KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES and
KAISER PERMANENTE CHILD ONLY
MEMBERSHIP AGREEMENTS AND EVIDENCE OF COVERAGE

MARYLAND

This plan has Excellent accreditation from the NCQA
See 2020 NCQA Guide for more information on Accreditation
NONDISCRIMINATION NOTICE

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

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

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

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

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


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) ያስተካከል:

**MLحكمًا: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجاني.**

العربية (Arabic)

1-800-777-7902 (TTY: 711).

Ɓàsɔ̀-wùɖù (Bassa)

**Nota:** Si tu parles en baasa, des services d'assistance linguistique gratuits sont disponibles pour vous. Communiquez au 1-800-777-7902 (TTY: 711).

বাংলা (Bengali)

যদি আপনি বাংলা বলতে পারেন, তাহলে লিঙ্গচর্চায় ভাষা সহায়তা প্রদানের জন্য উপলব্ধ আছে। কেফ করুন 1-800-777-7902 (TTY: 711).
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, stellen Ihnen kostenlos sprachliche Hilfeleistungen zur Verfügung. Rufnummer: 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).

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


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

SECTION 1: INTRODUCTION TO YOUR KAISER PERMANENTE HEALTH PLAN  1.1

Welcome to Kaiser Permanente ........................................................................ 1.1
Our Commitment to Diversity and Nondiscrimination ..................................... 1.1
About This Agreement .................................................................................... 1.1
How Your Health Plan Works ......................................................................... 1.3
Kaiser Permanente for Individuals and Families Plan / Kaiser Permanente Child Only Services
   Overview ....................................................................................................... 1.4
Enrollment Through the Exchange ................................................................. 1.4
Eligibility for a Kaiser Permanente Individuals and Families Plan ...................... 1.4
Eligibility for a Kaiser Permanente Child Only Plan ........................................ 1.5
Eligibility for Catastrophic Coverage Plans ..................................................... 1.6
Member Rights and Responsibilities: Our Commitment to Each Other .......... 1.7
Health Savings Account Qualified Plans ......................................................... 1.9
Payment of Premium ....................................................................................... 1.10
Annual Enrollment Period and Effective Date of Coverage .............................. 1.11
Special Enrollment Periods Due to Triggering Events .................................... 1.11
Length of Special Enrollment Periods ............................................................. 1.16
Effective Date for Special Enrollment Periods ................................................ 1.16
Restrictions on Qualified Health Plan Selection .............................................. 1.18
Premium Payment Changes Due to Special Enrollments ................................. 1.18
Premium Payment Requirements for Special Open Enrollment Periods .......... 1.19
Additional Special Enrollment Period for a Child Under Guardianship ............ 1.20
Special Enrollment Periods and Effective Date of Coverage for American Indians and Alaska
   Natives Who Enroll Through the Exchange ................................................ 1.20
Notice of Your Effective Date of Coverage .................................................... 1.20

SECTION 2: HOW TO GET THE CARE YOU NEED  2.1

Making and Cancelling Appointments and Who to Contact ............................. 2.1
Advance Directives to Direct Your Care While Incapacitated ........................... 2.1
Receiving Health Care Services ..................................................................... 2.2
Your Kaiser Permanente Identification Card .................................................. 2.2
Choosing Your Primary Care Plan Physician .................................................. 2.3
Getting a Referral .......................................................................................... 2.3
Continuity of Care for New Members ............................................................ 2.5
Getting Emergency and Urgent Care Services .............................................. 2.7
Hospital Admissions ...................................................................................... 2.7
Getting Assistance from Our Advice Nurses .................................................. 2.7
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

Age Limit / Misstatement of Age 6.7
Spousal Conversion Privileges Upon Death of the Subscriber 6.7
Transfer of Membership: Changing from Dependent to Subscriber Under a Kaiser Permanente for Individuals and Families Membership Agreement 6.7
Transfer of Membership: Changing from a Kaiser Permanente Child Only Member to a Subscriber Under a Kaiser Permanente for Individuals and Families Membership Agreement 6.7
Reinstatement of Membership 6.8

SECTION 7: OTHER IMPORTANT PROVISIONS OF YOUR PLAN 7.1

Applications and Statements 7.1
Assignment 7.1
Attorney Fees and Expenses 7.1
Contestability 7.1
Contracts with Plan Providers 7.2
Governing Law 7.2
Legal Action 7.2
Mailed Notices 7.2
Overpayment Recovery 7.3
Privacy Practices 7.3

APPENDICES

Important Terms You Should Know DEF.1
Adult Dental Plan Appendix B.1
Pediatric Dental Plan Appendix C.1
Summary of Cost Shares Appendix CS.1
Outpatient Prescription Drug Benefit Appendix Rx.1
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

SECTION 1: Introduction to Your Kaiser Permanente Health Plan

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

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

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

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

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

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

About This Agreement
Once you are enrolled in this Plan, you become a Member of Kaiser Permanente. A Member may be a Subscriber and/or any eligible Dependents who are enrolled in a Kaiser Permanente for Individuals and Families Plan, or an eligible child enrolled in a Kaiser Permanente Child Only Plan. Members are sometimes referred to by the terms “you” and “your.” Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., is sometimes referred to as “Health Plan,” “we,” “us,” “our” and “Kaiser Permanente.”

Under no circumstances should the terms “you” or “your” be interpreted to mean a Financially Responsible Person, Parent/Guardian or any other nonmember reading or interpreting this Agreement on behalf of a Member.

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

Purpose of this Agreement
This Agreement serves two important purposes. It:
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

1. Is a legally binding contract between a Member and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.; and
2. Provides evidence of your health care coverage under this Kaiser Permanente Individuals and Families Membership Agreement or Kaiser Permanente Child Only Membership Agreement, as applicable.

Acceptance of Agreement
Payment of due Premium indicates to the Health Plan that a Subscriber or Financially Responsible Person accepts this Agreement in full. Acceptance of this Agreement confirms that a Subscriber or Financially Responsible Person and the Health Plan agree to all of the provisions contained within it.

Right to Reject Agreement
You may return this Agreement to the Health Plan within ten (10) days of receiving it if you feel the Agreement is not satisfactory for any reason. If you return this Agreement and it is received by us within ten (10) days, you will receive a full refund of paid Premium and the Agreement will be void and canceled. This right may not be exercised if any Member covered under the Agreement utilizes the Services of the Health Plan within the aforementioned ten (10) day period.

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

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

Entire Contract
This Agreement, including all appendices attached, constitutes the entire contract between you and us, and replaces any earlier Agreement that may have been issued to you by us.

This Agreement will only be modified as allowed or required by law. We may not amend this Agreement with respect to any matter, including rates.

No agent or other person, except an officer of the Health Plan, has the authority to:
  1. Waive any conditions or restrictions of this Agreement;
  2. Extend the time for paying required Premium; or
  3. Bind the Health Plan in any way, verbally or otherwise, by:
     a. Making any promise or representation; or
     b. Giving or receiving any information.

No change in this Agreement will be considered valid unless recorded in a written amendment signed by an officer of the Health Plan and attached to this Agreement.

This Agreement is undersigned by us immediately below. Your signature is not required.
How Your Health Plan Works
The Health Plan provides Health Care Services to Members through an integrated medical care system, rather than reimbursement of expenses on a fee-for-service basis. Please keep this direct service nature in mind as you read this Agreement. Our integrated medical care system is made up of various entities. The relationship between them is explained immediately below.

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

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

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

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

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

Liability for Amounts Owed By the Health Plan
Members are not liable for any amounts owed to the Medical Group or Plan Hospitals by the Health Plan, as stipulated by contracts between these entities.
Kaiser Permanente for Individuals and Families/Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

Kaiser Permanente for Individuals and Families Plan/Kaiser Permanente Child Only Plan Services Overview

Health Care Services are provided to you through an integrated medical care system using Plan Providers located in our state-of-the-art Plan Medical Centers and through affiliated Plan Providers located throughout our Service Area.

Getting the care you need is easy. Health Care Services are accessible at Plan Medical Centers, which are conveniently located throughout the Washington, DC and Baltimore Metropolitan Areas. At our Plan Medical Centers, we have integrated teams of specialists, nurses and technicians working alongside your Primary Care Plan Physician to support your health and wellbeing. Pharmacy, optical, laboratory and X-ray facilities are also available at many Plan Medical Centers.

Under this Agreement, you must receive Services from Plan Providers within our Service Area, except for:

1. Emergency Services, as described in Section 3: Benefits, Exclusions and Limitations;
2. Urgent Care Services outside of our Service Area, as described in Section 3: Benefits, Exclusions and Limitations;
3. Continuity of Care for New Members, as described in Section 2: How to Get the Care You Need;
4. Approved referrals, as described in Section 2: How to Get the Care You Need under the Getting a Referral provision, including referrals for Clinical Trials, as described in Section 3: Benefits, Exclusions and Limitations.

Enrollment Through the Exchange

The Health Plan will enroll all Qualified Individuals that apply for coverage with us through the Exchange only if the Exchange:

1. Notifies us that the individual is a Qualified Individual; and
2. Transmits all the information necessary for us to enroll the applicant.

Eligibility for a Kaiser Permanente Individuals and Families Plan

This provision describes who is eligible for a Kaiser Permanente Individuals and Families Plan. See the next provision of this section for information on eligibility requirements for a Kaiser Permanente Child Only Plan.

Member Eligibility

Members may be accepted for enrollment and continuing coverage hereunder only upon meeting all of the applicable requirements below, which are set forth by the Health Plan or Exchange, depending on how you applied for coverage.

Subscribers

For Subscribers who enroll directly through the Health Plan during an annual open or a special enrollment period: To be a Subscriber you must apply during an annual open enrollment period or a special enrollment period, both of which are described within this section of your EOC.
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

For Subscribers who enroll through the Exchange: The Exchange will determine whether an individual is a Qualified Individual under this Plan in accordance with 45 CFR §155.305 and 45 CFR §156.265(b).

Any Subscriber under a Kaiser Permanente for Individuals and Families Plan must reside within our Service Area at the time of enrollment to be eligible for this Plan.

Dependents
To be a Dependent you must be:
1. The Subscriber’s Spouse or Domestic Partner.
2. A Dependent child of the Subscriber or the Subscriber's Spouse or Domestic Partner who is under the limiting age of 26. A Dependent child under the limiting age is defined as either:
   a. A biological child, stepchild, lawfully adopted child or foster child placed for legal adoption with the Subscriber or the Subscriber's Spouse or Domestic Partner; or
   b. An unmarried grandchild, or unmarried child under testamentary or court-appointed guardianship of the Subscriber or the Subscriber's Spouse or Domestic Partner.
3. A Dependent child under the limiting age of 26 who is not a natural or adopted child, but for whom the Subscriber or the Subscriber's Spouse or Domestic Partner has received a court or administrative order.

An unmarried child who is covered as a Dependent when they reach the limiting age under requirement #2 above may continue coverage if he/she is incapable of self-support by reason of mental incapacity or physical handicap. The child must be chiefly dependent upon the Subscriber or the Subscriber's Spouse or Domestic Partner for support and maintenance. Proof of incapacity and dependency must be provided when requested by the Health Plan.

For Subscribers who enroll a Dependent through the Exchange: Subscribers who apply for coverage through the Exchange must notify the Exchange of any change in eligibility of a Dependent for any reason other than the child becomes age 26.

Eligible children of the Subscriber or Subscriber’s Spouse or Domestic Partner who live outside of our Service Area are eligible for Dependent coverage. However, the only covered Services outside of our Service Area are:
1. Emergency Services;
2. Urgent Care Services;
3. 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; and
4. Services received when a Dependent is transitioning from a previous carrier to Kaiser Permanente.

Eligibility for a Kaiser Permanente Child Only Plan
This provision describes who is eligible for a Kaiser Permanente Child Only Plan. See the preceding provision of this section for information on eligibility requirements for a Kaiser Permanente Individuals and Families Plan.
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

**Member Eligibility**
Members may be accepted for enrollment and continuing coverage hereunder only upon meeting all of the applicable requirements below, which are set forth by the Health Plan or Exchange, depending on how you applied for coverage.

**Subscribers**
For Subscribers who enroll directly through the Health Plan during an annual open or a special enrollment period: To be a Subscriber you must apply during an annual open enrollment period or a special enrollment period, both of which are described within this section of your EOC.

For Members who enroll through the Exchange: The Exchange will determine if an individual is a Qualified Individual under this Plan in accordance with 45 CFR §155.305 and 45 CFR §156.265(b).

Any Subscriber under a Kaiser Permanente Child Only Plan must reside within our Service Area at the time of enrollment to be eligible for this Plan.

Additionally, for a child to become a Member under this Kaiser Permanente Child Only Plan, they must:

1. Be a child under the age of 21.
2. Have a Financially Responsible Person and/or Parent/Guardian with legal authority to enter into this Agreement on behalf of a Member who is:
   a. Under age 18; or
   b. Between the ages of 18-21 and incapable of making such decisions by reason of mental incapacity.

A minor or anyone under the age of 18 cannot apply for coverage on their own behalf without the binding written consent of a Financially Responsible Person and/or Parent/Guardian.

After the initial twelve (12) months of enrollment and at each subsequent twelve (12) month renewal period, the Parent/Guardian must prove that the Member still meets all eligibility requirements for a Kaiser Permanente Child Only Plan.

**Ineligible Persons**
The following people are not eligible for membership under a Kaiser Permanente Child Only Plan:

1. Any person over age 21; or
2. Unborn children.

**Eligibility for Catastrophic Coverage Plans**
This provision applies only to Members with catastrophic coverage. Some Plans offer catastrophic coverage, depending on Member age and other factors. Review the Cost Sharing information provided in this Agreement to determine whether or not you are enrolled in catastrophic coverage.

**Member Eligibility**
In order to enroll and to continue enrollment in our catastrophic Plan, you and each Dependent must individually meet one of the following requirements:

1. You and your Dependent(s) must not have reached age 30 before January 1st of the Calendar Year. If you reach age 30 on or after January 1st, your catastrophic coverage will continue until
the end of the current Calendar Year. However, you will no longer meet the age qualification for
catastrophic coverage beginning January 1st of the next year; or
2. The Health Plan has certified that for the 1st day of the current Calendar Year, you and/or your
Dependent are exempt from the shared responsibility payment for the reasons identified in
Internal Revenue Code Section 5000A(e)(1)(relating to individuals without affordable coverage)
or 5000A(e)(5) (relating to individuals with hardships).

Member Rights and Responsibilities: Our Commitment to Each Other
Kaiser Permanente is committed to providing you with quality Health Care Services. In the 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 or your Authorized Representative, Parent/Guardian or a
Financially Responsible Person, as applicable, have the right to:
1. Receive information that empowers you to be involved in health care decision making. This
includes the right to:
   a. Actively participate in discussions and decisions regarding your health care options;
   b. Receive and be helped to understand information related to the nature of your health status or
condition, including all appropriate treatment and non-treatment options for your condition
and the risks involved – no matter what the cost is or what your benefits are;
   c. Receive relevant information and education that helps promote your safety in the course of
treatment;
   d. Receive information about the outcomes of health care you have received, including
unanticipated outcomes. When appropriate, family members or others you have designated
will receive such information;
   e. Refuse treatment, providing you accept the responsibility and consequences of your decision;
   f. Give someone you trust the legal authority to make decisions for you if you ever become
unable to make decisions for yourself by completing and giving us an Advance Directive, a
Durable Power of Attorney for Health Care, Living Will, or other health care treatment
directive. You can rescind or modify these documents at any time;
   g. Receive information about research projects that may affect your health care or treatment.
You have the right to choose to participate in research projects; and
   h. Receive access to your medical records and any information that pertains to you, except as
prohibited by law. This includes the right to ask us to make additions or corrections to your
medical record. We will review your request based on applicable federal and state law to
determine if the requested additions are appropriate. If we approve your request, we will
make the correction or addition to your protected health information. If we deny your
request, we will tell you why and explain your right to file a written statement of
disagreement. The Member or Member’s Authorized Representative will be asked to provide
written permission before a Member’s records are released, unless otherwise permitted by
law.
2. Receive information about Kaiser Permanente and your Plan. This includes the right to:
   a. Receive the information you need to choose or change your Primary Care Plan Physician, including the name, professional level and credentials of the doctors assisting or treating you;
   b. Receive information about Kaiser Permanente, our Services, our practitioners and Providers, and the rights and responsibilities you have as a Member. You also can make recommendations regarding Kaiser Permanente’s Member rights and responsibility policies;
   c. Receive information about financial arrangements with physicians that could affect the use of Services you might need;
   d. Receive Emergency Services when you, as a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed;
   e. Receive covered urgently needed Services when traveling outside Kaiser Permanente’s Service Area;
   f. Receive information about what Services are covered and what you will have to pay and to examine an explanation of any bills for Services that are not covered; and
   g. File a complaint, grievance or appeal about Kaiser Permanente or the care you received without fear of retribution or discrimination, expect problems to be fairly examined, and receive an acknowledgement and a resolution in a timely manner.

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

Member Responsibilities
As a Member of Kaiser Permanente, you or your Parent/Guardian, as applicable, are responsible to:

1. Promote your own good health:
   a. Be active in your health care and engage in healthy habits;
   b. Select a Primary Care Plan Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics or Family Practice as your Primary Care Plan Physician. You may also choose a personal OB/GYN in addition to Primary Care Plan Physician;
   c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you;
d. Work with us to help you understand your health problems and develop mutually agreed upon treatment goals;
e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment;
f. Do your best to improve your health by following the treatment plan and instructions your Primary Care Plan Physician or health care professional recommends;
g. Schedule the health care appointments your Primary Care Plan Physician or health care professional recommends;
h. Keep scheduled appointments or cancel appointments with as much notice as possible; and
i. Inform us if you no longer live within the Plan Service Area.

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

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

Health Savings Account-Qualified Plans

This provision only applies if you are enrolled in a qualified High Deductible Health Plan. It does not apply to Members with catastrophic Plan coverage. A Health Savings Account is a tax-exempt account established under Section 223(d) of the Internal Revenue Code for the exclusive purpose of paying current and future Qualified Medical Expenses. Contributions to such an account are tax deductible, but in order to qualify for and make contributions to a Health Savings Account, a Member must be enrolled in a qualified High Deductible Health Plan.

A qualified High Deductible Health Plan provides health care coverage that includes an:
1. Individual Deductible of $1,400.00 or greater and a family Deductible of $2,800.00 or greater; and
2. Individual Out-of-Pocket Maximum of no more than $6,900.00 and a family Out-of-Pocket Maximum of no more than $13,800.00 in the current Calendar Year.

In a qualified High Deductible Health Plan, all Deductible, Copayment and Coinsurance amounts must be counted toward the Out-of-Pocket Maximum. Review the Cost Sharing information contained within this Agreement to see whether or not this Plan meets the High Deductible Health Plan requirements described in this paragraph. A Plan is a qualified High Deductible Health Plan only if it meets those requirements.
requirements. Enrollment in a qualified High Deductible Health Plan is only one of the eligibility requirements for establishing and contributing to a Health Savings Account. Other requirements include the following prohibitions: The Member must not be:

1. Covered by other health coverage that is not also a Health Savings Account-qualified plan, with certain exceptions;
2. Enrolled in Medicare; and/or
3. Able to be claimed as a Dependent on another person’s tax return.

Please note that the tax references contained in this Agreement relate to federal income tax only. The tax treatment of Health Savings Account contributions and distributions under a state’s income tax laws may differ from the federal tax treatment. Kaiser Permanente does not provide tax advice. Contact your financial or tax advisor for more information about your eligibility for a Health Savings Account or to obtain tax advice.

Payment of Premium

Premium may be paid in different ways depending on how you applied for coverage under this Plan. This may include payment directly to the Health Plan or through the Exchange. In consideration of the timely Premium paid to the Health Plan or Exchange, we agree to arrange Health Care Services in accordance with the terms, conditions, limitations and exclusions of this Agreement.

Members covered under a Kaiser Permanente Child Only Plan may require someone to contractually agree to pay due Premium on their behalf. That individual is known as the Financially Responsible Person.

This Plan is contributory in that the Subscriber, on behalf of his/herself and any applicable Dependents, or a Financially Responsible Person, on behalf of a child Member, is responsible for payment of all required Premium. Premium is due directly to Health Plan no later than the 1st day of the coverage month, or through the Exchange, as applicable.

The Financially Responsible person may be a Parent/Guardian, but sometimes they are different people. In the event that the Financially Responsible Person and Parent/Guardian:

1. Are not the same person, then this Agreement is a legally binding contract between the:
   a. Health Plan;
   b. Financially Responsible Person; and
   c. Parent/Guardian who holds the legal authority to make medical decisions for a Member under age 18 or who is age 18 or older, but incapable of making medical decisions by reason of mental incapacity.
2. Is the same person, he/she shall be recognized as having the rights and responsibilities of both the Financially Responsible Person and the Parent/Guardian under this Agreement.

When requested by the Parent/Guardian, more than one (1) eligible child, when properly enrolled and for whom Premium has been paid, may be covered under this Agreement.

Only Members for whom the Health Plan has received the appropriate Premium payments are entitled to coverage under this Agreement, except as provided in Section 6: Extension of Benefits, and then only
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

for the period for which such Premium is received, in accordance with Section 6: Termination Due to
Nonpayment of Premium.

The Premium due under this Agreement is determined by the Health Plan upon application for coverage. The Subscriber or Financially Responsible Person, as applicable, will be given at least sixty-two (62) days’ notice of any Premium change upon renewal.

For Members who enroll through the Exchange: If you use Advance Premium Tax Credit, your monthly Premium payment may change if you take fewer or more tax credits due to changes in your income or the addition of loss of members of your household. Use of Advance Premium Tax Credit may have an impact on your income tax return. Kaiser Permanente does not provide tax advice. Contact your financial or tax advisor for more information about your eligibility for Advance Premium Tax Credit or to obtain tax advice.

Annual Enrollment Period and Effective Date of Coverage
There is an annual enrollment period during which Qualified Individuals may:

1. Enroll in this Plan;
2. Discontinue enrollment in this Plan; or
3. Change enrollment from this Plan to another Plan offered by us.

The annual enrollment period shall begin on November 1, 2019 and extend through December 15, 2019.

If a Qualified Individual enrolls in this Plan during the annual enrollment period for 2020, the effective date of coverage shall be January 1, 2020, for completed applications received on or before December 15, 2019.

Special Enrollment Periods Due to Triggering Events
When a triggering event occurs, a special enrollment period will be provided. If you and/or any Dependents are eligible to enroll in this Plan or another Plan offered by us during the special enrollment period, we will process your enrollment following your Plan selection and submission of any necessary information to confirm the occurrence of a triggering event. If we do not receive the Plan selection and any other required information necessary to confirm the triggering event in a timely manner, then no changes in enrollment can be made by us, except as otherwise specified below.

A triggering event occurs when:

1. You or your Dependent:
   a. Loses Minimum Essential Coverage;
   b. Are enrolled in any non-calendar year group health plan or individual health plan coverage even when you or your Dependent as the option to renew such coverage; or
   c. Loses pregnancy related coverage under Medicaid or loses access to healthcare Services through coverage provided to a pregnant woman’s unborn child; or
   d. Loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act. This triggering event allows you a special enrollment period only once per calendar year. The date of the loss of coverage is the last day you and/or your Dependent would have medically needy coverage.
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r Permanente Child Only Membership Agreement and Evidence of Coverage

Note: Loss of Minimum Essential Coverage does not include voluntary termination of coverage or other loss due to a) failure to pay premiums on a timely basis including, but not limited to, COBRA premiums prior to the expiration of COBRA coverage or b) situations allowing for a rescission of coverage pursuant to federal law.

2. You:
   a. Gain a Dependent or become a Dependent through marriage, birth, adoption, placement for adoption or placement in foster care, or through a child support order or other court order.
      i. In the case of marriage, you or your spouse must demonstrate having minimum essential coverage, medically needy coverage, pregnancy related coverage under Medicaid, or access to healthcare Services through coverage provided to a pregnant woman’s unborn child for one (1) or more days during the sixty (60) days preceding your date of marriage. This requirement is waived if you or your spouse can show they lived in a foreign country or in a United States territory for one (1) or more days during the sixty (60) days preceding your date of marriage or qualify as an American Indian or Alaskan Native, as defined by §4 of the federal Indian Health Care Improvement Act or lived for (1) or more days during the sixty (60) days preceding your date of marriage or during the most recent open enrollment period or special enrollment period in a service area where no Qualified Health Plan was available through the Exchange.
   b. Lose a Dependent or are no longer considered a Dependent through divorce or legal separation, as defined by state law in the state in which the divorce or legal separation occurs, or if you or your Dependent die.

3. You or your Dependent become newly eligible for enrollment in a Qualified Health Plan through the Exchange because you or your Dependent newly satisfy the requirements regarding becoming:
   a. A citizen, national or lawfully-present individual in the United States; or
   b. No longer incarcerated.

Note: For the triggering event listed above in item #3, enrollment is only permissible in a Qualified Health Plan through the Exchange.

4. You or your Dependent’s enrollment or non-enrollment in a Qualified Health Plan is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation, misconduct or inaction of an officer, employee or agent of the Exchange or U.S. Department of Health and Human Services, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities as determined by the Exchange.

For the triggering event immediately listed above, you or your Dependent may enroll in any Qualified Health Plan or change to any Qualified Health Plan, regardless if you or your Dependent are currently enrolled in a Qualified Health Plan.
5. You or your Dependent adequately demonstrate to the Exchange that the Qualified Health Plan in which you or your Dependent enrolled in substantially violated a material provision of its contract with respect to you or your Dependent as determined by the Exchange.

6. You or your Dependent who are enrolled in the same Plan, through the Exchange, are determined newly-eligible or ineligible for Advance Premium Tax Credit or have a change in eligibility for federal cost-sharing reductions.
   a. For Members who enroll outside of the Exchange, you or your Dependent may only enroll in any Health Plan if newly ineligible for Advanced Premium Tax Credit or newly ineligible for cost-sharing reductions.
   b. You or your Dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for Advanced Premium Tax Credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with Internal Revenue Code regulation 1.36B-2(c)(3), including as a result of your or their employer discontinuing or changing available coverage within the next sixty (60) days, provided you or your Dependent are allowed to terminate existing coverage.
   c. You were previously ineligible for Advanced Premium Tax Credit solely because of a household income below one hundred percent (100%) of the federal poverty level (FPL) and, during the same time period, you were ineligible for Medicaid because you were living in a non-Medicaid expansion State, either experience a change in household income or moves to a different state resulting in your becoming newly eligible for advance payments of the premium tax credit.

Note: The triggering events listed above in items #6b and #6c only permits enrollment in a Qualified Health Plan through the Exchange. If you or your Dependent are newly eligible for cost-sharing reductions and not enrolled in a silver-level Qualified Health Plan, you or your Dependent may enroll only in a silver-level Qualified Health Plan.

