guide to

YOUR 2025 BENEFITS AND SERVICES

kaiserpermanente.org

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

GROUP
EVIDENCE OF COVERAGE

MARYLAND

SIGNATURE CARE DELIVERY SYSTEM

ACCREDITED NCQA HEALTH PLAN ACCREDITED ★★★★★

See 2025 NCQA Guide for more information on accreditation

KAISER PERMANENTE®

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

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

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

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

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

The basic protections provided by the Corporation are:

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

- $500,000 in aggregate for basic hospital, medical, and surgical insurance, or major medical insurance

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

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

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

or

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

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

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You're protected from balance billing for:

Emergency services

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

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

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

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, or when an in-

network provider is not available. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

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

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

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

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

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

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

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

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate 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, 4000 Garden City Dr., Hyattsville, MD 20785, telephone number: 1-800-777-7902.

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

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

لعربية (Arabic) ملحوظة: إذا كنت تتحدث اللغة العربية فإن خدمات المساعدة اللغوية متوفرة لك مجانا. اتصل برقم **1-800-777-7902** (TTY: **711**).

Ɓaŝɔ́ɔ̀ 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 bɛ́ìn m̀ gbo kpáa. Ɖá **1-800-777-7902** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন 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 می‌کنید تسهیلات زبانی رایگان برای شما مهیا می‌باشد. 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) સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક 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'dęę', t'áá jiik'eh, éí ná hóló, 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 آپکو 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

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

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

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

Kaiser Permanente Signature[SM]

Kaiser Permanente Signature[SM] provides health care benefits to Members using Plan Providers located in our Plan Medical Centers and through affiliated Plan Providers located throughout our Service Area, which is described in the "Definitions" section of this EOC.

To make your health care easily accessible, Health Plan provides conveniently located Plan Medical Centers and medical offices throughout the Washington and Baltimore metropolitan areas. We have placed an integrated team of specialists, nurses, and technicians alongside our physicians, all working together at our state-of-the-art Plan Medical Centers. In addition, we have added pharmacy, optical, laboratory, and X-ray facilities at most of our Plan Medical Centers.

You must receive care from Plan Providers within our Service Area, except for:
1. Emergency Services, as described in Section 3 – Benefits;
2. Urgent Care Services received outside our Service Area, as described in Section 3 – Benefits;
3. Authorized referrals, as described under "Getting a Referral" in Section 2 – How to Obtain Services;
4. Covered Services received in other Kaiser Permanente Regions or Group Health Cooperative Service Areas, as described in Section 2 – How to Obtain Services;
5. Clinical Trials, as described in Section 3 – Benefits; and
6. Continuity of Care, as described in Section 2 – How to Obtain Services

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

Who Is Eligible

General

To be eligible to enroll and to remain enrolled, you must meet the following requirements:
1. You must meet your Group's approved eligibility requirements (your Group is required to inform Subscribers of the Group's eligibility requirements) and meet the Subscriber or Dependent eligibility requirements below; and
2. You must live or work in our Service Area (our Service Area is described in the "Definitions" section).

   However, you or your Spouse's eligible children who live outside our Service Area are eligible for coverage for certain limited services. Specifically, coverage is limited to Emergency Services, Urgent Care Services, and Clinical Trials provided outside of our Service Area, and Services received in connection with an approved referral, unless you elect to bring the Dependent within our Service Area to receive covered Services from Plan Providers.

Subscribers

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

in those requirements).

Dependents

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

1. Your Spouse. A Spouse must be lawfully married to the Subscriber as recognized by the laws of the State of Maryland or in a jurisdiction where such marriage is legal;
2. Your Domestic Partner;
3. Your, your Spouse's, or your Domestic Partner's child who is under the age limit specified on the Summary of Services and Cost Shares section, including:
    a. a biological child;
    b. a stepchild;
    c. an adopted child from the earlier of (a) a judicial decree of adoption; or (b) the assumption of custody of a prospective adoptive child, pending adoption;
4. A grandchild of the Subscriber, Subscriber's Spouse, or Subscriber's Domestic Partner (a step-grandchild) or other dependent child relative who:
    a. are under the age limit specified on the Summary of Services and Cost Shares section;
    b. is unmarried;
    c. resides with the Subscriber; and
    d. is the dependent of the Subscriber**;** and
5. A legal ward of the Subscriber, Subscriber's Spouse, or Subscriber's Domestic Partner who:
    a. is unmarried;
    b. is under the testamentary or court-appointed guardianship, other than temporary guardianship of less than 12 months' duration;
    c. resides with the Subscriber;
    d. is a dependent of the Subscriber; and
    e. are under the age limit specified on the Summary of Services and Cost Shares section.

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

1. They are incapable of self-sustaining employment because of a mental or physical incapacity that occurred prior to reaching the age limit for Dependents;
2. They are chiefly dependent of their support from you, your Spouse, or other covered member; and
3. You provide us proof of their incapacity and dependency within 60 days after they attain the age limit. (See the "Disabled Dependent Certification" section for additional eligibility requirements).

Disabled Dependent Certification

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

1. If your Dependent is incapacitated, you are required to contact your Employee Benefit Division for the necessary documentation. Please complete the documentation and return it to the Employee Benefit Division. You are required to provide the documentation within 60 days after your Dependent reaches the dependent age limit so that the Dependent's Membership is not terminated. Upon receipt of the documentation, it will be determined if the individual is eligible as a disabled Dependent. If a determination about eligibility is not made before the termination date, coverage will continue until a determination is made.
2. If we determine that your Dependent does not meet the eligibility requirements as a disabled Dependent, you will be notified that he or she is not eligible and the membership termination date.
3. If we determine that your Dependent is eligible as a disabled Dependent, there will be no lapse in coverage. Also, two years after the date that your Dependent reached the age limit, you must provide us documentation of his or her incapacity and dependency every 2 years within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled Dependent. Documentation of your Dependent's incapacity and dependency may be requested less than once every 2 years; however, such documentation must be provided within 60 days after requested.

Genetic Information

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

authorization from the Member from whom the test result or genetic information was obtained.

Enrollment and Effective Date of Coverage

Membership begins at 12:00 a.m. Eastern Time (the time at the location of the administrative office of Health Plan at 4000 Garden City Drive, Hyattsville, MD 20785) on the membership effective date. Eligible individuals may enroll as follows:

Open Enrollment

Your Group will let you know your membership effective date, as well as when the open enrollment period begins and ends.

During the open enrollment period, you may elect to enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting an approved enrollment application to your Group during the open enrollment period.

During the open enrollment period you may also voluntarily disenroll from coverage or transfer coverage between Health Plan and all other alternate health care plans available through the Group.

New Employees and Their Dependents

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting an approved enrollment application to your Group within 60 days after you become eligible (you should check with your Group to see when new employees become eligible).

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

Special Enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during Open Enrollment or you become eligible as described in this "Special Enrollment" section.

Special Enrollment Due to New Dependents

For existing Subscribers, newly born and newly adopted children/grandchildren, and individuals for whom guardianship has been newly granted by court or testamentary appointment, will be automatically covered for 31 days as described below. If additional premium is required, this coverage will not continue at the end of the 31 days unless the child is enrolled within 60 days, and the additional premium is paid.

You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, within 60 days after marriage, birth, adoption, or placement for adoption by submitting to your Group an approved enrollment application.

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

1. For new Spouse, the first day of the month following the date of marriage to the Subscriber.
2. For newborn children and grandchildren, the moment of birth. Newborn must be enrolled within 60 days of the date of birth for coverage beyond the first 31 days.
3. For children, stepchildren, grandchildren, legal ward, adopted children, or other child relative who become eligible through Subscriber's marriage, the first day of the month following the date of marriage between the Subscriber and new Spouse.
4. For newly adopted children and grandchildren (including children newly placed for adoption), the "date of adoption."

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

   If payment of additional Premium is required to provide coverage for the child, then, in order for coverage to continue beyond 31 days from the date of adoption, notification of adoption and additional Premium must be provided within 60 days of the date of adoption.

5. For an eligible grandchild, other than a newborn or newly adopted grandchild, the date the grandchild is placed in your or your Spouse's custody. An eligible grandchild must reside in the employee's home and receive sole support from the employee.

If payment of additional Premium is required to provide coverage for the child, additional Premium must be provided within 60 days of the date of the placement.

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

   If payment of additional Premium is required to provide coverage for the child, additional Premium must be provided within 60 days of the enrollment of the child.

Special Enrollment Due to Court or Administrative Order

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

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

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

If payment of additional Premium is required to provide coverage for the child, additional Premium must be provided within 60 days of the enrollment of the child. Enrollment for such child will be allowed in accordance with Section 15-405(c) of the Insurance Article, which provides for the following:

1. An insuring parent is allowed to enroll in a family member's coverage and include the child in that coverage regardless of enrollment period restrictions;
2. A non-insuring parent, child support agency, or Maryland Department of Health is allowed to apply for health insurance coverage on behalf of the child and include the child in the coverage regardless of enrollment period restrictions; and
3. Health Plan may not terminate health insurance coverage for a child eligible under this subsection unless written evidence is provided that:
   a. the court or administrative order is no longer in effect;
   b. the child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;
   c. the employer has eliminated family member's coverage for all of its employees; or
   d. the employer no longer employs the insuring parent, except if the parent elects to enroll in COBRA, coverage shall be provided for the child consistent with the employer's plan for postemployment health insurance coverage for Dependents.

If the child has health insurance coverage through an insuring parent, Health Plan will:

1. provide to the non-insuring parent membership card, claim forms, and any other information necessary for the child to obtain benefits through the health insurance coverage; and
2. process the claim forms and make appropriate payment to the non-insuring parent, healthcare provider, or Maryland Department of Health if the non-insuring parent incurs expenses for healthcare provided to the child.

Special Enrollment Due to Loss of Other Coverage

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

1. The Subscriber or at least one of the Dependents had other coverage when he or she previously declined Health Plan coverage; and
2. The loss of the other coverage is due to one of the following:
   a. exhaustion of COBRA coverage or Continuation of Coverage under Maryland law;
   b. termination of employer contributions for non-COBRA coverage; however, the special enrollment period is still applicable even if the other coverage continues because the enrolling person is paying the amounts previously paid by the employer;
   c. loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (non-group) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, reaching the age limit for dependent children, or the Subscriber's death, termination of employment, or reduction in hours of employment;

d. loss of eligibility for Medicaid coverage or Child Health Insurance Program coverage, but not termination for cause; or
e. reaching a lifetime maximum on all benefits.

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

To request enrollment, the Subscriber must submit an approved enrollment or change of enrollment application to your Group within 60 days after loss of other coverage. The effective date of an enrollment resulting from loss of other coverage will be the 1st of the month following your qualifying life change.

Special Enrollment Due to Reemployment After Military Service

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

Special Enrollment Due to Eligibility for Premium Assistance Under Medicaid or CHIP

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

Premium

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

SECTION 2 – How to Obtain Services

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

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

1. Emergency Services, in Section 3 – "Benefits";
2. Urgent Care Outside our Service Area, in Section 3 – "Benefits";
3. Getting a Referral, in this section;
4. Receiving Care in Another Kaiser Foundation Health Plan Service Area, as described in this section;
5. Clinical Trials, in Section 3 – "Benefits";
6. Continuity of Care for New Members, in this Section; and
7. Continuing Care Patients, in this section

Your Primary Care Plan Physician

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

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

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

my.kp.org/maryland

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

Inside the Washington, D.C. Metropolitan Area
1-855-839-5763
TTY 711

Outside the Washington, D.C. Metropolitan Area
1-855-839-5763
TTY 711

Our Member Services Representatives are available to assist you Monday through Friday from 7:00 a.m. until 11:00 p.m Eastern Standard Time (EST).

Continuity of Care for New Members

At the request of a new Member, or a new Member's parent, guardian, designee, or health care provider, Health Plan shall:

1. Accept a preauthorization issued by the Member's prior carrier, managed care organization, or third-party administrator; and
2. Allow a new enrollee to continue to receive health care Services being rendered by a non-Plan Provider at the time of the Members' or Member's enrollment under this Agreement.

As described below, Health Plan will accept the preauthorization and allow a new Member to continue to receive Services from a non-Plan Provider for:

1. The lesser of the course of treatment or 90 days; and
2. The duration of up to three trimesters of a pregnancy and the initial postpartum Visit.

Accepting Preauthorization for Services

Health Plan shall accept a preauthorization for the procedures, treatments, medications, or other Services covered under this Agreement. For new Member's, Health Plan will not disrupt or require reauthorization for an active

course of treatment for covered Services for at least ninety (90) days after the date of enrollment.

Services from Non-Plan Providers
Health Plan shall allow a new Member to continue to receive covered health care Services being rendered by a non-Plan Provider at the time of the Member's transition to our plan for the following conditions:
1. Acute conditions;
2. Serious chronic conditions;
3. Pregnancy;
4. Mental health conditions and substance use disorders; and
5. Any other condition on which the non-Plan Provider and Health Plan reach agreement.

Examples of acute and serious chronic conditions may include bone fractures; joint replacements; heart attack; cancer; HIV/AIDS; and organ transplants.

Transitioning to Our Services
At the end of the time period in (1) or (2) above, we may elect to perform our own review to determine the need for continued treatment, and to authorize continued Services as described below under "Getting a Referral."

Continuity of Care Limitation for Preauthorization
With respect to any benefit or Service provided through the Maryland Medical Assistance fee-for-service program, preauthorization will be accepted only for:
1. Enrollees transitioning from the Maryland Medical Assistance Program to the Health Plan.
2. Only for behavioral health and dental benefits, to the extent they are authorized by a third-party administrator.

Continuity of Care for Existing Members

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

Continuing Care Patient

A Continuing Care Patient, as defined in the ***Definitions*** section, receiving care from a Participating Provider may elect to continue to receive transitional care from such provider if the provider's Participating Provider contract is terminated or non-renewed for reasons other than for failure to meet applicable quality standards or for fraud. Health Plan will notify each Member who is a Continuing Care Patient at the time of termination or non-renewal on a timely basis of such termination and the Member's right to elect transitional care.

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

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

Getting a Referral

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

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

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

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

1. The initial consultation for treatment of mental illness, emotional disorders, or drug or alcohol abuse provided by a Plan Provider. The Behavioral Health Access Unit may be reached at 1-866-530-8778.
2. Obstetric and gynecological Services provided by an obstetrician/gynecologist, a certified nurse-midwife, or any other Plan Provider authorized to provide obstetric and gynecological Services including routine care and the ordering of related obstetrical and gynecological Services that are covered under the Agreement.
3. Optometry Services.
4. Urgent Care Services provided within our Service Area.

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

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

Standing Referrals to Specialists

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

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

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

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

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

You must have an approved written or verbal referral to the non-Plan specialist or non-Plan Non-Physician Specialist in order for us to cover the Services. 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. Copayments for approved referral Services are the same as those required for Services provided by a Plan Provider. You will not be liable for an amount that exceeds the cost sharing that would have applied if your provider was a Participating Provider. Services received for mental health or substance use disorders are provided at no greater cost to the Member than if the covered Service were provided by a provider on the Health Plan's provider panel.

Second Opinions

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

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

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

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

You will incur the same Cost Share for Emergency Services furnished by non-Plan Providers as Plan Providers and such Cost Share will be calculated based on the Allowable Charge in accordance with applicable law if your Cost Share is not a fixed amount. Any Cost Share payments made by you for Emergency Services will apply toward your in-network Annual Copayment Maximum, including the annual limitation on cost sharing.

