guide to
YOUR BENEFITS
AND SERVICES

kaiserpermanente.org

YOUR GROUP AGREEMENT

This plan has Accreditation from the NCQA.
See 2022 NCQA Guide for more information on Accreditation.

KAISER PERMANENTE®

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

EOC-COVER (1/05)

Wrap

Kaiser Permanente
Virginia Large Group Agreement

TABLE OF CONTENTS

INTRODUCTION 1

SECTION 1 - TERM OF AGREEMENT 1

SECTION 2 - AMENDMENT OF AGREEMENT 2

SECTION 3 - TERMINATION OF AGREEMENT 2

Termination on Notice 2

Termination for Non-Payment of Premium 2

Termination for Fraud, Intentionally Furnishing Incorrect or Incomplete Information, and / or Violation of Contribution or Participation Requirements 2

Termination for Movement Outside of the Service Area 2

Discontinuance of Product or All Products within a Market 2

Termination for Non-Compliance with Health Plan Provisions 3

Termination of an Employer Group through an Association 3

SECTION 4 - PREMIUM AND PAYMENTS 3

Premium Payments for New Members 4

Premium Payments for Terminating Members 4

Premium Increase Due to Tax or Other Charge 4

Premium Rebates 4

Clerical Errors 4

Cost Shares 4

Limit on Cost Shares 5

SECTION 5 - ELIGIBILITY AND ENROLLMENT 5

SECTION 6 - MISCELLANEOUS PROVISIONS 5

Assignment 5

Attorney Fees and Costs 5

Confirmation of Employer Group Contribution Rate Changes for Grandfathered Health Plans 5

Delegation of Claims Review Authority 6

Governing Law 6

Indemnification 6

Medical Claims Experience 6

Member Information 7

No Waiver 7

Notices 7

Right to Examine Records 8

Representation Regarding Waiting Periods 8

Kaiser Permanente
Virginia Large Group Agreement

INTRODUCTION

This Group Agreement (Agreement), including the Group Agreement Face Sheet, sometimes referred to as "Face Sheet," Group Application and Evidence of Coverage (EOC), all of which are incorporated herein by reference, constitutes the contract between the Group and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan

The Health Plan is responsible for fulfilling its obligations under this Agreement with respect to itself and its product(s), as described in the EOC.

Pursuant to this Agreement, the Health Plan will provide covered Services and items to Members in accord with the EOC.

The Group acknowledges acceptance of this Agreement by signing the Face Sheet and returning it to the Health Plan. If the Group does not return it to the Health Plan, Group will be deemed to have accepted this Agreement if the Group either pays the Health Plan any amount toward due Premium or enrolls a person under this Agreement.

SECTION 1 - TERM OF AGREEMENT

This Agreement is effective from the date specified on the Face Sheet unless terminated as set forth in the Termination of Agreement section below.

Unless this Agreement terminates pursuant to the ***Termination of Agreement*** section below, the Health Plan will either extend the term of this Agreement pursuant to the ***Amendment of Agreement*** section immediately below or offer the Group a new agreement to become effective immediately after termination of this Agreement.

Except as expressively provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m. Eastern Time on the termination date.

SECTION 2 - AMENDMENT OF AGREEMENT

Upon forty-five (45) days prior written notice to the Group, the Health Plan may amend this Agreement with regard to Premiums, benefits, limitations, exclusions and/or conditions, to be effective on the Anniversary Date.

When decreasing benefits or increasing rates by more than 35 percent, Health Plan must notify Group at least sixty (60) days prior to the effective date of such change.

In addition, the Health Plan may, subject to government approval, amend this Agreement at any time by giving forty-five (45) days' prior written notice to the Group in order to:

1. Comply with applicable law;
2. Reduce or expand the Health Plan Service Area.

All amendments are deemed accepted by the Group unless the Group gives the Health Plan written notice of non-acceptance at least thirty (30) days before the effective date of the amendment, in which event this Agreement terminates the date before the effective date of the amendment.

SECTION 3 - TERMINATION OF AGREEMENT

This Agreement will terminate under any of the conditions listed below.

Within five (5) business days of issuing written notice of termination to the Group, the Health Plan will mail a legible copy of the notice to each Subscriber.

Termination on Notice

The Group may terminate this Agreement effective the day before any Anniversary Date by giving at least ninety (90) days prior written notice to the Health Plan.

The Health Plan will extend benefits for covered Services to Members, with Premium, as defined in the ***Extension of Benefits*** provision, which can be found in ***Section: 6 Termination of Membership***.

Termination for Non-Payment of Premium

When Group fails to pay Premium on or before the Premium Due Date, Group shall have a period of thirty-one (31) days to pay all Premiums owed ("Grace Period"). The Grace Period shall begin the day after the Premium Due Date. This Agreement will remain in full force and effect throughout the Grace Period and Group will remain responsible for payment of Premiums during the Grace Period (and any additional period prior to termination, if that occurs). If the Health Plan receives full payment of Premiums on or before the last day of the Grace Period, this Agreement will remain in effect according to its terms and conditions. If Group fails to pay all Premiums owed (including those owed for the Grace Period) on or before the last day of the Grace Period, then the Health Plan may, at its option and in lieu of any other remedy, terminate this Agreement without further extension or consideration. The grace period shall continue in full force unless the group has given the Health Plan written notice of discontinuance in accordance with the terms of the agreement and in advance of the date of discontinuance.

The Health Plan will notify Group of the past-due amount and the effective date of termination. Such notice shall be sent at least fifteen (15) days prior to the effective date of termination.

If Premiums are paid after the Grace Period ends, the Health Plan may charge interest on the overdue Premiums Interest shall not accrue during the Grace Period, and the interest rate shall be six (6) percent per year or the maximum amount permitted by applicable law, whichever is less.

Termination for Fraud, Intentionally Furnishing Incorrect or Incomplete Information, and/or Violation of Contribution or Participation Requirements

If the Group fails to (a) adhere to the Health Plan's contribution or participation requirements, including those listed in the ***Eligibility and Enrollment*** section below, or (b) performs an act that constitutes fraud or intentional misrepresentation of material information to the Health Plan under the terms of coverage, the Health Plan will terminate this Agreement with thirty-one (31) days' prior written notice to the Group.

Termination for Movement Outside of the Service Area

The Health Plan may terminate this Agreement upon thirty-one (31) days' prior written notice to Group if no eligible person lives, resides or works in Health Plan's Service Area as described in the EOC.

Discontinuance of Product or All Products within a Market

The Health Plan may terminate a particular product, or all products offered in a large group market, as

permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If the Health Plan discontinues offering a particular product, Health Plan may terminate this Agreement upon ninety (90) days written notice prior to the date of nonrenewal to each affected Subscriber, plan sponsor, participant and beneficiary.

The Health Plan shall then offer the Group another product available at that time to groups in its respective market. The Health Plan shall act uniformly without regard to the claims experience of any affected plan sponsor, or any health status-related factor of any affected individual.

Health status-related factor means a factor related to:

1. Health status;
2. Medical condition;
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability including conditions arising out of acts of domestic violence; or
8. Disability.

If the Health Plan discontinues offering all products to large group markets, the Health Plan may terminate this Agreement upon one-hundred eighty (180) days' written notice to the Group. And, upon at least thirty (30) working days before that notice shall give notice, to the Commissioner, and may not write new business for groups in the state for a five (5)-year period beginning on the date of notice to the commissioner. No other product will be offered to the Group.

Termination for Non-Compliance with the Health Plan Provisions

The Health Plan may terminate an employer Group for failure to comply with the Health Plan provisions that have been approved by the State Corporation Commission.

Termination of an Employer Group through an Association

If an employer who is enrolled as part of an association violates any of the conditions of continued eligibility, as outlined in this section of the Group Agreement, the Health Plan may terminate the employer group's eligibility, however, to do so, the entire association's eligibility must be terminated. Under no condition may the Health Plan choose to terminate the individual employer groups' participation with the Health Plan without also terminating the entire association eligibility.

SECTION 4 - PREMIUM AND PAYMENTS

The Group will pay to the Health Plan, for each Subscriber and their Dependent(s) (collectively "Members"), the amount(s) specified on the Face Sheet for each month on or before the date on the monthly invoice or, if Group is self-pay, then the date indicated on the Face Sheet to which the Health Plan and Group agree in writing, but in no event later than the last day of the month preceding the month of coverage (the "Premium Due Date"). Only Members for whom the Health Plan has received the appropriate Premium payment are entitled to coverage under this Agreement and then only for the period for which the Health Plan has received appropriate payment.