7. You or your Dependent gain access to new Qualified Health Plan’s as a result of a permanent move and
   a. Had minimum essential coverage, medically needy coverage, pregnancy related coverage under Medicaid, or access to healthcare Services through coverage provided to a pregnant woman’s unborn child for one (1) or more days during the sixty (60) days preceding the date of the permanent move; or
   b. Were living in a foreign country or in a United States territory for one (1) or more days during the sixty (60) days preceding the permanent move; or
   c. Qualify as an American Indian or Alaskan Native, as defined by §4 of the federal Indian Health Care Improvement Act; or
   d. Lived for (1) or more days during the sixty (60) days preceding your date of permanent move or during the most recent open enrollment period or special enrollment period in a service area where no Qualified Health Plan was available through the Exchange.

8. You or your Dependent:
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

a. Gains or maintains status as an American Indian or Alaskan Native, as defined by section 4 of the federal Indian Health Care Improvement Act, may enroll in a Qualified Health Plan through the Exchange or change from one Qualified Health Plan to another through the Exchange one time per month; or

b. Are or become a Dependent of an American Indian or Alaskan Native, as defined by section 4 of the federal Indian Health Care Improvement Act, may enroll in a Qualified Health Plan through the Exchange or change from one Qualified Health Plan to another through the Exchange one time per month.

For the triggering event immediately listed above, you or your Dependent may enroll in any Qualified Health Plan or change to any Qualified Health Plan, regardless if you or your Dependent are currently enrolled in a Qualified Health Plan.

**Note:** Your Dependent must have enrolled, or is enrolling, in a plan on the same application as the Member and may change from one Qualified Health Plan to another once per month at the same time as the Member.

9. You or your Dependent demonstrate to the Exchange in accordance with guidelines issued by the Department of Health and Human Services that you or your Dependent meet exceptional circumstances as the Exchange may determine.

For the triggering event immediately listed above, you or your Dependent may enroll in any Qualified Health Plan or change to any Qualified Health Plan, regardless if you or your Dependent are currently enrolled in a Qualified Health Plan.

**Note:** The triggering events listed above in items #8 and #9 only permits enrollments in a Qualified Health Plan through the Exchange.

10. You or your Dependent, including an unmarried victim within a household, are a victim of domestic abuse or spousal abandonment, enrolled in minimum essential coverage, and seeks to obtain coverage separate from the perpetrator of the abuse or abandonment. The Dependent of a victim of domestic abuse or spousal abandonment may enroll in coverage at the same time as the victim and on the same application as the victim.

For the triggering event immediately listed above, you or your Dependent may enroll in any Qualified Health Plan or change to any Qualified Health Plan, regardless if you or your Dependent are currently enrolled in a Qualified Health Plan.

11. You or your Dependent:

a. Apply for coverage through the Exchange during the annual open enrollment period or due to a triggering event, are assessed by the Exchange as potentially eligible for Medicaid of the Children’s Health Insurance Program (CHIP) and are determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than sixty (60) days after the triggering event; or
b. Apply for coverage at the State Medicaid or CHIP agency during the annual open enrollment period and is determined ineligible for Medicaid or CHIP after open enrollment has ended.

12. You or your Dependent adequately demonstrate to the Exchange that a material error related to plan benefits, service area or premium influenced your decision to purchase a Qualified Health Plan through the Exchange.

For the triggering event immediately listed above, you or your Dependent may enroll in any Qualified Health Plan or change to any Qualified Health Plan, regardless if you or your Dependent are currently enrolled in a Qualified Health Plan.

13. At the option of the Exchange, you provide satisfactory documentary evidence to verify your eligibility for an insurance affordability program or enrollment in a Qualified Health Plan through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period prescribed by federal regulation or you are below one hundred percent (100%) of the FPL and did not enroll in coverage while waiting for the Department of Health and Human Services to verify your citizenship or status as a national or lawful presence.

Note: The triggering events listed above in items #12 and #13 only permit enrollment in a Qualified Health Plan through the Exchange.

If you or your Dependent are enrolling in an off-Exchange plan, you may do so without any restrictions.

14. You or your Dependent are confirmed by a provider to be pregnant.

For the triggering event immediately listed above, you or your Dependent may enroll in any Qualified Health Plan or change to any Qualified Health Plan, regardless if you or your Dependent are currently enrolled in a Qualified Health Plan.

15. At the option of the Exchange, you or your Dependent experiences a decrease in household income, is determined eligible by the Exchange for Advance Premium Tax Credit and had minimum essential coverage for one or more days during the sixty (60) days preceding the date of the financial change.

16. You or your Dependent newly gain access to an individual coverage health reimbursement account (HRA) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA). You or your Dependent will qualify for this special enrollment period regardless if you or your Dependent were previously offered or enrolled in an individual coverage HRA or previously provided QSEHRA, as long as you or your Dependent were not enrolled in the individual coverage HRA or covered by the QSEHRA on the day immediately prior to this triggering event.

For the triggering event immediately listed above, you or your Dependent may enroll in any Qualified Health Plan or change to any Qualified Health Plan, regardless if you or your Dependent are currently enrolled in a Qualified Health Plan.
Length of Special Enrollment Periods
Except as specifically provided in this section with respect to specific triggering events, you will have sixty (60) days from the date of the triggering event to select a Qualified Health Plan.

1. For the triggering event associated with loss of coverage (item #1 above) or becoming eligible for Advance Premium Tax Credit due to a change in eligibility for employer sponsored coverage (item #6b above), you will have sixty (60) days before and sixty (60) days after the triggering event to select a Qualified Health Plan.

2. For the triggering event associated with a permanent move (item #7 above), you will have sixty (60) days before and sixty (60) days after the triggering event to select a Qualified Health Plan.

3. For the triggering event associated with a change in eligibility for Exchange coverage due to a change in income or permanent move (item #6c above), you will have sixty (60) days before and sixty (60) days after the triggering event to select a Qualified Health Plan.

4. For the triggering event associated with a release from incarceration (item #3b above), you will have sixty (60) days before and sixty (60) days after the triggering event to select a Qualified Health Plan.

5. For the triggering events where the Exchange determines a special enrollment period is warranted (items #4, #5 or #9 above), the enrollment period that the Exchange provides.

6. For the triggering events listed above in items #4 and #5, if the Exchange determines a special enrollment period is warranted, then the Exchange will provide the enrollment period. However, if selection is for off-Exchange plans, you will have (60) days before or (60) days after the date of the triggering event to enroll.

7. For the triggering event due to pregnancy (item #14 above), you will have (90) days from the date the provider gives confirmation of the pregnancy.

8. For the triggering event associated with gaining access to an individual coverage HRA or being newly provided a QSEHRA (item #16 above), you will have sixty (60) days before the triggering events to select a Qualified Health Plan, unless the HRA or QSEHRA was not required to provide the notice setting forth its terms to you at least ninety (90) days before the beginning of the plan year, in which case you will have sixty (60) days before or after the triggering event to select a Qualified Health Plan.

Effective Date for Special Enrollment Periods
The regular coverage effective date depends on when the plan selection is received. For a Qualified Health Plan selection received by the Exchange for coverage through the Exchange or received by us for off-Exchange coverage:

1. between the first and the fifteenth day of any month, the coverage effective date is the first day of the following month; and
2. between the sixteenth and the last day of any month, the coverage effective date is the first day of the second following month.

For the triggering events listed below:
1. For birth, adoption, or placement for adoption, coverage is effective the date the birth, adoption or placement for adoption occurs.
2. For placement in foster care, coverage is effective the date the placement in foster care occurs or, if enrollment is through and permitted by the Exchange, you may elect a coverage effective date the first day of the following month or you may elect a regular coverage effective date.
3. For marriage, coverage is effective on the first day of the month following plan selection.
4. For the special enrollment periods described in items #4, #5, #9, #11, #12 or #13 under Special Enrollment Periods Due to Triggering Events, the Exchange will determine the coverage effective date based on the circumstances. For off-Exchange plans, the special enrollment periods described in items #4, #5 or #11 will follow the regular coverage effective date.
5. For loss of coverage (item #1 under Special Enrollment Periods Due to Triggering Events), loss of eligibility for employer-sponsored coverage (item #6b under Special Enrollment Periods Due to Triggering Events), gaining access to a new Qualified Health Plan due to a permanent move (item #7 under Special Enrollment Periods Due to Triggering Events), becoming newly eligible to enroll in a Qualified Health Plan through the Exchange as a result from release from incarceration (item #3b under Special Enrollment Periods Due to Triggering Events) or becoming newly eligible for Advance Premium Tax Credit due to a permanent move (item #6d under Special Enrollment Periods Due to Triggering Events), if the Qualified Health Plan selection is made on or before the day of the triggering event, the coverage effective date is the first day of the month following the date of the triggering event. If the plan selection is made after the date of the triggering event, then the regular coverage effective dates apply.
6. For a child support order or other court order (item #2a under Special Enrollment Periods Due to Triggering Events), the coverage effective date shall be no later than the date the court order is effective or, if enrollment is through and permitted by the Exchange, you may elect a coverage effective date the first day of the following month or you may elect a regular coverage effective date.
7. If you or your Dependent dies (item #2b under Special Enrollment Periods Due to Triggering Events), the coverage effective date shall be the first day of the month following the plan selection or you may elect a regular coverage effective date.
8. For confirmation of pregnancy, the coverage effective date shall be the 1st day of the month in which the confirmation of pregnancy was received.
9. For gaining access to an individual coverage health reimbursement account (HRA) or being newly provided a QSEHRA, if the plan selection coverage is made before the day of the triggering event, coverage is effective on the 1st day of the month following the date of the triggering event or if the triggering events is on the 1st day of the month, then coverage is effective on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, the coverage is effective on the 1st day of the month following the plan selection.

**Note: For Members who enroll through the Exchange:** At your option, the Exchange must provide a coverage effective date that is no more than one (1) month later than the effective date specified in this Agreement if your enrollment is delayed until after the Exchange verifies your eligibility for a special
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

enrollment period and the assignment of a coverage effective date consistent with this Agreement would result in you being required to pay two (2) or more months of retroactive premium to effectuate coverage or avoid termination for non-payment.

Restrictions on Qualified Health Plan Selection
For Members who enroll through the Exchange and are currently in a Qualified Health Plan, if you qualify for a special enrollment period or you are adding a Dependent to your Qualified Health Plan other than when the triggering event is for birth, adoption, placement for adoption or placement in foster care (item #2a under Special Enrollment Periods Due to Triggering Events), inadvertent error (item #4 under Special Enrollment Periods Due to Triggering Events), you or your Dependent becoming newly eligible for cost-sharing reduction (item #6a under Special Enrollment Periods Due to Triggering Events), you or your Dependent’s status as an American Indian or Alaskan Native (item #8 under Special Enrollment Periods Due to Triggering Events), exceptional circumstances (item #9 under Special Enrollment Periods Due to Triggering Events), eligibility due to domestic violence (item #10 under Special Enrollment Periods Due to Triggering Events), material error (item #12 under Special Enrollment Periods Due to Triggering Events), you or your Dependent being confirmed by a provider to be pregnant (item #14 under Special Enrollment Periods Due to Triggering Events) or you or your Dependent newly gaining access to an individual coverage HRA or you or your Dependent being newly provided a QSEHRA (item #16 under Special Enrollment Periods Due to Triggering Events), you and your Dependent may make changes to your enrollment in the same Qualified Health Plan or may change to another Qualified Health Plan within the same level or coverage (or one metal level higher or lower, if no such Qualified Health Plan is available) or, at your or your Dependent’s option, your Dependent may enroll in any separate Qualified Health Plan.

If Health Plan’s eligibility rules do not allow you to enroll your Dependent to your Qualified Health Plan, the Exchange must allow you and your Dependent to change to another Qualified Health Plan within the same level of coverage (or one metal level higher or lower, if no such Qualified Health Plan is available) or allow your Dependent to enroll in a separate Qualified Health Plan.

In addition, if you have gained a Dependent, as described above in item #2a under Special Enrollment Periods Due to Triggering Events, then you may add the Dependent to your current Qualified Health Plan or, if the eligibility rules do not allow such dependent to enroll, then you and your Dependent may change to another Qualified Health Plan within the same level of coverage (or one metal level higher or lower, if no such Qualified Health Plan is available) or, at your or your Dependent’s option, your Dependent may enroll in any separate Qualified Health Plan.

You or your Dependent may enroll in any Qualified Health Plan if you or your Dependent are not currently enrolled in a Qualified Health Plan. If you are currently enrolled in a Qualified Health Plan, you may enroll in another Qualified Health Plan within the same level of coverage.

Premium Payment Changes Due to Special Enrollments
Your Premium may change if you:
1. Choose a new Plan;
2. Switch to coverage other than self-only by adding Dependents; or
3. Reduce the number of covered Dependents.

**Premium Payment Requirements for Special Open Enrollment Periods**

**When No Additional Premium is Required**
If you experience a triggering event then enroll during a special enrollment period, coverage will be effective as of the date described above in the event that no additional Premium is required.

**When Additional Premium is Due**
If additional Premium is required following enrollment after you experience a triggering event, the Premium is due the date coverage becomes effective. If the premium is not paid prior to the coverage effective date, coverage never becomes effective. The only exceptions are in the case of a triggering event involving:

1. Birth;
2. Adoption; and
3. Placement for adoption.

Under those circumstances, coverage will terminate as of the 31st day during the sixty (60) day period if additional due Premium is not paid before expiration of the sixty (60) day enrollment period mentioned above under *Effective Date for Special Enrollment Periods* in this section.

**Additional Special Enrollment Period for a Child Under Guardianship**
A newly-eligible Dependent child for whom guardianship has been granted by court or testamentary appointment may be added outside of the Annual Enrollment Period and Special Enrollment Periods described above. The effective date of coverage for a newly-eligible Dependent child for whom guardianship has been granted by court or testamentary appointment is the date of appointment.

The newly-eligible Dependent child will be covered automatically for the first thirty-one (31) days following the newly eligible Dependent child’s effective date of coverage. Coverage of a newly-eligible child shall consist of coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

**When No Additional Premium is Required**
If no additional Premium is required, then the coverage must continue beyond the thirty-one (31) days automatically, even if the newly-eligible Dependent child is not affirmatively enrolled. Notification and enrollment of the newly-eligible Dependent child is suggested to expedite the claims process, but it is not required.

**When Additional Premium is Due**
If additional Premium is due within the aforementioned thirty-one (31) day automatic coverage period in order to add the newly-eligible Dependent child to the coverage, then and only then may Health Plan require notification of appointment of the new Dependent and payment of the required additional Premium in order to continue coverage beyond the thirty-one (31) day period.
Kaiser Permanente for Individuals and Families/  
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

Special Enrollment Periods and Effective Date of Coverage for American Indians and Alaska Natives Who Enroll Through the Exchange

For American Indian and Alaska Native Members who enroll through the Exchange: This provision only applies to individuals who are American Indian or Alaska Native, as defined in §4 of the federal Indian Health Care Improvement Act and enroll in a Plan on the Exchange. If you meet those criteria, you may enroll in a Plan, or change from one Plan in the Exchange to another Plan in the Exchange once per month. If you enroll in a plan between the first and the fifteenth day of the month, the coverage effective date of the new Plan will be the 1st day of the following month. If you enroll in a plan between the 16th and last day of the month, the coverage effective date will be the first day of the second following month.

Notice of Your Effective Date of Coverage

The Health Plan will notify you and any enrolled Dependents of your effective date of coverage under this Plan based on the rules described above.
SECTION 2: How to Get the Care You Need

Making and Cancelling Appointments and Who to Contact

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

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

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

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

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

If your Primary Care Plan Physician is not located at one of our Plan Medical Centers, you may need to contact his/her office directly for assistance making or canceling an appointment. The telephone number for their office is located on your Kaiser Permanente identification card.

Choosing or Changing Your Primary Care Plan Physician

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

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

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

Customer Service

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

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

Advance Directives to Direct Your Care While Incapacitated

Advance directives are legal forms that help you control the kind of health care you will receive if you become very ill or unconscious. We ask that you please consider the benefits of completing a:
1. Durable Power of Attorney for Health Care, which lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your views on life support and other treatments; and

2. Living Will and the Natural Death Act Declaration to Physicians, which lets you write down your wishes about receiving life support and other treatment.

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

Receiving Health Care Services

To receive the Services covered under this Agreement, you must be a current Health Plan Member for whom Premium has been paid. 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 current Member under this Plan, we agree to arrange health care Services in accordance with the terms, conditions, limitations and exclusions of this Agreement. You may receive these Services and other benefits specified in this Agreement when provided, prescribed or directed by Plan Providers within our Service Area.

You have your choice of Plan Physicians and Facilities within our Service Area. Covered Services are available only from the Medical Group, Plan Facilities and in-Plan Skilled Nursing Facilities. Neither the Health Plan, Medical Group nor any Plan Physicians have any liability or obligation extending from any Service or benefit sought or received by a Member from any non-Plan:

1. Doctor;
2. Hospital;
3. Skilled Nursing Facility;
4. Person;
5. Institution; or
6. Organization, except when you:
   a. Have a pre-authorized referral, or other approval, for the Services; or
   b. Are covered under the Emergency Services or Urgent Care Services provisions in Section 3: Benefits, Exclusions and Limitations.

Emergency and Urgent Care Services, in addition to Services associated with pre-authorized referrals, or other approvals, are the only Services a Member may seek outside of the Service Area.

Your Kaiser Permanente Identification Card

Digital Kaiser Permanente Identification Card

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

1. Log into the Kaiser Permanente mobile app; and
2. Select “Member ID Card” from the menu options.
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

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

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

Your Medical Record Number is used to identify your medical records and membership information. You should always have the same Medical Record Number.

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

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

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

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

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

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

Getting a Referral
Our Plan Physicians offer primary medical, pediatric and OB/GYN care as well as specialty care in areas such as general surgery, orthopedic surgery, dermatology and other medical specialties. We have 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.
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

All referrals will be subject to review and approval, which is known as authorization, in accordance with the terms of this Agreement. We will notify you when our review is complete.

Receiving an Authorized Specialist or Hospital Referral
If your Plan Provider decides that you require covered Services from a Specialist, you will receive an authorized referral to a Plan Provider who specializes in the type of care you need.

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

When you need authorized covered Services at a Plan Hospital, you will be referred to a Plan Hospital. We may direct that you receive the 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.

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

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

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

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

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

1. The Member has been diagnosed with a condition or disease that requires specialized health care Services or medical care; and the Health Plan:
   a. Does not have a Plan Specialist or Non-Physicians Specialist with the professional training and expertise to treat or provide health care Services for the condition or disease; or
   b. Cannot provide reasonable access to a Specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care Services for the condition or disease without unreasonable delay or travel.
You must have an approved verbal or written referral to the non-Plan Specialist or Non-Physician Specialist in order for the Health Plan to cover the Services. The Cost Share amounts for approved referral Services are the same as those required for Services provided by a Plan Provider.

**Services that Do Not Require a Referral**

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

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

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

**Continuity of Care for New Members**

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

1. Accept a 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 Member’s enrollment under this Agreement.

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

1. Lesser of the course of treatment or ninety (90) days; and
2. Up to three (3) trimesters of a pregnancy and the initial postpartum visit.

**Transitioning to our Services**

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

**Accepting Preauthorization for Services**

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

If the Health Plan requires a preauthorization for a prescription drug, the preauthorization request shall allow a health care provider to indicate whether a prescription drug is to be used to treat a chronic condition.

If the health care provider indicates the prescription drug is to treat a chronic condition, the Health Plan may not request a reauthorization for a repeat prescription for the prescription drug for one (1) year or for the standard course of treatment for the chronic condition being treated, whichever is less.
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

The Health Plan shall accept preauthorization from the health care provider for at least the initial thirty (30) days of the Covered Person’s prescription drug benefit coverage. At the end of the applicable time period, we may elect to perform our own review to allow the preauthorization for the prescription drug. The Health Plan shall accept preauthorization from the health care provider if:

1. The prescription drug is a covered benefit under the current health care provider; or
2. The dosage for the approved prescription drug changes and the change is consistent with Federal Food and Drug Administration labeled dosages.

Health Plan may not accept preauthorization for a change in dosage for an opioid. If the Health Plan requires a preauthorization for a prescription drug, we shall provide notice of the new requirement at least thirty (30) days before the requirement of the new preauthorization in writing and/or electronically.

If the Health Plan denies coverage for a prescription drug, the Health Plan shall provide a detailed written explanation for the denial of coverage, including whether the denial was based on a required preauthorization.

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

**Continuity of Care Limitation for Preauthorization**

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

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

**Services from Non-Plan Providers**

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

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

Examples of acute and serious chronic conditions may include:

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

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

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

 Bills for Emergency Services
If you receive a bill from a hospital, physician or ancillary provider for emergency Services that were provided to you, simply mail proof of payment and a copy of the bill to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. Please mail or fax your proof to us within one (1) year at the following address:

Kaiser Permanente National Claims Administration - Mid-Atlantic States
PO Box 371860
Denver, CO 80237-9998
Fax: 1-866-568-4184

For more information on the payment or reimbursement of covered services and how to file a claim, see Filing for Payment or Reimbursement of a Covered Service or Post-Service Claim in Section 5: Filing Claims, Appeals and Grievances.

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

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

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

If you are not sure you are experiencing a medical emergency, or for Urgent Care Services for symptoms such as a sudden rash, high fever, severe vomiting, ear infection or sprain, you may call our advice nurses at 1-800-777-7904 or 711 (TTY). You may also call 1-800-677-1112 from anywhere in the United States, Canada, Puerto Rico or the Virgin Islands.

Getting a Second Opinion
You are welcome to receive a second medical opinion from a Plan Physician. We will assist you to arrange an appointment for a second opinion upon request.
Receiving Care in Another Kaiser Foundation Health Plan Service Area

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

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

Payment Toward Your Cost Share and When You May Be Billed

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

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

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

2. You receive diagnostic Services during a treatment visit. For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services, such as laboratory tests. You may be asked to pay your Cost Share for these additional diagnostic Services.

3. You receive treatment Services during a diagnostic visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services, such as an outpatient procedure. You may be asked to pay your Cost Share for these additional treatment Services.

4. You receive non-preventive Services during a no-charge courtesy visit. For example, you go in for a blood pressure check or meet and greet visit and the provider finds a problem with your health and performs diagnostic or treatment Services. You may be asked to pay your Cost Share for these additional diagnostic or treatment Services.

5. You receive Services from a second provider during your visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay your Cost Share for the consultation with the specialist.
Note: If your plan is subject to a Deductible, any required Deductible amount must be met by the Member prior to our payment of non-preventive or diagnostic Services.
SECTION 3: Benefits, Exclusions and Limitations

Your Benefits

The benefits described in this section are covered only when:

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

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

1. Emergency Services, as described in this section;
2. Urgent Care Services outside of our Service Area, as described in this section;
3. Continuity of Care for New Members, as described in Section 2: How to Get the Care You Need;
4. Approved referrals, as described under Getting a Referral in Section 2: How to Get the Care You Need, including referrals for clinical trials as described in this section.

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

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

List of Benefits

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

<table>
<thead>
<tr>
<th><strong>Acupuncture Services</strong></th>
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<tbody>
<tr>
<td>Coverage is provided for Medically Necessary acupuncture Services when provided by a provider licensed to perform such Services.</td>
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</table>

<table>
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<tr>
<th><strong>Allergy Services</strong></th>
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<tbody>
<tr>
<td>Coverage is provided for allergy testing and treatment, including the administration of injections and allergy serum.</td>
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<tr>
<th><strong>Ambulance Services</strong></th>
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<tbody>
<tr>
<td>Coverage is provided for Ambulance Services when it is Medically Necessary to be transported in an ambulance to or from the nearest Hospital where needed medical Services can be appropriately provided.</td>
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</table>

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

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

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

**Benefit-Specific Exclusions:**
- The dentist or specialist’s dental care Services.

<table>
<thead>
<tr>
<th><strong>Blood, Blood Products and their Administration</strong></th>
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<tbody>
<tr>
<td>Coverage is provided for all cost recovery expenses for blood, blood products, derivatives, components, biologics and serums, including autologous Services, whole blood, red blood cells, platelets, plasma, immunoglobulin and albumin.</td>
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<table>
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<tr>
<th><strong>Bone Mass Measurement</strong></th>
</tr>
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<tbody>
<tr>
<td>Coverage is provided for bone mass measurement for the prevention, diagnosis and treatment of osteoporosis when requested by a Health Care Provider for a Qualified Individual. We do not cover bone mass measurement for Members who do not meet the criteria of a Qualified Individual.</td>
</tr>
</tbody>
</table>

A Qualified Individual means an individual:
1. Who is estrogen deficient and at clinical risk for osteoporosis;
2. 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;
3. Receiving long-term gluco-corticoid (steroid) therapy;
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

| 4. With primary hyper-parathyroidism; or |
| 5. Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy. |

### Chiropractic Services

Coverage is provided for a limited number of chiropractic visits per condition per Calendar Year.

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

#### Benefit-Specific Limitations:

Coverage is limited to up to twenty (20) chiropractic visits per condition per Calendar Year.

### Clinical Trials

Clinical trials are defined as treatment that is:

1. Approved by an institutional review board;
2. Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and
3. Approved by:
   a. An institute or center of the National Institutes of Health; or
   b. The Food and Drug Administration; or
   c. The Department of Veterans’ Affairs; or
   d. The Department of Defense.

Coverage is provided for Services received in connection with a clinical trial if all of the following conditions are met:

1. The Services would be covered if they were not related to a clinical trial;
2. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   a. A Plan Provider makes this determination;
   b. You provide us with medical and scientific information establishing this determination;
3. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside of the state in which you live;
4. The clinical trial is a phase I, phase II, phase III or phase IV clinical trial related to the prevention, detection or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
   a. The study or investigation is conducted under an investigational new drug application reviewed by the FDA;
   b. The study or investigation is a drug trial that is exempt from having an investigational new drug application; or
   c. The study or investigation is approved or funded by at least one (1) of the following:
      i. The National Institutes of Health;
      ii. The Centers for Disease Control and Prevention;
      iii. The Agency for Health Care Research and Quality;
      iv. The Centers for Medicare & Medicaid Services;
      v. A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs;
      vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
vii. The Department of Veterans Affairs, Department of Defense or the Department of Energy; but only if the study or investigation has been reviewed and approved through a system of peer review that the United States Secretary of Health and Human Services determines meets all of the following requirements:
   a) It is comparable to the National Institutes of Health system of peer review of studies and investigations; and
   b) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

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

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

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

**Benefit-Specific Exclusions:**
We do not cover:

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

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**Diabetes Treatment, Equipment and Supplies**

Coverage is provided for diabetes treatment, equipment and supplies, insulin syringes, needles and test strips for glucose monitoring equipment under the prescription coverage. Coverage for insulin pumps and glucose monitoring equipment is provided under the Durable Medical Equipment coverage.