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

Bills for Emergency Services

When you receive a bill from a hospital, physician or ancillary provider for Emergency Services that were provided to you, you should either:

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

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

If you have already paid the bill, then please send proof of payment and a copy of the bill to the address listed above. Please remember to include your medical record number on your proof. For more information on the payment or reimbursement of covered Services and how to file a claim, see "Filing for Payment/Reimbursement of a Post-Service Claim" in "Section 5 – Getting Assistance; Health Care Service Review; and the Grievance and Appeal Process".

Getting Advice from Our Advice Nurses

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

Inside the Washington, D.C. Metropolitan Area
703-359-7878
TTY 711

Outside the Washington, D.C. Metropolitan Area
1-800-777-7904
TTY 711

After office hours, call 1-800-677-1112. You can call this number from anywhere in the United States, Canada, Puerto Rico, or the Virgin Islands.

Our advice nurses are registered nurses (RNs) specially trained to help assess medical problems and provide medical

advice. They can help solve a problem over the phone and instruct you on self-care at home if appropriate. If the problem is more severe and you need an appointment, they will help you get one.

Cost-Sharing for Non-Emergency Services

When a non-participating provider provides non-Emergency Services at a Plan Hospital or a Plan Facility, your Cost Share will be the same cost sharing amount for the same Service(s) from a participating provider unless the non-participating provider has satisfied the notice and consent requirements of §149.420(c) through (i) with respect to those non-Emergency Services. Any cost sharing requirement for the items and Services will be calculated based on the Recognized Amount. Such Cost Share shall count toward your Annual Copayment Maximum. You will not be liable for any additional payment other than your Cost Share for non-Emergency Services. We will make payment for the items and Services directly to the non-participating provider. The payment amount will be equal to the amount by which the Out-of-Network Rate exceeds the cost sharing amount for the items and Services.

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

Making Appointments

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

Inside the Washington, D.C. Metropolitan Area
703-359-7878
TTY 711

Outside the Washington, D.C. Metropolitan Area
1-800-777-7904
TTY at 711

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

Using Your Identification Card

Each Member has a Health Plan ID card with a Medical Record Number on it. Use your card when you call for advice, make an appointment, or go to a Plan Provider for care. The Medical Record Number is used to identify your medical records and membership information. You should always have the same Medical Record Number. If you need to replace your card, or if we ever inadvertently issue you more than one Medical Record Number, please let us know by calling our Member Services Department in the Washington, D.C. metropolitan area at 1-855-839-5763, or in the Baltimore, Maryland metropolitan area at 1-855-839-5763. Our TTY is 711.

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

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 Copayment or Coinsurance shown in the "Summary of Services and Cost Shares" and in Section 4: Exclusions, Limitations and Reductions. For more information about receiving care in other Kaiser Foundation Health Plan service areas, including availability of Services, and provider and facility locations, please contact Member Services Department:

Inside the Washington, D.C. Metropolitan Area

1-855-839-5763
TTY 711

Outside the Washington, D.C. Metropolitan Area
1-855-839-5763

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

The following visiting Member care is covered when it is provided or arranged by a Plan Physician in the Service area you are visiting. Certain Services, such as transplant Services or infertility Services, are not covered for visiting members. Visiting member benefits may not be the same as those you receive in your home Service area.

Hospital Inpatient Care:
- Physician Services
- Room and board
- Necessary Services and supplies
- Maternity Services
- Prescription drugs

Outpatient Care:
- Office Visits
- Outpatient surgery
- Physical, speech, and occupational therapy (limited to 50 days per contract year combined for physical therapy, occupational, and speech therapy)
- Allergy tests and allergy injections
- Dialysis care

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

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

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

Substance Abuse Treatment Other Than for Emergency or Urgent Care Services:
- Outpatient Visits and inpatient hospital days.

Skilled Nursing Facility Care:
- Up to 180 days per contract year

Home Health Care:
- Home health care Services inside the visited Service Area

Hospice Care:
- Home-based hospice care inside the visited Service Area

Pre-Authorization Required for Certain Services
- Inpatient physical rehabilitation services covered in your home region may also be available to you as a visiting Member. Preauthorization from your home region is required.
- Other Services that require preauthorization in your home region may also be available to you when you are visiting another Kaiser Foundation Health Plan or Group Health Cooperative Service area, once you have obtained preauthorization from your home region.

Also, some Services require preauthorization from the region or Service Area you are visiting. Please contact Member Services in the region or Group Health Cooperative Service area you will be visiting for more information.

Visiting Member Service Exclusions

The following Services, equipment, and supplies are not covered under your visiting Member benefits. For coverage information, refer to the **Section 3: Benefits**.

1. Services not covered under your EOC;
2. Services that are not Medically Necessary;
3. Physical examinations for insurance, employment, or licensing, and any related services;
4. Drugs for the treatment of sexual dysfunction disorders;
5. Dental Services and dental X-rays (nonemergency or nonurgent dental Services/X-rays are covered under a different benefit);
6. Services to reverse voluntary infertility;
7. Infertility Services;
8. Services related to conception by artificial means, such as in vitro fertilization (IVF) and gamete intrafallopian tube transfer (GIFT);
9. Experimental Services, except for all clinical trials;
10. Cosmetic surgery or other Services performed mainly to change appearance;
11. Custodial ("at home") care and care provided in a nursing home;
12. Services related to sexual reassignment surgery and treatment;
13. Organ transplants and related Services;
14. Alternative medicine and complementary care and, such as chiropractic Services;
15. Services related to bariatric surgery and treatment; and
16. Services that are excluded or limited in your home Service Area.

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.

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

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

SECTION 3 – Benefits

The Services described in this section are covered only when:

1. You are a Member on the date the Services are rendered, except as provided for "Extension of Benefits" as described in Section 6 of this EOC;
2. You have met any requirement described in the "Copayments" section of the Summary of Services and Cost Shares Appendix;
3. You have not met the maximum benefit for the Service, if any (a maximum benefit applies per Member per contract year);
4. The Services are Medically Necessary; and
5. You receive the Services from a Plan Provider except as specifically described in this EOC.

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

1. Emergency Services;
2. Urgent Care outside our Service Area;
3. Receiving Care in Another Kaiser Foundation Health Plan Service Area, as described Section 2 – How to Obtain Services;
4. Authorized referrals to non-Plan Providers (as described in Section 2);
5. Visiting Member Services, as described in Section 2;
6. Clinical Trials;
7. Continuity of Care, as described in Section 2; and
8. Continuing Care Patients, as described in Section 2.

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

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

A. Outpatient Care

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

- Primary care Visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics and gynecology Services (refer to "Preventive Health Care Services" for coverage of preventive care Services);
- Specialty care Visits (refer to Section 2 – "How to Obtain Services," for information about referrals to Plan specialists);
- Consultations and immunizations for foreign travel;
- Diagnostic examinations, including digital rectal exams and prostate-specific antigen (PSA) tests provided:
    - for men who are between 40 and 75 years of age;
    - when used for male patients who are at high risk for prostate cancer;
    - when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; or
    - when used for staging in determining the need for a bone scan in patients with prostate cancer.
- Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiological imaging, in accordance with the latest screening guidelines issued by the American Cancer Society. Your initial screening colonoscopy will be preventive;
- Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis when the bone mass measurement is requested by a Plan Provider for a qualified individual who is:
    - an estrogen-deficient individual at clinical risk for osteoporosis;
    - an individual 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;
    - an individual receiving long-term glucocorticoid (steroid) therapy;
    - an individual with primary hyperparathyroidism; or

- an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Note: As described here, diagnostic testing is not preventive care and may include an office Visit, outpatient surgery, diagnostic imaging, or X-ray and laboratory Services. The applicable Cost Share will apply based on the place and type of Service provided. (Refer to "Preventive Health Care Services" for coverage of preventive care tests and screening Services.)

- Outpatient surgery;
- Anesthesia, including Services of an anesthesiologist;
- Chemotherapy and radiation therapy;
- Respiratory therapy;
- Medical social Services;
- House calls when care can best be provided in your home as determined by a Plan Provider;
- After-hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to the Urgent Care provision for covered Services; and
- Lymphedema Services. Refer to "Durable Medical Equipment" for covered Services.

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

B. Hospital Inpatient Care

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

- Room and board (includes bed, meals, and special diets), including private room when deemed Medically Necessary;
- Specialized care and critical care units;
- General and special nursing care;
- Operating and recovery room;
- Plan Physicians' and surgeons' Services, including consultation and treatment by specialists;
- Anesthesia, including Services of an anesthesiologist;
- Medical supplies;
- Chemotherapy and radiation therapy;
- Respiratory therapy; and
- Medical social Services and discharge planning.

Hospitalization and Home Health Visits Following Mastectomy

We cover the cost of inpatient hospitalization Services for a minimum of 48 hours following a mastectomy, which is the surgical removal of all or part of a breast as a result of breast cancer. A Member may request a shorter length of stay following a mastectomy if the Member decides, in consultation with the Member's attending physician that less time is needed for recovery.

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

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

C. Accidental Dental Injury Services

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

- The accident has been reported to your primary care Plan Physician within 72 hours of the accident.
- A Plan Provider provides the restorative dental Services.
- The injury occurred as the result of an external force that is defined as violent contact with an external object, not force incurred while chewing.

- The covered Services must begin within 60 days of the injury.
- The covered Services are provided during the 12 consecutive months commencing from the date that treatment for the injury started.

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

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

Accidental Dental Injury Services Exclusions:
- Services provided by non-Plan Providers.
- Services provided after 12 months from the date treatment for the injury commenced.
- Services for teeth that have been avulsed (knocked out) or that have been so severely damaged that in the opinion of the Plan Provider, restoration is impossible.
- An injury that results from chewing or biting is not considered an accidental injury

D. Allergy Services

We cover the following allergy Services:
- Evaluations and treatment; and
- Injection Visits and serum.

E. Ambulance Services

We cover licensed ambulance Services only if: (1) your medical condition requires either the basic life support, advanced life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer; and (2) the ambulance transportation has been ordered by a Plan Provider. Coverage is also provided for Medically Necessary transportation or Services, including Medically Necessary Air Ambulance Services 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. Cost Shares for Air Ambulance Services provided by a non-Plan Provider will not exceed that of Cost Shares for Air Ambulance Services provided by a Plan Provider and will apply toward Annual Copayment Maximum.

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 non-emergent transportation Services provided by selected transport carriers when ordered by a Plan Provider at no charge.

We will not cover emergency ambulance or non-emergent transportation Services in any other circumstances, even if no other transportation is available. We cover licensed ambulance non-emergent transportation Services ordered by a Plan Provider only inside our Service Area, except as covered under the "Emergency Services" provision in this section of the EOC.

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

F. Anesthesia for Dental Services

We cover general anesthesia and associated hospital or ambulatory facility Services for dental care provided to Members:
- Who are 7 years of age or younger or are developmentally disabled;
    - For whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition; and

  - For whom a superior result can be expected from dental care provided under general anesthesia; or
- Who are 17 years of age or younger and 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; or
- For adults age 17 and older when the Member's medical condition requires that dental Service be performed in a hospital or ambulatory surgical center for the safety of the Member (e.g., heart disease and hemophilia).

General anesthesia and associated hospital and ambulatory facility charges will be covered only for dental care that is provided by:
- A fully accredited specialist in pediatric dentistry; or
- A fully accredited specialist in oral and maxillofacial surgery; and
- For whom hospital privileges have been granted.

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

G. Blood, Blood Products, and Their Administration

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

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

Blood, Blood Products, and Their Administration Limitations:
- Member recipients must be designated at the time of procurement of cord blood.

Blood, Blood Products, and Their Administration Exclusions:
- Directed blood donations.

H. Chemical Dependency and Mental Health Services

Mental Illness, Emotional Disorders, Drug and Alcohol Misuse Services

We cover the treatment of mental illnesses, emotional disorders, drug and alcohol misuse for conditions that in the opinion of a Plan Provider would be Medically Necessary and treatable. For the purposes of this benefit provision, drug and alcohol misuse means:

1. Unlawful use of drug and/or alcohol;
2. Drug and/or Alcohol abuse; or
3. Drug and/or Alcohol dependence.

We cover inpatient Services in a licensed or certified facility or program, including hospital inpatient and a licensed or certified residential treatment center. Covered Services include all medical Services of physicians and other health professionals as performed, prescribed, or directed by a physician, including but not limited to:
- Individual therapy;
- Group therapy;
- Electroconvulsive Therapy (ECT);
- Drug therapy;
- Education;
- Psychiatric nursing care; and
- Appropriate Hospital Services.

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

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

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

- Diagnostic evaluations;
- Crisis intervention;
- Individual therapy;
- Group therapy;
- Psychological and neuropsychological testing for diagnostic purposes;
- Medical treatment for withdrawal symptoms;
- Visits for the purpose of monitoring drug therapy;
- Opioid treatment Services; and
- Professional charges for intensive outpatient treatment in a provider's office or other professional setting.

We also cover all office Visits for inpatient care, partial hospitalization, and outpatient care.

Chemical Dependency and Mental Health Services Exclusions:

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

Psychiatric Residential Crisis Services

We cover residential crisis Services that are:

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

Psychiatric Residential Crisis Services Exclusion:

- Long-term residential treatment Services

I. Chiropractic and Acupuncture Services

We cover Medically Necessary outpatient chiropractic Services in accordance with Health Plan coverage guidelines.

We cover Medically Necessary outpatient acupuncture Services for chronic pain management or chronic illness management.

J. Cleft Lip, Cleft Palate, or Both

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

K. Clinical Trials

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

- The cost of an investigational drug or device, except as provided below for off-label use of an FDA-approved drug or device;

- The cost of non–health care Services that may be required as a result of treatment in the clinical trial; or
- Costs associated with managing the research for the clinical trial.

We cover the patient costs incurred for clinical trials as a result of:

- prevention, early detection, and treatment studies on cancer or other life-threatening diseases or conditions; the treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer or any other life-threatening condition;
- the treatment is being provided in a clinical trial approved or funded, including funding through in-kind contributions, by:
  - one of the National Institutes of Health (NIH);
  - an NIH cooperative group or an NIH center;
  - the FDA in the form of an investigational new drug application, including drug trials that are exempt from having an investigational new drug application reviewed by the FDA;
  - the Federal Department of Veterans Affairs;
  - 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;
  - Centers for Disease Control and Prevention;
  - the Agency for Health Care Research and Quality;
  - the Centers for Medicare & Medicaid Services;
  - the Department of Defense;
  - a cooperative group or center for the four previously mentioned entities;
  - a cooperative group or center for the Department of Veterans Affairs;
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
  - the Department of Energy.
- 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;
- there is no clearly superior, non-investigational treatment alternative; and
- the available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.

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

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

L. Diabetic Equipment, Supplies, and Self-Management

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

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

Note: Insulin is not covered under this benefit.

Diabetic Equipment, Supplies, and Self-Management Limitation:
Diabetic equipment and supplies are limited to Health Plan preferred equipment and supplies unless the equipment

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

Inside the Washington, D.C. Metropolitan Area
1-855-839-5763
TTY 711

Outside the Washington, D.C. Metropolitan Area
1-855-839-5763
TTY 711

M. Dialysis

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

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

We cover the following renal dialysis Services:

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

Note: Inpatient dialysis is covered under the Hospital Inpatient Care benefit.

We cover the following self-dialysis Services:

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

We cover home dialysis, which includes:

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

Members traveling outside the Service Area may receive pre-planned dialysis Services for up to sixty (60)-days of travel per contract year. Prior Authorization is required.