When this Agreement terminates, if Group does not have another agreement with the Health Plan, then

the due date for all Premium amounts will be the earlier of:

1. The last Premium Due Date; or
2. The termination date of this Agreement.

Premium Payments for New Members

Premium is due and payable for new members monthly in accordance with the proration type (Full Month, Half, Month, Daily or Second) that was selected on the group application. The Group shall continue to pay the Premium for each Subscriber and his or her Family Dependents covered under this Agreement until the Group provides written notice to the Health Plan to terminate such coverage.

Premium Payments for Terminating Members

Premium is due and payable monthly in accordance with the proration type (Full Month, Half, Month, Daily or Second) that was selected on the group application regardless of the termination date The Group shall continue to pay the Premium for each Subscriber and his or her Family Dependents covered under this Agreement until the Group provides written notice to the Health Plan to terminate such coverage.

The Health Plan will not terminate coverage until it has received the Group's written notice. The effective date of termination will be the later of (1) the date requested in the written notice; or (2) the date written notice is received by the Health Plan.

Premium Increase Due to Tax or Other Charge

If a government agency or other taxing authority imposes or increases a tax or other charge (excluding a tax on or measured by net income) upon Health Plan or any of its contracting providers (or any of their activities), then beginning on the effective date of that tax or charge, the Health Plan may calculate the Group's Premium to include the Group's share of the new or increased tax or charge, subject to regulatory approval where required. The Group's share is determined by dividing the number of Members enrolled through the Group by the total number of Members enrolled in the applicable Service Area.

Premium Rebates

If state or federal law requires the Health Plan to rebate Premium from this or any earlier contract year and the Health Plan rebates Premium to the Group, those responsible to represent that the Group will use that rebate for the benefit of Members, in a manner consistent with the requirements of the Public Health Service Act, the Affordable Care Act, and the obligations of a fiduciary under the Employee Retirement Income Security Act (ERISA).

Clerical Errors

If a clerical or administrative error made by the Group or Health Plan results in an eligible person being incorrectly enrolled or not enrolled, then such error will be rectified by the Group and Health Plan within ninety (90) days of the error being found.

If the Group's written notice to add an eligible person is received more than ninety (90) days from the eligible person's effective date, the Health Plan will only enroll the eligible person a maximum of ninety (90) days retroactively from the date that the Health Plan received the written notice from the Group. Refunds or payments will be made accordingly by the Group or Health Plan, whichever is applicable.

Cost Shares
Members must pay or arrange for payment of amounts they owe the Health Plan, Plan Hospitals or Medical Group. The Cost Share is the amount of Allowable Charge for a covered Service and is due at the time the Member receives a Service.

Limit on Cost Shares
There are limits to the total amount of Cost Shares paid by a Member in a contract year for certain Services covered under this EOC. The Copayment Maximum and the Out-of-Pocket Maximum, if applicable, are provided in the Summary of Services and Cost Shares in the EOC.

SECTION 5 - ELIGIBILITY AND ENROLLMENT

No change in the Group's eligibility or participation requirements is effective for purposes of this Agreement unless the Health Plan consents in writing.

The Group must:

1. Hold an Open Enrollment Period at least once a year during which all eligible persons may enroll in the Health Plan or in any other health care plan available through the Group;
2. Offer enrollment in the Health Plan to all eligible persons on conditions no less favorable than those for any other health care plan available through the Group;
3. Contribute to all health care plans available through the Group on a basis that does not financially discriminate against Health Plan or against eligible persons who choose to enroll in the Health Plan. In no case will the Group's contribution be less than one-half the rate required for a single Subscriber for the plan in which the Subscriber is enrolled.

SECTION 6 - MISCELLANEOUS PROVISIONS

Assignment
The Health Plan may assign this Agreement.

The Group may not assign this Agreement or any of the rights, interests, claims for money due, benefits, or obligations hereunder without prior written consent of the Health Plan.

This Agreement shall be binding on the successors and permitted assignees of the Health Plan and the Group.

Attorney Fees and Costs
If the Group or Health Plan institutes legal action against the other to collect any sums owed under this Agreement, the party that substantially prevails will be reimbursed for its reasonable litigation expenses, including attorneys' fees, by the other party.

Confirmation of Employer Group Contribution Rate Changes for Grandfathered Health Plans
For any coverage identified in an Evidence of Coverage as a "grandfathered health plan" under the Patient Protection and Affordable Care Act (ACA), the Group must immediately inform the Health Plan if this coverage does not meet (or no longer meets) the requirements for grandfathered status including, but not limited to, any change in its contribution rate to the cost of any grandfathered health plan(s) during the contract year. The Group represents that, for any coverage identified as a "grandfathered health plan" in

the applicable Evidence of Coverage, the Group has not decreased its contribution rate more than five percent (5%) for any rate tier for such grandfathered health plan when compared to the contribution rate in effect on March 23, 2010, for the same plan. The Health Plan will rely on the Group's representation in issuing and/or continuing any and all grandfathered health benefit plan coverage.

Delegation of Claims Review Authority

The Health Plan is a named fiduciary to review claims under this Agreement. The Group delegates to the Health Plan the discretion to determine whether a Member is entitled to benefits under this Agreement. In making these determinations, the Health Plan has the authority to review claims in accordance with the procedures contained herein and to construe this Agreement to determine whether the Member is entitled to benefits.

Governing Law

Except as preempted by federal law, this Agreement will be governed in accordance with the laws of the Commonwealth of Virginia, where Health Plan is licensed. Any provision required to be in this Agreement by federal or state law shall bind the Group and Health Plan, whether or not it is set forth herein.

Indemnification

The Health Plan will indemnify and hold harmless the Group and its agents, officers and employees acting in their capacity as agents of the Group (collectively, "Group Parties"), against any claims, actions, costs (including reasonable attorneys' fees), damages or judgments, to the extent that they arise out of the Health Plan's acts or omissions under this Agreement.

The Group will give the Health Plan written notice of any claim that Group at any time contends is subject to this provision within thirty (30) days after receiving notice of the claim, and will tender to the Health Plan the opportunity, at the Health Plan's expense, to arrange and direct the defense of any action or lawsuit related to the claim. If the Health Plan accepts the tender, then the Health Plan will have no obligation to Group Parties with respect to attorneys' fees incurred by Group Parties. Upon request, Group Parties will give the Health Plan all information and assistance reasonably necessary for defense of the claim. The foregoing indemnification applies only to claims or actions against Group Parties by third parties, including Members, and does not apply to any claim or action by the Health Plan that seeks to enforce the Health Plan's rights under this Agreement.

The Group will indemnify and hold harmless the Health Plan and its agents, officers, and employees, acting in their capacity as agents of the Health Plan (collectively, Health Plan Parties) against any claims, actions, costs (including reasonable attorneys' fees), damages, or judgments, to the extent that they arise out of the Group's acts or omissions under this Agreement.

The Health Plan will give the Group written notice of any claim that the Health Plan at any time contends is subject to this provision within thirty (30) days after receiving notice of the claim, and will tender to the Group the opportunity, at the Group's expense, to arrange and direct the defense of any action or lawsuit related to the claim. If the Group accepts the tender, then the Group will have no obligation to the Health Plan Parties with respect to attorneys' fees incurred by Health Plan Parties.

Upon request, Health Plan Parties will give the Group all information and assistance reasonably necessary for defense of the claim. The foregoing indemnification applies only to claims or actions against Health Plan Parties by third parties, including Members, and does not apply to any claim or action by the Group

that seeks to enforce the Group's rights under this Agreement.

Medical Claims Experience

Upon request, the Health Plan shall provide the Group with a complete record of the Group's medical claims experience or medical costs incurred under this Agreement, if the Group employed an average of at least one-hundred (100) individuals who were Subscribers on business days during the preceding twelve (12)-month period.

The record shall include all claims incurred for the lesser of:

1. The period of time since the Agreement was issued or issued for delivery; or
2. The period of time since the Agreement was last renewed.

This record will be made available promptly to the Group upon written request made not less than thirty (30) days prior to the renewal date of this Agreement. All records will be provided free of charge.

Nothing in this section shall require the disclosure of personal or privileged information about an individual that is protected from disclosure under any applicable federal or state law or regulation.

Member Information

The Group will inform Subscribers of eligibility requirements for Members and when coverage becomes effective and terminates. If the Health Plan gives the Group any information that is material to Members, the Group will disseminate that information to Subscribers by the next regular communication to them, but in no event no later than thirty (30) days after the Group receives the information. For purposes of this paragraph, "material" means information that a reasonable person would consider important in determining action to be taken.

The Group will provide electronic or paper summaries of benefits and coverage (SBCs) to participants and beneficiaries to the extent required by law, except that the Health Plan will provide SBCs to Members who make a request to the Health Plan.

