchase Covered Drugs" provision above, drugs obtained from a non-Plan Pharmacy.
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 not listed in our Formulary, except as described in this Rider.
6. Drugs that are considered to be experimental or investigational. Refer to Clinical Trials in Section 3.
7. Except as covered under this Outpatient Prescription Drug Rider, a drug (a) which can be obtained without a prescription, or (b) for which there is a non-prescription drug that is the identical chemical equivalent to a prescription drug (i.e., same active ingredient and dosage).

8. Drugs for which the Member is not legally obligated to pay, or for which no charge is made.
9. Blood or blood products. Refer to ***Blood, Blood Products and their Administration*** in Section 3.
10. Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes, including but not limited to drugs used to slow or reverse the effects of skin aging or to treat nail fungus or hair loss.
11. Medical foods. Refer to ***Medical Foods*** in Section 3.
12. Drugs for the palliation and management of terminal illness if they are provided by a licensed hospice agency to a Member participating in our hospice care program. Refer to ***Hospice Care Services*** in Section 3.
13. Replacement prescriptions as a result of damage, theft or loss.
14. Prescribed drugs and accessories that are needed for Services that are excluded under the EOC.
15. Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different than the Health Plan's standard packaging for prescription drugs.
16. Alternative formulations or delivery methods that are (1) different than the Health Plan's standard formulation or delivery method for prescription drugs; and (2) deemed not Medically Necessary.
17. Durable medical equipment, Prosthetic or Orthotic Devices and their supplies, including: peak flow meters, nebulizers, and spacers; and ostomy and urological supplies. Refer to ***Durable Medical Equipment*** and ***Prosthetic and Orthotic Devices*** in Section 3.
18. Drugs and devices provided during a covered stay in a hospital or Skilled Nursing Facility; or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits. This includes equipment and supplies associated with the administration of a drug. Refer to ***Drugs, Supplies and Supplements*** and ***Home Health Care*** in Section 3.
19. Bandages or dressings. Refer to ***Drugs, Supplies and Supplements*** and ***Home Health Care*** in Section 3.
20. Diabetic equipment and supplies. Refer to ***Diabetic Equipment, Supplies and Self-Management Training*** in Section 3.
21. Growth hormone therapy (GHT) for treatment of adults age 18 or older.
22. Immunizations and vaccinations solely for the purpose of travel. Refer to ***Outpatient Care*** in Section 3.
23. Any prescription drug product that is therapeutically equal to an over-the-counter drug, upon a review and determination by the Pharmacy and Therapeutics Committee.
24. Drugs for the treatment of sexual dysfunction disorders, such as erectile dysfunction.

F. COPAYMENTS AND COINSURANCE

For outpatient prescription drugs and/or items that are covered under this ***Outpatient Prescription Drug Benefit Rider*** 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 a coupon for payment of your Cost Sharing, the coupon amount, and any additional payment that you make, will accumulate to your Out-of-Pocket Maximum. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at kp.org/rxcoupons.

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

Tier 1: Includes commonly prescribed Generic Drugs.

Tier 2: Includes commonly prescribed Brand Name Drugs and commonly prescribed higher-cost Generic Drugs.

Tier 3: Includes all other Brand Name Drugs that are on the Formulary list and not included in Tier 1 or Tier 2. A limited number of Generic Drugs may also be included in Tier 3. Drugs on this tier also include Biosimilar Drugs.

Tier 4: As ***Specialty Drugs*** is defined above in the ***Definitions*** section within this ***Outpatient Prescription Drug Benefit Rider***.

30 Day Supply	**Plan Pharmacy**	**Participating Network Pharmacy**	**Mail Delivery**
Tier 1 Drugs	$20	$30	$20
Tier 2 Drugs	$30	$50	$30
Tier 3 Drugs	$45	$65	$45
Tier 4 Drugs	Refer to the applicable Generic and Brand Drugs Cost Share above	Refer to the applicable Generic and Brand Drugs Cost Share above	Refer to the applicable Generic and Brand Drugs Cost Share above

90-day Supply of Maintenance Medication	**Mail Delivery**	**Plan Pharmacy and Participating Network Pharmacy (if applicable)**
Tier 1 Drugs	2 Rx Copayment(s) shown above	3 Rx Copayment(s) shown above
Tier 2 Drugs	2 Rx Copayment(s) shown above	3 Rx Copayment(s) shown above
Tier 3 Drugs	2 Rx Copayment(s) shown above	3 Rx Copayment(s) shown above
Tier 4 Drugs	2 Rx Copayment(s) shown above	3 Rx Copayment(s) shown above

Weight management drugs for 50% of the Allowable Charge.