N. 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 visits:

- Oral, infused, or injected drugs, and radioactive materials used for therapeutic purposes, including chemotherapy. This includes off-label use of a drug when the drug is recognized in standard reference compendia or certain medical literature as appropriate in the treatment of the diagnosed condition;
- Injectable devices;
- The equipment and supplies associated with the administration of infused or injected drugs, devices, or radioactive materials;
- Medical and surgical supplies, including dressing, casts, hypodermic needles, syringes, or any other Medically Necessary supplies provided at the time of treatment; and

- Vaccines and immunizations approved for use by the federal Food and Drug Administration (FDA) that are not considered part of routine preventive care.

Note: Additional Services that require administration or observation by medical personnel are covered. "Preventive Health Services" for coverage of vaccines and immunizations that are part of routine preventive care; "Allergy Services" for coverage of allergy test and treatment materials; and "Family Planning Services" for the insertion and removal of contraceptive drugs and devices.

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

Drugs, Supplies, and Supplements Exclusions:

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

O. Durable Medical Equipment

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

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

Basic Durable Medical Equipment

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

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

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

Supplemental Durable Medical Equipment

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

- **Oxygen and Equipment**

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

- **Apnea Monitors**

We cover apnea monitors for infants for a period not to exceed 6 months.

- **Asthma Equipment**

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

- Spacers;
- Peak-flow meters; and
- Nebulizers.

- **Bilirubin Lights**

We cover bilirubin lights for infants for a period not to exceed 6 months.

- Lymphedema Equipment and Supplies

We cover the diagnosis, evaluation, and treatment of lymphedema, including:

- Equipment;
- Supplies;
- Complex decongestive therapy;
- Gradient compression garments; and
- Self–management training and education.

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

Durable Medical Equipment Exclusions:

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

P. Emergency Services

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

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

We cover Emergency Services as follows:

Inside Our Service Area

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

If you are at a hospital with an emergency medical condition which has not been Stabilized, you will not be transported to a Plan Hospital or your primary care Plan Physician's office unless:

1. after being informed of the hospital's obligation to and risk of transfer, you or your Authorized Representative request in writing transfer to another medical facility;
2. your physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another

medical facility outweigh in the increased risks to the you and, in the case of labor, to your unborn child from effecting the transfer; or

3. if a physician is not physically present in the emergency department at the time you are transferred, a qualified medical person has signed a certification, as described above in item #2, after a physician, in consultation with the qualified medical person, has made the determination described in the certification and, subsequently, countersigns the certification; and
4. the transfer is an appropriate transfer, as described below, to that facility.

Note: A certification described in items #2 and #3 above shall include a summary of the risks and benefits upon which the certification is based.

An appropriate transfer to a medical facility is a transfer:

1. in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to your health and, in the case of a woman in labor, the health of the unborn child;
2. in which the receiving facility:
    a. has available space and qualified personnel to provide your treatment; and
    b. has agreed to accept your transfer and to provide appropriate medical treatment;
3. in which the transferring hospital sends to the receiving facility all medical records, related to the emergency condition for which you have presented, available at the time of the transfer, including records related to your Emergency Medical Condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification provided, as described in the "Note" above, and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary Stabilizing treatment;
4. in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer, and
5. which meets such other requirements as the Secretary of Health and Human Services may find necessary in the interest of your health and safety.

Please refer to the Summary of Services and Cost Shares Appendix for charges.

Outside Our Service Area
Coverage is provided for Emergency Services if you are injured or become ill while temporarily outside our Service Area. Please refer to the Summary of Services and Cost Shares Appendix for charges.

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

Continuing Treatment Following Emergency Services

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

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

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

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

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

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

Post-Stabilization Care

Post-Stabilization Care are Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital, including the Emergency Department, after your treating physician determines that your Emergency Medical Condition is Stabilized. Post-Stabilization Care also includes durable medical equipment covered under this EOC, if it is Medically Necessary after your discharge from a hospital and related to the same Emergency Medical Condition. For more information about durable medical equipment covered under this EOC, see the "Durable Medical Equipment" under this "Section 3 – Benefits" section and the "Summary of Cost Shares" appendix.

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

To request Prior Authorization, you, your provider, including your non-Plan Provider, or someone else acting on your behalf, must call 1-800-225-8883 or the notification telephone number on the reverse side of your ID card before you receive the care. We will discuss your condition with the non-Plan Provider. If we determine that you require Post-Stabilization Care, we will authorize your care from the non-Plan Provider or arrange to have a Plan Provider, or other designated provider, provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated non-Plan Provider provide your care, we may authorize special transportation Services that are non-Plan Providers. If you receive care from a non-Plan Provider that we have not authorized, you may have to pay the full cost of that care.

When you receive Emergency Services from non-Plan Providers, Post-Stabilization Care may qualify as Emergency Services pursuant to federal law. We will not require Prior Authorization for such Post-Stabilization Care at a non-Plan Hospital when your attending non-Plan Provider determines that, after you receive Emergency Services (screening and Stabilization), you are not able to travel using non-medical transportation or non-emergency medical transportation to an available Plan Provider located within a reasonable travel distance taking into account your medical condition. We also will not require Prior Authorization for Post-Stabilization Care received at a non-Plan Facility when you or your Authorized Representative are not in a condition to receive the information in the notice, described in 45 CFR §149.410(b)(3), and to provide informed consent.

Non-Plan Providers may provide notice and seek your consent to provide Post-Stabilization Care Services or other covered Services, as described in §149.420(c) through (g). Such Services will not be covered when you do not obtain Prior Authorization as described herein. If you, or your Authorized Representative, consent to the furnishing of Services by non-Plan Providers, then you will be responsible for paying for such Services in the absence of any Prior Authorization. The cost of such Services will not accumulate to your Annual Copayment Maximum costs.

Transport to a Service Area

If you obtain prior approval from us, or from the nearest Kaiser Foundation Health Plan Medical Center, we will cover necessary ambulance Services or other special transportation arrangements medically required to transport you to a Plan Hospital or Medical Center in our Service Area, or in the nearest Kaiser Foundation Health Plan Region, for continuing or follow-up treatment. **Note:** All ambulance transportation is covered under the "Ambulance Services" benefit in this section.

Continued Care in Non-Plan Facility Limitation

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

Filing Claims for Non-Plan Emergency Services

Keep all your receipts for Emergency Services provided by non-Plan Providers and verify that the non-Plan Provider has submitted the claims. All claims must be filed with us within 1 year of receipt of covered Services. Failure to submit such a request within 1 year of receipt of the covered services will not invalidate or reduce the amount of the

claim, if it was not reasonably possible to submit the request within the aforementioned time frame. If it is not reasonably possible to submit the claim within 1 year after the date of service, it shall be sent to us no later than 2 years from the time, proof is otherwise required. A Member's legal incapacity shall suspend the time to submit a claim. Such suspension period ends when legal capacity is regained.

Emergency Services Limitations:

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

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

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

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

Q. Family Planning Services

We cover the following:

- Women's Preventive Services (WPS), including:
  - Patient education and contraceptive method counseling for all women of reproductive capacity;
  - Coverage for FDA-approved contraceptive devices, hormonal contraceptive methods, the insertion or removal of contraceptive devices, including any Medically Necessary examination associated with the use of contraceptive drugs and devices; and
- **Note:** If a FDA approved contraceptive drug or device not on the formulary is ordered, the physician would have to provide a reason for medical necessity, in accordance with Section 15-831(c) and (d) of the Insurance Article. Reasons include: no formulary or device equivalent; formulary or device equivalent; has been ineffective in treating the disease or condition or has caused, or is likely to cause, an adverse reaction or other harm to the Member; or if the physician determines a contraceptive drug or device not on the formulary is Medically Necessary for the Member to adhere to the appropriate use of the drug or device. If the physician indicates that the non-formulary contraceptive is not Medically Necessary and administered at the Member's request, the Member may be billed for the cost of the medication. If a drug or device is added or removed from the formulary, the notice will be provided 30-days before the change is implemented.
  - Female sterilization.

Note: WPS are preventive care and are covered at no charge.

- Family planning counseling, including pre-abortion and post-abortion counseling and information on birth control.
- Male sterilization.
- Abortion care Services as permitted under Maryland state law.
- Instruction by a licensed health care provider on fertility awareness–based methods, which are methods of identifying times of fertility and infertility by an individual to avoid pregnancy, including: cervical mucous methods, sympto-thermal or sympto-hormonal methods, the standard days methods, and the lactational amenorrhea method.

Coverage of Fertility Preservation Procedures for Iatrogenic Infertility

We provide coverage for standard fertility preservation procedures that are medically necessary to preserve fertility due to a need for medical treatment that may directly or indirectly cause iatrogenic infertility.

Definitions:

- ***Iatrogenic infertility*** means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting the reproductive organs or processes.
- ***Medical treatment that may directly or indirectly cause iatrogenic infertility*** means medical treatment with a likely side effect of infertility as established by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologist, or the American Society of Clinical Oncology.
- ***Standard fertility preservation procedures*** means procedures to preserve fertility that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologist, or the American Society of Clinical Oncology. Standard fertility preservation procedures include sperm and oocyte cryopreservation and evaluations, laboratory assessments, medications, and treatments associated with sperm and oocyte cryopreservation.

Standard Fertility Preservation Procedures Exclusion:

- The storage of sperm or oocytes.

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

R. Habilitative Services

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

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

Habilitative Services Exclusions:

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

S. Hearing Services

Hearing Exams

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

Hearing Aids

We cover the following:

- Medically Necessary Hearing Aids for both children and adults. Hearing aid means a device that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by adults and children and is non-disposable.
- Hearing aid evaluations and diagnostic procedures to determine the Hearing Aid model which will best compensate for loss of hearing.
- Visits to verify that the Hearing Aid conforms to the prescription.
- Visits for fitting, counseling, adjustment, cleaning, and inspection.

Hearing Aid Limitations

- Coverage is provided for one Hearing Aid for each hearing-impaired ear every 36 months.

You are not required to obtain Hearing Aids for both ears at the same time. The 36-month benefit period extends separately for each ear, and commences at the initial point of sale for each ear.

- The type of Hearing Aid is limited to the models provided by Kaiser Permanente or the Kaiser Permanente–designated Hearing Aid vendor.

Hearing Services Exclusions:

Except as listed above for Hearing Aids, the following exclusions apply:

- Tests to determine an appropriate Hearing Aid.
- Hearing aids or tests to determine their efficacy.
- Replacement parts and batteries.
- Replacement of lost or broken Hearing Aids.
- Comfort, convenience, or luxury equipment or features.
- Hearing aids prescribed and ordered after termination of coverage.

T. Home Health Care

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

- Skilled nursing care;
- Home health aide Services; and
- Medical social Services.

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

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

Home Health Visits Following Mastectomy or Removal of Testicle

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

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

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

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

Home Health Care Limitations:

- Home Health Care visits shall be limited to 2 hours per visit. Intermittent care shall not exceed 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 hours, then each two-hour increment counts as a separate visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as 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 hours that counts as 2 visits.

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

Home Health Care Exclusions:

- Custodial care (see definition under "Exclusions" in the "Exclusions, Limitations, and Reductions" section of this EOC).
- Routine administration of oral medications, eye drops, ointments.
- General maintenance care of colostomy, ileostomy, and ureterostomy.
- Medical supplies or dressings applied by a Member or family caregiver.
- Corrective appliances, artificial aids, and orthopedic devices.
- Homemaker Services.
- Services not preauthorized by Health Plan.

- Care that a Plan Provider determines may be provided in a Plan Facility and we provide or offer to provide that care in one of these facilities.
- Transportation and delivery Service costs of Durable Medical Equipment, medications and drugs, medical supplies, and supplements to the home.

U. Hospice Care Services

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

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

- Nursing care;
- Physical, occupational, speech, and respiratory therapy;
- Medical social Services;
- Home health aide Services;
- Homemaker Services;
- Medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the terminally ill Member;
- Palliative drugs in accord with our drug formulary guidelines;
- Physician care;
- Medically Necessary 30 days of inpatient care, including care for pain management and acute symptom management;
- Respite Care for up to 14 days per contract year, limited to 5 consecutive days for any one inpatient stay;
- Counseling Services for the Member and his/her Family Members or Caregiver, including dietary counseling for the Member; and bereavement counseling for the Member's Family or Caregiver for a period of one year after the Member's death; and
- Services of hospice volunteers.

Definitions:

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

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

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

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

V. Infertility Services

We cover the following for the diagnosis and treatment of infertility including, Medically Necessary, non-Experimental/ Investigational artificial insemination /intrauterine insemination, IVF and fertility drugs administered as a part of IVF treatment, as follows:

- Artificial insemination and Intrauterine Insemination
    - We cover when:
        - For a Member whose spouse is of the opposite sex:

- The Member and the Member's spouse have a history of the inability to conceive after 1 year of unprotected vaginal intercourse and the Member's Spouse's sperm is used; and,
- The Member has had a fertility examination that resulted in a physician's recommendation advising artificial insemination or intrauterine insemination; and,
- The Member's spouse's sperm is used.

- For a Member whose Spouse is of the same sex, the Member has had a fertility examination that resulted in a physician's recommendation advising artificial insemination or intrauterine insemination.

- Benefits will not be provided for costs incurred by Member in obtaining donor sperm/eggs.

- In- Vitro Fertilization (IVF)
  - We cover when:
    - For a Member whose Spouse is of the opposite sex, the oocytes (eggs) are physically produced by the Member and fertilized with sperm physically produced by the Member's Spouse unless;
      - The Spouse is unable to produce and deliver functional sperm; and the inability to produce and deliver functional sperm does not result from:
        - A vasectomy; or
        - Another method of voluntary sterilization.
  - The Member and the Member's Spouse have a history of involuntary infertility, which may be demonstrated by a history of:
    - If the Member and the Member's spouse are of opposite sex, intercourse of at least 1 year duration failing to result in a successful pregnancy; or
    - If the Member and the Member's spouse are of the same sex, or for an unmarried Member, 3 attempts of artificial insemination over the course of 1 year failing to result in a successful pregnancy; or
    - The infertility of the Member or the Member's Spouse, or an unmarried Member, is associated with any of the following:
      - endometriosis;
      - exposure in utero to diethylstilbestrol, commonly known as DES;
      - blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
      - abnormal male factors, including oligospermia, contributing to the infertility;
  - The Member has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this EOC; and
  - The IVF procedures are performed at medical facilities that conform to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.
- For a Member whose Spouse is of the opposite sex, any charges associated with the collection of the Member's Spouse's sperm will not be covered unless the Spouse is also a Member. For a Member whose Spouse is of the same sex, benefits will not be provided for costs incurred by the Member in obtaining donor sperm.

Infertility services Exclusions: Artificial Insemination and Intrauterine Insemination

- Services to reverse voluntary, surgically induced infertility.
- Infertility Services when the infertility is the result of an elective male or female sterilization surgical procedure.
- Surrogates and gestational carriers are not covered in any case.
- For a Member whose Spouse is of the opposite sex when the service involves the use of donor egg(s) or donor embryo(s).

- When the service involves the participation of a common law Spouse, except in states that recognize the legality of those relationships.
- When the Member does not meet the conditions of coverage as described in the Infertility Services section of the Description of Covered Services.

Additionally, artificial insemination and intrauterine insemination benefits do not include benefits for cryopreservation, storage, and or thawing of sperm, egg(s), or embryo(s).