Coverage is also provided for self-management training for diabetes.

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**Dialysis**

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

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

We cover the following renal dialysis Services:

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

We cover the following self-dialysis Services:

1. Training for self-dialysis including the instructions for a person who will assist you with self-dialysis;
2. Services of the Plan Provider who is conducting your self-dialysis training; and
We cover home dialysis, which includes:
1. Hemodialysis;
2. Home intermittent peritoneal dialysis (IPD);
3. Home continuous cycling peritoneal dialysis (CCPD); and
4. Home continuous ambulatory peritoneal dialysis (CAPD).

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

### Durable Medical Equipment

Coverage for Durable Medical Equipment and Prosthetic Devices includes:
1. Durable Medical Equipment such as nebulizers and peak flow meters;
2. International normalized ratio (INR) home testing machines when deemed Medically Necessary by a Plan Physician;
3. Leg, arm, back or neck braces and the training necessary to use these prosthetics;
4. Internally implanted devices such as monofocal intraocular lens implants;
5. Artificial legs, arms or eyes and the training to use these prosthetics;
6. One (1) hair prosthesis for a Member whose hair loss results from chemotherapy or radiation treatment for cancer; and
7. Ostomy equipment and urological supplies.

### Emergency Services

Coverage is provided anywhere in the world for reasonable charges for Emergency Services should you experience an Emergency Medical Condition.

If you think you are experiencing an Emergency Medical Condition as defined in the section *Important Terms You Should Know*, then you should call 911, where available, immediately. If you are not sure whether you are experiencing an Emergency Medical Condition, please contact us at the number listed on the reverse side of your Kaiser Permanente identification card for immediate medical advice. Any emergency department/room visit that is not attributed to an Emergency Medical Condition, as defined in the section *Important Terms You Should Know*, will not be authorized by the Health Plan, and you will be responsible for all charges. In situations where the Health Plan authorizes, directs or refers the Member to the emergency room for a condition that is later determined not to meet the definition of an Emergency Medical Condition, the Health Plan would become responsible for charges.

In situations when the Health Plan authorizes, refers or otherwise allows a Member access to a Hospital emergency facility or other Urgent Care facility for a medical condition that requires emergency surgery, the Health Plan will reimburse the physician, oral surgeon, periodontist or podiatrist who performed the surgical procedure for any follow-up care that is:
1. Medically Necessary;
2. Directly related to the condition for which the surgical procedure was performed; and
3. Provided in consultation with the Member’s Primary Care Plan Physician.

The Health Plan will not impose any Copayment or other Cost-Sharing requirement for follow-up care that exceeds that which a Member would be required to pay had the follow-up care been rendered in-network, using members of the Health Plan’s provider panel.
Family Planning Services

Coverage is provided for family planning Services, including:

1. Prescription and over-the-counter contraceptive drugs or devices;
2. Coverage for the insertion or removal of contraceptive devices;
3. Medically Necessary examination associated with the use of contraceptive drugs or devices;
4. Voluntary female and male sterilization;
5. Voluntary termination of pregnancy; and
6. Instruction by a licensed health care provider on fertility awareness–based methods, which are methods of identifying times of fertility and infertility by an individual to avoid pregnancy, including cervical mucous methods, sympto-thermal or sympto-hormonal methods, the standard days methods, and the lactational amenorrhea method.

Note: Family planning Services that are defined as preventive care under the Affordable Care Act are covered at no charge.

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

Benefit-Specific Exclusions:

Services:

1. To reverse voluntary, surgically induced infertility.
2. To reverse a voluntary sterilization procedure for a Dependent minor, except FDA approved sterilization procedures for women with reproductive capacity; or
3. For sterilization for a Dependent minor, except FDA approved sterilization procedures for women with reproductive capacity.

Fertility Services

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

Definitions:

Iatrogenic infertility: An impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting the reproductive organs or process.

Medical treatment that may directly or indirectly cause iatrogenic infertility: Medical treatment with a likely side effect of infertility as established by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.

Standard fertility preservation procedures: Procedures to preserve fertility that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.

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

Benefit-Specific Exclusions:

1. Any charges associated with the storage of female Member’s eggs (oocytes) and/or male Member’s sperm.
Habilitative Services for Adults
Coverage is provided for Medically Necessary habilitative Services. Habilitative Services means Health Care Services and devices, including Services and devices that help an adult keep, learn or improve skills and functioning for daily living. Habilitative Services for adults includes Medically Necessary therapeutic care.

Therapeutic care means services provided by a speech-language pathologist, occupational therapist or physical therapist.

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

Benefit-Specific Limitations:
1. Members age 19 or older (beginning on the first day of the month immediately following the month in which the Member reaches age 19):
   a. Physical therapy: Limited to thirty (30) visits per condition, per Calendar Year.
   b. Speech therapy: Limited to thirty (30) visits per condition, per Calendar Year.
   c. Occupational therapy: Limited to thirty (30) visits per condition, per Calendar Year.

Habilitative Services for Children
Coverage is provided for Medically Necessary habilitative Services. Habilitative Services means Health Care Services and devices, including Services and devices for the treatment of a child that help the child keep, learn or improve skills and functioning for daily living. Habilitative Services may include Medically Necessary therapeutic care, behavioral health treatment, psychological care, orthodontics, oral surgery, otologic therapy, audiological therapy, cleft lip and cleft palate and other Services for people with disabilities in a variety of both inpatient and outpatient settings.

Therapeutic care means services provided by a speech-language pathologist, occupational therapist or physical therapist.

Behavioral health treatment means professional counseling and treatment programs, including applied behavior analysis, that are necessary to develop, maintain or restore, to the maximum extent practicable, the functioning of an individual.

Psychological care means direct or consultative services provided by a psychologist or social worker.

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

Benefit-Specific Exclusions:
We do not cover habilitative Services delivered through early intervention and school services.

Benefit-Specific Limitations:
Members from birth to until at least the end of the month the child turns age 19: No visit limits.

The Health Plan will only reimburse for covered habilitative Services provided in the Member’s educational setting when the Member’s educational setting is identified by the Member’s treating provider in a treatment goal as the location of the habilitative Services.

Hearing Services
Hearing Tests
We cover hearing tests to determine the need for hearing correction, when ordered by a Plan Provider.

Hearing Aids
Coverage is provided for one (1) hearing aid for each hearing-impaired ear every thirty-six (36) months.
Benefit-Specific Exclusions:
Replacement batteries to power hearing aids are not covered.

Home Health Care Services
Coverage is provided for Home Health Care Services:
1. As an alternative to otherwise covered Services in a Hospital or related institution; and
2. For Members who receive less than forty-eight (48) hours of inpatient hospitalization following a mastectomy or removal of a testicle, or who undergo a mastectomy or removal of a testicle on an outpatient basis, including:
   a. One (1) home visit scheduled to occur within twenty-four (24) hours after discharge from the Hospital or outpatient health care facility; and
   b. An additional home visit, if prescribed by the Member's attending physician.

For Home Health Care Services related to obstetrical admissions due to childbirth, see the Inpatient Hospital Services and Obstetrical Admissions benefit in this List of Benefits.

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

We cover Hospice Care Services within our Service Area and only when provided by a Plan Provider. Hospice Services include the following:
1. Nursing care;
2. Physical, occupational, speech and respiratory therapy;
3. Medical social Services;
4. Home health aide Services;
5. Homemaker Services;
6. Medical supplies, equipment and medication required to maintain the comfort and manage the pain of the terminally ill Member;
7. Palliative drugs in accordance with our drug formulary guidelines;
8. Physician care;
9. Short-term inpatient care; including care for pain management and acute symptom management as Medically Necessary;
10. Respite Care limited to five (5) consecutive days for any one inpatient stay;
11. Counseling Services for the Member and his Family Members, including dietary counseling for the Member; and bereavement counseling for the Member’s Family; and
12. Services of hospice volunteers.

Infertility Services
Coverage is provided for Medically Necessary infertility Services, including:
1. Services for diagnosis and treatment of involuntary infertility for females and males. Involuntary infertility may be demonstrated by a history of:
### Kaiser Permanente for Individuals and Families/
### Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

<table>
<thead>
<tr>
<th>Benefit-Specific Exclusions:</th>
<th>Benefit-Specific Limitations:</th>
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<tbody>
<tr>
<td>1. Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member’s eggs and/or male Member’s sperm for future attempts;</td>
<td>Coverage for in vitro fertilization (IVF) embryo transfer cycles, including frozen embryo transfer procedure, is limited to three (3) in vitro fertilization (IVF) attempts per live birth.</td>
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<td>2. Any charges associated with donor eggs, donor sperm or donor embryos;</td>
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<td>3. Services to reverse voluntary, surgically induced infertility;</td>
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<td>4. Infertility Services when the infertility is the result of an elective male or female sterilization surgical procedure;</td>
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Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

5. Gamete intrafallopian transfers (GIFT); zygote intrafallopian transfers (ZIFT); and prescription drugs related to such procedures.

### Infusion Services
Coverage is provided for infusion Services, including:
1. Enteral nutrition, which is delivery of nutrients by tube into the gastrointestinal tract; and.
2. All medications administered intravenously and/or parenterally.

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

For additional information on infusion therapy, chemotherapy and radiation, see the Infusion Therapy, Chemotherapy and Radiation benefit in this List of Benefits.

### Infusion Therapy, Chemotherapy and Radiation
Coverage is provided for chemotherapy, infusion therapy and radiation therapy visits.

Infusion therapy means treatment by placing therapeutic agents into the vein, including therapeutic nuclear medicine and parenteral administration of medication and nutrients.

For additional information on Infusion Services, see the Infusion Services benefit in this List of Benefits.

### Inpatient Hospital Services and Obstetrical Admissions
Coverage is provided for inpatient Hospital Services, including:
1. Room and board, such as:
   a. A ward, semi-private or intensive care accommodations. (A private room is covered only if Medically Necessary);
   b. General nursing care; and
   c. Meals and special diets.

Coverage is also provided for other services and supplies provided by a Hospital.

For obstetrical admissions, inpatient hospitalization coverage is provided, from the time of delivery, for at least forty-eight (48) hours for a normal vaginal delivery or ninety-six (96) hours for a normal cesarean section.

For a mother and newborn child who chooses in consultation with her attending provider to remain in the Hospital for less than the minimum period specified above, the Health Plan will provide coverage for and arrange one (1) home health visit to be provided within twenty-four (24) hours after Hospital discharge and an additional home health visit, if prescribed by the attending provider, in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child.

For a mother and newborn child who remain in the Hospital for at least the minimum period described above, the Health Plan will provide coverage for a home health visit if prescribed by the attending provider.

If the mother is required to remain hospitalized after childbirth for medical reasons, and the mother requests that the baby remain in the Hospital, coverage is provided for the newborn for up to four (4) days.
Maternity Services

The Health Plan considers all maternity as routine, including all high-risk pregnancy. Coverage is provided for pre-and post-natal services, which includes routine and non-routine office visits, telemedicine visits, x-ray, lab and specialty tests. Coverage is also provided for:

1. Birthing classes;
2. Breastfeeding support, supplies, and counseling from trained providers during pregnancy and/or in the postpartum period; and
3. Inpatient delivery and hospitalization; and
4. Outpatient delivery and all related Services (i.e. birthing centers, certified midwife).

Note: All pregnancy and maternity Services that are defined as preventive care by the Affordable Care Act are covered under preventive care Services at no charge. For HSA/HDHP Plans, only those specified maternity services identified by the Affordable Care Act (“ACA”) as preventive care services will be covered at no charge and not subject to the Deductible.

Medical Foods

Coverage is provided for medical food for persons with metabolic disorders when ordered by a Health Care Practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders.

Medical Nutrition Therapy and Counseling

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

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

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

Medical Office Care

Coverage is provided for care in medical offices for treatment of illness or injury.

Mental Health and Substance Abuse Services

Coverage is provided for Medically Necessary Services for mental disorders, mental illness, psychiatric conditions and substance abuse for Members including:

1. Professional Services by providers who are licensed, registered, certified or otherwise authorized professional mental health and substance use practitioners when acting within the scope of their license, registration, or certification, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors or marriage and family therapists.
   a. Diagnosis and treatment of psychiatric conditions, mental illness or mental disorders. Services include:
      i. Diagnostic evaluation;
      ii. Crisis intervention and stabilization for acute episodes;
      iii. Medication evaluation and management (pharmacotherapy);
      iv. Treatment and counseling, including individual and group therapy;
v. Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling;

vi. Opioid treatment Services; and

vii. Professional charges for intensive outpatient treatment in a provider’s office or other professional setting.

b. Electroconvulsive therapy (ECT);

c. Inpatient professional fees;

d. Outpatient diagnostic tests provided and billed by a licensed, registered, certified, or otherwise authorized mental health and substance abuse practitioner;

e. Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility; and

f. Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment.

2. Inpatient hospital and inpatient residential treatment centers Services, which includes room and board, such as:

a. Ward, semi-private or intensive care accommodations. (A private room is covered only if Medically Necessary);

b. General nursing care;

c. Meals and special diets; and

d. Other services and supplies provided by a hospital or residential treatment center.

3. Services such as partial hospitalization or intensive day treatment programs provided in a licensed or certified facility or program, which is equipped to provide mental health and substance abuse Services; and


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

**Benefit-Specific Exclusions:**

We do not cover:

1. Services by pastoral or marital counselors;

2. Therapy for the improvement of sexual functioning and pleasure;

3. Treatment for learning disabilities and intellectual disabilities;

4. Telephone therapy;

5. Travel time to the Member’s home to conduct therapy;

6. Services rendered or billed by schools or halfway houses or members of their staffs;

7. Marriage counseling; and

8. Services that are not Medically Necessary.

**Morbid Obesity Treatment**

Morbid obesity means a body mass index that is:

1. Greater than forty (40) kilograms per meter squared; or

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

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

Coverage is provided for diagnostic and surgical treatment of morbid obesity that is:

1. Recognized by the National Institutes of Health as effective for long-term reversal of morbid obesity; and

2. Consistent with guidelines approved by the National Institutes of Health.
Such treatment is covered to the same extent as for other Medically Necessary surgical procedures under this Agreement.

Surgical treatment of morbid obesity shall occur in a facility that is:
1. Designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence; and
2. Designated by the Health Plan.

If the Health Plan does not designate a facility for the surgical treatment of morbid obesity, then the Health Plan shall cover the surgical treatment of morbid obesity at any facility that is designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence with an approved referral.

**Obstetric/Gynecological Care**

Coverage is provided for obstetric/gynecological care from an obstetrician/gynecologist or other Plan Provider authorized to perform obstetric and/or gynecological Services, without requiring the woman to visit the Primary Care Plan Physician first, if:
1. The care is Medically Necessary, including the ordering of related obstetrical and gynecological Services;
2. After each visit for gynecological care, the obstetrician/gynecologist communicates with the woman’s Primary Care Plan Physician about any diagnosis or treatment rendered; and
3. The obstetrician/gynecologist communicates with the Primary Care Plan Physician before performing any Services that are completely unrelated to obstetrical or gynecological care.

**Oral Surgery/Temporomandibular Joint Services (TMJ)**

Coverage is provided for:
1. Orthognathic surgery, including inpatient and outpatient surgery to correct temporomandibular joint (TMJ) pain dysfunction syndrome and craniomandibular joint services, that are required because of a medical condition or injury that prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part;
2. Maxillary or mandibular frenectomy when not related to a dental procedure;
3. Alveolectomy when related to tooth extraction;
4. Surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures;
5. Treatment of non-dental lesions, such as removal of tumors and biopsies;
6. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses;
7. Removable appliances for TMJ repositioning; and
8. Therapeutic injections for TMJ.

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

**Benefit-Specific Exclusions:**

We do not cover:
1. Lab fees associated with cysts that are considered dental under our standards.
2. Oral surgery Services when the functional aspect is minimal and would not in itself warrant surgery.
3. Orthodontic Services.
4. Fixed or removable appliances that involve movement or repositioning of the teeth.
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

5. All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment or treatment of injury to natural teeth due to an accident if the treatment is received within six (6) months of the accident.

### Outpatient Hospital Services
Coverage is provided for outpatient Hospital Services.

### Prescription Drugs and Devices
Coverage is provided for prescription drugs and devices as described in the Outpatient Prescription Drug Benefit Appendix.

### Preventive Health Care Services
Coverage is provided for preventive care Services, including:

1. 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 recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography and prevention issued during or around November 2009 are not considered to be current. Visit: www.uspreventiveservicestaskforce.org;

2. Immunizations for routine use in children, adolescents and adults that have a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. A recommendation from the Advisory Committee on Immunization Practices of the CDC is considered to be: in effect after it has been adopted by the director of the CDC and for routine use if it is listed on the immunization schedules of the CDC. Visit: www.cdc.gov/vaccines/recs/ACIP;

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

4. With respect to women (to the extent not described in item #1 above), evidence-informed preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. To see the current guidelines, visit: http://mchb.hrsa.gov;

5. A voluntary Health Risk Assessment that can be completed by Members annually. Written feedback provided to Members will include recommendations for addressing identified risks;

6. All United States Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity;

7. Routine prenatal care;

8. 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; and

9. Medically Necessary digital tomosynthesis, commonly referred to as three-dimensional “3_D” mammography.

**Note:** If a new recommendation or guideline described in paragraphs “1” through “4” is issued after the effective date of the Plan, the new recommendation or guideline shall apply the first Calendar Year that begins on the date that is one (1) year after the date of the recommendation or guideline is issued.

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

Reconstructive breast surgery means surgery performed as a result of a mastectomy to reestablish symmetry between both breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

Mastectomy means the surgical removal of all or part of a breast.

Coverage is provided for:

1. Breast prosthesis;
2. All stages of reconstructive breast surgery performed on the non-diseased breast to achieve symmetry with the diseased breast when reconstructive surgery is performed on the diseased breast; regardless of the patient’s insurance status at the time the mastectomy or the time lag between the mastectomy and reconstruction; and
3. Physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Routine Foot Care

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

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

**Benefit-Specific Exclusions:**
Routine foot care is not provided to Members who do not meet the requirements of the limitations of this benefit.

**Benefit-Specific Limitations:**
Coverage is limited to Medically Necessary treatment of patients with diabetes or other vascular disease.

Services Approved by the Health Plan

Coverage is provided for any other Service approved by the Health Plan’s utilization management program.

Skilled Nursing Facility Services

Coverage is provided for Skilled Nursing Facility Services when deemed Medically Necessary.

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

**Benefit-Specific Limitations:**
Coverage is limited to a maximum of one-hundred (100) days per Calendar Year.

Telemedicine Services

We cover interactive telemedicine services.

Telemedicine is the real-time two-way transfer of medical data and information, and such services include the use of interactive audio, video or other electronic media used for the purpose of diagnosis, consultation or treatment as it pertains to the delivery of covered Health Care Services. Equipment utilized for interactive telemedicine should be of sufficient audio quality and visual clarity as to be functionally equivalent to a face-to-face encounter for professional medical services.

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

**Benefit-Specific Exclusions:**
We do not cover non-interactive telemedicine services consisting of an audio-only telephone conversation, electronic mail message and/or facsimile transmission.
Therapy and Rehabilitation Services

Coverage is provided for therapy and rehabilitation Services, including:

1. Unlimited Medically Necessary Hospital inpatient rehabilitative Services;
2. Outpatient rehabilitative Services. Members receive up to thirty (30) visits of:
   a. Physical therapy per condition, per year;
   b. Speech therapy per condition, per year; and
   c. Occupational therapy per condition per year.
3. Cardiac Rehabilitation for Members who have been diagnosed with significant cardiac disease, have suffered a myocardial infarction or have undergone invasive cardiac treatment immediately preceding referral for Cardiac Rehabilitation. Cardiac Rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling. Services include:
   a. Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, physician’s revision of exercise prescription and follow-up examination for physician to adjust medication or change regimen; and
   b. Up to ninety (90) visits per therapy type, per Calendar Year of physical therapy, speech therapy and occupational therapy for Cardiac Rehabilitation.
4. Pulmonary rehabilitation for Members diagnosed with significant pulmonary disease.

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

Benefit-Specific Exclusions:

We do not cover maintenance programs. Maintenance programs consist of activities that preserve the present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional progress is apparent or expected to occur.

Benefit-Specific Limitations:

Cardiac Rehabilitation limitations:
1. Services must be provided at a facility approved by the Health Plan that is equipped to provide cardiac rehabilitation.

Pulmonary rehabilitation limitations:
1. Services must be provided at a facility approved by the Health Plan that is equipped to provide pulmonary rehabilitation.
2. Coverage is limited to one (1) pulmonary rehabilitation program per lifetime.

Transplant Services

Coverage is provided for transplant Services for all non-experimental and non-investigational solid organ transplants and other non-solid organ transplant procedures. This includes, but is not limited to, autologous and non-autologous bone marrow, cornea, kidney, liver, heart, lung, heart/lung, pancreas and pancreas/kidney transplants.

Benefits include the cost of hotel lodging and air transportation for the covered recipient and a companion to and from the authorized site of the transplant. If the covered recipient is under age 18, hotel lodging and air transportation is provided for two (2) companions to and from the authorized site of the transplant.

Urgent Care Services

As described below, you are covered for Urgent Care Services anywhere in the world. Your Copayment or Coinsurance will be determined by the place of Service (i.e., at a Provider’s office or at an after-hours urgent care center).
Urgent Care Services are defined as Services required as the result of a sudden illness or injury, which requires prompt attention, but is not of an emergent nature.

**Inside our Service Area**

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

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

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

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

**Outside our Service Area**

If you are injured or become ill while temporarily outside the Service Area, we will cover reasonable charges for Urgent Care Services as defined in this section. Except as provided for emergency surgery below, all follow-up care must be provided by a Plan Provider or Plan Facility.

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

**Follow-up Care for Emergency Surgery**

In those situations when we authorize, refer or otherwise allow you access to a hospital emergency facility or other urgent care facility for a medical condition that requires emergency surgery, we will reimburse the physician, oral surgeon, periodontist or podiatrist who performed the surgical procedure for any follow-up care that is:

1. Medically Necessary;
2. Directly related to the condition for which the surgical procedure was performed; and
3. Provided in consultation with your primary care Plan Physician.

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

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

**Benefit-Specific Exclusions:**

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

**Benefit-Specific Limitations:**

We do not cover Services outside our Service Area for conditions that, before leaving the Service Area, you should have known might require Services while outside our Service Area, such as dialysis for ESRD, 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.

**Vision Services**

Coverage is provided for Vision Services for:

1. Pediatric Members, up until the end of the month they turn age 19, who may receive:
   a. One (1) routine eye examination each Calendar Year, including dilation if professionally indicated; and
b. One (1) pair of prescription eyeglass lenses and one (1) frame each Calendar Year from an available selection of frames; or

c. Contact lenses in lieu of lenses and frames limited to:
   i. Either one (1) pair elective prescription contact lenses from a select group per Calendar Year or multiple pairs of disposable prescription contact lenses from a select group per Calendar Year; or
   ii. Two (2) pair per eye for Medically Necessary contact lenses per Calendar Year;

a. Low vision services, including: one (1) comprehensive low vision evaluation every five (5) years, four (4) follow-up visits within any five (5) year period and prescribed optical devices such as high-power spectacles, magnifiers and telescopes.

b. Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.

2. Adult Members age 19 or older, who may receive:
   a. Routine and necessary eye exams including:
      b. Routine tests such as eye health and glaucoma tests; and
         c. Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.

Note: Discounts are available for certain lenses and frames.

Wellness Benefits

Coverage is provided for wellness benefits, including:

1. A health risk assessment that is completed by each individual on a voluntary basis; and
2. Written feedback to the individual who completes a health risk assessment, with recommendations for lowering risks identified in the completed health risk assessment.

X-ray, Laboratory and Special Procedures

Coverage is provided for outpatient laboratory and diagnostic Services such as:

1. Diagnostic Services;
2. Laboratory tests, including tests for specific genetic disorders such as preimplantation genetic disorder (PGD), for which genetic counseling is available;
3. Special procedures, such as electrocardiograms, electroencephalograms and intracytoplasmic sperm injection (ICSI) in conjunction with preimplantation genetic diagnosis (PGD) due to chromosomal abnormalities, if the Member meets medical guidelines;
4. Sleep lab and sleep studies; and
5. Specialty imaging, including CT, MRI, PET Scans, diagnostic Nuclear Medicine studies and interventional radiology.