No Waiver

The Health Plan's failure to enforce any provision of this Agreement will not constitute a waiver of that or any other provision, or impair Health Plan's right thereafter to require the Group's strict performance of any provision.

Notices

Notices from the Health Plan to the Group or from the Group to the Health Plan must be delivered in writing, except that the Group and Health Plan may each change its notice address by given written notice to the other. Notices are deemed given when delivered in person or deposited in a United States Postal Service receptacle for the collection of U.S. Mail.

If to the Health Plan:

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

If to the Group:

To the address indicated on the Face Sheet.

If to a Member:
To the latest address provided to Health Plan by the Member.

Right to Examine Records

Under reasonable notice, the Health Plan may examine the Group's records with respect to eligibility and payments provided under this Agreement.

Representation Regarding Waiting Periods

By entering into this Agreement, the Group hereby represents that the Group does not impose a waiting period exceeding ninety (90) days on its employees who meet the Group's substantive eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective, in accordance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

In addition, Group represents that eligibility data provided by the Group to the Health Plan will include coverage effective dates for the Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

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

By: ____
Gracelynn McDermott
Vice President Marketing, Sales & Business Development

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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

We recommend that you familiarize yourself with Section 5: Filing Claims, Appeals and Grievances of this Virginia Large Group Agreement and Evidence of Coverage and make use of it before taking any other action.

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

State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Consumer Services: (804) 371-9741 or toll-free (800) 552-7945
National toll-free (877) 310-6560
Fax: (804) 371-9944

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., or the Bureau of Insurance, have your policy number available.

Notice of Protection Provided by Virginia Life, Accident and Sickness Insurance Guaranty Association

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender and withdrawal values

- Health Insurance
  - $500,000 for health benefit plans
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of accident and sickness insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts is $350,000, except for health benefit plans, for which the limit is increased to $500,000.

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

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

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://scc.virginia.gov/boi/index.aspx

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network facility, you are protected from surprise billing or balance billing.

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

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

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference betweenwhat your plan agreed to pay, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who isinvolved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you which providers and facilities are in their networks. Providers and facilities must tell you with which provider networks they participate. This information is on the insurer's, provider's or facility's website or on request.

You are protected from balance billing for:

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

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

If you receive other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

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

When balance billing isn't allowed, you also have the followingprotections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network).Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services inadvance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay anin-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network servicestoward your in-network deductible and in-network out-of-pocket limit.

If you believe you've been wrongly billed, you may call the federal agencies responsible for enforcing the federal balance billing protection law at: **1-800-985-3059** and/or file a complaintwith the Virginia State Corporation Commission Bureau of Insurance at: scc.virginia.gov/pages/File-Complaint-Consumers or call **1-877-310-6560**.

Visit cms.gov/nosurprises for more information about your rights under federal law.

Consumers covered under (i) a fully-insured policy issued in Virginia, (ii) the Virginia state employee health benefit plan; or (iii) a self-funded group that opted-in to the Virginia protectionsare also protected from balance billing under Virginia law. Visit scc.virginia.gov/pages/Balance- Billing-Protection for more information about your rights under Virginia law.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

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

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

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

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

In the event of dispute, the provisions of the approved English version of the form will control.

HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। (ান করুন **1-800-777-7902** (TTY: **711**)।

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-777-7902**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-777-7902** (TTY: **711**).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: **711**) पर कॉल करें।

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-777-7902** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (TTY: **711**).

日本語 (Japanese) 注意事項： 日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-777-7902**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-777-7902** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hólǫ́, kojį' hódíílnih **1-800-777-7902** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-777-7902** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-800-777-7902** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-777-7902** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-777-7902** (TTY: **711**).

TABLE OF CONTENTS

SECTION 1 – INTRODUCTION TO YOUR KAISER PERMANENTE HEALTH PLAN 1.1

Welcome to Kaiser Permanente 1.1
Our Commitment to Diversity and Nondiscrimination 1.1
About This Group Agreement 1.1
How Your Health Plan Works 1.2
Kaiser Permanente Signature[SM] 1.3
Eligibility for This Plan 1.3
Disabled Dependent Certification 1.4
Rights and Responsibilities of Members: Our Commitment to Each Other 1.5
Payment of Premium 1.7
Payment of Copayments, Coinsurances and Deductibles 1.7
Open Enrollment 1.8
Enrollment Period and Effective Date of Coverage 1.8
Genetic Testing 1.10

SECTION 2 – HOW TO GET THE CARE YOU NEED 2.1

Making and Cancelling Appointments and Who to Contact 2.1
Advance Directives to Direct Your Care While Incapacitated 2.2
Using Your Kaiser Permanente Identification Card 2.2
Choosing Your Primary Care Plan Physician 2.3
Getting a Referral 2.3
Continuity of Care 2.5
Getting Emergency and Urgent Care Services 2.5
Hospital Admissions 2.6
Getting Assistance from Our Advice Nurses 2.6
Getting a Second Opinion 2.6
Receiving Care in Another Kaiser Foundation Health Plan Service Area 2.6
Payment Toward Your Cost Share and When You May Be Billed 2.7

SECTION 3 – BENEFITS, EXCLUSIONS AND LIMITATIONS 3.1

Your Benefits 3.1
List of Benefits 3.2
Exclusions 3.32
Limitations 3.34

SECTION 4 – COORDINATION OF BENEFITS 4.1

Coordination of Benefits 4.1
Order of Benefit Determination Rules 4.1
Military Service 4.3
Medicare and TRICARE Benefits 4.3
Workers' Compensation or Employer's Liability 4.3

SECTION 5 – FILING CLAIMS, APPEALS AND GRIEVANCES 5.1

Getting Assistance 5.1
Who to Contact 5.1
Procedure for Filing a Claim and Initial Claim Decisions 5.1
Pre-Service Claims 5.2
Concurrent Care Claims 5.3
Post-Service Claims 5.4
Reconsideration of an Adverse Decision 5.5
Appeals of Claim Decisions 5.5
Bureau of Insurance Independent External Appeals 5.9
Office of the Managed Care Ombudsman 5.10
The Office of Licensure and Certification 5.10
Customer Satisfaction Procedure 5.10

SECTION 6 – TERMINATION OF MEMBERSHIP 6.1

Termination of Membership 6.1
Extension of Benefits 6.2
Continuation of Coverage 6.3
Continuation of Group Coverage Under Federal Law 6.4
Coverage Available on Termination 6.4

SECTION 7 – OTHER IMPORTANT PROVISIONS OF YOUR PLAN 7.1

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

APPENDICES DEF.1

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

SECTION 1: Introduction to Your Kaiser Permanente Health Plan

Welcome to Kaiser Permanente

This health benefit Plan is offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (further referred to as "Health Plan," "we," "us," "our" and "Kaiser Permanente." throughout this Agreement). Kaiser Permanente provides you with many resources to support your health and wellbeing. This Membership Agreement and Evidence of Coverage (EOC) is one of them. It provides you with an overview of your Health Plan, including the benefits you are entitled to, how to get care, what services are covered and what part of the costs of your care you will have to pay.

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

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

Thank you for enrolling with Kaiser Permanente. We look forward to the opportunity to help you live a happier, healthier life!

Our Commitment to Diversity and Nondiscrimination

Diversity, inclusion and culturally competent medical care are defining characteristics of Kaiser Permanente. We champion the cause of inclusive care – care that is respectful of, and sensitive to the unique values, ideals and traditions of the cultures represented in our population. Our diverse workforce reflects the diversity of the people in the communities we serve.

We do not discriminate in our employment practices or the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, gender identity, status as a transgender individual, or physical, developmental or intellectual disability.

About This Group Agreement

Once you are enrolled under this Group Agreement, you become a Member. A Member may be a Subscriber and/or any eligible Dependents, once properly enrolled. Members are sometimes referred to by the terms "you" and "your."

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

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

Important Terms

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

Entire Contract

This EOC, including the large Group Agreement and any attached applications, riders and amendments, constitutes the entire contract between your Group and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. No portion of the charter or bylaws of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., shall constitute part of this contract unless it is set forth in full in the contract.

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

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

Purpose of this Group Agreement and EOC

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

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

Administration of this Group Agreement and EOC

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

Group Agreement and EOC Binding on All Members

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

Amendment of Group Agreement and EOC

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

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

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

No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, nor impair our right thereafter to require your strict performance of any provision.