Infertility services Exclusions: In-vitro fertilization

- Services to reverse voluntary, surgically induced infertility.
- Infertility Services when the infertility is the result of an elective male or female sterilization surgical procedure.
- Surrogates and gestational carriers are not covered in any case.
- For a Member whose Spouse is of the opposite sex, when the service involves the use of donor egg(s or donor embryo(s).
- When the service involves the participation of a common law Spouse, except in states that recognize the legality of those relationships.
- When the Member does not meet the conditions of coverage as described in the Infertility Services section of the Description of Covered Services.

Additionally, in vitro fertilization benefits do not include benefits for cryopreservation, storage, and or thawing of sperm, egg(s), or embryo(s).

Note: Cryopreservation may be covered under the Family Planning Services section as a part of standard fertility preservation procedures for iatrogenic infertility.

W. Infusion Therapy Services

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

X. Maternity Services

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

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

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

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

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

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

Y. Medical Foods

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

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

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

Medical Foods Exclusions:

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

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

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

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

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

Amino Acid-Based Elemental Formula Exclusions:

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

Z. Morbid Obesity Services

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

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

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

Morbid obesity means a body mass index that is (a) greater than 40 kilograms per meter squared; or (b) equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, diabetes, or any life-threatening or serious medical condition that is weight induced.

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.

AA. Nutritional Counseling/Medical Nutrition Therapy

We cover all Medically Necessary nutritional counseling provided by a licensed dietician-nutritionist, physician, physician assistant, or nurse practitioner for an individual at risk due to nutritional history, current dietary intake, medication use, or chronic illness or condition. This also includes unlimited medical nutrition therapy provided by a licensed dietician-nutritionist, working in coordination with a primary care physician, to treat a chronic illness or condition.

BB. 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 includes:

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

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

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

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

We also cover Medically Necessary oral restoration after major reconstructive surgery.

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

Oral Surgery Exclusions:

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

CC. Pediatric Autoimmune Neuropsychiatric Disorders

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

DD. Private Duty Nursing – Outpatient

We cover skilled nursing care that is not rendered in a hospital. Benefits are available for Medically Necessary Private Duty Nursing, as determined by Health Plan. Benefits are not provided for Private Duty Nursing rendered in a hospital.

Private Duty Nursing Limitation:

- Approved plan of care is required.

EE. Preventive Health Care Services

We cover the following preventive Services, without any Cost Sharing requirements, to any Member receiving any of the following Services from Plan Providers:

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

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

(c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (To see the current guidelines, visit HRSA at http://mchb.hrsa.gov); and
(d) With respect to women, such additional preventive care and screenings, not described in paragraph (a) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (To see the current guidelines, visit HRSA at http://mchb.hrsa.gov).
(e) A voluntary Health Risk Assessment that can be completed by Covered Persons annually. Written feedback provided to Covered Persons will include recommendations for addressing identified risks.
(f) All Food and Drug Administration–approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.
(g) Routine prenatal care.
(h) BRCA counseling and genetic testing. Any follow-up Medically Necessary treatment is covered at the applicable Cost Share based upon type and place of Service.
(i) Breastfeeding support, counseling, and supplies.

If a new recommendation or guideline described in (a)–(i) is issued after the effective date of the Plan, the new recommendation or guideline shall apply the first contract Year that begins on the date that is one year after the date of the recommendation or guideline is issued.

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

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

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

- Preventive care exams, including:
  - routine physical examinations and health screening tests appropriate to your age and sex;
  - well-woman examinations;
  - well child care examinations; and
  - well baby-care.
- Routine and necessary immunizations for children and adults in accordance with Plan guidelines. This includes immunizations required for participation in school athletics and Lyme Disease immunizations when Medically Necessary. Note: Travel immunizations are not preventive and are covered under the Outpatient Services section.
- Flu shots.
- An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
- Breast cancer screening:
  - In accordance with the latest screening guidelines issued by the American Cancer Society;
  - Digital tomosynthesis, commonly referred to as three-dimensional "3-D" mammography will be covered when the treating Plan physician determines that it is Medically Necessary.
- Bone mass measurement to determine risk for osteoporosis;
- Prostate cancer screening. Medically recognized diagnostic examinations including prostate-specific antigen (PSA) tests and digital rectal exams (a) for men who are between 40 and 75 years of age; (b) when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; (c) when used for staging in determining the need for a bone scan for patients with prostate cancer; or (d) when used for male Members who are at high risk for prostate cancer.
- Colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society;
- Cholesterol test (lipid profile);
- Diabetes screening (fasting blood glucose test);
- Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis, and HPV), subject to the following:
  - Annual chlamydia screening is covered for (1) women under the age of 20, if they are sexually active; and (2) women 20 years of age or older, and men of any age, who have multiple risk factors, which include (a)

a prior history of sexually transmitted diseases; (b) new or multiple sex partners; (c) inconsistent use of barrier contraceptives; or (d) cervical ectopy;
- Human Papillomavirus Screening (HPV) at the intervals recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;
- HIV tests;
- TB tests;
- Hearing loss screenings for newborns provided by a hospital prior to discharge; and
- Associated preventive care radiological and laboratory tests not listed above.

Pursuant to IRS Notice 2019-45, coverage is provided for expanded preventive care Services for laboratory and screenings without any cost sharing requirements:
- Retinopathy screening for diabetics
- HbA1C for diabetics
- Low density Lipoprotein laboratory test for people with heart disease
- INR laboratory test for liver failure and bleeding disorders

For coverage of glucose monitoring equipment, see the Diabetic Equipment, Supplies, and Self-Management benefit in Section 3.

For coverage of peak flow meters, see the Durable Medical Equipment benefit in Section 3.

For coverage of diagnostic breast examinations, supplemental breast examinations, and follow-up diagnostic imaging to assist in the diagnosis of lung cancer, please see the X-Ray, Laboratory and Special Procedures benefit in Section 3.

Preventive Health Services Limitations:
While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services. Applicable Cost Share will apply:
- Monitoring chronic disease,
- Follow-up Services after you have been diagnosed with a disease,
- Testing and diagnosis for specific diseases which you have been determined to be at high risk for contracting except as described above in the Preventive Health Care Services section,
- Services provided when you show signs or symptoms of a specific disease or disease process,
- Non-routine gynecological Visits.

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

FF. Prosthetic and Orthotic Devices

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

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

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

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

Artificial Arms, Legs, or Eyes
We cover:
- Artificial devices to replace, in whole or in part, a leg, an arm, or an eye;
- Components of an artificial device to replace, in whole or in part, a leg, an arm, or an eye; and
- Repairs to an artificial device to replace, in whole or in part, a leg, an arm, or an eye.

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

Coverage is provided once per contract year for:
1. Prostheses;
2. Components of prostheses;
3. Repairs to prostheses; and
4. Replacements of prostheses or prosthesis components if,
    a. An ordering Health Care Provider determines that the provision of a replacement prosthesis or component of the prosthesis is necessary;
        i. Because of a change in the physiological condition of the Member;
        ii. Unless necessitated by misuse, because of an irreparable change in the condition of the prosthesis or a component of the prosthesis; or
        iii. Unless necessitated by misuse, because the condition of the prosthesis or the component of the prosthesis requires repairs, and the cost of the repairs would be more than 60% of the cost of replacing the prosthesis or the component of the prosthesis.

Ostomy and Urological Supplies
We cover ostomy and urological supplies when prescribed by a Plan Provider and when your medical condition meets Health Plan's criteria for Medical Necessity. Covered equipment and supplies include, but is not limited to flanges, collection bags, clamps, irrigation devices, sanitizing products, ostomy rings, ostomy belts, and catheters used for drainage of urostomies.

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

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

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

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

Prosthetic and Orthotic Device Limitations:
- Coverage for mastectomy bras is limited to a maximum of four per contract year.
- Coverage for hair prosthesis is limited to one prosthesis per course of chemotherapy and/or radiation therapy.

Prosthetic and Orthotic Device Exclusions:
- Internally implanted breast prosthetics for cosmetic purposes.
- Repair or replacement due to loss, misuse or theft.

- Microprocessor and robotic-controlled external prosthetics not covered under the Medicare Coverage Database.
- More than one piece of equipment or device for the same part of the body, except for replacements; spare devices or alternate use devices.
- Dental prostheses, devices, and appliances, except as specifically covered under this EOC.
- Hearing aids, except as specifically covered under this EOC.
- Corrective lenses and eyeglasses, except as specifically covered under this EOC.
- Orthopedic shoes or other supportive devices, unless the shoe is an integral part of a leg brace, unless indicated above.
- Non-rigid appliances and supplies, including but not limited to Jobst stockings, elastic garments and stockings, and garter belts, except for equipment and supplies for the treatment of lymphedema covered under "Durable Medical Equipment" in the "Benefits" section.
- Comfort, convenience, or luxury equipment or features.

GG. Reconstructive Surgery

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

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

Reconstructive Surgery Exclusions:
Cosmetic surgery, plastic surgery, or other Services, supplies, dermatological preparations, and ointments, other than those listed above, that are intended primarily to improve your appearance, or are not likely to result in significant improvement in bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.

HH. Skilled Nursing Facility Care

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

We cover the following Services:
- Room and board;
- Physician and nursing care;
- Medical social Services;
- Medical and biological supplies; and
- Respiratory therapy.

Note: The following Services are covered, but not under this section:
- Blood (see "Blood, Blood Products, and Their Administration");
- Drugs (see "Drugs, Supplies, and Supplements");
- Durable Medical Equipment ordinarily furnished by a Skilled Nursing Facility, including oxygen dispensing equipment and oxygen (see "Durable Medical Equipment");
- Physical, occupational, and speech therapy (see "Therapy and Rehabilitation Services"); and
- X-ray, laboratory, and special procedures (see "X-ray, Laboratory, and Special Procedures").

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

- Inpatient care primarily for or solely for rehabilitation is not covered.

II. Telemedicine Services

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

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

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

Telemedicine Services Exclusion*:*
Services delivered through electronic mail messages, or facsimile transmissions.

JJ. Therapy and Rehabilitation Services - Outpatient

Rehabilitative Services include Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an illness. The goal of Rehabilitative Services is to return the individual to his/her prior skill and functional level.

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

- while you are confined in Plan Hospital; and
- for up to 50 days, including telehealth Visits, combined per contract year for outpatient physical therapy, occupational, or speech therapy per injury, incident, or condition in a Plan Medical Center, a Plan Provider's medical office, or a Skilled Nursing Facility, or as part of home health care. These limits do not apply to necessary treatment of cleft lip or cleft palate.

Physical, Occupational, and Speech Therapy Limitations:

- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Speech therapy is limited to treatment for speech impairments due to injury or illness.
- Physical therapy is limited to the restoration of an existing physical function, except as provided in the "Habilitative Services" section of this benefit.

Cardiac Rehabilitation Services
We cover Medically Necessary cardiac rehabilitation Services following coronary surgery or a myocardial infarction, for up to 90 Visits per therapy per contract period.

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

Pulmonary Rehabilitation Services
We cover pulmonary rehabilitation Services that are Medically Necessary.

Therapy and Rehabilitation Services Exclusions:

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

KK. Transplants

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

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

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

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

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

LL. Urgent Care

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

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

Inside Our Service Area
Coverage is provided for Urgent Care Services received from Plan Providers and Plan Facilities within the Service Area. Please refer to the Summary of Services and Cost Shares Appendix for charges.

If you require Urgent Care Services please call your primary care Plan Provider as follows:
- If your primary care Plan Physician is located at a Plan Medical Center, please call:

  Inside the Washington, D.C. Metropolitan Area 703-359-7878
  TTY at 711

  Outside the Washington, D.C. Metropolitan Area 1-800-777-7904
  TTY at 711

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

Outside Our Service Area
If you are injured or become ill while temporarily outside the Service Area, coverage is provided for Urgent Care Services as defined in this section. Please refer to the Summary of Services and Cost Shares Appendix for charges. All follow-up care must be provided by a Plan Provider or Plan Facility except as provided under "Follow-up Care for Emergency Surgery" below and if follow-up treatment outside the Service Area is required in connection with covered out-of-area Emergency Services or Urgent Care and we determine that a Member could not reasonably be expected to return to the Service Area for such care.

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

Follow-up Care for Emergency Surgery
In those situations when we authorize, refer, direct, or otherwise allow you access to a hospital emergency facility or other urgent care facility for a medical condition that requires emergency surgery, we will reimburse the physician, oral surgeon, periodontist, or podiatrist who performed the surgical procedure for any follow-up care that is:
- Medically Necessary; and
- directly related to the condition for which the surgical procedure was performed; and
- provided in consultation with your primary care Plan Physician.

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

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

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

MM. Vision Exam Services

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

Vision Services Exclusion (for Adults):
- All Services related to vision correction, including but not limited to eye examinations to determine the need for vision correction and to provide a prescription for corrective lenses;
- Eyeglass lenses and eyeglass frames;
- Eye exercises;
- All Services related to contact lenses including examinations, fitting and dispensing, and follow-up Visits;
- Orthoptic (eye training) therapy;
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism, including but not limited to radial keratotomy, photo-refractive keratectomy, and similar procedures.

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

Vision Exam Services Exclusions:
- Eye exercises;
- All Services related to contact lenses, including examinations, fitting and dispensing, and follow-up Visits;
- Orthoptic (eye training) therapy.

Pediatric Eye Exams
We cover the following for children under age 19 at no charge:
- One routine eye exam per year, including:
  - Routine tests such as eye health and glaucoma tests;
  - Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses; and
  - The initial exam for contact lenses.

Pediatric Lenses and Frames
We cover eyeglass frames and lenses for children, up until the end of the month they turn age 19 at no charge. The eyeglass frames and lenses are limited to a select group of frames and lenses from a Kaiser Permanente Optical Shop. Contact lenses from a select group, including Medically Necessary contact lenses, are covered in lieu of eyeglasses.

A child is also covered for glasses or contact lenses from outside the select group of eyeglass frames and lenses, as described below under Eyeglass Lenses, Eyeglass Frames, and Contact Lenses. The value of the free pair of glasses may not be applied toward the cost of any other pair of glasses or contact lenses. However, there is an allowance for additional glasses or contact lenses, as shown on the Summary of Services and Cost Shares.

In addition, we cover the following Services:

Eyeglass Lenses
Please refer to the Summary of Services and Cost Shares for pricing when regular eyeglass lenses are purchased at a

Kaiser Permanente Optical Shop. Regular eyeglass lenses are any lenses with a refractive value. If only one eye needs correction, we also provide a balance lens for the other eye.

Frames
Please refer to the Summary of Services and Cost Shares for pricing when eyeglass frames are purchased at a Kaiser Permanente Optical Shop. This pricing includes the mounting of eyeglass lenses in the frame, original fitting of the frames, and subsequent adjustment.

Contact Lenses
Please refer to your Summary of Services and Cost Shares for pricing. This pricing includes an initial fitting for contact lenses at a Kaiser Permanente Optical Shop. Initial fitting means the first time you have ever been examined for contact lens wear at a Plan Facility. The pricing includes the following Services:

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

Vision Exclusions:

- Sunglasses without corrective lenses unless Medically Necessary;
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures;
- Eye exercises;
- Non-corrective contact lenses;
- Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section;
- Replacement of lost or broken lenses or frames; and
- Orthoptic (eye training) therapy.