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

Exclusions

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

These exclusions apply to all Services that would otherwise be covered under this Agreement. Benefit-specific exclusions that apply only to a particular Service are noted in the List of Benefits in this section. When a service is not covered, all services, drugs, or supplies related to the non-covered service are excluded from coverage, except services we would otherwise cover to treat serious complications of the non-covered service. The following services
are excluded from coverage:

1. Services that are not Medically Necessary.
2. Services performed or prescribed under the direction of a person who is not a Health Care Practitioner.
3. Services that are beyond the scope of practice of the Health Care Practitioner performing the Service.
4. Other services to the extent they are covered by any government unit, except for veterans in Veterans Administration or armed forces facilities for services received for which the recipient is liable.
5. Services for which a Member is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.
6. Except for the pediatric vision benefit in the List of Benefits in this section – the purchase, examination, or fitting of eye glasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for the use in the treatment of a disease or injury.
7. Personal care services and domiciliary care services.
8. Services rendered by a Health Care Practitioner who is a Member’s spouse, mother, father, daughter, son, brother or sister.
9. Experimental services. This exclusion does not apply to Services covered under the clinical trials benefit in the List of Benefits in this section.
10. Practitioner, Hospital or clinical services related to radial keratotomy, myopic keratomileusis and surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error.
11. Medical or surgical treatment for reducing or controlling weight, unless otherwise specified in the List of Benefits in this section.
12. Services incurred before the effective date of coverage for a Member.
13. Services incurred after a Member’s termination of coverage, except as provided under Extension of Benefits in Section 6: Change of Residence, Plan Renewal and Termination, and Transfer of Plan Membership.
14. Cosmetic Services, including surgery or related Services and other Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies. Examples of Cosmetic Services include but are not limited to cosmetic dermatology, cosmetic surgical services and cosmetic dental services.
15. Services for injuries or diseases related to a Member’s job to the extent the Member is required to be covered by a workers’ compensation law.
16. Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor, union, trust, or similar persons or groups.
17. Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers or physical fitness equipment.
18. Charges for telephone consultations, failure to keep a scheduled visit or completion of any form.
19. Inpatient admissions primarily for diagnostic studies, unless authorized by the Health Plan.
20. The purchase, examination or fitting of hearing aids and supplies, and tinnitus maskers, unless otherwise specified in the List of Benefits in this section.
21. Travel, whether or not it is recommended by a Health Care Practitioner, except for:
   a. Covered ambulance Services; and
   b. Travel in connection with a covered transplant.
22. Except for Emergency Services and Urgent Care Services, services received while the Member is outside of the United States.
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

23. Unless otherwise specified in the List of Benefits in this section, or the Adult Dental Plan or Pediatric Dental Plan (whichever applies): Dental work or treatment that includes Hospital or professional care in connection with:
   a. The operation or treatment for the fitting or wearing of dentures;
   b. Orthodontic care or malocclusion;
   c. Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within six (6) months of the accident; and
   d. Dental implants.
24. Except as provided under the Adult Dental Plan or Pediatric Dental Plan (whichever applies): Accidents occurring while and as a result of chewing.
25. Routine foot care, except for Medically Necessary treatment for patients with diabetes or other vascular disease, as described in the List of Benefits in this section.
26. Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports or exams for their prescription or fitting, unless these services are deemed to be Medically Necessary.
27. Inpatient admissions primarily for physical therapy, unless authorized by the Health Plan.
28. Treatment of sexual dysfunction not related to organic disease.
29. Services that duplicate benefits provided under federal, state or local laws, regulations or programs.
31. Non-replacement fees for blood and blood products.
32. Lifestyle improvements or physical fitness programs, unless included in List of Benefits in this section.
33. Wigs or cranial prosthesis, except for one (1) hair prosthesis for a Member whose hair loss was the result of chemotherapy or radiation treatment for cancer as noted above in the List of Benefits in this section.
34. Weekend admission charges, except for emergencies and maternity, unless authorized by the Health Plan.
35. Outpatient orthomolecular therapy, including nutrients, vitamins and food supplements.
36. Services resulting from accidental bodily injuries arising out of a motor vehicle accident, to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
37. Services for conditions that State or local laws, regulations, ordinances or similar provisions require to be provided in a public institution.
38. Services for, or related to, the removal of an organ from a Member for the purposes of transplantation into another person unless the:
   a. Transplant recipient is covered under the Health Plan and is undergoing a covered transplant; and
   b. Services are not payable by another carrier.
39. Physical examinations required for obtaining or continuing employment, insurance or government licensing.
40. Non-medical ancillary Services such as vocational rehabilitation, employment counseling or educational therapy.
41. A private Hospital room unless Medically Necessary and authorized by the Health Plan.
42. Private duty nursing, unless authorized by the Health Plan.
43. Any claim, bill or other demand or request for payment for Health Care Services determined to be furnished as a result of a referral prohibited by §1-302 of the Health Occupations Article.
Limitations
We will make our best efforts to provide or arrange for your Health Care Services in the event of unusual circumstances that delay or render impractical the provision of Services under this Agreement, for reasons such as:

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

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

For personal reasons, some Members may refuse to accept Services recommended by their Plan Physician for a particular condition. If you refuse to accept Services recommended by your Plan Physician, he or she will advise you if there is no other professionally acceptable alternative. You may get a second opinion from another Plan Physician, as described under Getting a Second Opinion in Section 2: How to Get the Care You Need. If you still refuse to accept the recommended Services, the Health Plan and Plan Providers have no further responsibility to provide or cover any alternative treatment you may request for that condition.
SECTION 4: Subrogation, Reductions and Coordination of Benefits

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

Subrogation and Reductions, Explained

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

Reductions Overview
There may be occasions when your benefits are reduced as the result of the existence of other types of health benefit coverage available to you. For example, if there is duplicative coverage for your dependent under a primary health benefit plan purchased by your spouse, the costs of care may be divided between the available health benefit plans. For more information, see the Reductions Under Medicare and TRICARE Benefits and Coordination of Benefits provisions in this section.

The above scenarios are a couple of examples of when:

1. We may assert the right to recover the costs of benefits provided to you; or
2. A reduction in benefits may occur.

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

When Illness or Injury is Caused by a Third Party

If the Health Plan provides coverage under this Agreement when another party is alleged to be responsible to pay for treatment you receive, we have the right to subrogate to recover the costs of related benefits administered to you. To secure our 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.

The proceeds of any judgment or settlement that the Member or the Health Plan obtains shall first be applied to satisfy the Health Plan’s lien, regardless of whether the total amount of recovery is less than the actual losses and damages you incurred. However, you will not have to pay the Health Plan more than what you received from or on behalf of the third party for medical expenses.

Notifying the Health Plan of Claims and/or Legal Action
Within thirty (30) days after submitting or filing a claim or legal action against the third party, you must send written notice of the claim or legal action to us at the following address:
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Patient Financial Services
2101 East Jefferson Street, 4 East
Rockville, Maryland 20852

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

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

**The Health Plan’s Right to Recover Payments**

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

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

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

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

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

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

**Medicare**

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

**Worker’s Compensation Claims**

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

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Patient Financial Services
2101 East Jefferson Street, 4 East
Rockville, Maryland 20852

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

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

**Health Plan Not Liable for Illness or Injury to Others**

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

**Failure to Notify the Health Plan of Responsible Parties**

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

Failure to notify the Health Plan of your pursuit of claims against a third party due to their negligence is a violation of this Agreement. If a member dually recovers compensation by obtaining benefits from the Health Plan and compensation for the same loss from a responsible third party, the Health Plan reserves the right to directly pursue reimbursement of its expenses from the Member who received the settlement as compensation.
No Member, nor the legal representative they appoint, may take any action that would prejudice or prevent the Health Plan’s right to recover the costs associated with providing care to any Member covered under this Agreement.

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

**Pursuit of Payment from Responsible Parties**

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

In the event that medical records or other protected information that requires your consent to be released is requested from us, we will notify you to obtain your consent.

**Reductions Under Medicare and TRICARE Benefits**

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

TRICARE benefits are secondary by law.

**Coordination of Benefits**

**Coordination of Benefits Overview**

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

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

**Right to Obtain and Release Needed Information**

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

**Primary and Secondary Plan Determination**

The health benefit plan that pays first, which is known as the primary plan, is determined by using National Association of Insurance Commissioners Order of Benefits Guidelines. The primary plan provides benefits as it would in the absence of any other coverage.
The plan that pays benefits second, which is known as the secondary plan, coordinates its benefits with the primary plan, and pays the difference between what the primary plan paid, or the value of any benefit or Service provided, but not more than 100 percent of the total Allowable Expenses, and not to exceed the maximum liability of the secondary plan. The secondary plan is never liable for more expenses than it would cover if it had been primary.

**Coordination of Benefits Rules**

To coordinate your benefits, the Health Plan has rules. The following rules for the Health Plan are modeled after the rules recommended by the National Association of Insurance Commissioners. You will find the rules under **Order of Benefit Determination Rules** in this section.

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

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

**Members with a High Deductible Health Plan with a Health Savings Account option:** If you have other health care coverage in addition to a High Deductible Health Plan with a Health Savings Account option (as described in **Section 1: Introduction to Your Kaiser Permanente Health Plan** under the **Health Savings Account-Qualified Plans** provision), then you may not be eligible to establish or contribute to a Health Savings Account. Kaiser Permanente does not provide tax advice. Ask your financial or tax advisor about your eligibility.

**Assistance with Questions about the Coordination of Your Benefits**

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

**Order of Benefit Determination Rules**

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

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

**Rules for a Subscriber and Dependents**

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

**Rules for a Dependent Child/Parent**

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

2. **Dependent child with separated or divorced parents:** If two (2) or more plans cover a person as a dependent child, and that child’s parents are divorced, separated or are not living together, whether or not they have ever been married the following rules apply. If a court decree states that:

   a. One (1) of the parents is responsible for the dependent child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child’s health care expenses, but that parent’s spouse does, that parent’s spouse’s plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision; or
   b. Both parents are responsible for the dependent child’s health care expenses or health care coverage, the provisions of Subparagraph #1 of this provision: **Dependent Child with Parents Who Are Not Separated or Divorced**, shall determine the order of benefits; or
   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph #1 of this provision: **Dependent Child with Parents Who Are Not Separated or Divorced**, shall determine the order of benefits; or

   i. If there is no court decree allocating responsibility for the child’s health care expenses or health care coverage, the order of benefits for the child are as follows:
   a) The plan covering the custodial parent;
   b) The plan covering the custodial parent’s spouse;
   c) The plan covering the non-custodial parent; and then
   d) The plan covering the non-custodial parent’s spouse.

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

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

1. For a dependent child who has coverage under either or both parents’ plans and also has his or her own coverage as a dependent under a spouse’s plan, the rule in this provision for Longer or Shorter Length of Coverage applies.

2. In the event the dependent child’s coverage under the spouse’s plan began on the same date as the dependent child’s coverage under either or both parents’ plans, the order of benefits shall be determined by applying the birthday rule in this provision under the Dependent Child with Parents Who Are Not Separated or Divorced.

Active/Inactive Employee Coverage

1. A plan that covers a person as an employee who is neither laid off nor retired (or that employee's dependent) is primary to a plan that covers that person as a laid off or retired employee (or a laid off or retired employee's dependent).

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

3. This rule does not apply if the rule above in items #1 and #2 under the provision Rules for a Subscriber and Dependents can determine the order of benefits.

COBRA or State Continuation Coverage

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

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

3. This rule does not apply if the rule above in items #1 and #2 under the provision Rules for a Subscriber and Dependents can determine the order of benefits.

Longer/Shorter Length of Coverage

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

Effect of Coordination of Benefits on the Benefits of this Plan

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

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

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

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

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

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

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

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

Members with a High Deductible Health Plan with a Health Savings Account option who receive health benefits from the Department of Veterans Affairs: If a Member has actually received health benefits from the Department of Veterans Affairs within the past three (3) months, they will not be eligible to establish or contribute to a Health Savings Account, even when they are enrolled in a High Deductible Health Plan. Kaiser Permanente does not provide tax advice. Ask your financial or tax advisor about your eligibility.
SECTION 5: Filing Claims, Appeals and Grievances
This section provides you with information on how to file claims, Appeals and Grievances with the Health Plan and receive support with these processes.

Important Definitions
Several terms used within this section have special meanings. Please see the section Important Terms You Should Know for an explanation of these terms. They include:

1. Adverse Decision; 2. Appeal;
3. Appeal Decision; 4. Authorized Representative;
5. Commissioner; 6. Complaint;
7. Coverage Decision; 8. Emergency Case;
9. Filing Date; 10. Grievance;
13. Health Care Provider; 14. Health Care Service;
15. Notice of Appeal Decision; 16. Notice of Coverage Decision; and
17. Urgent Medical Condition.

Questions About Filing Claims, Appeals or Grievances
If you have questions about how to file a claim, Appeal or Grievance with the Health Plan, please contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY). Member Services representatives can also help you submit a request for payment and/or reimbursement for Emergency Services and Urgent Care Services outside of our Service Area.

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

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

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

We consider an itemized bill or a request for payment or reimbursement of the cost of covered services received from physicians, hospitals or other health care providers not contracting with us to be sufficient proof of the covered service you received or your post-service claim. Simply mail or fax proof of payment and a copy of the bill to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. Please mail or fax your proof to us within one (1) year at the following address:
Failure to submit such proof within one (1) year will not invalidate or reduce the amount of your claim if it was not reasonably possible to submit the proof within that time frame. If it is not reasonably possible to submit the proof within one (1) year after the date of service, we ask that you ensure that it is sent to us no later than two (2) years from the time proof is otherwise required. A Member’s legal incapacity shall suspend the time restrictions regarding the submission of proof; however, any suspension period will end when legal capacity is regained.

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

Health Plan Claim Evaluation and Payment
The Health Plan shall act upon claims promptly and pay them no more than thirty (30) days following receipt of your claim. Your claim should include all of the required information listed above. Payment for covered Services will be made to the provider of the Services, or, if the claim has been paid, reimbursement will be made to either the:

1. Member, for non-child only plans; or
2. Parent/Guardian or Financially Responsible Person who incurred the expenses resulting from the claim, for child-only plans.

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

The Health Education and Advocacy Unit, Office of the Attorney General
The Health Education and Advocacy Unit is available to assist you or your authorized Representative:

1. With filing an Appeal or Grievance under the Health Plan’s internal Appeal and Grievance processes, however:
   a. The Health Education and Advocacy Unit is not available to represent or accompany you or your Authorized Representative during any associated proceedings.

2. In mediating a resolution of the Adverse Decision or Coverage Decision with the Health Plan. At any time during the mediation:
   a. You or your Authorized Representative may file an Appeal or Grievance; and
   b. You, your Authorized Representative or a Health Care Provider acting on your behalf may file a:
      i. Complaint with the Commissioner, without first filing an Appeal, if the Coverage Decision involves an Urgent Medical Condition; or
      ii. Grievance, if sufficient information and supporting documentation are filed with the complaint that demonstrate a compelling reason to do so.
The Health Education and Advocacy Unit may be contacted at:
Office of the Attorney General
Consumer Protection Division
Attention: Health Education and Advocacy Unit
200 St. Paul Place
Baltimore, MD 21202
Phone: 410-528-1840
Toll-free: 1-877-261-8807
Fax: 410-576-6571
Website: www.oag.state.md.us
Email: mailto:consumer@oag.state.md.us

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

1. The Coverage Decision involves an Urgent Medical Condition for which care has not been rendered;
2. You or your Authorized Representative provides sufficient information and documentation in the Complaint that supports a compelling reason to not exhaust our internal process for resolving Grievances (protests regarding Adverse Decisions), such as, when a delay in receiving the Service could result in loss of life, serious impairment to a bodily function, or serious dysfunction to a bodily organ or part, or the Member remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Member to be a danger to him/herself or others, or the Member continuing to experience severe withdrawal symptoms. A Member is considered to be in danger to self or others if the Member is unable to function in activities of daily living or care for self without imminent dangerous consequences;
3. We failed to make a Grievance Decision for a pre-service Grievance within thirty (30) working days after the Filing Date, or the earlier of forty-five (45) working days or sixty (60) calendar days after the Filing Date for a post-service Grievance;
4. We or our representative failed to make a Grievance Decision for an expedited Grievance for an Emergency Case within twenty-four (24) hours after you or your Authorized Representative filed the Grievance;
5. We have waived the requirement that our internal Grievance process must be exhausted before filing a Complaint with the Commissioner; or
6. We have failed to comply with any of the requirements of our internal Grievance process.

In a case involving a retrospective denial, there is no compelling reason to allow you or your Authorized Representative to file a complaint without first exhausting our internal grievance process.
The Maryland Insurance Commissioner may be contacted at:
Maryland Insurance Administration
Attention: Consumer Complaint Investigation
Life and Health/Appeal and Grievance
200 St. Paul Place
Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000
Toll free/out-of-area: 1-800-492-6116
TTY: 1-800-735-2258
Fax: 410-468-2260 or 410-468-2270

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

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

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Member Services Appeals Unit
2101 East Jefferson Street
Rockville, MD 20852
Fax: 1-866-640-9826

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

If we need additional information to complete our internal Grievance process within five (5) working days after you or your Authorized Representative file a Grievance, we will notify you or your Authorized Representative that we cannot proceed with review of the Grievance unless we receive the additional information. If you require assistance, we will assist you to gather necessary additional information without further delay.

Grievance Acknowledgment
We will acknowledge receipt of your Grievance within five (5) working days of the Filing Date of the written Grievance notice. The Filing Date is the earliest of five (5) calendar days after the date of the mailing postmark or the date your written Grievance was received by us.

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

**Post-service Grievance**

If the Grievance requests payment for Health Care Services already rendered to you, a retrospective acknowledgment letter will be sent requesting additional information that may be necessary within five (5) working days after the Filing Date. We will also inform you or your Authorized Representative that a decision regarding the Grievance will be made and provided in writing. Such written notice will be sent within the earlier of forty-five (45) working days or sixty (60) calendar days of the Filing Date of the Grievance.

For both pre-service and post-service Grievances, we will send you or your Authorized Representative a letter requesting an extension if we anticipate that there will be a delay in our concluding the Grievance within the designated period. The requested extension period shall not exceed more than thirty (30) working days. If you or your Authorized Representative does not agree to the extension, then the Grievance will be completed in the originally designated time frame. Any agreement to extend the period for a Grievance Decision will be documented in writing.

If the pre-service or post-service Grievance is approved, a letter will be sent to you or your Authorized Representative confirming the approval. If the Grievance was filed by your Authorized Representative, then a letter confirming 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 or your Authorized Representative of the decision within thirty (30) working days. In the case of an extension to which was agreed, notice will be provided no later than the last day of the extension period for a pre-service Grievance, or the earlier of forty-five (45) working days or sixty (60) calendar days from the date of filing. Notice will be provided no later than the last day of the extension period for a post-service Grievance.

We will communicate our decision to you or your Authorized Representative verbally and will send a written notice of such verbal communication to you or your Authorized Representative within five (5) working days of the verbal communication.

**Grievance Decision Time Periods and Complaints to the Commissioner**

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

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

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

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

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

**Expedited Grievances for Emergency Cases**

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

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

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

If we determine that an Emergency Case does exist, then the expedited review request will be reviewed by a physician who is board certified or eligible in the same specialty as the treatment under review and who is neither the individual nor a subordinate of the individual who made the initial decision. If additional information is needed to proceed with the review, we will contact you or your Authorized Representative by telephone.

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

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

**Notice of Adverse Grievance Decision**

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

1. The specific factual basis for the decision in clear and understandable language;

2. References to any specific criteria or standards on which the decision was based, including but not limited to interpretive guidelines used by us. Additionally, you or your Authorized Representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of the associated claim;

3. A statement that you or your Parent/Guardian, as applicable, is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If any specific criteria were relied upon, either a copy of such criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, we will provide either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member’s medical circumstances, or a statement that such explanation will be supplied free of charge, upon request;

4. 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
   2101 East Jefferson Street
   Rockville, MD 20852
   Phone: 301-816-6482

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

6. The Commissioner’s address and telephone and facsimile numbers;

7. A statement the Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a complaint about the Health Plan with the Commissioner; and

8. The Health Education and Advocacy Unit’s address, telephone and facsimile numbers and email address.

**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. at 1-800-777-7902 or 711 (TTY).
Our Internal Appeal Process

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

Initiating an Appeal

These internal Appeal procedures are designed by the Health Plan to assure that concerns are fairly and properly heard and resolved. These procedures apply to a request for reconsideration of a Coverage Decision rendered by the Health Plan, in regard to any aspect of the Health Plan’s Health Care Service.

You or your Authorized Representative must file an Appeal within one-hundred eighty (180) calendar days from the date of receipt of the Coverage Decision. The Appeal should be sent to us at the following address:

Kaiser Foundation Health Plan of the Mid-Atlantic States
Attention: Member Services Appeals Unit
2101 East Jefferson Street
Rockville, MD 20852
Fax: 1-866-640-9826

You or your Authorized Representative may also initiate an Appeal by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY). Member Services Representatives are also available to describe to you or your Authorized Representative how Appeals are processed and resolved.

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

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

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

After the Health Plan receives the Appeal, we will respond to you or your Authorized Representative in writing within:

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

If the Health Plan’s review results in a denial, it will notify you or your Authorized Representative in writing within three (3) working days after the Appeal Decision has been verbally communicated. This notification will include:

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

Note: The Health Plan must provide notice of an 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. at 1-800-777-7902 or 711 (TTY).

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

Maryland Insurance Administration
Attention: Consumer Complaint Investigation
Life and Health
200 St. Paul Place
Suite 2700
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

Baltimore, MD 21202
Phone: 410-468-2000
Toll-free/out-of-area: 1-800-492-6116
TTY: 1-800-735-2258
Fax: 410-468-2260 or 410-468-2270
SECTION 6: Change of Residence, Plan Renewal and Termination, and Transfer of Plan Membership

This section explains what to do when your location of residence changes and provides you with information on Plan renewal and termination, and transfer of Plan membership.

Change of Residence

You are responsible to inform us if you move outside of the Health Plan’s Service Area, which is defined in the section Important Terms You Should Know.

For Members who enrolled for coverage directly through the Health Plan: If you move to another Kaiser Foundation Health Plan region, you must promptly apply to a Health Plan Office in that region to transfer your membership. Identical coverage may not be available in the new region. If you are no longer eligible for coverage in either the region you are moving from or the new region in which you have moved, the Health Plan will provide you with at least ninety (90) days’ notice of the termination of your coverage.

For Members who enrolled for coverage through the Exchange: If you move outside of the Exchange service area, you are no longer eligible for coverage through the Exchange. The Health Plan will provide you with at least ninety (90) days’ notice of the termination of your coverage.

Depending on the type of Plan in which you are enrolled, you may be able to obtain benefits while temporarily visiting another Health Plan region. For more information, see the provisions Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas and Payment Toward Your Cost Share and When You May Be Billed in Section 2: How to Get the Care You Need.

However, you have no right to benefits, except for Emergency Services and out-of-area Urgent Care Services as defined in Section 3: Benefits, Exclusions and Limitations, in the new region after residing there for more than ninety (90) days, unless you:

1. Have enrolled as a Member in the new region; or
2. Demonstrate, by prior application to the Health Plan, that your stay in the new region for a period longer than ninety (90) days is temporary, and the Health Plan approves a continuation of the prolonged temporary status in writing. Before your coverage is terminated, the Health Plan will provide you with at least ninety (90) days’ notification of the termination of your coverage.

Plan Renewal

This Plan is guaranteed renewable on an annual basis, subject to the redetermination of each Member’s eligibility by the Health Plan or Exchange, depending on how you enrolled for coverage. Each Member that remains eligible for coverage following redetermination of eligibility shall remain enrolled under this Plan, unless the Member’s coverage is terminated as described below.

Termination of Membership

Except as expressly provided in this section, all rights to Services and other benefits hereunder terminate as of the effective date of termination, except when the Extension of Benefits provision in this section applies.
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

If your membership terminates, all rights to benefits end at 11:59 p.m. Eastern Time on the termination date. The membership of any Dependents will end at the same time that the Subscriber’s membership ends. Members will be billed at Allowable Charges for any Services received following membership termination. The Health Plan and Plan Providers have no further responsibility under this Agreement after your membership terminates, except as provided under Extension of Benefits in this section.

Termination of Agreement
This Agreement continues in effect from the effective date hereof and from month-to-month thereafter, subject to:

1. **Termination Due to Loss of Eligibility for Catastrophic Plans**
   This provision applies only to Members with catastrophic coverage. For catastrophic plans, Subscribers and Dependent(s) will not be terminated from coverage during the current Calendar Year following proper enrollment in catastrophic Plan coverage, and provided that the Subscriber and any Dependent(s) reach age 30 on or after the 1st day of coverage, but before the current Calendar Year expires. Any Member who reaches age 30 before the Calendar Year expires will not be eligible for catastrophic Plan coverage for the next succeeding Calendar Year due to age requirements.

2. **Termination by Members Who Enrolled Through the Exchange**
   For Members who enroll through the Exchange: Members who enroll through the Exchange may terminate membership under this Agreement for any reason, including as a result of obtaining other Minimum Essential Coverage, by providing reasonable notice of the termination to the Exchange. The request will be reasonable if it is received at least fourteen (14) days prior to the requested effective date of termination or sooner, if required by applicable law.

The effective date of termination will be:

1. The date requested by the Member if reasonable notice was given to the Exchange, if:
   a. Less than fourteen (14) days’ notice was given, fourteen (14) days after the termination was requested by the Member; or
   b. The Health Plan is able to effectuate termination in less than fourteen (14) days, and the Member requested an earlier termination date, the date determined by the Health Plan.
2. At the option of the Exchange, the day before coverage under Medicaid or CHIP begins, should the Member be newly eligible for Medicaid or CHIP; or
3. The date of Member’s death; or
4. At the option of the Exchange, the date termination is requested by the Member or another prospective date selected by the Member, regardless if fourteen (14) days’ notice was given.

Members may retroactively terminate or cancel his or her coverage or enrollment in a Qualified Health Plan in the following circumstances:

1. The Member demonstrates to the Exchange that he or she attempted to terminate his or her coverage or enrollment in a Qualified Health Plan and experienced a technical error that did not allow the Member to terminate his or her coverage or enrollment through the Exchange, and requests retroactive termination within sixty (60) days after he or she discovered the technical error.
In the case of retroactive termination described in #1 above, the termination date will be no sooner than fourteen (14) days after the date that the Member can demonstrate he or she contacted the Exchange to terminate his or her coverage or enrollment through the Exchange, unless Health Plan agrees to an earlier effective date.

2. The Member demonstrates to the Exchange that his or her enrollment in a Qualified Health Plan through the Exchange was unintentional, inadvertent or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Exchange or U.S. Department of Health and Human Services, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. Such Member must request cancellation within sixty (60) days of discovering the unintentional, inadvertent or erroneous enrollment.

3. The Member demonstrates to the Exchange that he or she was enrolled in a Qualified Health Plan without his or her knowledge or consent by any third party, including third parties who have no connection with the Exchange, and requests cancellation within sixty (60) days of discovering the enrollment.

In the case of the retroactive termination, as described immediately above in #2 or #3, the cancellation date or termination date will be the original coverage effective date or a later date, as determined appropriate by the Exchange, based on the circumstances of the cancellation or termination.

Termination by the Exchange and the Health Plan

For Members who enroll through the Exchange: The Exchange may initiate termination of coverage in a Qualified Health Plan through the Exchange, and the Health Plan may terminate coverage and enrollment with the Health Plan and in such Qualified Health Plan:

1. When you are no longer eligible for coverage through the Exchange;
2. For non-payment of Premium, and the:
   a. Three (3)-month grace period required for Members receiving advance payments of the Advance Premium Tax Credit has been exhausted as described in 45 CFR 156.270(g); or
   b. Thirty-one (31) day grace period described under Termination Due to Nonpayment of Premium (in this provision) has been exhausted;
3. When you perform an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact. If required by the Exchange, the Health Plan must demonstrate, to the reasonable satisfaction of the Exchange, that termination is appropriate;
4. When the Qualified Health Plan terminates or is decertified;
5. When you change from one Qualified Health Plan to another during an annual open enrollment period or a special enrollment period as described in Section 1: Introduction to Your Kaiser Permanente Health Plan; or
6. When you were enrolled in the Qualified Health Plan without your knowledge or consent by a third party, including by a third party with no connection with the Exchange.
The Health Plan will provide notice of the termination of your coverage, including the effective date of and reason for the termination, promptly and without undue delay, except as stated otherwise in this section.

In the case of the Member being enrolled in the Qualified Health Plan without his or her knowledge or consent by a third party, including a third party with no connection with the Exchange, the Exchange may cancel your enrollment upon its determination that the enrollment was performed without your knowledge or consent and following reasonable notice to you (where possible). The termination date will be the original coverage effective date.