How Your Health Plan Works

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

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

Relations Among Parties Affected By This Group Agreement and EOC

Kaiser Permanente is comprised of three entities: the Health Plan, Medical Group and Plan Hospitals.
Please note that:

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

Additionally:

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

Patient Information Obtained By Affected Parties

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

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

Liability for Amounts Owed By the Health Plan

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

Kaiser Permanente Signature[SM]

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

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

1. Emergency Services, as described in ***Section 3: Benefits, Exclusions and Limitations;***
2. Urgent Care Services outside of our Service Area, as described in ***Section 3: Benefits, Exclusions and Limitations;***
3. Authorized Referrals, as described in ***Section 2: How to Get the Care You Need*** under the ***Getting a Referral*** provision, including referrals for Clinical Trials, as described in ***Section 3: Benefits, Exclusions and Limitations;***
4. Covered Services received in other Kaiser Permanente regions and Group Health Cooperative service areas; and
5. Non-emergency surgical and ancillary Services provided at a Plan Facility by a non-Plan Provider.

Eligibility for This Plan

Eligibility of a Member

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

1. Your Group's eligibility requirements that we have approved (your Group is required to inform Subscribers of the Group's eligibility requirements) and meet the Subscriber or Dependent eligibility requirements below.
2. You must work or reside inside our Service Area to be eligible for this Plan. However, you or your Spouse's eligible children who live outside our Service Area may be eligible to enroll if you are required to cover them pursuant to a Qualified Medical Child Support Order (QMCSO). A Dependent who attends school outside of our Service Area and meets the eligibility requirements listed below under ***Dependents*** is also eligible for enrollment. However, the only covered

Services outside of our Service Area are:

a. Emergency Services;

b. Urgent Care Services;

c. Services received in connection with an approved referral, unless you elect to bring the Dependent within our Service Area to receive covered Services; and

d. Approved Clinical Trials.

3. **Subscribers**

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

a. Only Full-Time Employees; or

b. Both Full-Time Employees and Part-Time Employees.

4. **Dependents**

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

a. Your lawful Spouse;

b. You or your Spouse's Dependent child who is under the age limit specified in the ***Summary of Services and Cost Share***s and who is:

i. A biological child, stepchild or foster child;

ii. A lawfully adopted child, or, from the date of placement, a child in the process of being adopted;

iii. A grandchild under testamentary or court-appointed guardianship of the Subscriber or the Subscriber's Spouse;

iv. A child for whom you or your Spouse have been granted legal custody (other than custody as a result of a guardianship); or

v. A child for whom you or your Spouse have the legal obligation to provide coverage pursuant to a child support order or other court order or court-approved agreement or testamentary appointment.

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

1. They are incapable of self-sustaining employment because of an intellectual disability or physical handicap that occurred prior to reaching the age limit for Dependents;
2. They receive 50 percent or more of their support and maintenance from you or your Spouse; and
3. You provide us proof of their intellectual disability or physical handicap and dependency within sixty (60) days after we request it, in accordance with the ***Disabled Dependent Certification*** requirements in this section.

Disabled Dependent Certification

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

1. If your Dependent is a Member and reaches the age limit specified in the ***Summary of Services and Cost Shares***, we will send you a notice of his or her membership termination due to loss of eligibility under this Plan at least ninety (90) days before the date that coverage will end. Your Dependent's membership will terminate as described in our notice unless you provide us with documentation of his or her intellectual disability or physical handicap and dependency within

sixty (60) days of your Dependent reaching the limiting age. Once proof of intellectual disability or physical handicap and dependency are received, we will make a determination as to whether he or she is eligible as a disabled Dependent. If you provide proof of intellectual disability or physical handicap and dependency to us:

a. Prior to the termination date in the notice and we do not make an eligibility determination before the termination date, the Dependent's coverage will continue until we make a determination.
b. Within the sixty (60) days following the Dependent reaching the limiting age and we determine that your Dependent is eligible as a disabled Dependent, then there will be no lapse in coverage.

2. If we determine that your Dependent does not meet the eligibility requirements as a disabled Dependent, we will notify you that he or she is not eligible and advise you of the child's membership termination date.

3. Beginning two (2) years after your Dependent reaches the limiting age you are required to provide us with proof of his or her continued intellectual disability or physical handicap and dependency annually. Proof must be received within sixty (60) days of our request. Once received, we will determine whether he or she remains eligible as a disabled Dependent. We reserve the right to request proof of your Dependent's intellectual disability or physical handicap and dependency less frequently than once per year; however, proof still must be received within sixty (60) days of our request.

Rights and Responsibilities of Members: Our Commitment to Each Other

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

Rights of Members

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

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

medical record. We will review your request based on applicable federal and state law to determine if the requested additions are appropriate. If we approve your request, we will make the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. You or your authorized representative will be asked to provide written permission before a Member's records are released, unless otherwise permitted by law.

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

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

<u>Responsibilities of Members</u>

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

1. **Promote your own good health:**
   a. Be active in your health care and engage in healthy habits;
   b. Select a Primary Care Plan Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics, or Family Practice as your Primary Care Plan Physician. You may also choose a personal OB/GYN in addition to Primary Care Plan

Physician;

c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you;
d. Work with us to help you understand your health problems and develop mutually agreed upon treatment goals;
e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment;
f. Do your best to improve your health by following the treatment plan and instructions your Primary Care Plan Physician or health care professional recommends;
g. Schedule the health care appointments your Primary Care Plan Physician or health care professional recommends;
h. Keep scheduled appointments or cancel appointments with as much notice as possible; and
i. Inform us if you no longer live within the Plan Service Area.

2. **Know and understand your Plan and benefits:**
   a. Read about your health care benefits in this contract and become familiar with them. Call us when you have questions or concerns;
   b. Pay your Plan Premium, and bring payment with you when your visit requires a Copayment, Coinsurance or Deductible;
   c. Let us know if you have any questions, concerns, problems or suggestions;
   d. Inform us if you have any other health insurance or prescription drug coverage; and
   e. Inform any network or nonparticipating provider from whom you receive care that you are enrolled in our Plan.

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

Payment of Premium

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

Payment of Copayments, Coinsurance and Deductibles

In addition to your monthly Premium payment, you may also be required to pay a Cost Share when you receive certain covered Services. A Cost Share may consist of a Copayment, Coinsurance, Deductible or a combination of these. Copayments are due at the time you receive a Service. You will be billed for any Deductible and/or Coinsurance you owe. **Note:** You will not be charged both a Copayment and Coinsurance for the same covered Service.

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

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

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

Open Enrollment

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

1. Yourself, as a new Subscriber, along with any of your eligible Dependents; or
2. Eligible Dependents, if you are already an existing Subscriber.

Enrollment Period and Effective Date of Coverage

When the Health Plan provides its annual open enrollment period, it will begin at least thirty (30) days prior to the 1st day of the contract year. The open enrollment period will extend for a minimum of thirty (30) days. During the annual open enrollment period an eligible employee may enroll or discontinue enrollment in this health benefit plan; or change their enrollment from this health benefit plan to a different health benefit plan offered by the large Employer.

Your Group will let you know when the open enrollment period begins and ends. Your membership will be effective at 12 a.m. Eastern Time (the time at the location of the administrative office of carrier at 2101 East Jefferson Street, Rockville, Maryland 20852) on the 1st day of the contract year.

New Employees and Their Dependents

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

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

Special Enrollment

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

1. Become eligible for a special enrollment period, as described in this section; or
2. Did not enroll in any coverage through your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling at a later time. The effective date of an enrollment resulting from this provision is no later than the 1st day of the month following the date your Group receives a Health Plan-approved enrollment or change of enrollment application from the Subscriber.

Special Enrollment Due to New Dependents

You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, within thirty-one (31) days after marriage, birth, adoption or placement for adoption or foster care; or guardianship has been granted by submitting to your Group a Health Plan-approved enrollment application.

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

1. **For new Spouse**, no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber.

2. **For newborn children, the moment of birth.** If payment of additional Premium is required to provide coverage for the newborn child then, in order for coverage to continue beyond thirty-one (31) days from the date of birth, notification of birth and payment of additional Premium must be provided within thirty-one (31) days of the date of birth, otherwise coverage for the newborn will terminate thirty-one (31) days from the date of birth.
3. **For newly adopted children, the date of adoptive or parental placement with a Subscriber or Subscriber's Spouse, for the purpose of adoption.** If a child is placed with the Subscriber within thirty-one (31) days of birth, such child will be considered a newborn of the Subscriber as of the date of adoptive or parental placement.

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

   Once coverage is in effect, it will continue according to the terms of this EOC, unless the placement is disrupted prior to a final decree of adoption and the child is removed from placement with the Subscriber. In such case, coverage will terminate on the date the child is removed from placement.
4. **For children who are newly eligible for coverage as the result of foster care placement or guardianship granted by court or testamentary appointment, the date of court or testamentary appointment.** If payment of addition Premium is required to provide coverage for the child, notification of the court or testamentary appointment may be provided at any time but, payment of Premium must be provided within thirty-one (31) days of the enrollment of the child, otherwise, enrollment of the child terminates thirty-one (31) days from the date of court or testamentary appointment.