NN. X-ray, Laboratory, and Special Procedures

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

- Diagnostic imaging;
- Laboratory tests, including preimplantation genetic tests (PGT) for specific genetic disorders such as monogenic / single gene defect (PGT-M) or inherited structural chromosome rearrangements (PGT-SR), for which genetic counseling is available;
- Special procedures, such as:
  - Electrocardiograms;
  - Electroencephalograms; and
  - Bone mass measurement for the diagnosis and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A "qualified individual" means:
    - an estrogen-deficient individual at clinical risk for osteoporosis;
    - an individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic 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;
    - an individual receiving long-term glucocorticoid (steroid) therapy;
    - an individual with primary hyperparathyroidism; or
    - an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

  Note: Refer to "Preventive Health Services" for coverage of preventive care tests and screening Services.
- Sleep laboratory and sleep studies; and
- Specialty imaging, including computerized tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET scans), Nuclear Medicine studies, and Interventional Radiology.
- Biomarker testing for the purpose diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition that is supported by medical and scientific evidence including testing:

- cleared or approved by the U.S. Food and Drug Administration;
- required or recommended for a drug approved by the U.S. Food and Drug Administration to ensure a Member is a good candidate for the drug treatment;
- required or recommended through a warning or precaution for a drug approved by the U.S. Food and Drug Administration to identify whether a Member will have an adverse reaction to the drug treatment or dosage;
- covered under a Centers for Medicare and Medicaid Services National Coverage Determination or Medicare Administrative Contractor Local Coverage Determination; or
- supported by nationally recognized clinical practice guidelines that are:
    - developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and that have a conflict of interest policy; and
    - established standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

Biomarker 1) means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention including known gene-drug interactions for medications being considered for use or already being administered and 2) includes gene mutations, characteristics of genes, or protein expressions.

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

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

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

We cover diagnostic breast examinations and supplemental breast examinations, including image-guided biopsies, and lung cancer screenings at no charge.

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

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

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

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

Lung cancer screening also includes recommended follow-up diagnostic imaging, such as diagnostic ultrasound, MRI, CT, and image-guided biopsy, to assist in the diagnosis of lung cancer for individuals for which lung cancer screening or follow-up diagnostic imaging is recommended by the United States Preventive Services Task Force.

SECTION 4 – Exclusions, Limitations, and Reductions

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

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

Exclusions

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

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

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

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

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

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

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

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

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

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

1. It cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or
2. It is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or

3. It is subject to the approval or review of an Institutional Review Board ("IRB") of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of Services; or
4. It is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity, or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

In making determinations whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:
1. your medical records,
2. the written protocols or other documents pursuant to which the Service has been or will be provided,
3. any consent documents you or your representative has executed or will be asked to execute, to receive the Service,
4. the files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
5. the published authoritative medical or scientific literature regarding the Service, as applied to your illness or injury, and
6. regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

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

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

Routine Foot Care Services
Routine foot care Services, except when Medically Necessary.

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

Travel and Lodging Expenses
Travel and lodging expenses, except that in some situations, if a Plan Physician refers you to a non-Plan Provider outside our Service Area as described under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines.

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

Workers' Compensation or Employer's Liability
Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to a "Financial Benefit"), is provided under any workers' compensation or employers' liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit; but we may recover the value of any covered Services from the following sources:
1. Any source providing a Financial Benefit or from whom a Financial Benefit is due; or
2. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employers' liability law.

Limitations

If Health Plan, for any reason beyond its control, is unable to provide the health services promised in this EOC, Health Plan shall be liable for reimbursement of the expenses necessarily incurred by any member in procuring the services through other providers, to the extent prescribed by the Insurance Commissioner of Maryland.

Reductions

Injury or Illness Caused by Third Party

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

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

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

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

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Other Party Liability & Recovery Dept.
4000 Garden City Drive
Hyattsville, MD 20785

In order for Health Plan to determine the existence of any rights we may have and to satisfy those rights, you must complete and send Health Plan all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay Health Plan directly. You must not take any action prejudicial to Health Plan's rights.

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

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

Medicare and TRICARE Benefits

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

Coordination of Benefits (COB)

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

1. The Primary Plan then provides benefits as it would in the absence of any other coverage.
2. The Plan that pays benefits second (Secondary Plan) coordinates with the Primary Plan, and pays the difference between what the Primary Plan paid, or the value of any benefit or Service provided, and 100 percent of total

Allowable Expenses. The Secondary Plan is never liable for more expenses than it would cover if it had been Primary.

If you have any questions about COB, please call our Member Services Call Center.

Inside the Washington, D.C., Metropolitan Area
1-855-839-5763
TTY 711

Outside the Washington, D.C. Metropolitan Area
1-855-839-5763
TTY 711

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

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

Definitions
"Plan": Any of the following that provides benefits or Services for, or because of, medical care or treatment: Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepaid group practice or individual practice coverage. "Plan" does not include an individually underwritten and issued, guaranteed renewable, specified disease policy or intensive care policy that does not provide benefits on an expense-incurred basis, or automobile insurance. It also does not include all of the types of coverage specified in Section 3.K.(4) of the NAIC Coordination of Benefits Model Regulation:

1. Hospital indemnity coverage benefits or other fixed indemnity coverage;
2. Accident only coverage;
3. Limited health benefit coverage;
4. School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on "to and from school" basis;
5. Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
6. Medicare supplement policies;
7. A state plan under Medicaid; or
8. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-government plan.

"Health Plan": Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., providing Services or benefits for health care. Health Plan is a Plan.

"Allowable Expense" means a health care Service or expense, including Copayments, that is covered in full or in part by any of the Plans covering the Member. This means that an expense or health care Service or a portion of an expense or health care Service that is not covered by any of the Plans is not an allowable expense. For example, if a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room usually is not an Allowable Expense. Allowable Expense does not include coverage for dental care except as provided under "Accidental Dental Injuries" in the "Benefits" section.

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

Order of Benefit Determination Rules

1. If another Plan does not have a COB provision, that Plan is the Primary Plan.
2. If another Plan has a COB provision, the first of the following rules that apply will determine which Plan is the Primary Plan:
   a. Subscriber/Dependent. A Plan that covers a person as a Subscriber is Primary to a Plan that covers the person as a dependent.
   b. Subscriber/Dependent. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:
      i. Secondary to the plan covering the person as a dependent; and
      ii. Primary to the plan covering the person as other than a dependent,

      Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

- **Dependent Child/Parents.**
  1. **Not Separated or Divorced.** When Health Plan and another Plan cover the same child as a Dependent of different persons, called "parents": (i) the Plan of the parent whose birthday falls earlier in the year is Primary to the Plan of the parent whose birthday falls later in the year; or (ii) if both parents have the same birthday, the Plan that covered a parent longer is Primary Plan.
  2. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married: If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;
  3. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;
  4. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or
  5. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
     a. The plan covering the custodial parent;
     b. The plan covering the custodial parent's spouse or domestic partner;
     c. The plan covering the non-custodial parent; then
     d. The plan covering the non-custodial parent's spouse or domestic partner.

- **Dependent Child/Non-Parent.** For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the dependent child provisions above, as if those individuals were parents of the child.

- **Dependent Child/Own Coverage.**
  1. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule for "Longer or Shorter Length of Coverage" applies.
  2. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule under the "Dependent Child/ Parents Not Separated or Divorced" provision above.

- **Active/Inactive Employee.** A Plan that covers a person as an employee who is neither laid off nor retired (or as such an employee's dependent) is the Primary Plan. The Plan which covers that person as a laid off or retired employee (or as such an employee's dependent) is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

- **COBRA or State Continuation Coverage.**
  1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

  2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

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

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

Effect of COB on the Benefits of this Plan

When Health Plan is the Primary Plan, COB has no effect on the benefits or Services provided under this Agreement. When Health Plan is a Secondary Plan as to one or more other Plans, its benefits may be coordinated with the Primary Plan carrier using the guidelines below. COB shall in no way restrict or impede the rendering of Services provided by Health Plan. At the Member's request, Health Plan will provide or arrange for covered Services and then seek coordination with a Primary Plan.

1. **Coordination with This Plan's Benefits.** Health Plan may coordinate benefits payable or may recover the reasonable cash value of Services it has provided when the sum of:
   a. The benefits that would be payable for, or the reasonable cash value of, the Services provided as Allowable Expenses by Health Plan in the absence of this COB provision; and
   b. The benefits that would be payable for Allowable Expenses under one or more of the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim thereon is made that exceeds Allowable Expenses in a Claim Determination Period. In that case, the Health Plan benefits will be coordinated, or the reasonable cash value of any Services provided by Health Plan may be recovered, from the Primary Plan, so that they and the benefits payable under the other Plans do not total more than the Allowable Expenses.
2. **Right to Reserve and Release Needed Information.** Certain information is needed to apply these COB rules. Health Plan will decide the information it needs, and may get that information from, or give it to, any other organization or person. Health Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under Health Plan must give Health Plan any information it needs.
3. **Facility of Payment.** If a payment made or Service provided under another Plan includes an amount that should have been paid or provided by or through Health Plan, Health Plan may pay that amount to the organization which made that payment. The amount paid will be treated as if it were a benefit paid by Health Plan.
4. **Right of Recovery.** If the amount of payments by Health Plan is more than it should have paid under this COB provision, or if it has provided Services that should have been paid by the Primary Plan, Health Plan may recover the excess or the reasonable cash value of the Services, as applicable, from one or more of:
   a. The persons it has paid or for whom it has paid;
   b. Insurance companies; or
   c. Other organizations.

Military Services

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

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

Getting Assistance

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

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

Inside the Washington, D.C., Metropolitan Area
1-855-839-5763
TTY 711

Outside the Washington, D.C. Metropolitan Area
1-855-839-5763
TTY 711

Definitions

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

Adverse Decision: (a) A utilization review decision made by Health Plan, or a Health Care Provider acting on behalf of the Health Plan that:
1. a proposed or delivered Service is or was not Medically Necessary, appropriate or efficient; and
2. may result in non-coverage of the Health Care Service; or (b) a denial by Health Plan of a request by the Member for an alternative standard or a waiver of a standard to satisfy the requirements of a wellness program.

An Adverse Decision includes a utilization review determination based on a Prior Authorization or step-therapy requirement.

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

Appeal: A protest filed by a Member or his or her Authorized Representative with Health Plan under its internal appeal process regarding a Coverage Decision concerning a Member.

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

Authorized Representative: (For use in this "Section 5 – Getting Assistance; Health Care Service Review; and the Grievance and Appeal Process"): An individual authorized by the Member or Parent/Guardian, as applicable, or otherwise authorized under State of Maryland law to act on the Member's behalf to file claims or complaints and to submit Appeals or Grievances to the Health Plan. A Health Care Provider may act on behalf of a Member with the Member's express consent, or without such consent.

Commissioner: The Maryland Insurance Commissioner.

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

Coverage Decision: An initial determination by Health Plan or a representative of Health Plan that results in non-coverage of a Health Care Service. Coverage Decision includes a determination by a Health Plan that an individual is not eligible for coverage under the Health Plan's health benefit plan; any determination by Health Plan that results in the rescission of an individual's coverage under a health benefit plan; or a determination including non-payment

of all or any part of a claim that a Health Care Service is not covered under this Agreement. A Coverage Decision does not include an Adverse Decision or a pharmacy inquiry.

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

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

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

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

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

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

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

1. A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of Health Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
    a. Placing the Member's life or health in serious jeopardy;
    b. The inability of the Member to regain maximum function;
    c. Serious impairment to bodily function;
    d. Serious dysfunction of any bodily organ or part; or
    e. The Member remaining seriously mentally ill with symptoms that cause the Member to be a danger to self or others; or
2. A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that could not be adequately managed without the care or treatment that is the subject of the Coverage Decision.

The Health Care Service Review Program

Pre-Service Reviews

If you do not have an Emergency Case and you have not received the Health Care Service or course of treatment you are requesting, including pharmaceutical Services not submitted electronically, then, within two working days of receiving all necessary information, Health Plan will make its determination.

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

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

We must receive the information requested by the notice, within 45 calendar days from the receipt of the notice identifying the additional necessary information, or we will make our decision based upon the information we have available to us at that time.

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

If an admission, procedure, or Service is pre-authorized, Health Plan will:
1. Notify the provider by telephone within one working day of pre-authorization; and
2. Confirm the pre-authorization with you and the provider in writing within five working days of our decision.

If pre-authorization is denied, or an alternate treatment or Service is recommended, Health Plan will:
1. Notify the provider by telephone within one working day of making the denial or alternate treatment or Service recommendation; and
2. Confirm the denial decision with you, your Authorized Representative, and your health care provider in writing within five working days of making our decision.

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

Emergency Expedited Pre-Service Reviews

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

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

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

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

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

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

Concurrent Reviews

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

After receipt of the initial request for health care Services and confirming through a complete review of information already submitted by the Health Care Provider, if Health Plan determines that we do not have sufficient information

to make a determination, Health Plan shall promptly, but not later than three (3) calendar days after receipt of the initial request, inform the Health Care Provider that additional information must be provided by specifying:

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

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

If Health Plan authorizes or certifies an extended stay or additional Health Care Services under the concurrent review, Health Plan will:
1. Promptly notify the Health Care Provider of the determination;
2. Notify the provider by telephone within one working day after receipt of the information necessary to make the determination; and
3. Confirm the authorization in writing with you or your Authorized Representative within five working days after the decision was made. The written notification will include the number of extended days or next review date, or the new total number of Health Care Services approved.

If the request for extended stay or additional Health Care Services is denied, Health Plan will:
1. Notify the provider and/or you or your Authorized Representative of the denial by telephone within one working day after receipt of the information necessary to make the determination; and
2. Confirm the denial in writing with you, your Authorized Representative, and your health care provider within five working days after the telephone notification. Coverage will continue for Health Care Services until you or your Authorized Representative and the provider rendering the Health Care Service have been notified of the denial decision in writing.

You or your Authorized Representative may then file an Appeal or Grievance, as appropriate, as described below under "Internal Grievance and Appeal Processes." If you filed a request for additional Services before the end of an approved course of treatment, you may continue to receive those Services during the time your Appeal or Grievance is under consideration. If your Appeal or Grievance is then denied, you will be financially responsible for the entire cost of those Services.

Step-therapy Exception

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

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

If additional information is needed to make a determination after confirming through a complete review of the information already submitted by the health care provider, Health Plan will request the information promptly, but not later than three (3) calendar days after receipt of the initial request, by specifying:

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

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

Reconsideration

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

reconsideration, the physician shall provide the Health Care Provider with the following contact information for the Health Care Provider to use to contact the physician:

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

Filing for Payment/Reimbursement of a Post-Service Claim

When the Health Plan receives a notice of claim, we will provide you with the appropriate forms for filing proof of loss. If we do not provide you with claim forms within fifteen (15) days of your notice to us, then you will be considered to have complied with the proof of loss requirements of this Agreement after you have submitted written proof that details the occurrence and the character and extent of the loss for which you have made a claim.

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

If you are unable to access the electronic form or obtain a paper form, you may also file your claim by submitting the following information we need to process your claim:

1. Member Name;
2. Member Medical Record Number (MRN);
3. The date the Member received the Services;
4. Where the Member received the Services;
5. The Physician who provided the Services;
6. Reason you believe Health Plan should pay for the Services; and
7. A copy of the bill, the Member's medical record(s) for the Services, and the receipt, if the Service have already been paid for.

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

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

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

A request for payment or reimbursement of the cost of covered services received from physicians, hospitals or other Health Care Providers not contracting with us must be submitted to the Health Plan within 1 year of receipt of the covered services. Failure to submit such a request within 1 year of receipt of the covered services will not invalidate or reduce the amount of the claim, if it was not reasonably possible to submit the request within the aforementioned time frame. If it is not reasonably possible to submit the claim within 1 year after the date of service, it shall be sent to us no later than 2 years of receipt of the covered services. A Member's legal incapacity shall suspend the time to submit a claim. Such suspension period ends when legal capacity is regained.