In the event that:

1. You are no longer eligible for coverage through the Exchange as stated in item #1, above; or
2. The Qualified Health Plan terminates or is decertified as stated in item #4, above:
   a. The Health Plan will continue coverage for you and your Dependents in the same health benefit plan outside of the Exchange, but without the availability of Advance Premium Tax Credit or cost-sharing reductions, meaning that you will be fully liable for all applicable Premium, Deductibles, Copayments and Coinsurance for such coverage, whereupon the terms and conditions of the Membership Agreement applicable to such coverage shall apply.

**Termination Due to Loss of Eligibility**

*For Members who enroll through the Exchange:* If you are no longer eligible for coverage through the Exchange, you will be terminated on the last day of the month following the month in which notice of ineligibility was sent to you by the Exchange, unless you request an earlier termination date.

**Termination Due to Nonpayment of Premium for Members Who Receive Advance Premium Tax Credit**

*For Members who receive APTC:* We will provide a grace period of three (3) months for a Member, who when failing to timely pay Premium, is receiving advance payments of the premium tax credit.

We will send written notice stating when the grace period begins. We will pay claims for benefits you receive during the 1st month of the grace period. For the second (2nd) and third (3rd) months of the grace period, we are not required to pay any claims for Services rendered in the second (2nd) and third (3rd) months of the grace period unless we receive all outstanding Premium – including Premium due during the grace period – by the end of the three (3)-month grace period. If we do not receive all outstanding Premium by the end of the three (3)-month grace period, your membership will end at 11:59 p.m. Eastern Time on the last day of the 1st month of the grace period.

If applicable law does not require a three (3)-month grace period, then the grace period will be as it is explained in the **Termination Due to Nonpayment of Premium for All Other Members** provision in this section. Our notice regarding your failure to pay Premium on time will inform you about the grace period (the time frame in which you must pay overdue Premium to avoid termination) and whether or not coverage continues during the grace period.
**Termination Due to Nonpayment of Premium for All Other Members**

If we do not receive your full Premium on time, we will provide a thirty-one (31) day grace period for the payment of each Premium falling due after the 1st Premium, during which time this Agreement will remain in force. If we do not receive all outstanding Premium by the end of the thirty-one (31) day grace period, your membership will end at 11:59 p.m. Eastern Time on the last day of the grace period.

Upon the payment of a claim under this Agreement, any Premium then due and unpaid or covered by any note or written order may be deducted from the claim payment.

**Termination When a Member Changes Plans**

If you change from one Qualified Health Plan to another, your membership will terminate on the day before the effective date of coverage in the new Qualified Health Plan.

**Termination for Cause**

We may terminate your membership for cause if you:

1. Knowingly perform an act, practice or omission that constitutes fraud; or
2. Make an intentional misrepresentation of material fact.

If the fraud or intentional misrepresentation was made by:

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

We will send written notice to the Subscriber or the Dependent at least thirty-one (31) days before the termination date.

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

**Discontinuance of Coverage**

If the Health Plan elects to discontinue offering this particular health benefit product in the individual market, the Health Plan shall:

1. Give you notice of its decision at least ninety (90) days in advance of the effective date of discontinuation; and
2. Offer you the option to purchase any other individual health benefit offered by the Health Plan in the state; and
3. Act uniformly without regard to any health status related factor of enrolled individuals or individuals who may become ineligible for the coverage.

If the Health Plan elects not to renew all of its individual health benefit Plans in the state, the Health Plan:

1. Shall give notice of its decision to the affected individuals at least one-hundred eighty (180) days before the effective date of non-renewal;
2. At least thirty (30) working days before that notice, shall give notice to the Commissioner; and
3. May not write new business for individuals in the state for a five (5) year period beginning on the date of notice to the Commissioner.
Extension of Benefits

If your coverage with us has terminated, we will extend benefits for covered Services, without receipt of Premium, in the following instances:

1. If you have a claim in progress at the time your coverage terminates, the Health Plan will continue to provide benefits for Services related to the claim, in accordance with the policy in effect at the time coverage terminates. Coverage will cease at the point that you are released from the care of a physician for the condition that is the basis of the claim, or twelve (12) months from the date your coverage ends, whichever comes first.

2. If you have ordered eyeglasses or contact lenses before the date your coverage ends, we will provide benefits for covered eyeglasses or contact lenses received within thirty (30) days following the date you placed the order.

3. If you are in the midst of a course of covered dental treatment at the time your coverage ends, we will continue to provide benefits, in accordance with the Agreement in effect at the time your coverage ended, for a period of ninety (90) days following the date your coverage ended.

4. If you are in the midst of a course of covered orthodontic treatment at the time your coverage ends, we will continue to provide benefits, in accordance with the Agreement in effect at the time your coverage ended, for a period of:
   a. Sixty (60) days following the date your coverage ended if the orthodontist has agreed to or is receiving monthly payments; or
   b. Until the later of sixty (60) days following the date your coverage ended, or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

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

Limitations on Extension of Benefits:
The Extension of Benefits provisions listed above do not apply if:

1. Coverage is terminated due to you or a Financially Responsible Person’s failure to pay required Premium;

2. Coverage is terminated due to fraud or material misrepresentation by the you or your Parent/Guardian or a Financially Responsible Person; or

3. Any coverage provided by a succeeding health benefit plan:
   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 Agreement; and
   b. Does not result in an interruption of benefits to you.

Return of Pro Rata Portion of Premium in Certain Cases
If your rights hereunder are terminated under this section, prepayments received on your account applicable to a period after the effective date of termination are refunded to the Subscriber or Financially Responsible Person, as applicable. Amounts due on claims, if any, less any amounts due to the Health Plan, Plan Hospitals or Medical Group, shall be refunded to the Subscriber within thirty (31) days. In such cases, neither the Health Plan, Plan Hospitals, Medical Group nor any Physician has any further
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

liability or responsibility under this Agreement, except as provided under Extension of Benefits in this section.

Age Limit/Misstatement of Age
This Agreement will continue in effect until the end of the period for which the Health Plan has accepted the payment if:

1. An individual Agreement establishes, as an age limit or otherwise, a date after which the coverage provided by the Agreement will not be effective and the:
   a. Date falls within a period for which the Health Plan accepts a payment for the Agreement; or
   b. Health Plan accepts a payment for the Agreement after the date specified in this section.

An equitable adjustment of payments will be made in the event the age of the Member has been misstated. The Health Plan’s liability is limited to the refund, upon request, of the payment made for the period not covered by the Agreement if the age of the Member is misstated and according to the correct age of the Member the coverage provided by the Agreement would:

1. Not have become effective; or
2. Have ceased before the acceptance of the payment for the Agreement.

Spousal Conversion Privileges Upon Death of the Subscriber
Agreements written to include coverage for the spouse of the Subscriber shall, in the event of the death of the Subscriber, allow the spouse to become the successor Subscriber, if the spouse is eligible for coverage through the Health Plan or Exchange, as applicable. This conversion privilege does not apply to a Domestic Partner.

Transfer of Membership: Changing from Dependent to Subscriber Under a Kaiser Permanente for Individuals and Families Membership Agreement
A Member who enrolled as a Dependent under this Kaiser Permanente for Individuals and Families Membership Agreement but ceases to qualify as a Dependent for any reason except those described in the either Termination for Cause or Termination for Nonpayment of Premium provisions in this section, may enroll as a Subscriber under this Agreement within thirty-one (31) days after ceasing to qualify as a Dependent.

Transfer of Membership: Changing from a Kaiser Permanente Child Only Member to a Subscriber Under a Kaiser Permanente for Individuals and Families Membership Agreement
This provision does not apply to Members enrolled in a Kaiser Permanente for Individuals and Families Plan. A Member who reaches age 21 and ceases to qualify for this Kaiser Permanente Child Only Membership Agreement will remain covered under this Agreement until the last day of the Calendar Year. The Member may then enroll as a Subscriber under the same Plan offered as a Kaiser Permanente for Individuals and Families Membership Agreement within thirty-one (31) days after ceasing to qualify under this Kaiser Permanente Child Only Membership Agreement. The Member will be given notice of their option to transfer to a Kaiser Permanente Individuals and Families Membership Plan.
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

Agreement at least thirty-one (31) days prior to the Member reaching age 21.

**Reinstatement of Membership**

If any renewal Premium is not paid in full within the time granted the Subscriber for payment, a later acceptance of Premium in full by us or by any agent authorized by us to accept the Premium, without requiring a reinstatement application in connection with the acceptance of the Premium in full, shall reinstate the Agreement.

However, if we or the agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Agreement will be reinstated upon approval of the application by us or, lacking approval, upon the 45th day following the date of the conditional receipt, unless we have previously notified the Subscriber in writing of its disapproval of the reinstatement application.

In all respects the Subscriber and the Health Plan shall have the same rights under the reinstated Agreement as they had under the contract immediately before the due date of the defaulted Premium, subject to any provisions endorsed on, or attached to the Agreement in connection with the reinstatement.

Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.
SECTION 7: Other Important Provisions of Your Plan

This section contains additional special provisions that apply to this EOC.

Applications and Statements

Any applications, forms or statements specified in this Agreement, or that we request in our normal course of business, must be completed by you or your Authorized Representative or Financially Responsible Person, if applicable.

Assignment

A Member or Parent/Guardian, if applicable, may assign benefits in writing to a non-Plan Provider from whom the Member receives covered Services. A copy of this written assignment must accompany a claim for payment submitted to us by the non-Plan Provider or you.

The claim for payment is considered proof of having received the service. We request that the claim be submitted to us within one (1) year from the date of service. Late submission of your proof of the service will not reduce the amount of nor invalidate your claim. If it is not reasonably possible to submit the claim within one (1) year, then we will accept it up two (2) years from the date of service. A Member’s legal incapacity suspends any time requirements regarding timely submission of a claim. If legal capacity is regained, the suspension of any time requirement for claim submission ends, and the aforementioned requirements will become enforceable under this Agreement.

If a Member receives a payment from us for covered Services rendered by a non-Plan provider that remains unpaid, then the Member or Financially Responsible Person is responsible to pay the non-Plan provider.

Attorney Fees and Expenses

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

Contestability

This Agreement may not be contested, except for non-payment of Premium, after it has been in force for two (2) years from the date it was issued.

Absent of fraud, each statement made by a Subscriber or Member is considered a representation; not a warranty. Therefore, a statement made to effectuate coverage may not be used to avoid coverage or reduce benefits under the Agreement unless:

1. The statement is documented in writing and signed by the Subscriber, Member, Parent/Guardian or Financially Responsible Person; and
2. A copy of the statement is provided to the Subscriber, Member, Parent/Guardian or Financially Responsible Person.
Contracts with Plan Providers

Plan Provider Relationship and Compensation
The relationship between the Health Plan and Plan Providers are those of independent contractors. Plan Providers are paid in various ways, including salary, capitation, per diem rates, case rates, fee for service and incentive payments. If you would like additional information about the way Plan Providers are paid to provide or arrange medical and Hospital Services for Members, please refer to your Provider Directory or contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Plan Provider Termination
If our contract with any Plan Provider terminates, for reasons unrelated to fraud, patient abuse, incompetence or loss of licensure status while you are under the care of that Plan Provider, you may continue to see that provider and we will retain financial responsibility for covered Services you receive, in excess of any applicable Cost Sharing for a period not to exceed ninety (90) days from the date we have notified you or your Parent/Guardian or Financially Responsible Person of the Plan Provider’s termination.

Primary Care Plan Physician Termination
If our contract with your Primary Care Plan Physician terminates for reasons unrelated to fraud, patient abuse, incompetence, or loss of licensure status while you are under the care of that Primary Care Plan Physician, you may continue to see that provider and we will retain financial responsibility for covered Services you receive in excess of any applicable Cost Sharing, for a period not to exceed ninety (90) days from the date we have notified you of the Plan Physician’s termination, or until you have chosen a new Primary Care Plan Physician, whichever occurs first.

Governing Law
This Agreement will be administered under the laws of the State of Maryland, except when preempted by federal law. Any provision that is required to be in this Agreement by federal or state law shall bind both Members and the Health Plan, regardless of whether or not it is set forth in this Agreement.

Legal Action
No legal action may be brought to recover on this Agreement:
1. Before the expiration of sixty (60) days after you have provided us with proof of loss in accordance with the terms of this Agreement; or
2. After the expiration of three (3) years from the date that proof of loss was required to be provided.

Mailed Notices
Our notices to you will be sent to the most recent address we have on file for the Subscriber. You are responsible for notifying us of any change in address. Subscribers who move should promptly contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).
You may mail a change of address notice to the Health Plan by postage prepaid U.S. Mail to:

MD-DP-SEC7(01-18) 7.2
Overpayment Recovery

We may recover any overpayment we make for Services from:

1. Anyone who receives an overpayment; or
2. Any person or organization obligated to pay for the Services.

In the event of an overpayment to a Health Care Provider, we may only retroactively deny reimbursement to that Health Care Provider during the six (6) month period after the date we paid a claim submitted by that Health Care Provider.

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. Your PHI is individually identifiable information about your health, the Health Care Services you receive, and payment for your health care. You may generally:

1. See and receive copies of your PHI;
2. Correct or update your PHI; and
3. Ask us for an account of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, health research and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give PHI to others, such as government agencies or in judicial actions. We will not use or disclose your PHI for any other purpose without written authorization from you or your Authorized Representative, except as described in our Notice of Privacy Practices. Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our Notice of Privacy Practices, which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request. To request a copy, contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

You can also find the notice at your local Plan Facility or online at www.kp.org.
Important Terms You Should Know
This section is alphabetized for your convenience. The terms defined in this section have special meanings. The following terms, when capitalized and used in this Agreement, mean:

**Agreement:** The entirety of this EOC document, including all attached appendices, which constitutes the entire contract between a Member and Kaiser Foundation Health Plan of the Mid-Atlantic State, Inc., and which replaces any earlier Agreement that may have been issued to you by us.

**Advance Premium Tax Credit:** A tax credit based on estimated income that certain individuals who qualify can take to lower monthly payments for health insurance Premium. This definition only applies to plans offered on the Exchange.

**Adverse Decision:** A utilization review decision made by 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.

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

**Allowable Charges:** means either for:
1. Services provided by the Health Plan or Medical Group: The amount in the Health Plan's schedule of Medical Group and the Health Plan charges for Services provided to Members;
2. Items obtained at a Plan Pharmacy: The cost of the item calculated on a discounted wholesale price plus a dispensing fee;
3. All other Services: The amount:
   a. The provider has contracted or otherwise agreed to accept;
   b. The provider has negotiated with the Health Plan;
   c. Stated in the fee schedule that providers have agreed to accept as payment for those Services; or
   d. That the Health Plan pays for those Services.

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

**Allowable Expense:** (For use in relation to Coordination of Benefits provisions only, which are located in Section 4: Subrogation, Reductions and Coordination of Benefits): A Health Care Service or expense, including Deductibles, Copayments or Coinsurance, 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.
American Indian/Alaska Native: Any individual as defined in §4 of the federal Indian Health Care Improvement Act.

Appeal: A protest filed by a Member, a Member’s representative, or a health care provider with a carrier under its internal appeal process regarding a coverage decision concerning a Member.

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

Authorized Representative: An individual authorized in writing 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 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.

Calendar Year: The calendar year during which the Health Maintenance Organization provides coverage for benefits.

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 Coordination of Benefits provision or a similar provision takes effect.

Coinsurance: The percentage of Allowable Charges allocated to the Health Plan and to the Member.

Commissioner: The Maryland Insurance Commissioner.

Complaint: A protest filed with the Commissioner involving a Coverage Decision or Adverse Decision.

Copayment: The specified charge that a Member must pay each time Services of a particular type or in a designated setting are received.

Cost Shares: The Deductible, Copayment or Coinsurance for covered Services, as shown in the Appendix – Summary of Cost Shares.

Cost Sharing: Any expenditure required by or on behalf of a Member with respect to Essential Health Benefits. Such term includes Deductibles, Copayments, Coinsurance or similar charges, but excludes Premiums, balance billing amounts for non-network providers and spending for non-covered Services.

Cost-Sharing Reductions: Reductions in Cost Sharing for certain Members enrolled in a Silver level plan in the Exchange or for an individual who is an American Indian/Alaska Native enrolled in a Qualified Health Plan on the Exchange.

Coverage Decision: An initial determination by the Health Plan or a representative of the Health Plan that results in non-coverage of a Health Care Service. Coverage Decision includes:

1. A determination by the Health Plan that an individual is not eligible for coverage under the Health Plan’s health benefit plan;
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2. Any determination by the Health Plan that results in the rescission of an individual's coverage under a health benefit plan; and
3. Nonpayment of all or any part of a claim.

A Coverage Decision does not include an Adverse Decision or pharmacy inquiry.

D

Deductible: This definition applies only to Members with health benefit Plans that require the Member to meet a Deductible. The amount of Allowable Charges that must be incurred by an individual or a family per year before the Health Plan begins payment. This definition only applies to Deductible Health Maintenance Organization and High Deductible Health Plan plans.

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 the Who is Eligible provision in Section 1: Introduction to your Kaiser Permanente Health Plan).

Domestic Partner: An individual in a relationship with another individual of the same or opposite sex, provided both individuals:
1. Are at least age 18;
2. Are not related to each other by blood or marriage within four (4) degrees of consanguinity under civil law rule;
3. Are not married or in a civil union or domestic partnership with another individual;
4. Have been financially interdependent for at least six (6) consecutive months prior to application in which each individual contributes to some extent to the other individual’s maintenance and support with the intention of remaining in the relationship indefinitely; and
5. Share a common primary residence.

Domiciliary Care: Services that are provided to aged or disabled individuals in a protective, institutional or home-type environment. Domiciliary care includes shelter, housekeeping services, board, facilities and resources for daily living, and personal surveillance or direction in the activities of daily living.

Durable Medical Equipment: Equipment furnished by a supplier or a home health agency that:
1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally, is not useful to an individual in the absence of a disability, illness or injury; and
4. Is appropriate for use in the home.

E

Eligible Individual: An individual determined to be eligible for enrollment through the Individual Exchange in accordance with 45 CFR §155.305 and 45 CFR §156.265(b). This definition only applies to plans on the Exchange.
Emergency Case: A case in which an Adverse Decision was rendered pertaining to Health Care Services which have yet to be delivered and such Health Care Services are necessary to treat a condition or illness that, without immediate medical attention would:

1. Seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function; or
2. Cause the Member to be in danger to self or others; or
3. Cause the Member to continue using intoxicating substances in an imminently dangerous manner.

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

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

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

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

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).

Exchange: The Maryland Health Benefit Exchange established as a public corporation under § 31-102 of Title 31 of the Maryland Insurance Code. This definition applies only to plans offered on the Exchange.

Experimental Services: Services that are not recognized as efficacious as that term is defined in the Institute of Medicine Report on Assessing Medical Technologies that is current when the care is rendered. “Experimental Services” do not include clinical trials, as provided in Section 3: Benefits, Exclusions and Limitations.
Family: An individual and:
  1. Spouse;
  2. Dependent minor(s);
  3. Spouse and Dependent minor(s); or
  4. Domestic Partner.

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

Family Planning Services: Counseling, implanting or fitting of contraceptive devices and follow-up visits after a Covered Person selects a birth control method, voluntary sterilization for males and females, and voluntary termination of pregnancy.

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

Filing Date: The earlier of five (5) days after the date of mailing or the date of receipt by the Health Plan when you mail information to us.

Financially Responsible Person or Guarantor: The person who contractually agrees to pay the Premium due. This definition only applies to Child Only Plans.

Genetic Birth Defect: A defect existing at or from birth, including a hereditary defect, which includes, but is not limited to, autism or an autism spectrum disorder and cerebral palsy.

Grievance: A protest filed by a Member or Parent/Guardian, as applicable, or by a provider or other Authorized Representative on behalf of the Member, with the Health Plan, through our internal grievance process regarding an Adverse Decision concerning the Member. A Grievance does not include a verbal request for reconsideration of a Utilization Review determination.

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

Habilitative Services: Health Care Services and devices that help a person 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 may 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.

Health Care Facility: A medical facility as defined in Health-General Article, §19-114, Annotated Code of Maryland.
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**Health Care Practitioner:** An individual as defined in Health-General Article, §19-132, Annotated Code of Maryland.

**Health Care Provider:** An individual or facility as defined in Health-General Article, §19-132, Annotated Code of Maryland.

**Health Care Service:** A health or medical care procedure or service rendered by a Health Care Provider that:
1. Provides testing, diagnosis or treatment of a human disease or dysfunction;
2. Dispenses drugs, medical devices, medical appliances or medical goods for the treatment of a human disease or dysfunction; or
3. Provides any other care, service, or treatment of disease or injury, the correction of defects or the maintenance of the physical and mental well-being of human beings.

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

**Health Maintenance Organization:** An organization as defined in Health-General Article, §19-701, Annotated Code of Maryland.

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

**Health Plan Region:** Each of the specific geographic areas where Kaiser Foundation Health Plan, Inc. or a related organization conducts a direct service health care program.

**Health Savings Account:** This definition only applies if you are enrolled in a qualified High Deductible Health Plan. It does not apply to Members with catastrophic Plan coverage. A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, the Member must be covered under a qualified High Deductible Health Plan and meet other tax law requirements. Kaiser Permanente does not provide tax advice. Consult with a financial or tax advisor for more information about your eligibility for a Health Savings Account. This definition only applies to qualified High Deductible Health Plan Plans.

**High Deductible Health Plan:** This definition applies only to Members with a High Deductible Health Plan. A health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. This definition only applies to High Deductible Health Plans.

**Home Health Care:** The continued care and treatment of a Member in the home if:
1. The institutionalization of the Member in a Hospital or related institution or Skilled Nursing Facility would otherwise have been required if Home Health Care Services were not provided; and
2. The plan of treatment covering the home Health Care Service is established and approved in writing by the Health Care Practitioner.

**Hospice Care:** Medical Services defined in 42 U.S.C. §1395x(dd).

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

**K**

**Kaiser Permanente:** Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Mid-Atlantic Permanente Medical Group, Inc. and Kaiser Foundation Hospital.

**Medical Group:** Mid-Atlantic Permanente Medical Group, Inc.

**Medically Necessary:** Medically Necessary means that the Service is all of the following:
1. Medically required to prevent, diagnose or treat the Member’s condition or clinical symptoms;
2. In accordance with generally accepted standards of medical practice;
3. Not solely for the convenience of the Member, the Member’s family and/or the Member’s provider; and
4. The most appropriate level of Service which can safely be provided to the Member. For purposes of this definition, “generally accepted standards of medical practice” means:
   a. Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
   b. Physician specialty society recommendations;
   c. The view of physicians practicing in the Kaiser Permanente Medical Care Program; and/or
   d. Any other relevant factors reasonably determined by us. Unless otherwise required by law, we decide if a Service (described in **Section 3: Benefits, Exclusions and Limitations**) is Medically Necessary and our decision is final and conclusive subject to the Member’s right to appeal, or go to court, as set forth in **Section 5: Filing Claims, Appeals and Grievances**.

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

**Member:** A person who is eligible and enrolled under this Agreement as a Subscriber or a Dependent, and for whom we have received applicable Premium. Members are sometimes referred to as “you” within this Agreement. Under no circumstances should the term “you” be interpreted to mean a Financially Responsible Person, Parent/Guardian or any other nonmember reading or interpreting this Agreement on behalf of a Member.
Minimum Essential Coverage: The type of coverage an individual needs to have to meet the individual responsibility requirement under the Patient Protection and Affordable Care Act.

Monthly Payments: Periodic membership charges paid by a Subscriber; or for Child Only Plans, a Parent/Guardian or Financially Responsible Person.

Multiple Risk Factors: Having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives or cervical ectopy.

Network: Plan Providers who have entered into a provider service contract with Kaiser Permanente to provide Services on a preferential basis.

Non-Physician Specialist: A Health Care Provider who is:
1. Not a physician;
2. Licensed or certified under the Health Occupations Article; and
3. 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.

Notice of Appeal Decision: Notice of the Appeal decision required to be sent per Section 5: Filing Claims, Appeals and Grievances shall:
1. States in detail in clear, understandable language the specific factual bases for the Health Plan’s Appeal Decision; and
2. Includes the following information:
   a. That the Member, Member’s Authorized Representative or a Health Care Provider acting on behalf of the Member has a right to file a complaint with the Commissioner within four (4) months after receipt of a Health Plan’s Appeal decision;
   b. The Commissioner’s address, telephone and facsimile numbers;
   c. A statement that the Health Advocacy Unit is available to assist the member in filing a complaint with the Commissioner; and
   d. The address, telephone and facsimile numbers and email address of the Health Advocacy Unit.

Notice of Coverage Decision: Notice of Coverage Decision required to be sent per Section 5: Filing Claims, Appeals and Grievances shall:
1. States in detail in clear, understandable language, the specific factual bases for the Health Plan’s Coverage Decision; and
2. Includes the following information:
   a. That the Member, Member’s Authorized Representative, or a Health Care Provider acting on behalf of the Member has a right to file an Appeal with the carrier;
   b. That the Member, Member’s Authorized Representative or a Health Care Provider acting on behalf of the Member may file a complaint with the Commissioner without first filing an
Appeal, if the Coverage Decision involves an Urgent Medical Condition for which care has not been rendered;

c. The Commissioner’s address and telephone and facsimile numbers;

d. That the Health Advocacy Unit is available to assist the Member or Member’s Authorized Representative in both mediating and filing an Appeal under the carrier’s internal Appeal process; and

e. The address, telephone and facsimile numbers and email address of the Health Advocacy Unit.

Out-of-Pocket Maximum: The maximum amount of Deductibles, Copayments and Coinsurance that an individual or family is obligated to pay for covered Services per Calendar Year.

Outpatient Rehabilitative Services: Occupational therapy, speech therapy and physical therapy, provided to Members not admitted to a Hospital or related institution.

Parent/Guardian: The person who has legal authority to make medical decisions for a Member under age 19 or a Member age 19 or older who is incapable of making such decisions by reason of mental incapacity. This definition applies only to Child Only plans.

Partial Hospitalization: The provision of medically-directed intensive or intermediate short-term psychiatric treatment for a period more than four (4) hours, but less than twenty-four (24) hours in a day for an individual patient in a Hospital, psychiatric day-care treatment center, community mental health facility or any other authorized facility.

Personal Care: Service that an individual normally would perform personally, but for which the individual needs help from another because of advanced age, infirmity, or physical or mental limitation. Personal care includes help in walking; help in getting in and out of bed, help in bathing, help in dressing, help in feeding, and general supervision and help in daily living.

Plan: The health benefit Plan described in this Agreement.