Special Enrollment Due to Court or Administrative Order

Within thirty-one (31) days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan-approved enrollment or change of enrollment application.

If the Subscriber fails to enroll a child under a court or administrative order, the child's other parent or the Department of Social Services may apply for coverage. A Dependent child enrolled under this provision may not be unenrolled unless we receive satisfactory written proof that:

1. The court or administrative order is no longer in effect; and
2. The child is or will be enrolled in comparable health coverage that will take effect not later than the effective date of termination under this EOC; or
3. Family coverage has been eliminated under this EOC.

Your Group will determine the effective date of an enrollment resulting from a court or administrative order, except that the effective date cannot be earlier than the date of the order and cannot be later than the first day of the month following the date of the order.

Special Enrollment Due to Loss of Other Coverage

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

1. Yourself, as a new Subscriber, along with any of your eligible Dependents; or
2. Eligible Dependents, if you are already an existing Subscriber, as long as the:

a. Enrolling person or at least one (1) of the Dependents had other coverage when you previously declined all coverage through your Group, and
b. Loss of the other coverage is due to:
   i. Exhaustion of COBRA coverage;
   ii. Termination of employer contributions for non-COBRA coverage;
   iii. Loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (non-group) plan for nonpayment.
      a) For example, this loss of eligibility may be due to legal separation or divorce, reaching the age limit for dependent children, death, termination of employment or reduction in hours of employment;
   iv. Loss of eligibility for Medicaid coverage or Child Health Insurance Program (CHIP) coverage, but not termination for cause; or
   v. Reaching a lifetime maximum on all benefits.

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

To request enrollment, the Subscriber must submit a Health Plan-approved enrollment or change of enrollment application to your Group within thirty-one (31) days after loss of other coverage, except that the timeframe for submitting the application is sixty (60) days if you are requesting enrollment due to loss of eligibility for Medicaid or CHIP coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the 1st day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

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

The effective date of an enrollment resulting from eligibility for the premium assistance under Medicaid or CHIP is no later than the 1st day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special Enrollment Due to Reemployment After Military Service
If you terminated your health care coverage because you were called to active duty military service, you may be able to be reenrolled in your Group's health Plan, if required by state or federal law. Please ask your Group for more information.

Genetic Testing

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

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

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

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

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

SECTION 2: How to Get the Care You Need

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

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

1. Emergency Services, as described in ***Section 3: Benefits, Exclusions and Limitations;***
2. Urgent Care Services outside of our Service Area, as described in ***Section 3: Benefits, Exclusions and Limitations;***
3. ***Continuity of Care***, as described in this section;
4. Approved Referrals, as described in this section under the ***Getting a Referral***, including referrals for Clinical Trials as described in ***Section 3: Benefits, Exclusions and Limitations;***
5. Covered Services received in other Kaiser Permanente regions and Group Health Cooperative service areas; and
6. Non-emergency surgical and ancillary Services provided at a Plan Facility by a non-Plan Provider.

Making and Cancelling Appointments and Who to Contact

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

Medical Emergencies

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

Medical Advice

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

Making or Canceling Appointments

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

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

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

Choosing or Changing Your Primary Care Plan Physician

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

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

You may also choose or change your Primary Care Plan Physician by phone by contacting Member

Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Customer Service:

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

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

Advance Directives to Direct Your Care While Incapacitated

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

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

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

Using Your Kaiser Permanente Identification Card

Digital Kaiser Permanente Identification Card

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

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

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

Using Your Kaiser Permanente Identification Card

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

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

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

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

Choosing Your Primary Care Plan Physician

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

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

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

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

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

Getting a Referral

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

If your Plan Provider decides that you require covered Services not available from us, he or she will refer you to a non-Plan Provider inside or outside our Service Area. You must have an approved referral to the non-Plan Provider in order for us to cover the Services.

Copayments or Coinsurance for approved referral Services provided by a non-Plan Provider are the same as those required for Services provided by a Plan Provider. **Note:** You will not be charged both a Copayment and Coinsurance for the same covered Service. When prior authorization is the responsibility of an in-network provider, any reduction or denial of benefits will not affect the enrollee.

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

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

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

Services that Do Not Require a Referral

There are specific Services that do not require a referral.

However, you must obtain the care from a Plan Provider. These Services include the following:

1. An initial consultation for treatment of mental illness, emotional disorders, and drug or alcohol misuse when provided by a Plan Provider. For continued treatment, you or your Plan Provider must contact the Behavioral Health Access Unit for assistance to arrange and schedule these covered Services. The Behavioral Health Access Unit may be reached at 1-866-530-8778;
2. OB/GYN Services provided by an OB/GYN, a certified nurse-midwife or any other Plan Provider authorized to provide OB/GYN Services, if the care is Medically Necessary, including routine care and the ordering of related, covered obstetrical and gynecological Services. A female Dependent age thirteen (13) years or older can receive direct access to Services from a participating obstetrician-gynecologist that is authorized to provide Services under this Agreement and is selected by the Dependent; and
3. Optometry Services.

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

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

Standing Referrals to Specialists

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

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

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

Referrals to Non-Plan Specialists and Non-Physician Specialists

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

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

You must have an approved referral to the non-Plan Specialist or Non-Physician Specialist in order for us to cover the Services. The Cost Share amounts for approved referral Services provided by non-Plan Providers are the same as those required for Services provided by a Plan Provider.

Under Virginia law, a non-Plan Provider shall not balance bill for (i) emergency Services or (ii) non-emergency Services provided at a Plan Facility if the non-emergency Services involve surgical or

ancillary Services provided by a non-Plan Provider.

If you are balance billed by a non-Plan physician or other non-Plan provider for authorized 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.***

Post-Referral Services Not Covered

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

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

Prior Authorization for Prescription Drugs

Requests for covered outpatient prescription drugs may be subject to certain utilization management protocols, such as prior authorization or step therapy.

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

To find out if a prescription drug is subject to prior authorization or step-therapy requirements, please see ***Drugs, Supplies and Supplements*** in ***Section 3 – Benefits, Exclusions and Limitations*** or the ***Benefits*** section of the ***Outpatient Prescription Drug Rider***, if applicable.

Continuity of Care

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

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

1. Has entered at least the 2nd trimester of pregnancy at the time of the provider's termination, except when terminated for cause. Such treatment may continue, at the Member's option, through the provision of postpartum care; or
2. Is determined to be terminally ill at the time of the Plan Provider's termination, except when terminated for cause. Such treatment may continue, at the Member's option, for the remainder of the Member's life.

Getting Emergency and Urgent Care Services

Emergency Services

Emergency Services are covered no matter when or where in the world they occur.

If you think you have a medical emergency, call 911, where available, or go to the nearest emergency room. For coverage information in the event of a medical emergency, including emergency benefits away from home, refer to ***Emergency Services*** in ***Section 3: Benefits, Exclusions and Limitations.***

Emergency Services are available from Plan Hospital emergency departments, which are open 24/7.

Emergency Services, with respect to an Emergency Medical Condition, means:

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, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and,
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under the Emergency Medical Treatment and Active Labor Act.

Urgent Care Services

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

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

Bills for Emergency and Urgent Care Services

If you are balance billed by a hospital, urgent care center, freestanding emergency department, physician or ancillary provider for Emergency or 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.***

Hospital Admissions

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

Getting Assistance from Our Advice Nurses

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

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

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

Getting a Second Opinion

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

Receiving Care in Another Kaiser Foundation Health Plan Service Area

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

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

Payment Toward Your Cost Share and When You May Be Billed

In most cases, you will be asked to make a payment toward your Cost Share at the time you receive Services. Cost Share payments made by you or on your behalf, (including manufacturer coupons, when accepted) will apply toward your Out-of-Pocket Maximum. If you receive more than one type of Services, such as Primary Care treatment and laboratory tests, you may be required to pay separate Cost Shares for each of those Services. In some cases, your provider may not ask you to make a payment at the time you receive Services, and you may be billed for your Cost Share.

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

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

However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services, such as laboratory tests. You may be asked to pay your Cost Share for these additional diagnostic Services.

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

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

SECTION 3: Benefits, Exclusions and Limitations

Your Benefits

The benefits described in this section are covered only when:

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

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

1. Emergency Services, as described in this section;
2. Urgent Care Services outside of our Service Area, as described in this section;
3. Continuity of Care for New Members, as described in ***Section 2: How to Get the Care You Need***;
4. Approved referrals, as described under ***Getting a Referral*** in ***Section 2: How to Get the Care You Need***, including referrals for clinical trials as described in this section.
5. Non-emergency surgical and ancillary Services provided at a Plan Facility by a non-Plan Provider.