Your Health Care Provider must submit within one-hundred and eighty days (180) from the date of a covered Service a claim for reimbursement of the covered Service.

Each Member claiming reimbursement hereunder shall complete and submit to the Health Plan such consents, releases, assignments and other documents as the Health Plan may reasonably request for the purpose of acting upon the claim.

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

Reimbursement for covered Services will be made within 30 days after the receipt of the request for payment. Reimbursement will be made to the applicable provider of the Services, or if the claim has been paid, to you, or in the case of a child, to the parent who incurred the expenses resulting from the claim or the Maryland Department of Health, as applicable.

If we deny payment of the claim, in whole or in part, the Member or Member's Authorized Representative may then file an Appeal or Grievance, as applicable.

Post-Service Claim Reviews

Health Plan will make its determination on post-Service review within 30 days of receiving a claim. If Health Plan approves the claim, benefits payable under your contract will be paid within thirty (30) days of receiving the receipt of written proof of loss. If we determine we cannot reimburse the claim because of (1) the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary, or (2) the claim is not clean and, therefore, we need more information to process such claim, we will notify you of the extension within the initial 30-day period. Our notice will explain the circumstances requiring the extension and the date upon which we expect to render a decision. If such an extension is necessary because we need information from you, then our notice of extension will specifically describe the required information which you need to submit. You must respond to requests for additional information within 45 calendar days or we will make our decision based upon the information we have available to us at that time.

We will send a notice to you or your Authorized Representative explaining that:

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

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

Internal Grievance and Appeal Processes

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

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

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

a. The Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a Grievance or Appeal under the internal grievance and appeals processes. However, the Health Education and Advocacy Unit is not available to represent or accompany you and/or your Authorized Representative during the proceeding of the internal grievance and appeals process;
b. The Health Education and Advocacy Unit can assist you and/or your Authorized Representative in mediating a resolution of the Adverse Decision or Coverage Decision with Health Plan, but at any time during the mediation, you and/or your Authorized Representative may file a Grievance or Appeal; and
c. You and/or your Authorized Representative may file a Complaint with the Commissioner without first filing a Grievance or Appeal as explained below under Maryland Insurance Commissioner.

The Health Education and Advocacy Unit may be contacted at:

Office of the Attorney General
Consumer Protection Division
Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
410-528-1840
1-877-261-8807 (toll free out-of-area)
1-410-576-6571 (facsimile)
www.oag.state.md.us (website)
heau@oag.state.md.us (e-mail address)

2. ***Maryland Insurance Commissioner***

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

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

b. You, your Authorized Representative, or a Health Care Provider provides sufficient information and supporting documentation in the Complaint that supports a compelling reason to not exhaust our internal process for resolving Grievances (protests regarding Adverse Decisions), such as when a delay in receiving the Health Care Service could result in loss of life, serious impairment to bodily function, serious dysfunction of a bodily organ, remain seriously mentally ill or using intoxicating substances with symptoms that cause the Member to be in danger to self or others, or the Member continuing to experience severe withdraw symptoms. A Member is considered to be in danger to self or others if the Member is unable to function in activities of daily living or care for self without imminent dangerous consequences.
c. We failed to make a Grievance Decision for a pre-Service Grievance within 30 working days after the filing date or 45 working days after the filing date for a post-Service Grievance;
d. We or our representative failed to make a Grievance Decision for an expedited Grievance for an Emergency Case within 24 hours after you or your Authorized Representative filed the Grievance;
e. We have waived the requirement that our internal grievance process must be exhausted before filing a Complaint with the Commissioner; or
f. We have failed to comply with any of the requirements of the internal grievance process.

The Maryland Insurance Commissioner may be contacted at:

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

3. ***Internal Grievance Process***

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

Initiating a Grievance

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

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

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

If within five working days after you, your Authorized Representative, or your health care provider who has filed a grievance on behalf of you, file a Grievance, we need additional information to complete our internal Grievance process, we shall ,after confirming through a complete review of any information already submitted by the health care provider, (1) notify you, your Authorized Representative, or your health care provider that we cannot proceed with review of the Grievance unless additional information is provided, (2) request the specific information, including any laboratory or diagnostic test or other medical information that must be submitted to complete the internal grievance process, and (3) provide the specific reference, language, or requirements from the criteria and standards used by Health Plan to support the need for the additional information. We will assist you or your Authorized Representative in gathering the necessary additional information without further delay.

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

a. **Pre-Service Grievance**
If the Grievance is for a Health Care Service that the Member is requesting (that is, the Health Care Service has not been rendered), an acknowledgment letter will be sent requesting any additional information that may be necessary within five working days after the filing date. We will also inform you and your Authorized Representative that a decision will be made regarding the Grievance in writing, and such written notice will be sent within 30 working days of the filing date of the Grievance or within five (5) working days of the decision, whichever comes first.

b. **Post-Service Grievance**
If the Grievance is asking for payment for Health Care Services already rendered, an acknowledgment letter will be sent requesting additional information that may be necessary within five working days after the filing date. We will also inform you and your Authorized Representative that a decision will be made in writing and such written notice will be made within 45 working days of the filing date of the Grievance or within five (5) working days of the decision, whichever comes first.

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

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

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

In addition, we will communicate our decision to you or your Authorized Representative verbally and will send a written notice of such verbal communication within five working days of the verbal communication to you and your Authorized Representative.

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

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

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

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

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

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

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

5. ***Notice of an Adverse Decision***

If our review of your request for a Service (including expedited) results in an Adverse Decision, we will provide you, your Authorized Representative, or your Health Care Provider acting on your behalf communication of our Adverse Decision orally by telephone, or with the affirmative consent from you, your Authorized Representative, or your Health Care Provider acting on your behalf, by text, facsimile, e-mail, an online portal, or other expedited means. Within five (5) business days after the Adverse Decision has been made for a non-Emergency Case or within one (1) day after a decision has been orally communicated for expedited cases, we will provide you, your Authorized Representative, or your Health Care Provider acting on your behalf written notice of the Adverse Decision. This written notice shall include:

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

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

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

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

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

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

6. ***Notice of Adverse Grievance Decision***

If our review of a Grievance, including an expedited Grievance, results in denial, we will provide you, or your Authorized Representative, and your Health Care Provider acting on your behalf communication of our Grievance Decision orally by telephone, or with the affirmative consent from you, your Authorized Representative, and your Health Care Provider acting on your behalf, by text, facsimile, e-mail, an online portal, or other expedited means. Within five (5) business days after the Grievance Decision has been made for a non-Emergency Case, or within one (1) day after a Grievance Decision has been orally communicated for expedited Grievances, we will provide you, your Authorized Representative, and your Health Care Provider acting on your behalf written notice of our Grievance Decision. This written notice shall include:

a. The specific factual basis for the decision stated in detail in clear and understandable language and the reasoning used to determine that the Health Care Service is not Medically Necessary and did not meet our criteria and standards used in conducting the utilization review;
b. The specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines used by the Health Plan, on which the decision was based, and may not solely use generalized terms such as “experimental procedure not covered”, “cosmetic procedure not covered”, “Service included under another procedure”, or “not Medically Necessary” or language directing the member to review the additional coverage criteria in your Evidence of Coverage;
c. a statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. In addition, you or your Authorized Representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of your or your Authorized Representative’s claim;
d. The name, business address, and business telephone number of the medical director who made the Grievance Decision;

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

   The business telephone number will be a dedicated number for Grievance Decisions and will not be the Health Plan’s general customer call number.

e. A description of your or your Authorized Representative’s right to file a complaint with the Commissioner within 4 months after receipt of our Grievance Decision;
f. The Commissioner’s address, telephone number, and facsimile number;
g. A statement that the Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a complaint about the Health Plan with the Commissioner;
h. The Health Education and Advocacy Unit’s address, telephone number, facsimile number, and electronic mail address; and
i. The Health Plan must provide notice of a Grievance Decision in a non-English language if certain thresholds are met for the number of people who are literate in the same non-English language. A threshold language applies to a county if at least 10% of the population is literate only in the same foreign language that is identified as a federally mandated non-English language. If we send you a notice of a Grievance Decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. You or your Authorized Representative may request translation of the notice by contacting Member Services.

7. ***Notice of Coverage Decision***

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

Decision. This written notice shall include:

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

8. ***Internal Appeal Process***

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

Initiating an Appeal

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

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

Kaiser Foundation Health Plan of Georgia, Inc.
Attention: Appeals Coordinator
Nine Piedmont Center
3495 Piedmont Rd NE
Atlanta, GA 30305-1736
Fax: 1-404-364-4743

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

Member Service Representatives are available by telephone each day during business hours to describe how internal appeals are processed and resolved and to assist with filing an internal appeal. The Member Service Representative can be contacted Monday through Friday from 7:30 a.m. to 11:00 p.m. Eastern Standard Time (EST) at 1-855-839-5763, if calling within the local area, or 711 TTY (Telephonic Device for the Deaf).

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

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

give the Member or Member's Authorized Representative a reasonable opportunity to respond to the new information.

After the Health Plan receives the Appeal, we will respond to you, your Authorized Representative, and Health Care provider acting on behalf of the Member in writing within 30 calendar days for a pre-Service claim, or 60 calendar days for a post-Service claim.

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

a. the specific factual basis for the decision in clear understandable language;
b. reference to the specific plan provision on which determination was based. In addition, you or your Authorized Representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of your or your Authorized Representative's claim;
c. a description of you or your Authorized Representative's right to file a Complaint with the Commissioner within 4 months after receipt of our Appeals Decision;
d. the Commissioner's address, telephone number, and facsimile number;
e. a statement that the Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a complaint about the Health Plan with the Commissioner;
f. the Health Education and Advocacy Unit's address, telephone number, facsimile number, and electronic mail address; and
g. the Health Plan must provide notice of an appeal decision in a non-English language if certain thresholds are met for the number of people who are literate in the same non-English language. A threshold language applies to a county if at least 10% of the population is literate only in the same foreign language that is identified as a federally mandated non-English language. If we send you a notice of an appeal decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. You or your Authorized Representative may request translation of the notice by contacting Member Services.

Filing Complaints About Health Plan

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

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

SECTION 6 – Termination of Membership

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

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

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

Termination of Group Agreement

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

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

Termination Due to Loss of Eligibility

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

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

Termination for Cause

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

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

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

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

Termination for Nonpayment

Nonpayment of Premium

You are entitled to coverage only for the period for which we have received the appropriate Premium from your Group. There is a grace period of thirty-one (31) days for payment of each Premium due after the first Premium, unless Health Plan does not intend to renew the Agreement beyond the period for which premiums have been accepted and notice of the intention not to renew is delivered to the Group at least forty-five (45) days before the premium is due. During the grace period, the Agreement shall continue in force. The grace period shall begin the day after the Premium due date (the date the coverage period begins). If your Group fails to pay us the appropriate Premium for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

Nonpayment of Any Other Charges

We may terminate your membership if you fail to pay any amount you owe to Health Plan or Medical Group, or you fail to pay the applicable Cost Share to any Plan Provider. We will send written notice of the termination, including the amount of charges due, to the Subscriber at least 30 days before the termination date. If the Member pays the amount of the charges due, plus any administrative cost incurred in preparing and delivering the notice before the date of cancellation, membership will remain in full force and effect.

Extension of Benefits

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

1. If you are Totally Disabled at the time your coverage ends, we will continue to provide benefits for covered Services related to the condition causing the disability. Coverage will stop at the point you no longer qualify as being Totally Disabled, or up to 12 months from the date your coverage ends, whichever comes first.
2. If you have ordered eyeglasses or contact lenses before the date your coverage ends, we will provide benefits for covered eyeglasses or contact lenses received within 30 days following the date you placed the order.
3. If you are in the midst of a course of covered dental treatment at the time your coverage ends, we will continue to provide benefits, in accordance with the EOC in effect at the time your coverage ended, for a period of 90 days following the date your coverage ended.
4. If you are in the midst of a course of covered orthodontic treatment at the time your coverage ends, we will continue to provide benefits, in accordance with the EOC in effect at the time your coverage ended, for a period of:
    a. 60 days following the date your coverage ended if the orthodontist has agreed to or is receiving monthly payments; or
    b. until the latter of 60 days following the date your coverage ended, or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

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

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

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

Discontinuation of a Product or All Products

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

Continuation of Group Coverage Under Federal Law

COBRA

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

USERRA

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

Continuation of Coverage Under State Law

Death of the Subscriber

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

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

1. Group coverage under this section continues, for those Dependents who are eligible for state continuation coverage, only upon payment of applicable monthly charges, which may include an allowable reasonable administrative fee, not to exceed 2% of the entire cost to the employer, to your Group's Premium charge at the time specified by Group, and terminates on the earliest of:
2. Termination of this Agreement; or
    a. Eligibility of the Member under any other group health plan or entitlement to Medicare benefits; or
    b. Acceptance of coverage under any non-group health insurance plan or health maintenance organization; or
    c. Ceasing to qualify as a dependent child (only the coverage of the affected dependent child will terminate); or
    d. The effective date of an election by a Spouse or dependent child to no longer be covered under the group contract; or
    e. The premium due date on which the Spouse or dependent child fails to make timely payment of a required amount; or
    f. Expiration of 18 calendar months after the death of the Subscriber.

Divorce of the Subscriber and His/Her Spouse

If you are an individual who would otherwise lose coverage due to divorce from the Subscriber, you may continue uninterrupted coverage hereunder, upon arrangement with the Group in compliance with applicable Maryland law. This right applies to your Dependent children, including a child of the Subscriber born to you after the divorce.

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

1. Group coverage under this section continues, for those Dependents who are eligible for state continuation coverage, only upon payment of applicable monthly charges to Group at the time specified by Group, and terminates on the earliest of:
    a. Termination of this Agreement; or
    b. Eligibility of the Member under any other group health plan or entitlement to Medicare benefits; or
    c. Acceptance of coverage under any non-group health insurance plan or health maintenance organization; or
    d. Ceasing to qualify as a dependent child (only the affected dependent's coverage will be terminated); or
    e. Marriage of the Member who is the divorced spouse of the Subscriber (only the divorced spouse's coverage will be terminated); or
    f. The date on which the Spouse or dependent child elects to terminate coverage under the group contract.

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

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

1. Coverage under this section continues only upon payment of applicable monthly charges, which may include an allowable reasonable administrative fee not to exceed 2% of the entire cost to the employer, to your Group's Premium charge at the time specified by Group, and terminates on the earliest of:
    a. Termination of this Agreement; or
    b. Eligibility of the Subscriber under any other group health plan or entitlement to Medicare benefits; or
    c. The Subscriber's acceptance of coverage under any non-group health plan or health maintenance organization; or

d. Ceasing to qualify as a dependent (only the affected dependent's coverage will be terminated); or
e. Expiration of 18 calendar months after the termination of Subscriber's employment; or
f. The date of which the Subscriber fails to make timely payment of a required premium; or
g. The date on which the Subscriber elects to terminate coverage under the group contract.