Plan: (For use in relation to Coordination of Benefits provisions only, which are located in Section 4: Subrogation, Reductions and Coordination of Benefits): Any of the following that provides benefits or services for, or because of, medical care or treatment: Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepaid group practice or individual practice coverage. “Plan” does not include an individually underwritten and issued, guaranteed renewable, specified disease policy or intensive care policy, that does not provide benefits on an expense-incurred basis. “Plan” also does not include the medical benefits under an automobile policy, including benefits for personal injury protection. “Plan” also does not include:

1. Accident only coverage;
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Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

2. Hospital indemnity coverage benefits or other fixed indemnity coverage;
3. Specified disease or specified accident coverage;
4. Limited benefit health coverage, as provided for by Maryland state law;
5. School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four (24)-hour basis or on a “to and from school” basis;
6. Benefits provided in long-term insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
7. Medicare supplement policies;
8. A state plan under Medicaid; or
9. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

Plan Facility: A Plan Medical Center, Plan Hospital or another freestanding facility that is:
1. Operated by us or contracts to provide Services and supplies to Members; and
2. Included in the Signature provider network.

Plan Hospital: A Hospital that:
1. Contracts to provide inpatient and/or outpatient Services to Members; and
2. Is included in the Signature provider network.

Plan Medical Centers: 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 Office.

Plan Physician: Any licensed physician who is an employee of Medical Group, or any licensed physician (except for those physicians who contract only to provide Services upon referral) who:
1. Contracts to provide Services and supplies to Members; and
2. Is included in the Signature provider network.

Plan Provider: A Plan Physician or other Health Care Provider including but not limited to a Non-Physician Specialist, and Plan Facility that:
1. Is employed by or operated by an entity that participates in the Kaiser Permanente Medical Care Program; or
2. Contracts with an entity that participates in the Kaiser Permanente Medical Care Program.

Premium: The amount a Subscriber owes for coverage under this Agreement for his/her self and any covered Dependents; or for Child Only Plans, a Parent/Guardian or Financially Responsible Person.

Primary Care: Services rendered by a Health Care Practitioner in the following disciplines:
Kaiser Permanente for Individuals and Families/
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1. General internal medicine;
2. Family practice medicine;
3. Pediatrics; or

Qualified Health Plan: Any health plan that has an effective certification that it meets the standards recognized by the Exchange through which such plan is offered. This definition applies only to plans offered on the Exchange.

Qualified Individual: An individual (including a minor) who at the time of enrollment:
   1. Is seeking to enroll in a Qualified Health Plan offered to individuals through the Individual Exchange;
   2. Resides in the State of Maryland;
   3. Is not incarcerated, other than incarceration pending disposition of charges; and
   4. Is, and reasonably is expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

Note: This definition applies only to plans offered on the Exchange. Items #1 through #4, with the exception of item #2, applies to all individuals including minors.

Related Institution: An institution defined in the Health-General Article, §19-301, Annotated Code of Maryland.

Self-Only Coverage: Coverage for a Subscriber only, with no Dependents covered under this Agreement.

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

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

Skilled Nursing Facility: An institution, or a distinctive part of an institution, licensed by the Department of Health and Mental Hygiene, which is primarily engaged in providing:
   1. Primarily engaged in providing:
      a. Skilled nursing care, and related Services, for residents who require medical or nursing care,
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

b. Rehabilitation Services for the rehabilitation of injured, disabled, or sick persons; and
2. Certified by the Medicare Program as a Skilled Nursing Facility.

Specialist: A Health Care Practitioner who is not providing Primary Care Services.

Specialty Services: Care provided by a Health Care Practitioner who is not providing Primary Care Services.

Spouse: The Member’s legal husband or wife.

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

T
Totally Disabled:
1. For Subscribers and Adult Dependents: In the judgment of a Medical Group Physician, a Member is totally disabled by reason of injury or sickness if the Member is unable to perform each and every duty pertaining to his or her occupation during the first fifty-two (52) weeks of the disability. After the first fifty-two (52) weeks, a Member is totally disabled if he or she 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.

2. For Dependent Children and Members covered under a Child Only Plan: In the judgment of a Plan Physician, an illness or injury which makes the child unable to substantially engage in any of the normal activities of children in good health and like age.

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

Urgent Medical Condition: As used in Section 5: Filing Claims, Appeals and Grievances, a condition that satisfies either of the following:
1. A medical condition, including a physical, mental health or dental condition, where the absence of medical attention within seventy-two (72) hours could reasonably be expected by an individual, acting on behalf of the Health Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
   a. Placing the Member’s life or health in serious jeopardy;
   b. The inability of the Member to regain maximum function;
   c. Serious impairment to bodily function;
   d. Serious dysfunction of any bodily organ or part; or
e. The Member remaining seriously mentally ill with symptoms that cause the member to be a
danger to self or others.

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

This Adult Dental Plan Appendix is effective as of the date of your Kaiser Permanente Membership Agreement (Agreement) and shall terminate as of the date your Agreement terminates.

Health Plan will provide coverage or a schedule of fixed fees for adult dental services.

DEFINITIONS

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

Dental Services: A range of diagnostic, preventive, restorative, endodontic, periodontic, prosthetics, orthodontic and oral surgery services that are not covered benefits and for which fee schedule amounts are due as payment in full as set forth in this Agreement.

Covered Preventive Dental Services includes, but is not limited to oral evaluation, cleaning and certain diagnostic X-rays, that are covered benefits under this Agreement.

Dental Administrator means the entity that has entered into a contract with Health Plan to provide or arrange for the provision of Covered Preventive Dental Services. The name and information about the Dental Administrator can be found under General Provisions, see Section II, Paragraph F below.

Dental Fee means the discounted fees that a Participating Dental Provider charges you for a Dental Service. Dental Fees are reviewed annually and subject to change effective January 1st of each year.

Dental Specialist means a Participating Dental Provider that is a dental specialist.

General Dentist means a Participating Dental Provider that is a general dentist.

Participating Dental Provider means a licensed dentist who has entered into an agreement with Dental Administrator to provide Dental Services and/or other dental services at negotiated contracted rates.

II. GENERAL PROVISIONS

A. Subject to the terms, conditions, limitations, and exclusions specified in the Agreement, you may receive Covered Preventive Dental and Dental Services from Participating Dental Providers. You may receive Covered Dental Services from a non-Participating Dental Provider for emergencies, urgent care received outside Health Plan’s service area, and services obtained pursuant to a referral to a non-participating specialist.

B. Health Plan has entered into an Agreement with Dental Administrator to provide Covered Preventive Care Dental Services and certain other Dental Services through its Participating Dental Providers.

C. Attached is a list of Covered Preventive Dental Services and other Dental Services and the associated Dental Fees that you will be charged for which copayments are required. You will pay a fixed copayment for each preventive care office visit during which Covered Preventive Care Dental Services are provided. The fixed copayment does not apply to the following preventive services: intraoral complete series of radiographic images (D0210), panoramic radiographic image (D0330), additional cleaning beyond benefit limitation (D1110*), preventive resin restoration (D1352) and interim caries arresting medicament application per tooth (D1354). You will pay Dental Fees for certain other Dental Services you receive from Participating Dental Providers. You will pay the applicable Dental Fee directly to the Participating Dental Provider at the time services are rendered. The Participating Dental Provider has agreed to accept that Dental Fee as payment in full of the Member’s responsibility for that procedure. Neither Health Plan nor Dental Administrator are responsible for payment of these fees or for any fees incurred as the result of receipt of Dental Services or any other non-covered dental service.

D. You will receive a list of Participating Dental Providers from the Health Plan or from Dental Administrator. You should select a Participating Dental Provider, who is a “General Dentist”, from whom you and your
covered family members will receive Covered Preventive Dental Services and other Dental Services. Specialty care is also available should such care be required, however, you must be referred to a Dental Specialist by your General Dentist. Your Dental Fees are usually higher for care received by a Dental Specialist.

E. For assistance concerning the dental coverage benefit of your health insurance plan, you may contact the Health Plan’s Member Services Department at the following telephone numbers:

   Toll-Free Number: 800-777-7902
   TTY number is: TTY 711

F. **Dental Administrator:** Health Plan has entered into an agreement with Dominion Dental Services USA, Inc. d/b/a Dominion National to provide Covered Preventive Dental Services as described in this Appendix. You may obtain a list of Participating Dental Providers, Covered Dental Services and Dental Fees by contacting Dominion National Member Services specialists Monday through Friday from 7:30 a.m. to 6:00 p.m. (Eastern Time) at the following telephone numbers:

   Toll-Free Number: 855-733-7524
   TTY Line: TTY 711

Dominion National’s Integrated Voice Response System is available 24 hours a day for information about Participating Dental Providers in your area, or to help you select a Participating Dental Provider. The most up-to-date list of Participating Dental Providers can be found at the following website:

   DominionNational.com/kaiserdentists

Dominion National also provides many other secure features online at DominionNational.com

G. **Missed Appointment Fee:** Participating Dental Providers may charge you an administrative fee if you miss a scheduled dental appointment without giving 24 hours advance notice. The fee may vary depending on the Participating Dental Provider, however in no event shall the missed appointment fee exceed $25 for a single visit.

III. **SPECIALIST REFERRALS**

A. **Participating Specialist Referrals**

   If, in the judgment of your General Dentist, you require the Services of a specialist, you may be referred to a Dental Specialist who will provide Covered Dental Services to you at the Dental Fee for each procedure rendered.

B. **Non-Participating Specialist Referrals**

   Benefits may be provided for referrals to non-Participating Dental Provider specialists when:

   1. You have been diagnosed by your General Dentist with a condition or disease that requires care from a dental specialist; and
   2. Health Plan and Dental Administrator do not have a Participating Dental Provider specialist who possesses the professional training and expertise required to treat the condition or disease; or
   3. Health Plan and Dental Administrator cannot provide reasonable access to a Dental Specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

   The Member’s financial liability will be calculated as if the provider rendering the Covered Dental Services was a Participating Dental Provider.
C. **Standing Referrals to Dental Specialists**

1. If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires specialized care, your General Dentist may determine, in consultation with you and the Dental Specialist, that you would be best served through the continued care of a Dental Specialist. In such instances, the General Dentist will issue a standing referral to the Dental Specialist.

2. The standing referral will be made in accordance with a written treatment plan developed by the General Dentist, Dental Specialist, and you. The treatment plan may limit the number of visits to the Dental Specialist or the period of time in which visits to the Dental Specialist are authorized. 

Health Plan retains the right to require the Dental Specialist to provide the General Dentist with ongoing communication regarding your treatment and dental health status.

IV. **EXTENSION OF BENEFITS**

A. In those instances when your coverage with Health Plan has terminated, we will extend Covered Preventive Dental Services, without payment of Monthly Payments, in the following instances:

   1. If you are in the midst of a course of covered dental treatment at the time your coverage ends, in accordance with the Agreement and Dental Appendix in effect at the time your coverage ended, for a period of 90 days following the date your coverage ended.

   2. If you are in the midst of a course of covered orthodontic treatment at the time your coverage ends, in accordance with the Agreement and Dental Appendix 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 later 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, please notify us in writing.

B. **Extension of Benefit Limitations:**

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

   1. Coverage ends because of your failure to pay Monthly Payments;
   
   2. Coverage ends as the result of you committing fraud or material misrepresentation;
   
   3. When coverage is provided by a succeeding health plan and that health plan’s coverage:
      
      a. is provided at a cost to you that is less than or equal to the cost to you of the extended benefit available under this Appendix; and
      
      b. will not result in an interruption of the Covered Dental Services you are receiving.

V. **DENTAL EMERGENCIES OUTSIDE THE SERVICE AREA**

When a dental emergency occurs outside the Service Area, Dental Administrator will reimburse the non-participating provider directly. If the member has already paid the charges, the Dental Administrator will reimburse the member (upon proof of payment) instead of paying the provider directly for Dental Services that may have been provided. Reimbursement to the member is not to exceed $50.00 per incident. Services are limited to those procedures not excluded under Plan Limitations and Exclusions. Proof of payment must be submitted to Dental Administrator by provider within one hundred eighty (180) days of treatment. The Dental Administrator will allow Members to submit claims up to one (1) year after the date of service. However, a Member’s legal incapacity shall suspend the time to submit a claim; and the suspension period ends when legal capacity is regained. Failure to submit a claim within one (1) year after the date of services does not invalidate or reduce the amount of the claim if it was not reasonably possible to submit the claim within one (1) year after the date of services; and the claim is submitted within two (2) years after the date of service. Proof of payment should be mailed to: Dominion National, 251 18th Street South, Suite 900,
Arlington, VA 22202, ATTN: Accounting Dept. Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. You must receive all post-emergency care from your Participating Dental Provider.

VI. EXCLUSIONS AND LIMITATIONS
A. Plan Exclusions

The following services are not covered under this Appendix:

1. Services which are covered under worker’s compensation or employer’s liability laws.
2. Services which are not necessary for the patient’s dental health as determined by the Plan.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
4. Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan which is described in the Evidence of Coverage.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism or development malformations where, in the opinion of the Plan, such services should not be performed in a dental office (except as may be otherwise covered in your medical plan as described in the Evidence of Coverage).
6. Dispensing of drugs, except as may be otherwise covered in your medical plan as is described in the Agreement.
8. Treatment required for conditions resulting from major disaster, epidemic, war or acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
9. Replacement due to loss or theft of prosthetic appliance.
10. Procedures not listed as a covered benefit under this Plan.
11. Services provided by a non-Participating Dental Provider that was not pre-authorized or otherwise approved by the Dental Administrator, Health Plan or Participating Dental Provider (with the exception of out-of-area emergency or urgent care, covered dental services and services obtained pursuant to a referral to a non-participating specialist).
12. Services related to the treatment of TMD (Temporomandibular Disorder).
13. Services related to procedures that have such a degree of complexity as not to be performed by a general dentist, unless your participating general dentist refers you to a dental specialist who will provide covered dental services at the dental fee established by the Plan for each procedure rendered.
14. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by the Plan.
15. The Invisalign system and similar specialized braces are not a covered benefit. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient’s responsibility.
16. Services which are provided without cost to Member by any federal, state, municipal, county, or other political subdivision (with the exception of Medicaid).
17. Services that cannot be performed because of the general health of the patient.
18. Procedures relating to the change and maintenance of vertical dimension or major restoration of occlusion, or to alter the occlusion (bite) through full mouth adjustment/grinding of the teeth. This does not exclude minor occlusal adjustments on individual teeth to remove high spots or smooth out rough or sharp areas.
19. Lab Fees for excisions and biopsies, except as may be otherwise covered in your medical plan that is described in the Agreement.
20. Treatment of cleft palate, anodontia, malignancies or neoplasms, except as may be otherwise covered in your medical plan as described in Section 3 of the Agreement.
21. Experimental procedures, implantations, or pharmacological regimens which in the opinion of the Plan, are not necessary for the patient’s dental health.
22. Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
23. Charges for second opinions, unless pre-authorized.
24. Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
25. Occlusal guards, except for the purpose of controlling habitual grinding.

B. Plan Limitations
Covered Dental Services are subject to the following limitations:

1. Two (2) evaluations are covered per calendar year, per patient, including a maximum of one (1) comprehensive evaluation, which is limited to once per calendar year.
2. One (1) problem focused evaluation is covered per calendar year.
3. Two (2) teeth cleanings are covered per calendar year. One additional cleaning is covered during pregnancy and for diabetic patients.
4. One (1) topical fluoride or fluoride varnish is covered per calendar year.
5. Two (2) sets of bitewing x-rays are covered per calendar year, per patient.
6. One (1) set of full mouth x-rays or panoramic film is covered every three (3) years.
7. One (1) interim caries arresting medicament application per primary tooth is covered per lifetime.
8. Replacement of a filling is covered if it is more than two (2) years from the original date of placement.
9. Replacement of a bridge, crown or denture is covered if it is more than seven (7) years from the date of original placement.
10. Crown and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider’s Usual, Customary, and Reasonable (UCR) fee, minus 25%.
11. Relining and rebasing of dentures is limited to once every 24 months.
12. Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
13. Root planing or scaling is covered once every 24 months per quadrant.
14. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, once per two years.
15. Full mouth debridement is limited to once per lifetime.
16. Procedure code D4381 is limited to one (1) benefit per tooth for three (3) teeth per quadrant or a total of 12 teeth for all four (4) quadrants per 12 months. Must have pocket depths of five (5) millimeters or greater.
17. Periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site.
18. Periodontal maintenance after active therapy is covered twice per calendar year, within 24 months after definitive periodontal therapy.
19. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1110, limited to once per two years.
20. Coronectomy - intentional partial tooth removal, once per lifetime.
21. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available).

This Appendix is subject to all the terms and conditions of the Agreement to which this Appendix is attached. This Appendix does not change any of those terms and conditions, unless specifically stated in this Appendix.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
$30 Preventive Dental Plan
2020 Discounted Schedule of Dental Fees

Procedures not shown in this list are not covered. Detailed dental benefits may be found in the Adult Dental Plan Appendix. Refer to the description of your dental benefit for a complete description of the terms and conditions of your covered benefit.

Fees quoted in the “You pay to Dentist” column apply only when performed by a participating general dentist. If specialty care is required, your general dentist must refer you to a participating specialist except as otherwise described in the Adult Dental Plan Appendix. Services received from non-participating dentists are not covered under this plan except for: (1) benefits provided under a referral to a non-Participating dental provider under Section III.B of the Adult Dental Plan Appendix; (b) for dental emergencies as described in Section V. of the Adult Dental Plan Appendix; and (3) for Continuity of Care for new Members, as described in Section 2 of the contract form.

**FC$30:** You pay a combined fixed copayment (FC) of $30 for any visit during which one or more of the following procedures are performed: (a) an oral exam (D0120, D0140, D0150, D0170 or D0180); (b) X-rays (D0220, D0230, D0240, D0250, D0270, D0272, D0273, D0274, D0277, D0340, D0350 or D0351); (c) a pulp vitality test (D0460); (d) a diagnostic cast (D0470); (e) a routine cleaning (D1110); (f) fluoride application (D1206 or D1208); or (g) you are given oral hygiene or counseling instructions (D1310, D1320 or D1330). You pay a separate fee for any other procedure performed.

**NOTE:** The Schedule of Dental Fees is reviewed annually and is subject to change effective January 1 of each year. Contact Dominion for details toll-free at 855-733-7524, Monday through Friday, 7:30 a.m. to 6 p.m., (TTY 711).

<table>
<thead>
<tr>
<th>ADA CODE</th>
<th>DESCRIPTION OF SERVICES</th>
<th>YOU PAY TO DENTIST</th>
<th>YOU PAY TO SPECIALIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation- established patient</td>
<td>FC$30</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral eval - problem focused</td>
<td>FC$30</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral eval - new or established patient</td>
<td>FC$30</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D0170</td>
<td>Re-eval - limited, problem focused</td>
<td>FC$30</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D0180</td>
<td>Comp. periodontal eval - new or established patient</td>
<td>FC$30</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral – complete series of radiographic images</td>
<td>$54</td>
<td>$69</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral - periapical first radiographic image</td>
<td>FC$30</td>
<td>$14</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral - periapical each add. radiographic image</td>
<td>FC$30</td>
<td>$11</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral - occlusal radiographic image</td>
<td>FC$30</td>
<td>$21</td>
</tr>
<tr>
<td>D0250</td>
<td>Extraoral - 2D projection radiographic image</td>
<td>FC$30</td>
<td>$26</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing - single radiographic image</td>
<td>FC$30</td>
<td>$14</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings - two radiographic images</td>
<td>FC$30</td>
<td>$21</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings - three radiographic images</td>
<td>FC$30</td>
<td>$28</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings - four radiographic images</td>
<td>FC$30</td>
<td>$31</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewings - 7 to 8 radiographic images</td>
<td>FC$30</td>
<td>$47</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic radiographic images</td>
<td>$43</td>
<td>$55</td>
</tr>
<tr>
<td>D0340</td>
<td>2D cephalometric radiographic images</td>
<td>FC$30</td>
<td>$55</td>
</tr>
<tr>
<td>D0350</td>
<td>2D oral/facial photographic images</td>
<td>FC$30</td>
<td>$29</td>
</tr>
<tr>
<td>D0351</td>
<td>3D photographic image</td>
<td>FC$30</td>
<td>$32</td>
</tr>
<tr>
<td>D0460</td>
<td>Pulp vitality tests</td>
<td>FC$30</td>
<td>$35</td>
</tr>
<tr>
<td>D0470</td>
<td>Diagnostic casts</td>
<td>FC$30</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D1110</td>
<td>Prophylaxis (cleaning) – adult</td>
<td>FC$30</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D1110*</td>
<td>Additional cleaning (expecting mothers and Diabetics)</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical application of fluoride varnish</td>
<td>FC$30</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D1208</td>
<td>Topical application of fluoride – excluding varnish</td>
<td>FC$30</td>
<td>No Benefit</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Fee</td>
<td>Benefit</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>------</td>
<td>---------</td>
</tr>
<tr>
<td>D1310</td>
<td>Nutritional counseling for control of dental disease</td>
<td>$83</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D1320</td>
<td>Tobacco counseling for control and prev. of oral disease</td>
<td>$83</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D1330</td>
<td>Oral hygiene instructions</td>
<td>$83</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D1352</td>
<td>Prev resin rest. Mod/high caries risk – perm. Tooth</td>
<td>$30</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D1354</td>
<td>Interim caries arresting medicament application – per tooth</td>
<td>$15</td>
<td>No Benefit</td>
</tr>
</tbody>
</table>

**Restorative Dentistry (Fillings)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>Amalgam - 1 surface</td>
<td>$68</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam – 2 surfaces</td>
<td>$88</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam – 3 surfaces</td>
<td>$105</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam - &gt;=4 surfaces</td>
<td>$126</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite -1 surface, anterior</td>
<td>$83</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite – 2 surfaces, anterior</td>
<td>$105</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite – 3 surfaces, anterior</td>
<td>$129</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite - &gt;=4 surfaces, anterior</td>
<td>$163</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2390</td>
<td>Resin-based composite crown, anterior</td>
<td>$216</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2391</td>
<td>Resin-based composite – 1 surface, posterior</td>
<td>$108</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite - 2 surfaces, posterior</td>
<td>$143</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin-based composite 3 surfaces, posterior</td>
<td>$179</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2394</td>
<td>Resin-based composite - &gt;=4 surfaces, posterior</td>
<td>$204</td>
<td>No Benefit</td>
</tr>
</tbody>
</table>

**Crows & Bridges**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2510</td>
<td>Inlay – metallic – 1 surface</td>
<td>$493</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2520</td>
<td>Inlay – metallic – 2 surfaces</td>
<td>$556</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2530</td>
<td>Inlay – metallic – 3 or more surfaces</td>
<td>$604</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2542</td>
<td>Onlay – metallic-2 surfaces</td>
<td>$641</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2543</td>
<td>Onlay – metallic-3 surfaces</td>
<td>$653</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2544</td>
<td>Onlay – metallic-4 or more surfaces</td>
<td>$657</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2610</td>
<td>Inlay – porcelain/ceramic – 1 surface</td>
<td>$541</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2620</td>
<td>Inlay – porcelain/ceramic – 2 surfaces</td>
<td>$576</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2630</td>
<td>Inlay – porcelain/ceramic - &gt;=3 surfaces</td>
<td>$665</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2642</td>
<td>Onlay – porcelain/ceramic – 2 surfaces</td>
<td>$616</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2643</td>
<td>Onlay – porcelain/ceramic - 3 surfaces</td>
<td>$666</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2644</td>
<td>Onlay – porcelain/ceramic - &gt;=4 surfaces</td>
<td>$710</td>
<td>No Benefit</td>
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<tr>
<td>D2650</td>
<td>Inlay – resin-based composite – 1 surface</td>
<td>$498</td>
<td>No Benefit</td>
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<tr>
<td>D2651</td>
<td>Inlay – resin-based composite – 2 surfaces</td>
<td>$538</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2652</td>
<td>Inlay – resin-based composite - &gt;=3 surfaces</td>
<td>$699</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2662</td>
<td>Onlay – resin-based composite – 2 surfaces</td>
<td>$568</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2663</td>
<td>Onlay – resin-based composite – 3 surfaces</td>
<td>$699</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2664</td>
<td>Onlay – resin-based composite - &gt;=4 surfaces</td>
<td>$662</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2710</td>
<td>Crown – resin based composite (indirect)</td>
<td>$277</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2712</td>
<td>Crown – 3/4 resin-based composite (exclusive of veneers)</td>
<td>$255</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2720</td>
<td>Crown – resin with high noble metal</td>
<td>$675</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2721</td>
<td>Crown – resin with predom. Base metal</td>
<td>$601</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2722</td>
<td>Crown – resin with noble metal</td>
<td>$628</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2740</td>
<td>Crown – porcelain/ceramic</td>
<td>$741</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2750</td>
<td>Crown – porcelain fused to high noble metal</td>
<td>$755</td>
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</tr>
<tr>
<td>D2751</td>
<td>Crown – porcelain fused to high noble metal</td>
<td>$653</td>
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</tr>
<tr>
<td>D2752</td>
<td>Crown – porcelain fused to noble metal</td>
<td>$679</td>
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<tr>
<td>D2780</td>
<td>Crown – 3/4 cast high noble metal</td>
<td>$724</td>
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</tr>
<tr>
<td>D2781</td>
<td>Crown – 3/4 cast predominantly base metal</td>
<td>$566</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2782</td>
<td>Crown – 3/4 cast noble metal</td>
<td>$611</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2783</td>
<td>Crown – 3/4 porcelain/ceramic</td>
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</tr>
<tr>
<td>D2790</td>
<td>Crown – full cast high noble metal</td>
<td>$675</td>
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</tr>
<tr>
<td>Code</td>
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<td>Cost</td>
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<td>------------------------------------------------------------------------------</td>
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<tr>
<td>D2791</td>
<td>Crown – full cast predominantly base metal</td>
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<td>D2792</td>
<td>Crown – full cast noble metal</td>
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</tr>
<tr>
<td>D2794</td>
<td>Crown – titanium</td>
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<td>No Benefit</td>
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<tr>
<td>D2910</td>
<td>Recement inlay</td>
<td>$68</td>
<td>No Benefit</td>
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<tr>
<td>D2920</td>
<td>Recement crown</td>
<td>$68</td>
<td>No Benefit</td>
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<tr>
<td>D2932</td>
<td>Prefabricated resin crown</td>
<td>$254</td>
<td>No Benefit</td>
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<tr>
<td>D2940</td>
<td>Protective restoration</td>
<td>$77</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2941</td>
<td>Interim therapeutic rest., prim. Dentition</td>
<td>$49</td>
<td>No Benefit</td>
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<tr>
<td>D2950</td>
<td>Core buildup, including any pins</td>
<td>$172</td>
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<tr>
<td>D2951</td>
<td>Pin retention – per tooth, in addition to restoration</td>
<td>$40</td>
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</tr>
<tr>
<td>D2952</td>
<td>Post and core in addition to crown</td>
<td>$252</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2954</td>
<td>Prefab. Post and core in addition to crown</td>
<td>$224</td>
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</tr>
<tr>
<td>D2955</td>
<td>Post removal (not in conj. With endo. Therapy)</td>
<td>$194</td>
<td>No Benefit</td>
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<tr>
<td>D2980</td>
<td>Crown repair necessitated by restorative material failure</td>
<td>$138</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2981</td>
<td>Inlay repair necessitated by restorative material failure</td>
<td>$138</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D2982</td>
<td>Onlay repair necessitated by restorative material failure</td>
<td>$138</td>
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### Endodontic Services