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

For authorized Services provided within our Service Area by a Plan Provider or a non-Plan Provider, you will not incur any additional cost sharing beyond that which is indicated in your Summary of Cost Shares.

If you are balance billed by a hospital, freestanding emergency department, urgent care center, physician or ancillary provider for covered 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.***

This Agreement does not pay for all health care services, even if they are Medically Necessary. Your right to benefits is limited to the covered Services contained within this contract. To view your benefits,

see the ***List of Benefits*** in this section.

List of Benefits

The following benefits are covered by the Health Plan. Benefits are listed alphabetically for your convenience. Some benefits are subject to benefit-specific limitations and/or exclusions, which are listed, when applicable, directly below each benefit. A broader list of exclusions that apply to all benefits, regardless of whether they are Medically Necessary, is provided under ***Exclusions*** in this section.

Accidental Dental Injury Services

We cover Medically Necessary dental Services as a result of accidental injury, regardless of the date of such injury. Coverage is provided when all of the following conditions have been satisfied:

1. A Plan Provider provides the restorative dental Services.
2. The injury occurred as the result of an external force that is defined as violent contact with an external object, not force incurred while chewing.
3. The covered Services must be requested within sixty (60) days of the injury, for injuries occurring on or after the effective date of coverage.

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

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

Benefit-Specific Exclusion:

1. Services provided by non-Plan Providers.

Allergy Services

We cover the following allergy Services:

1. Evaluations and treatment; and
2. Injections and serum.

Ambulance Services

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

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

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

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

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

We cover licensed ambulance and ambulette (non-emergent transportation) Services ordered by a Plan Provider only inside our Service Area, except as covered under ***Emergency Services***.

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

Benefit-Specific Exclusions:

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

Anesthesia for Dental Services

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

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

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

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

Benefit-Specific Exclusions:

1. The dentist or Specialist’s dental Services.

Autism Spectrum Disorder (ASD)

We cover Services for the diagnosis and treatment of Autism Spectrum Disorder (ASD) for Members of any age. Autism Spectrum Disorder (ASD) means any pervasive developmental disorder, including:

1. Autistic disorder;
2. Asperger’s Syndrome;
3. Rett Syndrome;
4. Childhood disintegrative disorder; or
5. Pervasive Developmental Disorder – Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

For the purposes of this benefit, diagnosis of ASD means Medically Necessary assessments, evaluations, or tests to diagnose whether an individual has ASD. The diagnosis of ASD shall be made by a Plan Provider or a licensed psychologist who determines the care, including behavioral health treatments and therapeutic care, to be Medically Necessary.

Treatment for ASD shall be identified in a treatment plan and include the following care prescribed or ordered for an individual diagnosed with ASD by a Plan Provider who determines the care to be Medically Necessary:

1. Behavioral health treatment;
2. Pharmacy care;
3. Psychiatric care;
4. Psychological care;
5. Therapeutic care; and
6. Applied Behavior Analysis (ABA), when provided or supervised by a board-certified behavior analyst licensed by the Virginia Board of Medicine.

Applied Behavior Analysis (ABA) is 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. The prescribing practitioner shall be independent of the provider of applied behavior analysis.

A treatment plan means a plan for the treatment of ASD developed by a Plan Provider pursuant to a comprehensive evaluation or re-evaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

Blood, Blood Products and their Administration

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

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

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

Benefit-Specific Limitation:

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

Benefit-Specific Exclusion:

1. Directed blood donations.

Chemical Dependency and Mental Health Services

We cover the treatment of mental illnesses including, but not limited to, Biologically Based Mental Illness, emotional disorders, and Drug and Alcohol Misuse.

For the purposes of this benefit provision:

1. Drug and Alcohol Misuse means a disease that is characterized by a pattern of pathological use of a drug and/or alcohol with repeated attempts to control its use and with significant negative consequences in at least one the following areas of life: medical, legal, financial or psycho-social;
2. Biologically Based Mental Illness means any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's ability to function. Specifically, the following diagnoses are defined as Biologically Based Mental Illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and

drug and alcoholism addiction.

While you are hospitalized, we cover all medical Services of physicians and other health professionals as performed, prescribed or directed by a Physician including:

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

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

We cover Medically Necessary treatment in a licensed or certified residential treatment center.

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

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

1. Evaluations;
2. Crisis intervention;
3. Individual therapy;
4. Group therapy;
5. Psychological testing;
6. Medical treatment for withdrawal symptoms; and
7. Visits for the purpose of monitoring drug therapy.

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

Benefit-Specific Exclusions:

1. Services in a facility whose primary purpose is to provide treatment for alcoholism, drug misuse, or drug addiction, except as described above.
2. Services provided in a psychiatric residential treatment facility, except as described above.
3. Services for Members who, in the opinion of the Plan Provider, are seeking Services for non-therapeutic purposes.
4. Psychological testing for ability, aptitude, intelligence or interest.
5. Services on court order or as a condition of parole or probation, unless determined by the Plan Provider to be necessary and appropriate.
6. Evaluations that are primarily for legal or administrative purposes, and are not medically indicated.

Cleft Lip, Cleft Palate or Ectodermal Dysplasia

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

Clinical Trials

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

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

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

1. The Services would be covered if they were not related to a clinical trial;
2. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   a. A Plan Provider makes this determination;
   b. You provide us with medical and scientific information establishing this determination;
3. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside of the state in which you live;
4. The clinical trial is a phase I, phase II, phase III or phase IV clinical trial related to the prevention, detection or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
   a. The study or investigation is conducted under an investigational new drug application reviewed by the FDA;
   b. The study or investigation is a drug trial that is exempt from having an investigational new drug application;
   c. An institutional review board of an institution in the state which has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the National Institutes of Health; or
   d. The study or investigation is approved or funded by at least one (1) of the following:
      i. The National Institutes of Health;
      ii. The Centers for Disease Control and Prevention;
      iii. The Agency for Health Care Research and Quality;
      iv. The Centers for Medicare & Medicaid Services;
      v. A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs;
      vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
      vii. The Department of Veterans Affairs, Department of Defense or the Department of Energy; but only if the study or investigation has been reviewed and approved though a

system of peer review that the United States Secretary of Health and Human Services determines meets all of the following requirements:

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

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

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

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

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

Benefit-Specific Exclusions:

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

Diabetic Equipment, Supplies, and Self-Management Training

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

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

Note: Insulin is covered under the ***Outpatient Prescription Drug Rider*** attached to this EOC, if applicable. If the Outpatient Prescription Drug Rider does not apply, insulin is covered under this benefit.

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

Benefit-Specific Limitations:

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

1. Was prescribed by a Plan Provider; and
2. There is no equivalent preferred equipment or supply available, or an equivalent preferred equipment or supply has been ineffective in treating the disease or condition of the Member or has caused or is likely to cause an adverse reaction or other harm to the Member.

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

Dialysis

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

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

We cover the following renal dialysis Services:

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

We cover the following self-dialysis Services:

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

We cover home dialysis, which includes:

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

Members requiring dialysis outside of the Service Area for a limited time period may receive pre-planned dialysis Services in accordance to prior authorization requirements.

Drugs, Supplies and Supplements

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

1. Oral, infused or injected drugs and radioactive materials used for therapeutic purposes including chemotherapy. This includes off-label use of a drug when the drug is recognized in Standard Reference Compendia or certain medical literature as appropriate in the treatment of the diagnosed condition. Standard Reference Compendia means American Hospital Formulary Service Drug Information, National Comprehensive Cancer Network's Drugs & Biologics Compendium, or Elsevier Gold Standard's Clinical Pharmacology;
2. Injectable devices;
3. The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
4. Medical and surgical supplies including dressing, splints, casts, hypodermic needles, syringes or any other Medically Necessary supplies provided at the time of treatment;
5. Vaccines and immunizations approved for use by the FDA that are not considered part of routine preventive care;

6. Any drug prescribed to treat a covered condition, even those typically used as a customary treatment for another condition, so long as the drug has been approved by the FDA and is recognized for treatment of the covered condition in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature;
7. Any drug approved by the FDA for use in the treatment of cancer, even if that drug has not been approved by the FDA for treatment of the specific type of cancer for which the drug has been prescribed, as long as the drug has been recognized as safe and effective for treatment of the member's type of cancer; and
8. 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 for a patient with intractable cancer pain.

Note: Dispensing limitations for FDA-approved prescription drugs used in the treatment of cancer pain management for patients with intractable cancer pain will be waived.