Coverage Under the Continuation Provision of Group's Prior Plan

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

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

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

SECTION 7 – Miscellaneous Provisions

Administration of Agreement

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

Advance Directives

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

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

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

Inside Washington, D.C. Metropolitan Area
1-855-839-5763
TTY 711

Outside the Washington, D.C. Metropolitan Area
1-855-839-5763
TTY 711

Amendment of Agreement

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

Applications and Statements

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

Assignment

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

Attorney Fees and Expenses

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

Contestability

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

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

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

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

Contracts with Plan Providers

Health Plan and Plan Providers are independent contractors. Your Plan Providers are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee for Service, and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call our Member Services Call Center in the Washington, D.C. metropolitan area at 1-855-839-5763, or in the Baltimore, Maryland metropolitan area at 1-855-839-5763. Our TTY is 711.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from non-Plan Providers, except as provided in this EOC for:

1. Emergency Services;
2. Urgent Care outside our Service Area;
3. Authorized referrals; or
4. Care in other Health Plan Regions.

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

Governing Law

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

Notice of Non-Grandfathered Coverage

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

Groups and Members Are Not Health Plan's Agents

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

Member Rights and Responsibilities

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

Member Rights

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

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

h. Receive access to your medical records and any information that pertains to you, except as prohibited by law. This includes the right to ask us to make additions or corrections to your medical record. We will review your request based on HIPAA criteria to determine if the requested additions are appropriate. If we approve your request, we will make the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. You, or your Authorized Representative, will be asked to provide written permission before your records are released, unless otherwise permitted by law.

2. **Receive information about Kaiser Permanente and your plan. This includes your right to:**
   a. Receive the information you need to choose or change your primary care Plan Physician, including the name, professional level, and credentials of the doctors assisting or treating you.
   b. Receive information about Kaiser Permanente, our Services, our practitioners and providers, and the rights and responsibilities you have as a Member. You also can make recommendations regarding Kaiser Permanente's Member rights and responsibility policies.
   c. Receive information about financial arrangements with physicians that could affect the use of Services you might need.
   d. Receive Emergency Services when you, as a prudent layperson, acting reasonably, would have believed that an Emergency Medical Condition existed, and receive information regarding cost sharing, payment obligations and balance billing protections for Emergency Services.
   e. Receive covered urgently needed Services when traveling outside Kaiser Permanente's Service Area.
   f. Receive information about what Services are covered and what you will have to pay, and to examine an explanation of any bills for Services that are not covered.
   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 acknowledgment and a resolution in a timely manner.

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

Member Responsibilities

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

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

2. **Know and understand your plan and benefits:**
   a. Read about your health care benefits in this EOC and become familiar with them. Call us when you have questions or concerns.
   b. Pay your plan premiums and bring payment with you when your Visit requires a Copayment.
   c. Let us know if you have any questions, concerns, problems, or suggestions.

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

Named Fiduciary

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

No Waiver

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

Nondiscrimination

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

Notices

Our notices to you will be sent to the most recent address we have on file for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Services Call Center in the Washington, D.C. metropolitan area at 1-855-839-5763, or in the Baltimore, Maryland metropolitan area at 1-855-839-5763 as soon as possible to give us their new address. Our TTY is 711.

Overpayment Recovery

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

Privacy Practices

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

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

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

Provider Directory Information Requirements

If a Member is furnished, by a non-Participating Provider, an item or Service that would otherwise be covered if provided by a Participating Provider, and the Member relied on a database, provider directory, or information regarding the provider's network status provided by Health Plan through a telephone call or electronic, web-based, or Internet-based means which incorrectly indicated that the provider was a Participating Provider for the furnishing of such item or Service, then the following apply:

1. The Copayment, Coinsurance, and/or other Cost Sharing requirement for such item or Service furnished by a non-Participating Provider is the same as the Copayment, Coinsurance, and/or other Cost Sharing requirement listed in the EOC for the item or Service when provided by a Participating Provider; and
2. Any Cost Sharing payments made with respect to the item or Service will be counted toward any applicable in-network Annual Copayment Maximum.
3. The Member will not be liable for an amount that exceeds the Cost Sharing that would have applied to the Member if the provider was a Participating Provider.

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

By: _____
Gracelyn McDermott
Vice President, Marketing, Sales & Business Development

Definitions

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

Air Ambulance Service: Medical transport of a patient by rotary wing air ambulance (as defined in 42 CFR 414.605) or fixed wing air ambulance (as defined in 42 CFR 414.605).

Allowable Charges (AC) means either:

1. For Services provided by Health Plan or Medical Group, the amount in the Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members;
2. For items obtained at a Plan Pharmacy, the "Member Standard Value," which means the cost of the item calculated on a discounted wholesale price plus a dispensing fee;
3. For all other Services,
    a. the amount the provider has contracted to accept;
    b. the amount the provider has negotiated with the Health Plan;
    c. Health Plan must pay the non-Plan Provider pursuant to state law, when it is applicable, or federal law, including the Out-of-Network Rate, or in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the provider and us;
    d. The fee schedule, that providers have agreed to accept as determining payment for Services, states; or
    e. Health Plan pays for those Services

    For non-Plan Providers, the Allowable Charge shall not be less than the Out-of-Network amount the Health Plan must pay pursuant to §19-710.1 of the Health General Article of the Annotated Code of Maryland, when such statutory provision (state law) is applicable.

Ancillary Service: Services that are:

1. Items and Services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner;
2. Items and Services provided by assistant surgeons, hospitalists, and intensivists;
3. Diagnostic Services, including radiology and laboratory Services; and
4. Items and Services provided by a non-participating provider if there is no participating provider who can furnish such item or Service at such facility.

Authorized Representative: An individual authorized under state law to provide consent on behalf of a Member provided that the individual is not a provider affiliated with the facility or employee of the facility unless such provider or employee is a family member of the patient.

Coinsurance: The percentage of Allowable Charges that you must pay when you receive a covered Service as listed under "Copayments" in the Summary of Services and Cost Shares section.

Continuing Care Patient is a Member who, with respect to a provider or facility:

1. Is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;
2. Is undergoing a course of institutional or inpatient care from the provider or facility;
3. Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
4. Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. Is or was determined to be terminally ill, as determined under section 1861(dd)(3)(A) of the Social Security Act, and is receiving treatment for such illness from such provider or facility.

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

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

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements see "Who Is Eligible" in Section 1 – Introduction).

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

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

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

1. An appropriate medical screening examination, including those that are provided in specialized facilities that are staffed by behavioral health providers trained to provide crisis Services, as required federal under the Emergency Medical Treatment and Active Labor Act (EMTALA), section 1867 of the Social Security Act, that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department, to evaluate such Emergency Medical Condition;
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment required under EMTALA, or would be required under EMTALA if EMTALA applied to an Independent Freestanding Emergency Department, to Stabilize the patient, regardless of the department of the hospital in which such further examination or treatment is furnished; and
3. Except as further described in this paragraph 3, covered Services, also referred to as Post-Stabilization Care, that are furnished by a Non-Plan Provider or non-participating emergency facility after you are Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Visit in which the Emergency Services are furnished:
    a. When, under applicable federal law, the covered Services described in item #3 are not included as Emergency Services if all of the following conditions are met:
        i. The attending emergency physician or Treating Provider determines that the Member is able to travel using nonmedical transportation or nonemergency medical transportation to a participating provider or an available Plan Hospital or Plan Facility located within a reasonable travel distance, taking into account the Member's medical condition;
        ii. The provider or facility furnishing such additional covered Services satisfies the notice and consent requirements set forth in federal regulation 45 C.F.R § 149.420(c) through (g) with respect to such covered Services, provided that the written notice additionally (1) identifies Plan Providers to whom you can be referred when a non-Plan Provider proposes to furnish covered Services at a Plan Hospital or Plan Facility when a non-Plan Provider proposes to provide such covered Services and (2) includes a good faith estimate of the charges for covered Services to be furnished by a non-participating providers at a non-Plan Hospital or non-Plan Facility by non-Plan Providers during the Visit; and
        iii. The Member, or an Authorized Representative of such Member, is in a condition to receive the information in the consent as described in item #3, as determined by the attending emergency physician or Treating Provider using appropriate medical judgment, and to provide informed consent in accordance with applicable State law; or
    b. When the covered Services are not rendered by a Health Care Provider who is subject to state law prohibiting balance billing (§19-710(p) of the Health-General Article).

Essential Health Benefits has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient Services; emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder Services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative Services and devices; laboratory Services; preventive and wellness Services and chronic disease management; and pediatric Services, including oral and vision care.

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

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

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

These services will include physical and occupational therapy, speech-language pathology and other Services for people with disabilities in a variety of inpatient and/or outpatient settings, including, but not limited to applied behavioral analysis for the treatment of autism spectrum disorder.

Hearing Aid: A device that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by adults and children and is non-disposable.

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

Independent Freestanding Emergency Department: A health care facility that is geographically separate and distinct and licensed separately from a Hospital under applicable State law and provides any Emergency Services.

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

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

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

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

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

Non-Physician Specialist: A health care provider who:
1. Is not a physician;
2. Is licensed or certified under the Health Occupations Article; and
3. Is certified or trained to treat or provide health care Services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider; or
4. That is licensed as a behavioral health program under §7.5-401 of the Health-General Article.

Out-of-Network Rate: With respect to an item or service furnished by a non-Plan Provider, non-participating Emergency Facility, or non-Plan Provider of Air Ambulance Services, means:
1. In a State that has an All-Payor Model Agreement applicable to the covered Service, the amount Health Plan is required to pay. For certain covered Services billed by Maryland hospitals, this is the amount for the Service under Maryland's All-Payer Model Agreement as approved by the Health Services Cost Review Commission (HSCRC).
2. If there is no such All-Payer Model Agreement amount applicable to the covered Service, then under Maryland law, the amount Health Plan is required to pay pursuant to §19-710.1 of the Maryland Health-General Article.
3. If no All-Payer Model Agreement or State law amount, as described in items #1 and #2 above, applies to the covered Service, an amount agreed upon by Health Plan and the non-Plan Provider.

4. If items #1, #2, and #3 above does not apply, then an amount determined by a certified independent dispute resolution (IDR) entity under the federal IDR process, as described in section 2799A–1(c) or 2799A–2(b) of the federal Public Health Service Act, as applicable.

Plan: Kaiser Permanente.

Plan Facility: A Plan Medical Center, a Plan Hospital, or another freestanding facility that (a) is operated by us, directly or indirectly, or contracts to provide Services and supplies to Members, and (b) is included in your Signature provider network.

Plan Hospital: A hospital that (a) contracts, directly or indirectly, to provide inpatient and/or outpatient Services to Members and (b) is included in your Signature provider network.

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

Plan Pharmacy: Any pharmacy located at a Plan Medical Center Contracts, directly or indirectly, to provide Services to Member, and is included in the Signature provider network.

Plan Physician: Any licensed physician who is an employee of Medical Group, or any licensed physician (except for those physicians who contract only to provide Services upon referral) who (a) contracts to provide Services and supplies to Members and (b) is included in your Signature provider network.

Plan Provider: A Plan Physician or other health care provider, including but not limited to a Non-Physician Specialist, and Plan Facility that (a) is employed by or operated by an entity that participates in the Kaiser Permanente Medical Care Program, or (b) contracts, directly or indirectly, with an entity that participates in the Kaiser Permanente Medical Care Program.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive after your attending emergency physician or Treating Provider determines that your Emergency Medical Condition is Stabilized. We cover Post-Stabilization Care only when (1) it is considered to be Emergency Services under federal law, without Prior Authorization, or, (2) we determine that such Services are Medically Necessary pursuant to a request for Prior Authorization for the Service(s).

Premium: Periodic membership charges paid by Group.

Prior Authorization: Our determination that a proposed Service is covered and Medically Necessary pursuant to Our Quality Resource Management Program in advance of your receipt of the Service.

Qualifying Payment Amount: The amount calculated using the methodology described in federal regulation 45 C.F.R. § 149.140(c)), which is based on the median contracted rate for all individual plans issued by Health Plan for the same or similar Service that is:

1. Provided by a provider in the same or similar specialty or facility of the same or similar facility type; and
2. Provided in the geographic region in which the item or Service is furnished.

The median contracted rate is subject to additional adjustments specified in the applicable federal regulation.

Recognized Amount: With respect to an item or service furnished by a Non-Participating Provider or Non-Participating Emergency Facility, means an amount that is determined as follows:

1. In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to the Service, the amount Health Plan is required to pay under the All-Payer Model Agreement for such Service. For certain Services billed by Maryland hospitals, this is the amount for the Service under Maryland's All-Payer Model Agreement as approved by the HSCRC.
2. If there is no such All-Payer Model Agreement applicable to the Service, then under Maryland law, the amount that Health Plan is required to pay pursuant to §19-710.1 of the Maryland Health-General Article.
3. If no All-Payer Model Agreement or State law amount, as described in items #1 and #2 above, applies to the covered Service, then the lesser of the amount billed by the non-Plan Provider, or the Qualifying Payment Amount.

Service Area: The areas of the District of Columbia; the following Virginia counties – Arlington, Fairfax, King George, Loudoun, Spotsylvania, Stafford, Prince William, and specific ZIP codes within Caroline, Culpeper,

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

Services: A health care item or Service that is covered under this EOC and Medically Necessary to prevent, diagnose, or treat a medical condition.

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

Spouse: means:

1. Your legal husband or wife. The person to whom you are legally married under applicable law; or
2. Your domestic partner who:
    a. Is at least eighteen (18) years old;
    b. Is not related to you by blood or marriage within four degrees of consanguinity under civil law rule;
    c. Is not married or in a civil union or domestic partnership with another individuals;
    d. In relation to you, has been financially interdependent for at least six (6) months prior to application in which both of you contributes to some extent to the others maintenance and support with the intention of remaining in the relationship; and
    e. Shares a common primary residence with you.

    An individual who asserts a domestic partnership will be required to provide:
    a. An affidavit signed under penalty of perjury by two individuals stating that they have established a domestic partnership;
    b. Proof of any one of the documents below indicating a common primary residence between you and your domestic partner:
        i. Common ownership of the primary residence via joint deed or mortgage payment;
        ii. Common leasehold interest in the primary residence;
        iii. Driver's license or State-issued identification listing a common address; or
        iv. Utility or other household bill with both your and your domestic partner's name appearing; and
    c. Proof of any one of the document below indicating financial interdependence between you and your domestic partner:
        i. Joint bank account or credit account;
        ii. Designation as the primary beneficiary for life insurance or retirement benefits of the domestic partner
        iii. Designation as primary beneficiary under the domestic partner's will;
        iv. Mutual assignments of valid durable powers of attorney under Estates and Trusts Article, §13-601, Annotated Code of Maryland;
        v. Mutual valid written advanced directives under Health-General Article, §5-601 et seq., Annotated Code of Maryland, approving the other domestic partner as health care agent;
        vi. Joint ownership or holding of investments; or
        vii. Joint ownership or lease of a motor vehicle.

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

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status (unless coverage is provided under a continuation of coverage provision) and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in Section 1 – Introduction).

Totally Disabled:

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

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

Treating Provider: A physician or other health care provider who has evaluated the Member's Emergency Medical Condition.

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

Visit: The instance of going to or staying at a health care facility, and, with respect to Services furnished to a Member at a health care facility, includes, in addition to Services furnished by a provider at the health care facility, equipment and devices, telemedicine Services, imaging Services, laboratory Services, and preoperative and postoperative Services, regardless of whether the provider furnishing such Services is at the health care facility.

Kaiser Permanente
Large Group Agreement and Evidence of Coverage
Maryland

Summary of Services and Cost Shares

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

DEPENDENT AGE LIMIT
Eligible Dependent children are covered as follows:

- Biological, adopted and stepchildren to the end of the month in which they turn 26.
- Grandchildren, legal wards and other child relatives to the end of the month in which they turn 25.

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

You are responsible for payment of all Cost Shares at the time you receive a Service. Failure to pay your Cost Shares may result in termination of your Membership (refer to ***Section 6, Termination for Nonpayment***).