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

Tobacco Cessation Drugs for the treatment of tobacco dependence for no charge.

Drugs required to be covered by the Affordable Care Act (ACA) without Cost Sharing, including over-the-counter medications when prescribed by a Plan Provider, and obtained at a Plan or Participating Network Pharmacy for no charge.

Please visit the following websites for a list of these drugs:

Kaiser Permanente Commercial Formulary

http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

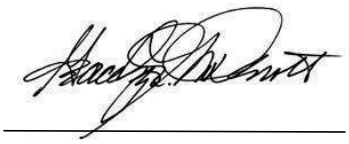
If the Cost Share for the prescription drug is greater than the Allowable Charge for the prescription drug, the Member will only be responsible for the Allowable Charge for the prescription drug.

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 the 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.
2101 E. Jefferson Street, Rockville, MD 20852
301-816-2424

EXTENDED INFERTILITY SERVICES RIDER

GROUP EVIDENCE OF COVERAGE

This Extended Infertility 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 your Group Agreement and Group Evidence of Coverage terminates.

The following benefits, limitations, and exclusions for Extended Infertility Services are hereby added to ***Section 3: Benefits, Limitations and Exclusions*** of the Group Evidence of Coverage (herein collectively referred to as the Group EOC) in consideration of the application and payment of the additional Premiums for such Services.

A. Benefits

We cover in vitro fertilization (IVF) and Medically Necessary intracytoplasmic sperm injection (ICSI), if:

1. A Member whose Spouse is of the opposite sex, the Member's oocytes are fertilized with the Member's Spouse's sperm; unless:
   a. The Spouse is unable to produce and deliver functional sperm; and the inability to produce and deliver functional sperm does not result from:
      i. A vasectomy; or
      ii. Another method of voluntary sterilization;
2. The Member and the Member's Spouse have a history of involuntary infertility, which may be demonstrated by a history of:
   a. Intercourse of at least two (2) years' duration failing to result in a pregnancy when the Member and the Member's Spouse are of opposite sexes; or
   b. If the Member and the Member's Spouse are of the same sex, six (6) attempts of artificial insemination over the course of two (2) years failing to result in a pregnancy; or
   c. The Member or the Member's Spouse has infertility associated with any of the following:
      i. Endometriosis;
      ii. Exposure in utero to diethylstilbestrol, commonly known as DES;
      iii. Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
      iv. Abnormal male factors, including oligospermia, contributing to the infertility; and
3. The Member has been unable to attain a pregnancy through a less costly infertility treatment for which coverage is available under this EOC, unless such lower cost procedures are contraindicated by a referring endocrinologist; and

4. The IVF procedures are performed at medical facilities that conform to applicable guideline or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.

We also cover IVF if the Member and the Member's Spouse have a history of involuntary infertility, and meets medical guidelines for Pre-implantation genetic diagnosis (PGD).

Note: Diagnostic procedures, Medically Necessary laboratory procedures and drugs administered by or under the direct supervision of a Plan Provider are covered under this Rider.

B. Limitations

1. Coverage for in-vitro fertilization embryo transfer cycles, including frozen embryo transfer (FET) procedure, is limited to three (3) attempts per lifetime, not to exceed a maximum lifetime benefit of $100,000.
2. Outpatient infertility drugs for the treatment of in vitro fertilization apply toward the $100,000 lifetime benefit.

C. Exclusions

- Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member's eggs and/or male Member's sperm for future attempts.
- Any charges associated with obtaining donor eggs, donor sperm or donor embryos.
- Infertility Services when the member does not meet medical guidelines established by the American Society of Reproductive Medicine and the American Society for Reproductive Endocrinology.
- Services not preauthorized by Health Plan.
- Services to reverse voluntary, surgically induced infertility.
- Infertility Services when the infertility is the result of an elective male or female surgical procedure.
- Assisted reproductive technologies and procedures, including, but not limited to: gamete intrafallopian transfers (GIFT); zygote intrafallopian transfers (ZIFT); and prescription drugs related to such procedures.

D. Your Cost Share

You pay the following Copayment or Coinsurance for each Service:

- You pay 50% of AC*

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