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

Certain drugs may require prior authorization or step-therapy. For more information, see ***Getting a Referral in Section 2: How to Get the Care You Need***.

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

Benefit-Specific Exclusions:

1. Drugs, supplies, and supplements which can be self-administered or do not require administration or observation by medical personnel.
2. Drugs for which a prescription is not required by law.
3. Drugs for the treatment of sexual dysfunction disorders.
4. Drugs for the treatment of infertility.
5. Contraceptive drugs, unless otherwise covered under an ***Outpatient Prescription Drug Rider*** attached to this EOC.

Durable Medical Equipment

Durable Medical Equipment is defined as equipment that:

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

Durable Medical Equipment does not include coverage for Prosthetic Devices, such as implants, artificial eyes or legs, or Orthotic Devices, such as braces or therapeutic shoes. Refer to ***Prosthetic and Orthotic Devices*** for coverage of Prosthetic Devices and Orthotic Devices.

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

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

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

<u>Supplemental Durable Medical Equipment</u>
We cover the following Durable Medical Equipment for home use as separate benefits, and as indicated below.

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

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

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

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

1. Spacers
2. Peak-flow meters
3. Nebulizers

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

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

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

Benefit-Specific Exclusions:

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

5. Devices for testing blood or other body substances, except as covered under the ***Diabetes Equipment, Supplies and Self-Management Training*** benefit.
6. Electronic monitors of the heart or lungs, except infant apnea monitors, and oximetry monitors for patients on home ventilation.
7. Services not preauthorized by the Health Plan.

Early Intervention Services

We cover Medically Necessary early intervention Services for Dependents from birth to age 3 who are certified by the Department of Behavioral Health and Developmental Services ("the Department") as eligible for Services under Part C of Individuals with Disabilities Education Act. These Services consist of:

1. Speech and language therapy;
2. Occupational therapy;
3. Physical therapy; and
4. Assistive technology Services and devices.

Early intervention Services for the population certified by the Department are those Services listed above which are determined to be medically necessary by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include services which enhance functional ability without effecting a cure. Benefits for Services listed shall not be limited by the exclusion of Services that are not Medically Necessary. The benefit maximums for physical, occupational, and speech therapy listed in ***Therapy and Multidisciplinary Rehabilitation Services*** will not apply if you get that care as part of the early intervention benefit.

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

Benefit-Specific Exclusion:

1. Care which has been provided under federal, state or local early intervention programs, including school programs, at no cost to the member.

Emergency Services

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

If you think you are experiencing an Emergency Medical Condition you should call 911 immediately. If you are not sure whether you are experiencing an Emergency Medical Condition, please contact us at the number listed on the reverse side of your ID card for immediate medical advice. You or your representative must notify the Health Plan as soon as possible, and not to exceed forty-eight (48) hours or the 1st business day, whichever is later, if you receive care at a hospital emergency room (ER) to ensure coverage. If the emergency room visit was not due to an "Emergency Medical Condition," as defined in the ***Important Terms You Should Know*** section of this EOC, and was not authorized by the Health Plan, you will be responsible for all charges.

We cover Emergency Services as follows:

Inside our Service Area

We cover emergency room surgical or ancillary Services for Emergency Services provided within our Service Area by a Plan Provider or a non-Plan Provider. You will not incur any additional cost sharing for Emergency Services beyond that which is indicated in your Summary of Cost Shares. Coverage provided by a non-Plan Provider is limited to Emergency Services required before you can, without medically harmful consequences, be transported to a Plan Hospital or your Primary Care Plan Physician's office.

Outside of our Service Area

We cover charges for Emergency Services if you are injured or become ill while temporarily outside of our Service Area but within the United States. We cover emergency room surgical or ancillary Services when received by a non-Plan Provider at a Plan Facility. You will not incur any additional cost sharing for Emergency Services beyond that which is indicated in your Summary of Services and Cost Shares.

We do not cover Services for conditions that, before leaving the Service Area, you should have known might require Services while you are away, such as 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 extreme personal emergency.

Note: Surgical or ancillary Services are professional Services including surgery, anesthesiology, pathology, radiology, or hospitalist Services and laboratory Services.

Outside the United States

If you are injured or become ill while temporarily outside the United States, we will cover charges for Emergency Services as defined in this section; subject to the same Cost Shares that would apply if the Service was provided inside our Service Area. You will not incur any additional cost sharing for Emergency Services beyond that which is indicated in your Summary of Cost Shares.

Continuing Treatment Following Emergency Services

Inside our Service Area

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

Inside another Kaiser Permanente Region

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

Outside of our Service Area

All other continuing or follow-up care for Emergency Services received outside of our Service Area must be authorized by us, until you can safely return to the Service Area.

Transport to a Service Area

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

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

Continued Care in Non-Plan Facility Limitation

If you are admitted to a non-Plan Hospital, you or someone on your behalf must notify us within the later of forty-eight (48) hours of any hospital admission, or on the 1st business day following the admission, unless it was not reasonably possible to notify us within that time. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us, of if you choose not to be transferred, we will not cover any Services you receive after transfer would have been possible.

Filing Claims for Non-Plan Emergency Services

Keep all your receipts for Emergency Services provided by non-Plan Providers and verify that the non-Plan Provider has submitted the claims. All claims must be filed with us within six (6) months of the date of the Service, or as soon as reasonably possible in order to assure payment.

Bills for Emergency Services

If you are balance billed by a hospital, freestanding emergency department, physician or ancillary provider for Emergency 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.***

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

Benefit-Specific Limitations:

1. **Notification:** If you receive care at a hospital emergency room or are admitted to a non-Plan hospital, you, or someone on your behalf, must notify us as soon as possible, but not later than forty-eight (48) hours after the emergency room visit or hospital admission, or the next business day, whichever is later, unless it was not reasonably possible to notify us. If you are admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. Once your emergency condition has been stabilized, all continuing, and follow-up treatment must be authorized by us. If you do not notify us and obtain authorization for a continued hospital stay once your condition has stabilized, we will not cover the inpatient hospital charges you incur after transfer would have been possible.
2. **Continuing or Follow-up Treatment:** We do not cover continuing or follow-up treatment after Emergency Services unless authorized by the Health Plan. We cover only the out-of-Plan Emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside of our Service Area or in another Kaiser Foundation Health Plan or allied plan Service area.

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

Family Planning Services

We cover the following:

1. Women's Preventive Services (WPS), including:
   a. Patient education and contraceptive method counseling for all women of reproductive capacity;
   b. Coverage for FDA-approved contraceptive devices, hormonal contraceptive methods, and the insertion or removal of contraceptive devices, including any Medically Necessary examination associated with the use of contraceptive drugs and devices; and
   c. Female sterilization;
   Note: WPS are preventive care and are covered at no charge.
2. Family planning counseling, including pre-abortion and post-abortion counseling;
3. Male sterilization (i.e., vasectomies);
4. Voluntary termination of pregnancy is covered through the 17th week of pregnancy; and
5. Therapeutic termination of pregnancy, as permitted under applicable law, if the fetus is believed to have an incapacitating chromosomal, metabolic or anatomic defect or deformity that has been certified by a Plan Provider.

Note: We cover Services for interruption of pregnancy, limited to the following circumstances: (1) when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself; or (2) When the pregnancy is the result of an alleged act of rape or incest.

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

Hearing Services

Hearing Exams

We cover hearing tests to determine the need for hearing correction. Refer to ***Preventive Health Care Services*** for coverage of newborn hearing screenings.

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

Benefit-Specific Exclusions:

1. Tests to determine an appropriate hearing aid.
2. Hearing aids or tests to determine their efficacy; except as specifically provided in this section, or as provided under a ***Hearing Services Rider***, if applicable.

Home Health Care

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

1. Skilled nursing Services;
2. Home health aide Services;
3. Medical social Services and
4. Remote patient monitoring

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

Remote Patient Monitoring is the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

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

Home Health Visits Following Mastectomy or Removal of Testicle

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

1. One (1) home visit scheduled to occur within twenty-four (24) hours following his or her discharge; and
2. One (1) additional home visit, when prescribed by the patient's attending physician.

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

Benefit-Specific Limitation:

1. Home Health Care visits shall be limited to two (2) hours per visit. Intermittent care shall not exceed three (3) visits in one day. The visit maximum does not apply to home visits following mastectomy or testicle removal, or postpartum home visits.