Copayments	
Covered Service	**You Pay**
Outpatient Care	
Office visits (for other than preventive health care Services)	
Primary care office visits	$15 per visit
Specialty care office visits	$15 per visit
Outpatient surgery	No charge
Diagnostic testing (not preventive screening) as described under Outpatient Care in Section 3	No charge
Anesthesia	No charge
Chemotherapy and radiation therapy	No charge
Respiratory therapy	No charge
Hospital Inpatient Care	
All charges incurred during a covered stay as an inpatient in a hospital	No charge
Accidental Dental Injury Services	
Office visits	$15 per visit
All other related Services	Applicable Cost Shares will apply, based on type and place of Service
Allergy Services	
Evaluations and treatment	$15 per visit
Injection visits and serum	$15 per visit

Copayments	
Covered Service	**You Pay**
Ambulance Services By a licensed ambulance Service, per encounter	No charge
Non-emergent transportation Services (ordered by a Plan Provider)	No charge
Anesthesia for Dental Services Anesthesia and associated hospital or ambulatory Services for certain individuals only (as described under Anesthesia for Dental Services in Section 3).	No charge
Blood, Blood Products, and their Administration	No charge
Chemical Dependency and Mental Health Services Treatment of mental illness, emotional disorders, drug and alcohol abuse described in the "Benefits" section	No charge
Inpatient psychiatric and substance abuse care, including detoxification	No charge
Residential treatment center	No charge
Partial hospitalization	No charge
Outpatient psychiatric and substance abuse care • Individual therapy • Group therapy	 $15 per visit $7 per visit
Psychiatric Residential Crisis Services	No charge
Methadone treatment	No charge
All other outpatient treatment	No charge
Medication management	$15 per visit
Chiropractic and Acupuncture Services	$15 per visit
Cleft Lip, Cleft Palate, or Both	Applicable cost shares will apply, based on type and place of service
Clinical Trials	Applicable cost shares will apply, based on type and place of service
Diabetic Equipment, Supplies, and Self-Management Training Diabetic equipment and supplies	 No charge
Self-management training • Training during office visit	 $15 per visit

Copayments	
Covered Service	**You Pay**
• Other training (See Section 3 for description of benefits)	No charge
Dialysis	
Inpatient care	No charge
Outpatient Care	No charge
Drugs, Supplies, and Supplements Administered by or under the supervision of a Plan Provider	No charge
Durable Medical Equipment	No charge
Emergency Room Services	
Observation for less than 24 hours	$150 per visit ($75 for facility and $75 for Physician) (waived if admitted)
Observation for 24 hours or more	No charge
Note: If criteria are not met for a medical emergency, Plan coverage is 50% of Allowable Charge, plus the two $75 copayments	
Family Planning Services	
Office visits (other than WPS)	$15 per visit
Abortion care Services	No charge
Tubal ligations	No charge
Male sterilization	No charge
Women's Preventive Services (WPS), including all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity are covered under Preventive Care at no charge.	
Standard fertility preservation procedures for iatrogenic infertility	$15 per visit
Instruction on fertility awareness-based methods	No charge
Habilitative Services - Outpatient	
Physical, Occupational or Speech Therapy	$15 per visit
Applied Behavioral Analysis (ABA)	$15 per visit
Assistive Devices	No charge
Hearing Services	
Hearing tests (newborn hearing screening tests are covered	$15 per visit

Copayments	
Covered Service	**You Pay**
under preventive health care Services at no charge) Hearing aids	
• Hearing aid tests	No charge
• Hearing aids (Limited to a single hearing device per hearing impaired ear, every 36 months)	No charge
Home Health Care Limited to a maximum benefit of 120 days per Member per contract year. The visit maximum does not apply to home visits following mastectomy or testicle removal; or postpartum home visits.	No charge
Hospice Care Services	No charge
Infertility Services (Inpatient treatment, outpatient surgery, or outpatient visits) **Note:** Coverage for in vitro fertilization (IVF) is limited to a maximum of three attempts per live birth with a lifetime benefit maximum of $100,000 and artificial insemination is limited to six attempts.	No charge
Infusion Therapy	Applicable Cost Shares will apply, based on type and place of Service
Maternity Services Prenatal and postpartum visits (after confirmation of pregnancy), including diagnostic tests	No charge
Delivery and all inpatient services	No charge
Postpartum home visits (as described in Section 3)	No charge
Breast Pumps	No charge
Maternity Services that are required by the Affordable Care Act are covered under Preventive Care Services at no charge.	
Medical Foods (including Amino Acid-based Elemental Formula)	No charge
Morbid Obesity Services	Applicable Cost Shares will apply based on type and place of Service
Nutritional Counseling/Medical Nutrition Therapy	$15 per visit
Oral Surgery	No charge
Pediatric Autoimmune Neuropsychiatric Disorders	Applicable Cost Shares will apply based on type and place of Service

Copayments	
Covered Service	**You Pay**
Private Duty Nursing - Outpatient	No charge
Prescription Drugs Benefits are not available through Health Plan for Pharmacy-dispensed Prescription Drugs. Benefits available through Health Plan for Prescription Drugs, intended for outpatient use, are limited to injectable Prescription Drugs that require administration by a Plan Provider. Benefits are also available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Plan Provider, and dispensed in the office of a Plan Provider.	Not covered
Preventive Health Care Services	No charge
Prosthetic and Orthotic Devices See Section 3 for description of benefits	No charge
Reconstructive Surgery	No charge
Skilled Nursing Facility Care (Limited to a maximum benefit of 180 days per contract year)	No charge
Telemedicine Services	No charge
Therapy and Rehabilitation Services - Outpatient (Physical/Occupational Therapy services must be pre-certified after the 20th visit, based on medical necessity; Limited to 50 days per contract year combined for Physical, Occupational and Speech Therapy)	$15 per visit
Transgender Surgery	Applicable Cost Share will apply, based on place of Service
Transplants	No charge
Pre-transplant dental Services • Dental Services Office Visit	$15 per visit
• All other related Services	Applicable Cost Shares will apply based on type and place of Service
Urgent Care	$15 per visit
Vision Exam Services (adult age 19 or older) Eye exams	
• Routine (one per contract year)	No charge
• Non-routine	$15 per visit

Copayments	
Covered Service	**You Pay**
Eyewear –Lenses (per contract year)	Member allowance:
Single vision	$52.00
Bifocal (single)	$82.00
Bifocal (double)	$88.20
Trifocal	$101.00
Lenticular	$181.00
Eyewear -Frames (per contract year)	Member allowance: $45.00
Contact lenses (per contract year) Per pair, in lieu of frames and lenses:	Member allowance:
Medically Necessary	$285.00
Cosmetic	$97.00
Note: Member pays any cost above the allowance.	
Vision Services (for children under age 19) **Note:** A child is covered until the end of the month in which the child attains age 19.	
Eye exams	
• Routine (one per contract year)	No charge
• Non-routine	$15 per visit
Note: Pediatric vision hardware chosen from a select group is covered at no charge and is covered up until the end of the month they turn age 19.	
Eyeglass lenses and frames	No charge
Contact lenses	No charge
Low vision aids	No charge
Note: Contact lenses, including medically necessary contact lenses, are covered in lieu of eyeglasses.	
Additional Vision Services (for children until the end of the month in which the child turns age 19) For pediatric vision hardware not included in select group, the member pays any cost above the State provided allowed amount.	
• Frames	Allowed Amount $70
• Lenses	
- Basic Single Vision	Allowed Amount $40
- Basic Bifocals	Allowed Amount $60

Copayments	
Covered Service	**You Pay**
- Basic Trifocals	Allowed Amount $80
- Basic Lenticular	Allowed Amount $100
• Contact lenses (in lieu of frames and lenses)	
- Contact lenses	Allowed Amount $105
- Medically Necessary Contacts	Allowed Amount $225
X-ray, Laboratory and Special Procedures Diagnostic imaging and laboratory tests	
Inpatient Services	No charge
Outpatient Services	No charge
Specialty Imaging (including CT, MRI, PET Scans, Nuclear Medicine); Interventional Radiology and Special Procedures	
Inpatient Services	No charge
Outpatient Services	No charge
Sleep lab and sleep studies	No charge

Copayment Maximum

The Copayment Maximum is the limit to the total amount of Copayments you must pay in a contract year for the Basic Health Services (listed below) covered under this EOC. Once you have met the Copayment Maximum, you will not be required to pay any additional Copayments for these Basic Health Services. After two or more Members of a Family Unit combined have met the Family Copayment Maximum, the Copayment Maximum will be met for all Members of the Family Unit for the rest of the contract year.

Basic Health Services. Except as excluded below, the following Services are considered Basic Health Services that apply toward the Copayment Maximum:

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

Copayment Maximum Exclusions. The following Services, if covered, are ***not*** considered Basic Health Services and ***do not*** apply toward your Copayment Maximum. Your Cost Share for these Services will continue to apply even after you have met your Copayment Maximum:

- Adult vision Services

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

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

Annual Copayment Maximum	
Combined total of allowable Copayments for Basic Health Services	**Individual Copayment Maximum** $1,500 per individual per contract year **Family Copayment Maximum** $3,000 per Family Unit per contract year

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

STATE OF MARYLAND EMPLOYEE AND RETIREE HEALTH AND WELFARE BENEFITS PROGRAM TRANSGENDER SURGERY RIDER

This Transgender Surgery Rider (herein called "Rider") is effective as of the date of your State of Maryland Employee and Retiree Health and Welfare Benefits Program Agreement and State of Maryland Employee and Retiree Health and Welfare Benefits Program Evidence of Coverage, and shall terminate as of the date your State of Maryland Employee and Retiree Health and Welfare Benefits Program Agreement and State of Maryland Employee and Retiree Health and Welfare Benefits Program Evidence of Coverage.

The following benefits and exclusions for Transgender Surgery are hereby added to the "Benefits" Section of this State of Maryland Employee and Retiree Health and Welfare Benefits Program (herein referred to as the Group EOC), in consideration of the application and payment of the additional Premium for such Services:

A. Benefits

We cover the following services:

1. Outpatient psychotherapy/mental health services for gender dysphoria and associated co-morbid psychiatric diagnoses. The benefits are the same as any other outpatient mental health service in the Program.

2. Continuous hormone replacement therapy. The benefits are the same as any other eligible drug in the Program. Note the following clarifications:
    - Hormones injected by a medical provider (for example during an office visit) are covered by the medical plan.
    - Oral and self injected hormones from a pharmacy are not covered under the medical plan. Refer to the Benefit Guide for specific prescription drug product coverage and exclusion terms. They are covered under the separately provided prescription drug plan, if enrolled.

3. Outpatient laboratory testing to monitor continuous hormone therapy. The benefits are the same as any other outpatient diagnostic service in the program.

4. Gender reassignment surgery. Medically necessary gender reassignment procedures are covered, as follows. The procedures identified in this paragraph and any combination of procedures within each type of transition – male-to-female transition: orchiectomy, penectomy, clitoroplasty, labiaplasty, vaginoplasty, thyroid chondroplasty; female-to-male transition: vaginectomy, hysterectomy, mastectomy, salpingo-oophorectomy, ovariectomy, metoidioplasty, phalloplasty, scrotoplasty, placement of testicular prostheses; either: urethroplasty – are considered medically necessary for treatment of gender dysphoria when all of the following criteria are met:

    a. The individual is at least 18 years of age; and

    b. The individual has capacity to make fully informed decisions and consent for treatment; and

    c. The individual has been diagnosed with gender dysphoria and exhibits all of the following:

        1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and

        2. The gender dysphoria (pre- and post-diagnosis) has been present persistently for

at least two years; and

3. The gender dysphoria is not a symptom of another mental disorder; and

4. The gender dysphoria causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

d. For individuals without a medical contraindication or not otherwise unable to take hormones, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician. (Hormonal therapy is not required as a prerequisite to a mastectomy.); and

e. Documentation that the individual has completed a minimum of 12 months of successful continuous, substantially full-time real-life experience in their new gender, across a wide range of life experiences and events that may occur throughout the year, (The real-life experience is not required as a perquisite to a mastectomy, augmentation mammoplasty, thyroid chondroplasty, hysterectomy, salpingo-oophorectomy, or orchiectomy.); and

f. Regular participation in psychotherapy and/or ongoing clinical treatment throughout the real-life experience may be required when recommended by a treating medical or behavioral health practitioner or when medically necessary; and

g. If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; and

h. Two referrals from qualified mental health professionals who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) are required. At least one of the professionals submitting a letter must have a doctoral degree (Ph.D., M.D., Ed.D, D.Sc., D.S.W., or Psy.D) and be capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two providers, one of whom has met the doctoral degree specifications, in addition to the specifications set forth above. One letter signed by an appropriate provider is sufficient to support benefits for a mastectomy. The medical documentation should include the start date of living full time in the new gender, when applicable.

5. Augmentation mammoplasty. Provided the criteria above for gender reassignment surgery have been satisfied, augmentation mammoplasty (including breast prosthesis if necessary) may be covered for male-to-female transgender individuals if the Physician prescribing hormones and the treating surgeon have documented that, after undergoing hormone treatment for 12 months, breast size continues to cause clinically significant distress in social, occupational, or other areas of functioning.

6. Facial feminization and masculinization.

B. <u>Exclusions</u>

The surgeries and procedures identified below are excluded from coverage:

1. Nipple/areola reconstruction, except in connection with a covered augmentation mammoplasty or mastectomy
2. Breast enlargement procedures, except in connection with a covered augmentation mammoplasty
3. Brow lift
4. Cheek implants
5. Chin/nose implants
6. Collagen injections

7. Electrolysis
8. Facial bone reconstruction
9. Face/forehead lift
10. Hair removal/hairplasty/hair transplantation
11. Jaw shortening/sculpturing/facial bone reduction
12. Lip reduction/enhancement
13. Liposuction
14. Neck tightening
15. Reversal of genital or breast surgery or reversal of surgery to revise secondary sex characteristics
16. Voice modification surgery
17. Voice therapy/voice lessons
18. Rhinoplasty
19. Removal of redundant skin, except in connection with a covered surgery
20. Replacement of tissue expander with permanent prosthesis testicular insertion, except as a component of a covered placement of a testicular prosthesis
21. Second stage phalloplasty
22. Surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis including pump and/or cylinders and/or reservoir
23. Testicular prostheses, except as a component of a covered placement of a testicular prosthesis (subsequent replacement or correction of such prosthesis subject to rules and limitations applicable to all prosthetic devices)
24. Blepharoplasty
25. Penile prosthesis (non-inflatable/inflatable), except in connection with a covered phalloplasty (implantation of the prosthesis shall not be considered a second stage phalloplasty) in a female-to-male transition (subsequent replacement or correction of such prosthesis subject to rules and limitations applicable to all prosthetic devices)
26. Testicular expanders, except as a component of a covered placement of a testicular prosthesis
27. Laryngoplasty
28. Mastopexy
29. Abdominoplasty

C. <u>Your Cost Share</u>

Refer to the Summary of Services and Cost Shares in this Group EOC for the applicable Cost Share for each covered Service.

This Rider is subject to all the terms and conditions of the State of Maryland Employee and Retiree Health and Welfare Benefits Program Agreement and the State of Maryland Employee and Retiree Health and Welfare Benefits Program Evidence of Coverage to which this Rider is attached. This Rider does not change any of those terms and conditions, unless specifically stated in this Rider.

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

By: _____
Gracelyn McDermott
Vice President, Marketing, Sales, & Business Development