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>D3110</td>
<td>Pulp cap – direct (excl. final restoration)</td>
<td>$47</td>
<td>No Benefit</td>
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<tr>
<td>D3120</td>
<td>Pulp cap – indirect (excl. final restoration)</td>
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<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy (excl. final restor.)</td>
<td>$104</td>
<td>$122</td>
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<td>D3221</td>
<td>Pulpal debridement</td>
<td>$126</td>
<td>No Benefit</td>
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<tr>
<td>D3310</td>
<td>Endodontic therapy, anterior tooth</td>
<td>$482</td>
<td>$554</td>
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<tr>
<td>D3320</td>
<td>Endodontic therapy, premolar tooth (excl final restoration)</td>
<td>$576</td>
<td>$663</td>
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<tr>
<td>D3330</td>
<td>Endodontic therapy, molar tooth (excl final restoration)</td>
<td>$755</td>
<td>$867</td>
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<tr>
<td>D3333</td>
<td>Internal root repair of perforation defects</td>
<td>No Benefit</td>
<td>$225</td>
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<td>D3346</td>
<td>Retreat of prev. root canal therapy, ant.</td>
<td>No Benefit</td>
<td>$609</td>
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<tr>
<td>D3347</td>
<td>Retreat of prev. root canal therapy, premolar</td>
<td>No Benefit</td>
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<tr>
<td>D3348</td>
<td>Retreat of prev. root canal therapy, molar</td>
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<tr>
<td>D3410</td>
<td>Apicoectomy - anterior</td>
<td>$422</td>
<td>$524</td>
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<tr>
<td>D3421</td>
<td>Apicoectomy - premolar (first root)</td>
<td>$471</td>
<td>$655</td>
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<tr>
<td>D3425</td>
<td>Apicoectomy - molar (first root)</td>
<td>$518</td>
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<td>D3426</td>
<td>Apicoectomy - (each add. Root)</td>
<td>$314</td>
<td>$371</td>
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<td>D3427</td>
<td>Periradicular surg. w/o apicoectomy</td>
<td>$402</td>
<td>$504</td>
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<tr>
<td>D3430</td>
<td>Retrograde filling – per root</td>
<td>$118</td>
<td>$295</td>
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<tr>
<td>D3450</td>
<td>Root amputation - per root</td>
<td>$205</td>
<td>$330</td>
</tr>
<tr>
<td>D3920</td>
<td>Hemisection, not inc. root canal therapy</td>
<td>$258</td>
<td>$305</td>
</tr>
<tr>
<td>D3950</td>
<td>Canal prep/fitting of preformed dowel or post</td>
<td>$154</td>
<td>$216</td>
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</table>

### Periodontics

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
<th>Benefit</th>
</tr>
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<tbody>
<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty - &gt;3 cont. teeth, per quad.</td>
<td>$372</td>
<td>$439</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty - &lt;=3 teeth, per quad.</td>
<td>$161</td>
<td>$190</td>
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<tr>
<td>D4240</td>
<td>Gingival flap proc., inc. root planing - &gt;3 cont. teeth, per quad</td>
<td>$479</td>
<td>$566</td>
</tr>
<tr>
<td>D4241</td>
<td>Gingival flap proc, inc. root planing - &lt;=3 cont. teeth, per quad</td>
<td>$121</td>
<td>$239</td>
</tr>
<tr>
<td>D4260</td>
<td>Osseous surgery - &gt;3 cont. teeth, per quad</td>
<td>$709</td>
<td>$836</td>
</tr>
<tr>
<td>D4261</td>
<td>Osseous surgery - &lt;=3 cont. teeth, per quad</td>
<td>$452</td>
<td>$534</td>
</tr>
<tr>
<td>D4268</td>
<td>Surgical revision proc., per tooth</td>
<td>$389</td>
<td>$562</td>
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<tr>
<td>D4274</td>
<td>Mesial/distal wedge procedure, single tooth</td>
<td>$329</td>
<td>$466</td>
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<tr>
<td>D4341</td>
<td>Perio scaling and root planing - &gt;3 cont teeth, per quad.</td>
<td>$137</td>
<td>$194</td>
</tr>
<tr>
<td>D4342</td>
<td>Perio scaling and root planing - &lt;= 3 teeth, per quad</td>
<td>$99</td>
<td>$117</td>
</tr>
<tr>
<td>D4346</td>
<td>Scaling in presence of generalized moderate or severe gingival inflammation</td>
<td>$76</td>
<td>$103</td>
</tr>
<tr>
<td>D4355</td>
<td>Full mouth debridement</td>
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<td>$175</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Fee 1</td>
<td>Fee 2</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>D4381</td>
<td>Localized delivery of antimicrobial agents</td>
<td>$33</td>
<td>$44</td>
</tr>
<tr>
<td>D4910</td>
<td>Periodontal maintenance</td>
<td>$83</td>
<td>$110</td>
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</table>

**Prosthetics (Dentures)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee 1</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110</td>
<td>Complete denture - maxillary</td>
<td>$845</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5120</td>
<td>Complete denture - mandibular</td>
<td>$845</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5130</td>
<td>Immediate denture - maxillary</td>
<td>$910</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5140</td>
<td>Immediate denture - mandibular</td>
<td>$910</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5211</td>
<td>Maxillary partial denture - resin base</td>
<td>$653</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5212</td>
<td>Mandibular partial denture - resin base</td>
<td>$653</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5213</td>
<td>Maxillary partial dent. - cast metal</td>
<td>$906</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5214</td>
<td>Mandibular partial dent. - cast metal</td>
<td>$906</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5221</td>
<td>Immediate maxillary partial denture – resin base</td>
<td>$653</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5222</td>
<td>Immediate mandibular partial denture – resin base</td>
<td>$653</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5223</td>
<td>Immediate maxillary partial denture – cast metal frame work with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>$906</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5224</td>
<td>Immediate mandibular partial denture – cast metal frame work with resin denture bases (including any conventional clasps, rests and teeth)</td>
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<td>No Benefit</td>
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<tr>
<td>D5225</td>
<td>Maxillary partial denture - flexible base</td>
<td>$904</td>
<td>No Benefit</td>
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<tr>
<td>D5226</td>
<td>Mandibular partial denture - flexible base</td>
<td>$1004</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5282</td>
<td>Removable unilateral partial denture - one piece cast metal, maxillary</td>
<td>$510</td>
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</tr>
<tr>
<td>D5283</td>
<td>Removable unilateral partial denture - one piece cast metal, mandibular</td>
<td>$510</td>
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<tr>
<td>D5410</td>
<td>Adjust complete denture - maxillary</td>
<td>$79</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5411</td>
<td>Adjust complete denture - mandibular</td>
<td>$79</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5421</td>
<td>Adjust partial denture - maxillary</td>
<td>$79</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5422</td>
<td>Adjust partial denture - mandibular</td>
<td>$79</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5511</td>
<td>Repair broken complete denture base, mandibular</td>
<td>$101</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5512</td>
<td>Repair broken complete denture base, maxillary</td>
<td>$101</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace missing or broken teeth - complete denture</td>
<td>$77</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5611</td>
<td>Repair resin partial denture base, mandibular</td>
<td>$102</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5612</td>
<td>Repair resin partial denture base, maxillary</td>
<td>$102</td>
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<tr>
<td>D5621</td>
<td>Repair cast partial framework, mandibular</td>
<td>$147</td>
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<td>D5622</td>
<td>Repair cast partial framework, maxillary</td>
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<tr>
<td>D5630</td>
<td>Repair or replace broken retentive/clasping material – per tooth</td>
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<td>D5640</td>
<td>Replace broken teeth - per tooth</td>
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<td>D5650</td>
<td>Add tooth to existing partial denture</td>
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<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture – per tooth</td>
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<tr>
<td>D5670</td>
<td>Replace all teeth and acrylic on cast metal framework (maxillary)</td>
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<tr>
<td>D5671</td>
<td>Replace all teeth and acrylic on cast metal framework (mandibular)</td>
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<tr>
<td>D5710</td>
<td>Rebase complete maxillary denture</td>
<td>$344</td>
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<tr>
<td>D5711</td>
<td>Rebase complete mandibular denture</td>
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<td>No Benefit</td>
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<tr>
<td>D5720</td>
<td>Rebase maxillary partial denture</td>
<td>$265</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D5721</td>
<td>Rebase mandibular partial denture</td>
<td>$265</td>
<td>No Benefit</td>
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<tr>
<td>D5730</td>
<td>Reline complete maxillary denture (chairside)</td>
<td>$214</td>
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<td>D5731</td>
<td>Reline complete mandibular denture (chairside)</td>
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<tr>
<td>Code</td>
<td>Description</td>
<td>Fee</td>
<td>Benefit</td>
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<td>----------</td>
<td>------------------------------------------------------------------------------</td>
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<tr>
<td>D5740</td>
<td>Reline maxillary partial denture (chairside)</td>
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<tr>
<td>D5741</td>
<td>Reline mandibular partial denture (chairside)</td>
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<tr>
<td>D5750</td>
<td>Reline complete maxillary denture (laboratory)</td>
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<tr>
<td>D5751</td>
<td>Reline complete mandibular denture (lab)</td>
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<tr>
<td>D5760</td>
<td>Reline maxillary partial denture (lab)</td>
<td>$250</td>
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<tr>
<td>D5761</td>
<td>Reline mandibular partial denture (lab)</td>
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<td>D5810</td>
<td>Interim complete denture (maxillary)</td>
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<td>No Benefit</td>
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<td>D5811</td>
<td>Interim complete denture (mandibular)</td>
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<td>D5820</td>
<td>Interim partial denture (maxillary)</td>
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<td>Interim partial denture (mandibular)</td>
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<td>D5850</td>
<td>Tissue conditioning, maxillary</td>
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<tr>
<td>D5851</td>
<td>Tissue conditioning, mandibular</td>
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</table>

**Bridges & Pontics**

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<th>Benefit</th>
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<tbody>
<tr>
<td>D6000</td>
<td>ALL IMPLANT SERVICES - 15% DISCOUNT (incl. D0360-D0363 cone beam imaging w/ implants)</td>
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<tr>
<td>D6081</td>
<td>Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure</td>
<td>$99</td>
<td>No Benefit</td>
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<tr>
<td>D6210</td>
<td>Pontic - cast high noble metal</td>
<td>$610</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6211</td>
<td>Pontic - cast predom. base metal</td>
<td>$624</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6212</td>
<td>Pontic - cast noble metal</td>
<td>$586</td>
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<tr>
<td>D6214</td>
<td>Pontic – titanium</td>
<td>$571</td>
<td>No Benefit</td>
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<tr>
<td>D6240</td>
<td>Pontic - porcelain fused to high noble metal</td>
<td>$755</td>
<td>No Benefit</td>
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<tr>
<td>D6241</td>
<td>Pontic - porcelain fused to predom. base metal</td>
<td>$653</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6242</td>
<td>Pontic - porcelain fused to noble metal</td>
<td>$679</td>
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<tr>
<td>D6245</td>
<td>Pontic - porcelain./ceramic</td>
<td>$741</td>
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<tr>
<td>D6250</td>
<td>Pontic - resin with high noble metal</td>
<td>$745</td>
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<td>Pontic - resin with predom.base metal</td>
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<tr>
<td>D6252</td>
<td>Pontic - resin with noble metal</td>
<td>$717</td>
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<tr>
<td>D6545</td>
<td>Retainer - cast metal for resin bonded fixed prosthesis</td>
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<td>D6548</td>
<td>Ret. - porc./ceramic for resin bonded fixed prosthesis</td>
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<td>Resin retainer for resin bonded fixed prosthesis</td>
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<tr>
<td>D6600</td>
<td>Retainer inlay - porc./ceramic, two surfaces</td>
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<td>Retainer inlay - porc./ceramic, &gt;=3 surfaces</td>
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<td>D6602</td>
<td>Retainer inlay - cast high noble metal, 2 surfaces</td>
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<tr>
<td>D6603</td>
<td>Retainer inlay - cast high noble metal, &gt;=3 surfaces</td>
<td>$468</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6604</td>
<td>Retainer inlay - cast predom. base metal, 2 surfaces</td>
<td>$422</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6605</td>
<td>Retainer inlay - cast predom. base metal, &gt;=3 surfaces</td>
<td>$404</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6606</td>
<td>Retainer inlay - cast noble metal, two surfaces</td>
<td>$384</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6607</td>
<td>Retainer inlay - cast noble metal, &gt;=3 surfaces</td>
<td>$426</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6608</td>
<td>Retainer onlay -porc./ceramic, two surfaces</td>
<td>$437</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6609</td>
<td>Retainer onlay - porc./ceramic, &gt;=3 surfaces</td>
<td>$458</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6610</td>
<td>Retainer onlay - cast high noble metal, 2 surfaces</td>
<td>$501</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6611</td>
<td>Retainer onlay - cast high noble metal, &gt;=3 surfaces</td>
<td>$548</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6612</td>
<td>Retainer onlay - cast predom. base metal, 2 surfaces</td>
<td>$431</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6613</td>
<td>Retainer onlay - cast predom. base metal, &gt;=3 surfaces</td>
<td>$478</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6614</td>
<td>Retainer onlay - cast noble metal, two surfaces</td>
<td>$454</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6615</td>
<td>Retainer onlay - cast noble metal, &gt;=3 surfaces</td>
<td>$501</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6624</td>
<td>Retainer inlay – titanium</td>
<td>$468</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6634</td>
<td>Retainer onlay – titanium</td>
<td>$548</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6720</td>
<td>Retainer crown - resin with high noble metal</td>
<td>$747</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6721</td>
<td>Retainer crown - resin with predom. base metal</td>
<td>$666</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6722</td>
<td>Retainer crown - resin with noble metal</td>
<td>$696</td>
<td>No Benefit</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Cost</td>
<td>Benefit</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------</td>
<td>---------------</td>
</tr>
<tr>
<td>D6740</td>
<td>Retainer crown - porc./ceramic</td>
<td>$741</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6750</td>
<td>Retainer crown - porc. fused to high noble metal</td>
<td>$639</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6751</td>
<td>Retainer crown - porc. fused to predom. base metal</td>
<td>$571</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6752</td>
<td>Retainer crown - porc. fused to noble metal</td>
<td>$599</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6780</td>
<td>Retainer crown - 3/4 cast high noble metal</td>
<td>$724</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6781</td>
<td>Retainer crown - 3/4 cast predom. base metal</td>
<td>$566</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6782</td>
<td>Retainer crown - 3/4 cast noble metal</td>
<td>$578</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6783</td>
<td>Retainer crown - 3/4 porc./ceramic</td>
<td>$808</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6790</td>
<td>Retainer crown - full cast high noble metal</td>
<td>$675</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6791</td>
<td>Retainer crown - full cast predom. base metal</td>
<td>$601</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6792</td>
<td>Retainer crown - full cast noble metal</td>
<td>$628</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6794</td>
<td>Retainer crown – titanium</td>
<td>$679</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6930</td>
<td>Recement fixed partial denture</td>
<td>$88</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6940</td>
<td>Stress breaker</td>
<td>$205</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D6980</td>
<td>Fixed partial denture repair, by report</td>
<td>$206</td>
<td>No Benefit</td>
</tr>
</tbody>
</table>

**Oral Surgery**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7111</td>
<td>Extraction, coronal remnants - primary tooth</td>
<td>$72</td>
<td>$85</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root</td>
<td>$83</td>
<td>$97</td>
</tr>
<tr>
<td>D7210</td>
<td>Extraction, erupted tooth req. elev, etc.</td>
<td>$149</td>
<td>$176</td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth - soft tissue</td>
<td>$183</td>
<td>$216</td>
</tr>
<tr>
<td>D7230</td>
<td>Removal of impacted tooth - partially bony</td>
<td>$250</td>
<td>$295</td>
</tr>
<tr>
<td>D7240</td>
<td>Removal of impacted tooth - completely bony</td>
<td>$295</td>
<td>$347</td>
</tr>
<tr>
<td>D7241</td>
<td>Removal of imp. tooth - completely bony, with unusual surg. complications</td>
<td>$363</td>
<td>$429</td>
</tr>
<tr>
<td>D7250</td>
<td>Removal of residual tooth roots</td>
<td>$167</td>
<td>$199</td>
</tr>
<tr>
<td>D7251</td>
<td>Coronectomy - intentional partial tooth removal</td>
<td>$363</td>
<td>$429</td>
</tr>
<tr>
<td>D7270</td>
<td>Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth</td>
<td>$279</td>
<td>$330</td>
</tr>
<tr>
<td>D7280</td>
<td>Exposure of an unerupted tooth</td>
<td>$312</td>
<td>$369</td>
</tr>
<tr>
<td>D7282</td>
<td>Mobiliz. of erupted or malpos. tooth to aid eruption</td>
<td>$96</td>
<td>$210</td>
</tr>
<tr>
<td>D7285</td>
<td>Incisional biopsy of oral tissue - hard (bone, tooth)</td>
<td>$196</td>
<td>$231</td>
</tr>
<tr>
<td>D7286</td>
<td>Incisional biopsy of oral tissue - soft</td>
<td>$184</td>
<td>$216</td>
</tr>
<tr>
<td>D7291</td>
<td>Transseptal fiberotomy/supra crestal fiberotomy, by report</td>
<td>$142</td>
<td>$169</td>
</tr>
<tr>
<td>D7310</td>
<td>Alveoloplasty in conj. with extractions - per quadrant</td>
<td>$150</td>
<td>$177</td>
</tr>
<tr>
<td>D7311</td>
<td>Alveoloplasty in conj. w/ extractions</td>
<td>$130</td>
<td>$154</td>
</tr>
<tr>
<td>D7320</td>
<td>Alveoloplasty not in conj. with extractions - per quadrant</td>
<td>$193</td>
<td>$227</td>
</tr>
<tr>
<td>D7321</td>
<td>Alveoloplasty not in conj. w/ extractions</td>
<td>$40</td>
<td>$84</td>
</tr>
<tr>
<td>D7471</td>
<td>Removal of lateral exostosis</td>
<td>$314</td>
<td>$370</td>
</tr>
<tr>
<td>D7472</td>
<td>Removal or torus palatinus</td>
<td>$263</td>
<td>$311</td>
</tr>
<tr>
<td>D7473</td>
<td>Removal or torus mandibularis</td>
<td>$271</td>
<td>$320</td>
</tr>
<tr>
<td>D7485</td>
<td>Reduction of osseous tuberosity</td>
<td>$297</td>
<td>$351</td>
</tr>
<tr>
<td>D7510</td>
<td>Incision and drainage of abscess - intraoral soft tissue</td>
<td>$108</td>
<td>$127</td>
</tr>
<tr>
<td>D7511</td>
<td>Incision and drainage of abscess – intraoral soft tissue comp.</td>
<td>$226</td>
<td>$260</td>
</tr>
<tr>
<td>D7910</td>
<td>Suture of recent small wounds up to 5 cm</td>
<td>$246</td>
<td>$290</td>
</tr>
<tr>
<td>D7960</td>
<td>Frenulectomy (frenectomy or frenotomy) - separate proc.</td>
<td>$266</td>
<td>$314</td>
</tr>
<tr>
<td>D7963</td>
<td>Frenuloplasty</td>
<td>$99</td>
<td>$245</td>
</tr>
<tr>
<td>D7970</td>
<td>Excision of hyperplastic tissue - per arch</td>
<td>$456</td>
<td>$539</td>
</tr>
<tr>
<td>D7971</td>
<td>Excision of pericoronal gingiva</td>
<td>$225</td>
<td>$265</td>
</tr>
<tr>
<td>D7972</td>
<td>Surgical reduction of fibrous tuberosity</td>
<td>$78</td>
<td>$185</td>
</tr>
<tr>
<td>D7979</td>
<td>Non-surgical sialolithotomy</td>
<td>$30</td>
<td>$75</td>
</tr>
</tbody>
</table>

**Orthodontics- Pre-Authorization Required**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8090</td>
<td>Comp. ortho. treatment - adult dentition</td>
<td>No Benefit</td>
<td>$3658</td>
</tr>
<tr>
<td>D8660</td>
<td>Pre-orthodontic treatment visit</td>
<td>No Benefit</td>
<td>$413</td>
</tr>
<tr>
<td>D8670</td>
<td>Periodic ortho. treatment visit (as part of contract)</td>
<td>No Benefit</td>
<td>$118</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Benefit</td>
<td>Fee</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>D8680</td>
<td>Orthodontic retention (rem. of appl. and placement of retainers)</td>
<td>No Benefit</td>
<td>$516</td>
</tr>
<tr>
<td>D9110</td>
<td>Palliative (emergency) treatment of dental pain</td>
<td>$30</td>
<td>$75</td>
</tr>
<tr>
<td>D9210</td>
<td>Local anesthesia not in conj. Operative/surg. procedures</td>
<td>$0</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D9211</td>
<td>Regional block anesthesia</td>
<td>$0</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D9212</td>
<td>Trigeminal division block anesthesia</td>
<td>$0</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D9215</td>
<td>Local anesthesia in conj. w/ operative/surg. procedures</td>
<td>$0</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D9219</td>
<td>Evaluation for deep sedation or general anesthesia</td>
<td>$0</td>
<td>No Benefit</td>
</tr>
<tr>
<td>D9222</td>
<td>Deep sedation/general anesthesia - first 15 minute increment</td>
<td>$61</td>
<td>$136</td>
</tr>
<tr>
<td>D9223</td>
<td>Deep sedation/general anesthesia each subsequent 15 minute increment</td>
<td>$61</td>
<td>$136</td>
</tr>
<tr>
<td>D9230</td>
<td>Inhalation of nitrous oxide/analgesia, anxiolysis,</td>
<td>$36</td>
<td>$41</td>
</tr>
<tr>
<td>D9239</td>
<td>IV moderate conscious sedation/analgesia – first 15 minute increment</td>
<td>$61</td>
<td>$136</td>
</tr>
<tr>
<td>D9243</td>
<td>IV moderate conscious sedation/analgesia – each subsequent 15 minute increment</td>
<td>$61</td>
<td>$136</td>
</tr>
<tr>
<td>D9310</td>
<td>Consultation (diagnostic service by nontreating dentist)</td>
<td>$59</td>
<td>$96</td>
</tr>
<tr>
<td>D9439</td>
<td>Office visit - Not including an FC visit</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td>D9440</td>
<td>Office Visit - After Regularly Scheduled Hours</td>
<td>$27</td>
<td>$111</td>
</tr>
<tr>
<td>D9613</td>
<td>Infiltration of sustained release therapeutic drug – single or multiple sites</td>
<td>$190</td>
<td>$190</td>
</tr>
<tr>
<td>D9910</td>
<td>Application of desensitizing medicament</td>
<td>$30</td>
<td>$60</td>
</tr>
<tr>
<td>D9930</td>
<td>Treatment of complications post-surgical</td>
<td>$48</td>
<td>$48</td>
</tr>
<tr>
<td>D9944</td>
<td>Occlusal guard – hard appliance, full arch</td>
<td>$338</td>
<td>$519</td>
</tr>
<tr>
<td>D9945</td>
<td>Occlusal guard – soft appliance, full arch</td>
<td>$338</td>
<td>$519</td>
</tr>
<tr>
<td>D9946</td>
<td>Occlusal guard – hard appliance, partial arch</td>
<td>$338</td>
<td>$519</td>
</tr>
<tr>
<td>D9950</td>
<td>Occlusion analysis - mounted case</td>
<td>$169</td>
<td>$169</td>
</tr>
<tr>
<td>D9951</td>
<td>Occlusal adjustment - limited</td>
<td>$88</td>
<td>$115</td>
</tr>
<tr>
<td>D9952</td>
<td>Occlusal adjustment - complete</td>
<td>$372</td>
<td>$597</td>
</tr>
<tr>
<td>D9986</td>
<td>Missed appointment</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>D9995</td>
<td>Teledentistry – synchronous; real-time encounter</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>D9996</td>
<td>Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review</td>
<td>$20</td>
<td>$20</td>
</tr>
</tbody>
</table>

* All fees exclude the cost of noble and precious metals. An additional fee will be charged if these materials are used.

Only current ADA CDT codes are considered valid by Dominion Dental Services, Inc.
PEDIATRIC DENTAL PLAN APPENDIX

This Pediatric Dental Plan Appendix for Members under age 19, is effective as of the date of your Individual Evidence of Coverage (Evidence of Coverage) and shall terminate as of the date your Evidence of Coverage terminates. Coverage continues through end of the month in which the Member turns 19.

The following dental Services shall be included in the Kaiser Permanente Membership Evidence of Coverage.

I. DEFINITIONS

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

Covered Dental Services: A range of diagnostic, preventive, restorative, endodontic, periodontic, prosthetics, orthodontic and oral surgery Services that are covered under this Pediatric Dental Plan Appendix and listed in the Pediatric Dental Plan Schedule of Dental Fees attached to this Evidence of Coverage.

Covered Preventive Care Dental Services includes, but is not limited to oral evaluation, cleaning and certain diagnostic X-rays.

Dental Administrator means the entity that has entered into a contract with Health Plan to provide or arrange for the provision of Covered Dental Services. The name and information about the Dental Administrator can be found under General Provisions, see Section II, Paragraph F below.

Dental Fee means the discounted fees that a Participating Dental Provider charges you for a Covered Dental Service. Dental Fees are reviewed annually and subject to change effective January 1st of each year.

Dental Specialist means a Participating Dental Provider that is a dental specialist.

General Dentist means a Participating Dental Provider that is a general dentist.

Participating Dental Provider means a licensed dentist who has entered into an agreement with Dental Administrator to provide Covered Preventive Care Dental Services, Covered Dental Services and/or other dental Services at negotiated contracted rates.

II. GENERAL PROVISIONS

A. Subject to the terms, conditions, limitations, and exclusions specified in this Appendix, you may receive Covered Preventive Care Dental and Covered Dental Services from Participating Dental Providers. You may receive Covered Dental Services from a non-Participating Dental Provider for emergencies, urgent care received outside Health Plan’s Service Area, and Services obtained pursuant to a referral to a non-participating specialist. Services received from non-Participating Dental Provider are not covered under this plan except for: (1) benefits provided under a referral to a non-Participating Dental Provider under Section III.B below; (b) dental emergencies as described in Section V. below; and (3) Continuity of Care for new Members, as described in Section 2.