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

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

Benefit-Specific Exclusions:

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

Hospice Care Services

Hospice Care Services are for terminally ill Members. If a Plan Physician diagnoses you with a

terminal illness and determines that your life expectancy is six (6) months or less, you can choose Hospice Care Services through home or inpatient care instead of traditional Services otherwise provided for your illness. We cover Hospice Care Services in the home if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

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

Hospice Care Services include the following:

1. Nursing care;
2. Physical, occupational, speech and respiratory therapy;
3. Medical social Services;
4. Home health aide Services;
5. Homemaker Services;
6. Medical supplies and appliances;
7. Palliative drugs in accord with our drug formulary guidelines;
8. Physician care;
9. General hospice inpatient Services for acute symptom management including pain management;
10. Respite Care that may be limited to five (5) consecutive days for any one inpatient stay up to four (4) times in any contract year;
11. Counseling Services for the Member and his Family Members, including dietary counseling for the Member; and bereavement counseling for the Member's Family Members, for a period of one (1) year after the Member's death; and
12. Services of hospice volunteers.

Definitions:

1. **Family Member** means a relative by blood, marriage or adoption who lives with or regularly participates in the care of the terminally ill Member.
2. **Hospice Care** means a coordinated, interdisciplinary program of hospice care Services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health Services through home or inpatient care during the illness and bereavement counseling following the death of the Member.
3. **Respite Care** means temporary care provided to the terminally ill Member to relieve the Member's Caregiver from the daily care of the Member.
4. **Caregiver** means an individual primarily responsible for the day to day care of the Member during the period in which the Member receives Hospice Services.

Hospital Inpatient Care

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

1. Room and board (includes bed, meals and special diets), including private room when deemed Medically Necessary;
2. Specialized care and critical care units;
3. General and special nursing care;
4. Operating and recovery room;
5. Plan Physicians' and surgeons' Services, including consultation and treatment by Specialists;
6. Anesthesia, including Services of an anesthesiologist;

7. Medical supplies;
8. Chemotherapy and radiation therapy;
9. Respiratory therapy; and
10. Medical social Services and discharge planning.

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

Minimum Stay for Hysterectomy

We cover a minimum stay in a hospital of not less than 23 hours laparoscopy-assisted vaginal hysterectomy; and a minimum stay in a hospital of not less than 48 hours coverage for a vaginal hysterectomy including as provided in this section. A shorter period of hospital stay may be determined appropriate between you and your physician.

Minimum Stay for Mastectomy

We cover a minimum hospital stay of no less than forty-eight (48) hours following a radical or modified radical mastectomy and no less than twenty-four (24) hours following a total or partial mastectomy with lymph node dissection.

Infertility Services

We cover the following:

1. Services for diagnosis and treatment of involuntary infertility for females and males; and
2. Artificial insemination.

Notes:

1. Involuntary infertility means the inability to conceive after one (1) year of unprotected vaginal intercourse.
2. Diagnostic procedures and any covered drugs administered by or under the direct supervision of a Plan Provider are covered under this provision. Refer to the ***Outpatient Prescription Drug Rider***, if applicable, for coverage of outpatient infertility drugs.

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

Benefit-Specific Exclusions:

1. Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member's eggs and/or male Member's sperm for future attempts.
2. With the exception of those seeking artificial insemination, assisted reproductive procedures and any related testing or Service that includes the use of donor sperm, donor eggs or donor embryos.
3. Any charges associated with obtaining donor eggs, donor sperm or donor embryos.
4. 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.
5. Services not preauthorized by the Health Plan.
6. Services to reverse voluntary, surgically induced infertility.
7. Infertility Services when the infertility is the result of an elective male or female surgical procedure.
8. Assisted reproductive technologies and procedures, including, but not limited to: in vitro fertilization (IVF); gamete intrafallopian transfers (GIFT); zygote intrafallopian transfers (ZIFT); assisted hatching; and prescription drugs related to such procedures.

Maternity Services

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

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

"Non-routine obstetrical care" includes:

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

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

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

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

Note: Prior authorization is not required for the interhospital transfer of a newborn infant experiencing a life-threatening emergency condition or for the hospitalized mother of such newborn infant to accompany that infant.

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

Benefit-Specific Exclusions:

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

Medical Foods

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

Medical foods are intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and are formulated to be consumed under the direction of a Plan Provider.

Low protein modified foods are food products that are:

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

We cover medical equipment and supplies and Services that are required to administer the covered formulas or enteral products.

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

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

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

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

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

Benefit-Specific Exclusions:

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

Medical Nutrition Therapy and Counseling

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

1. Nutritional history;
2. Current dietary intake;
3. Medication use; or
4. Chronic illness or condition.

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

Morbid Obesity Services

We cover diagnosis and treatment of morbid obesity, including gastric bypass surgery or other surgical method, that is:

1. Recognized by the NIH as effective for long-term reversal of morbid obesity; and
2. Consistent with criteria approved by the NIH.

Morbid obesity is defined as:

1. A weight that is at least one-hundred (100) pounds over or twice the ideal weight for a patient's frame, age, height and gender, as specified in the 1983 Metropolitan Life Insurance tables; or
2. A Body Mass Index (BMI) that is equal to or greater than thirty-five (35) kilograms per meter squared with a comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary condition, sleep apnea or diabetes; or

3. A BMI of forty (40) kilograms per meter squared without such comorbidity.

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

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

Benefit-Specific Exclusion:

1. Services not preauthorized by the Health Plan.

Oral Surgery

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

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

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

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

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

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

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

<u>Temporomandibular Joint Services</u>

Coverage is provided for:

1. Orthognathic surgery, including inpatient and outpatient surgery to correct temporomandibular joint (TMJ) pain dysfunction syndrome and craniomandibular joint services, that are required because of a medical condition or injury that prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part; and
2. Removable appliances for TMJ repositioning; and
3. Therapeutic injections for TMJ.

The Health Plan provides coverage for cleft lip, cleft palate and ectodermal dysplasia under a separate benefit. Please see ***Cleft Lip, Cleft Palate or Ectodermal Dysplasia.***

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

Benefit-Specific Exclusions:

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

3. Orthodontic Services.
4. Dental appliances.

Outpatient Care

We cover the following outpatient care:

1. Primary Care visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics/gynecology (OB/GYN) Services. (Refer to ***Preventive Health Care Services*** for coverage of preventive care Services);
2. Specialty care visits (Refer to ***Section 2: How to Get the Care You Need*** for information about referrals to Plan Specialists);
3. Consultations and immunizations for foreign travel;
4. Diagnostic testing for care or treatment of an illness, or to screen for a disease for which you have been determined to be at high risk for contracting, including, but not limited to:
   a. Diagnostic examinations, including digital rectal exams and prostate antigen (PSA) tests provided in accordance with American Cancer Society guidelines to:
      i. Persons age 50 or older and
      ii. Persons age 40 or older who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society;
   b. Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations. Your initial screening colonoscopy will be preventive;
   c. Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A "qualified individual" means an individual:
      i. Who is estrogen deficient individual at clinical risk for osteoporosis;
      ii. With a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
      iii. Receiving long-term glucocorticoid (steroid) therapy;
      iv. With primary hyperparathyroidism; or
      v. Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;
5. Outpatient surgery;
6. Anesthesia, including Services of an anesthesiologist;
7. Chemotherapy and radiation therapy;
8. Respiratory therapy;
9. Medical social Services;
10. House calls when care can best be provided in your home as determined by a Plan Provider;
11. After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to ***Urgent Care*** for covered Services.

Refer to ***Preventive Health Care Services*** for coverage of preventive care tests and screening Services.

Additional outpatient Services are covered, but only as specifically described in this section, and

subject to all the limits and exclusions for that Service.

Preventive Health Care Services

In addition to any other preventive benefits described in the group contract or certificate, the Health Plan shall cover the following preventive Services and shall not impose any cost-sharing requirements, such as Deductibles, Copayment amounts or Coinsurance amounts to any Member receiving any of the following benefits for Services from Plan Providers:

1. Evidenced-based items or Services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009. (To see an updated list of the "A" or "B" rated USPSTF Services, visit: **www.uspreventiveServicestaskforce.org**);
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. (Visit the Advisory Committee on Immunization Practices at: **http://www.cdc.gov/vaccines/acip/index.html**);
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. (Visit HRSA at: **http://mchb.hrsa.gov**); and
4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (Visit HRSA at **http://mchb.hrsa.gov**), except for those Services excluded in ***Exclusions***.

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

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

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

1. Preventive care exams, including:
   a. Routine physical examinations and health screening tests appropriate to your age and sex;
   b. Well-woman examinations; and
   c. Well childcare examinations;
2. Routine and necessary immunizations (travel immunizations are not preventive and are covered under ***Outpatient Care***) for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;
3. An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
4. Low dose screening mammograms to determine the presence of breast disease is covered as follows:
   a. One mammogram for persons age 35 through 39;
   b. One mammogram biennially for persons age 40 through 49; and
   c. One mammogram annually for person 50 or older;