B. Health Plan has entered into an agreement with Dental Administrator to provide Covered Preventive Care Dental Services and certain other Covered Dental Services through its Participating Dental Providers.

C. Attached is a list of Covered Preventive Care Dental Services and other Covered Dental Services and the associated Dental Fees that you will be charged for each Service. You will pay a fixed copayment for each office visit. The fixed copayment does not apply to certain preventive Services. You will pay Dental Fees for certain other Covered Dental Services you receive from Participating Dental Providers. You will pay the applicable Dental Fee directly to the Participating Dental Provider at the time Services are rendered. The Participating Dental Provider has agreed to accept that Dental Fee as payment in full of the Member’s responsibility for that procedure. Neither Health Plan nor Dental Administrator are responsible for payment of these fees or for any fees incurred as the result of receipt of non-Covered Dental Services or any other non-covered dental service. Covered Dental Services are not subject to a Deductible, except for the Catastrophic plan. Copayments and Dental Fees set forth in the attached Pediatric Dental Plan Schedule of Dental Fees apply toward the Out-of-Pocket Limit in the Summary of
Services and Cost Shares of this Evidence of Coverage.

D. You will receive a list of Participating Dental Providers from the Health Plan or from Dental Administrator. You should select a Participating Dental Provider, who is a “General Dentist”, from whom you and your covered family members will receive Covered Preventive Care Dental Services and other Covered Dental Services. Specialty care is also available should such care be required, however, you must be referred to a Dental Specialist by your General Dentist.

E. For assistance concerning the dental coverage benefit of your health insurance plan, you may contact the Health Plan’s Member Services Department at the following telephone numbers:

   Within the Washington DC Metropolitan Area: 301-468-6000)
   Outside the Washington DC metropolitan area: 800-777-7902
   TTY number is: TTY 711

F. **Dental Administrator:** Health Plan has entered into an agreement with Dominion Dental Services USA, Inc. d/b/a Dominion National (“Dominion National”) to provide Covered Dental Services as described in this Appendix. You may obtain a list of Participating Dental Providers, Covered Dental Services and Dental Fees by contacting Dominion National Member Services specialists, Monday through Friday from 7:30 a.m. to 6:00 p.m. (Eastern Time), at the following telephone numbers:

   Toll-Free Number: 855-733-7524
   TTY Line: TTY 711

   Dominion National’s Integrated Voice Response System is available 24 hours a day for information about Participating Dental Providers in your area, or to help you select a Participating Dental Provider. The most up-to-date list of Participating Dental Providers can be found at the following website:

   DominionNational.com/kaiserdentists

   Dominion National also provides many other secure features online at DominionNational.com

G. **Missed Appointment Fee:** Participating Dental Providers may charge you an administrative fee if you miss a scheduled dental appointment without giving 24 hours advance notice. The fee may vary depending on the Participating Dental Provider, however in no event shall the missed appointment fee exceed $50 for a single visit.

III. **SPECIALIST REFERRALS**

A. **Participating Specialist Referrals**

   If, in the judgment of your General Dentist, you require the Services of a specialist, you may be referred to a Dental Specialist who will provide Covered Dental Services to you at the Dental Fee for each procedure rendered. Please note that a referral is not required to receive Covered Dental Services from a participating pediatric dentist.

B. **Non-Participating Specialist Referrals**

   Benefits may be provided for referrals to non-Participating Dental Provider specialists when:

   1. You have been diagnosed by your General Dentist with a condition or disease that requires care from a dental specialist; and

   2. Health Plan and Dental Administrator do not have a Participating Dental Provider specialist who possesses the professional training and expertise required to treat the condition or disease; or

   3. Health Plan and Dental Administrator cannot provide reasonable access to a Dental Specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

   The Member’s Cost Share will be calculated as if the provider rendering the Covered Dental Services was a Participating Dental Provider.
C. **Standing Referrals to Dental Specialists**

1. If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires specialized care, your General Dentist may determine, in consultation with you and the Dental Specialist, that you would be best served through the continued care of a Dental Specialist. In such instances, the General Dentist will issue a standing referral to the Dental Specialist.

2. The standing referral will be made in accordance with a written treatment plan developed by the General Dentist, Dental Specialist, and you. The treatment plan may limit the number of visits to the Dental Specialist or the period of time in which visits to the Dental Specialist are authorized. Health Plan retains the right to require the Dental Specialist to provide the General Dentist with ongoing communication regarding your treatment and dental health status.

IV. **EXTENSION OF BENEFITS**

A. In those instances when your coverage with Health Plan has terminated, we will extend Covered Dental Services, without payment of Premiums, in the following instances:

1. 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 Evidence of Coverage and Dental Appendix in effect at the time your coverage ended, for a period of 90 days following the date your coverage ended.

2. 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 Evidence of Coverage and Dental Appendix 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 later 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, please notify us in writing.

B. **Extension of Benefit Limitations:**

   The “Extension of Benefits” section listed above does not apply to the following:
   1. Coverage ends because of your failure to pay Premiums;
   2. Coverage ends as the result of you committing fraud or material misrepresentation;
   3. When coverage is provided by a succeeding health plan and that health plan’s coverage:
      a. is provided at a cost to you that is less than or equal to the cost to you of the extended benefit available under this Appendix; and
      b. will not result in an interruption of the Covered Dental Services you are receiving.

V. **DENTAL EMERGENCIES OUTSIDE THE SERVICE AREA**

When a dental emergency occurs outside the Service Area, Dental Administrator will reimburse the non-participating provider directly. If the member has already paid the charges, the Dental Administrator will reimburse the member (upon proof of payment) instead of paying the provider directly for Covered Dental Services that may have been provided. Reimbursement to the member is not to exceed $50.00 per incident. Services are limited to those procedures not excluded under Plan Limitations and Exclusions. Proof of payment must be submitted to Dental Administrator by provider within one hundred eighty (180) days of treatment. The Dental Administrator will allow Members to submit claims up to one (1) year after the date of service. However, a Member’s legal incapacity shall suspend the time to submit a claim; and the
suspension period ends when legal capacity is regained. Failure to submit a claim within one (1) year after the date of services does not invalidate or reduce the amount of the claim if it was not reasonably possible to submit the claim within one (1) year after the date of services; and the claim is submitted within two (2) years after the date of service. Proof of payment should be mailed to: Dominion National, 251 18th Street South, Suite 900, Arlington, VA 22202, ATTN: Accounting Dept. Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. You must receive all post-emergency care from your Participating Dental Provider.

VI. PRE-AUTHORIZATION OF BENEFITS
The Dental Administrator may require the treating dentist to submit a treatment plan prior to initiating Services. The Dental Administrator may request x-rays or other dental records prior to issuing the pre-authorization. The proposed Services will be reviewed and a pre-authorization will be issued to you or the dentist, specifying coverage. The pre-authorization is not a guarantee of coverage and is considered valid for 180 days.

VII. EXCLUSIONS AND LIMITATIONS

A. Exclusions
The following Services are not covered under this Appendix:

1. Services which are covered under worker’s compensation or employer’s liability laws.
2. Services which are not necessary for the patient’s dental health as determined by the Plan.
3. Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or development anomalies.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Dispensing of drugs.
6. Hospitalization for the following: the operation or treatment for the fitting or wearing of dentures; orthodontic care or malocclusion; operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for the removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident; and dental implants.
7. Procedures not listed as covered benefits under this Plan.
8. Services obtained outside of the dental office in which enrolled and that are not preauthorized or otherwise approved by such office or the Plan (with the exception of out-of-area emergencies).
9. Services performed by a Participating Specialist without a referral from a Participating General Dentist (with the exception of Orthodontics). A referral form is required. Participating dentists should refer to Specialty Care Referral Guidelines.
10. Any bill, or demand for payment, for a dental service that the appropriate regulatory board determines was provided as a result of a prohibited referral. “Prohibited referral” means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.
11. Non-medically necessary orthodontia is not a covered benefit under this policy. The provider agreements create no liability for payment by the Plan, and payments by the member for these services do not contribute to the Out-of-Pocket Maximum. The Invisalign system and similar specialized braces are not a covered benefit. See limitation #25 concerning Medically Necessary orthodontia.

B. Limitations
Covered Dental Services are subject to the following limitations:

1. One (1) evaluation (D0120, D0145, D0150, D0160) is covered two (2) times per calendar year, per patient, per provider/location.
2. One (1) teeth cleaning (D1110 or D1120) is covered two (2) times per calendar year, per patient.
3. One (1) topical fluoride application (D1206 or D1208) is covered two (2) times per calendar year, per patient; four (4) fluoride varnish treatments are covered per calendar year, per patient for children age three (3) and above; eight (8) topical fluoride varnishes are covered per calendar year, per patient up to age two (2).
4. Two (2) bitewing x-rays are covered per calendar year, per patient, per provider/location (D0270 does not have a frequency limitation).
5. One (1) set of full mouth x-rays or panoramic film is covered every three (3) years. Panoramic x-rays are limited to ages six (6) and above. No more than one (1) set of x-rays are covered per provider/location.
6. One (1) sealant per tooth is covered per lifetime, per patient (limited to occlusal surfaces of posterior permanent teeth without restorations or decay).
7. One (1) interim caries arresting medicament application per primary tooth is covered per lifetime.
8. One (1) space maintainer per 24 months, per quadrant (D1510, D1520 or D1575) or per arch (D1516, D1517, D1526 or D1527), per patient to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment).
9. Replacement of a filling is covered if it is more than three (3) years from the date of original placement.
10. Replacement of a crown or denture is covered if it is more than five (5) years from the date of original placement.
11. Replacement of a prefabricated resin and stainless steel crown (D2930, D2932, D2933, D2934) is covered if it is more than three (3) years from the date of original placement, per tooth, per patient.
12. Crown and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan.
13. Relining and rebasing of dentures is covered once per 24 months, per patient, only after six (6) months of initial placement.
14. Root canal treatment and retreatment of previous root canal are covered once per tooth per lifetime.
15. Periodontal scaling and root planing (D4341 or D4342), osseous surgery (D4260 or D4261) and gingivectomy or gingivoplasty (D4210 or D4211) are each limited to one per 24 months, per patient, per quadrant.
16. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu or a covered D1110, limited to once per two years.
17. Full mouth debridement is covered once per 24 months, per patient.
18. One (1) scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, per two (2) years.
19. Procedure Code D4381 is limited to one (1) benefit per tooth for three teeth per quadrant; or a total of 12 teeth for all four (4) quadrants per 12 months. Must have pocket depths of five (5) millimeters or greater.
20. Periodontal surgery of any type, including any associated material, is covered once every 24 months, per quadrant or surgical site.
21. Periodontal maintenance after active therapy is covered two (2) times per calendar year.
22. Coronectomy, intentional partial tooth removal, one (1) per lifetime.
23. All dental services that are to be rendered in a hospital setting require coordination and approval from both the dental insurer and the medical insurer before services can be rendered. Services delivered to the patient on the date of service are documented separately using applicable procedure codes.
24. Anesthesia requires a narrative of medical necessity be maintained in patient records. A maximum of 60 minutes of services are allowed for general anesthesia and intravenous or non-intravenous conscious sedation. Non-intravenous conscious sedation is not covered in conjunction with analgesia.
25. Orthodontics is only covered if Medically Necessary as determined by the Dental Administrator. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient’s responsibility.
26. Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available).

Only current ADA CDT codes are considered valid by the Dental Administrator.

Current Dental Terminology © American Dental Association.

This Appendix is subject to all the terms and conditions of the Evidence of Coverage to which this Appendix is attached. This Appendix does not change any of those terms and conditions, unless specifically stated in this Appendix.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Pediatric Dental Plan
2020 Schedule of Dental Fees

Procedures not shown in this list are not covered. Refer to the Pediatric Dental Plan Appendix for a complete description of the terms and conditions of your covered dental benefit.

Fees quoted in the “You pay to Dentist” column apply only when performed by a participating General Dentist or Dental Specialist. If specialty care is required, your general dentist must refer you to a participating specialist except as otherwise described in the Pediatric Dental Plan Appendix.

Annual Out-of-Pocket Maximum: You pay the Copayment set forth below for covered dental services until you reach the Out-of-Pocket Maximum shown in the Summary of Cost Shares in this EOC. You will not be charged more than the amount of your Out-of-Pocket Maximum for any dental services. Please refer to your medical plan for specific details.

NOTE: If you have any questions concerning this fee schedule, Contact Dominion for details at: toll-free at 855-733-7524, Monday through Friday, 7:30 a.m. to 6 p.m., (TTY 711).

<table>
<thead>
<tr>
<th>ADA CODE</th>
<th>DESCRIPTION OF SERVICES</th>
<th>YOU PAY TO DENTIST</th>
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<tbody>
<tr>
<td>D9439</td>
<td>Office visit</td>
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<td></td>
<td><strong>DIAGNOSTIC/PREVENTIVE</strong></td>
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<td>D0120</td>
<td>Periodic oral eval - established patient</td>
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<tr>
<td>D0140</td>
<td>Limited oral eval - problem focused</td>
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<td>D0145</td>
<td>Oral eval for a patient under 3 years of age</td>
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<tr>
<td>D0150</td>
<td>Comprehensive oral eval - new or established patient</td>
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<tr>
<td>D0160</td>
<td>Detailed and extensive oral eval - problem focused</td>
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</tr>
<tr>
<td>D0170</td>
<td>Re-evaluation - limited, problem focused</td>
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<tr>
<td>D0210</td>
<td>Intraoral - complete series of radiographic images</td>
<td>26</td>
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<td>D0220/30</td>
<td>Intraoral - periapical first radiographic image</td>
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<td>D0240</td>
<td>Intraoral - occlusal radiographic image</td>
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<td>D0250</td>
<td>Extraoral – 2D projection radiographic images</td>
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<td>D0270-74</td>
<td>Bitewing x-rays - 1 to 4 radiographic images</td>
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<td>D0277</td>
<td>Vertical bitewings - 7 to 8 radiographic images</td>
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<td>D0290</td>
<td>Posterior/anterior or lateral skull bone film</td>
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<tr>
<td>D0310</td>
<td>Sialography</td>
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<tr>
<td>D0320</td>
<td>Temporomandibular joint arthrogram, incl. injection</td>
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<tr>
<td>D0321</td>
<td>Other temporomandibular joint films, by report</td>
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<tr>
<td>D0330</td>
<td>Panoramic radiographic image</td>
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<tr>
<td>D0340</td>
<td>2D cephalometric radiographic image</td>
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</table>
D0350 2D oral/facial photographic images 0
D0351 3D photographic image 0
D0460 Pulp vitality tests 0
D0470 Diagnostic casts 0
D0486 Accession of brush biopsy sample 0
D0600 Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum 0
D0601 Caries risk assessment & documentation, with a finding of low risk 0
D0602 Caries risk assessment & documentation, with a finding of moderate risk 0
D0603 Caries risk assessment & documentation, with a finding of high risk 0
D1110 Prophylaxis (cleaning) - adult 0
D1120 Prophylaxis (cleaning) - child 0
D1206 Topical application of fluoride varnish 0
D1208 Topical application of fluoride – excluding varnish 0
D1310 Nutritional counseling for control of dental disease 0
D1320/30 Oral hygiene instructions 0
D1351 Sealant - per tooth 21
D1352 Prev resin rest. mod/high caries risk – perm. tooth 21
D1354 Interim caries arresting medicament application – per tooth 0

SPACE MAINTAINERS
D1510/20 Space maintainer - fixed/removable - unilateral 143
D1516 Space maintainer - fixed - bilateral, maxillary 198
D1517 Space maintainer - fixed - bilateral, mandibular 198
D1526 Space maintainer - removable - bilateral, maxillary 198
D1527 Space maintainer - removable - bilateral, mandibular 198
D1550 Re-cementation of space maintainer 34
D1555 Removal of fixed space maintainer, by non-originating dentist 44
D1575 Distal shoe space maintainer - fixed - unilateral 143

RESTORATIVE DENTISTRY (FILLINGS)
D2140 Amalgam - one surface, prim. or perm. 41
D2150 Amalgam - two surfaces, prim. or perm. 51
D2160 Amalgam - three surfaces, prim. or perm. 64
D2161 Amalgam - >=4 surfaces, prim. or perm. 78

RESIN/COMPOSITE RESTORATIONS (TOOTH COLORED)
D2330 Resin-based composite - one surface, anterior 69
D2331 Resin-based composite - two surfaces, anterior 83
D2332 Resin-based composite - three surfaces, anterior 99
D2335 Resin-based composite - >=4 surfaces, anterior 119
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>D2390</td>
<td>Resin-based composite crown, anterior</td>
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<tr>
<td>D2391</td>
<td>Resin-based composite - one surface, posterior</td>
<td>73</td>
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<tr>
<td>D2392</td>
<td>Resin-based composite - two surfaces, posterior</td>
<td>87</td>
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<tr>
<td>D2393</td>
<td>Resin-based composite - three surfaces, posterior</td>
<td>102</td>
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<tr>
<td>D2394</td>
<td>Resin-based composite - &gt;=4 surfaces, posterior</td>
<td>123</td>
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**CROWNS & BRIDGES***

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<th>Code</th>
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<th>Rate</th>
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<tr>
<td>D2510</td>
<td>Inlay - metallic - one surface</td>
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<tr>
<td>D2520</td>
<td>Inlay - metallic - two surfaces</td>
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<tr>
<td>D2530</td>
<td>Inlay - metallic - three or more surfaces</td>
<td>425</td>
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<tr>
<td>D2542</td>
<td>Onlay - metallic-two surfaces</td>
<td>458</td>
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<tr>
<td>D2543</td>
<td>Onlay - metallic-three surfaces</td>
<td>524</td>
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<tr>
<td>D2544</td>
<td>Onlay - metallic-four or more surfaces</td>
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<tr>
<td>D2610</td>
<td>Inlay - porcelain/ceramic - one surface</td>
<td>427</td>
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<tr>
<td>D2620</td>
<td>Inlay - porcelain/ceramic - two surfaces</td>
<td>427</td>
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<tr>
<td>D2630</td>
<td>Inlay - porcelain/ceramic - &gt;=3 surfaces</td>
<td>445</td>
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<tr>
<td>D2642</td>
<td>Onlay - porcelain/ceramic - two surfaces</td>
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<tr>
<td>D2643</td>
<td>Onlay - porcelain/ceramic - three surfaces</td>
<td>499</td>
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<td>D2644</td>
<td>Onlay - porcelain/ceramic - &gt;=4 surfaces</td>
<td>499</td>
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<tr>
<td>D2650</td>
<td>Inlay - resin-based composite - one surface</td>
<td>440</td>
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<td>D2651</td>
<td>Inlay - resin-based composite - two surfaces</td>
<td>440</td>
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<tr>
<td>D2652</td>
<td>Inlay - resin-based composite - &gt;=3 surfaces</td>
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<td>D2662</td>
<td>Onlay - resin-based composite - two surfaces</td>
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<td>D2663</td>
<td>Onlay - resin-based composite - three surfaces</td>
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<td>Onlay - resin-based composite - &gt;=4 surfaces</td>
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<tr>
<td>D2710</td>
<td>Crown - resin based composite (indirect)</td>
<td>272</td>
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<tr>
<td>D2712</td>
<td>Crown - 3/4 resin-based composite (indirect)</td>
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<tr>
<td>D2720/21/22</td>
<td>Crown - resin with metal</td>
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<tr>
<td>D2740</td>
<td>Crown - porcelain/ceramic</td>
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<tr>
<td>D2750/51/52</td>
<td>Crown - porcelain fused metal</td>
<td>523</td>
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<tr>
<td>D2780/81/82</td>
<td>Crown - 3/4 cast with metal</td>
<td>478</td>
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<tr>
<td>D2783</td>
<td>Crown - 3/4 porcelain/ceramic</td>
<td>511</td>
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<tr>
<td>D2790-94</td>
<td>Crown - full cast metal</td>
<td>495</td>
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<tr>
<td>D2910/20</td>
<td>Recement inlay, onlay/crown or partial coverage rest.</td>
<td>43</td>
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<tr>
<td>D2930</td>
<td>Prefab. stainless steel crown - prim. tooth</td>
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<tr>
<td>D2931</td>
<td>Prefab. stainless steel crown - perm. tooth</td>
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<tr>
<td>D2932</td>
<td>Prefabricated resin crown</td>
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<tr>
<td>D2933</td>
<td>Prefab. stainless steel crown w/ resin window</td>
<td>271</td>
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<tr>
<td>D2934</td>
<td>Prefab. esthetic coated primary tooth</td>
<td>296</td>
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<tr>
<td>D2940</td>
<td>Protective restoration</td>
<td>39</td>
</tr>
<tr>
<td>D2941</td>
<td>Interim therapeutic restoration, primary dentition</td>
<td>31</td>
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<tr>
<td>D2950</td>
<td>Core buildup, including any pins</td>
<td>125</td>
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<tr>
<td>D2951</td>
<td>Pin retention - per tooth, in addition to restoration</td>
<td>22</td>
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<tr>
<td>D2952</td>
<td>Post and core in addition to crown</td>
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<td>Code</td>
<td>Description</td>
<td>Cost</td>
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<td>D2954</td>
<td>Prefab. post and core in addition to crown</td>
<td>154</td>
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<tr>
<td>D2955</td>
<td>Post removal (not in conj. with endo. therapy)</td>
<td>105</td>
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<tr>
<td>D2960</td>
<td>Labial veneer (resin laminate) - chairside</td>
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<tr>
<td>D2961</td>
<td>Labial veneer (resin laminate) - laboratory</td>
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<td>D2962</td>
<td>Labial veneer (porcelain laminate) - laboratory</td>
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<td>D2980</td>
<td>Crown repair, necessitated by restorative material failure</td>
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<tr>
<td>D2981</td>
<td>Inlay repair necessitated by restorative material failure</td>
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<tr>
<td>D2982</td>
<td>Onlay repair necessitated by restorative material failure</td>
<td>102</td>
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<tr>
<td>D2983</td>
<td>Veneer repair necessitated by restorative material failure</td>
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<td><strong>PROSTHETICS (DENTURES)</strong></td>
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<tr>
<td>D5110/20</td>
<td>Complete denture - maxillary/mandibular</td>
<td>697</td>
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<tr>
<td>D5130/40</td>
<td>Immediate denture - maxillary/mandibular</td>
<td>722</td>
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<tr>
<td>D5211/12</td>
<td>Maxillary/mandibular partial denture - resin base</td>
<td>649</td>
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<tr>
<td>D5213/14</td>
<td>Maxillary/mandibular partial denture - cast metal</td>
<td>750</td>
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<tr>
<td>D5221/22</td>
<td>Immediate Maxillary/mandibular partial denture – resin base</td>
<td>649</td>
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<td>D5223/24</td>
<td>Immediate Maxillary/mandibular partial denture – cast metal</td>
<td>750</td>
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<tr>
<td>D5225/26</td>
<td>Maxillary/mandibular partial denture - flexible base</td>
<td>750</td>
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<tr>
<td>D5282</td>
<td>Rem. unilateral partial denture - one piece cast metal, maxillary</td>
<td>419</td>
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<tr>
<td>D5283</td>
<td>Rem. unilateral partial denture - one piece cast metal, mandibular</td>
<td>419</td>
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<tr>
<td>D5410/11</td>
<td>Adjust complete denture - maxillary/mandibular</td>
<td>38</td>
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<tr>
<td>D5421/22</td>
<td>Adjust partial denture - maxillary/mandibular</td>
<td>38</td>
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<tr>
<td>D5511</td>
<td>Repair broken complete denture base, mandibular</td>
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<td>D5512</td>
<td>Repair broken complete denture base, maxillary</td>
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<tr>
<td>D5520</td>
<td>Replace missing or broken teeth - complete denture</td>
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<tr>
<td>D5611</td>
<td>Repair resin partial denture base, mandibular</td>
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<tr>
<td>D5612</td>
<td>Repair resin partial denture base, maxillary</td>
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<tr>
<td>D5621</td>
<td>Repair cast partial framework, mandibular</td>
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<td>D5622</td>
<td>Repair cast partial framework, maxillary</td>
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<tr>
<td>D5630</td>
<td>Repair or replace broken retentive/clasping material – per tooth</td>
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<tr>
<td>D5640</td>
<td>Replace broken teeth - per tooth</td>
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<td>D5650</td>
<td>Add tooth to existing partial denture</td>
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<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture - per tooth</td>
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<td>D5670/71</td>
<td>Replace all teeth and acrylic on cast metal framework</td>
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<tr>
<td>D5710/11</td>
<td>Rebase complete maxillary/mandibular denture</td>
<td>260</td>
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<tr>
<td>D5720/21</td>
<td>Rebase maxillary/mandibular partial denture</td>
<td>260</td>
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<tr>
<td>D5730/31</td>
<td>Reline complete maxillary/mandibular denture (chairside)</td>
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<td>D5740/41</td>
<td>Reline maxillary/mandibular partial denture (chairside)</td>
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<td>D5750/51</td>
<td>Reline complete maxillary/mandibular denture (lab)</td>
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<td>Reline maxillary/mandibular partial denture (lab)</td>
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<td>D5810/11</td>
<td>Interim complete denture - maxillary/mandibular</td>
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<td>D5820/21</td>
<td>Interim partial denture - maxillary/mandibular</td>
<td>362</td>
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<tr>
<td>D5850/51</td>
<td>Tissue conditioning - maxillary/mandibular</td>
<td>79</td>
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<tr>
<td>D5863</td>
<td>Overdenture - complete maxillary</td>
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<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>D5864</td>
<td>Overdenture - partial maxillary</td>
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<td>D5865</td>
<td>Overdenture - complete mandibular</td>
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<td>Overdenture - partial mandibular</td>
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<tr>
<td>D5992</td>
<td>Adjustment of prosthetic appliance, by report</td>
<td>24</td>
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<tr>
<td>D5993</td>
<td>Cleaning and maintenance prosthetic appliance</td>
<td>18</td>
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**BRIDGES & PONTICS**

<table>
<thead>
<tr>
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<tr>
<td>D6058</td>
<td>Abutment supported porcelain/ceramic crown</td>
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<td>Abutment porc./metal crown- metal</td>
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<tr>
<td>D6066</td>
<td>Implant porc./metal crown</td>
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<tr>
<td>D6081</td>
<td>Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure</td>
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<tr>
<td>D6210/11/12</td>
<td>Pontic - metal</td>
<td>495</td>
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<tr>
<td>D6240/41/42</td>
<td>Pontic - porcelain fused metal</td>
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<tr>
<td>D6245</td>
<td>Pontic - porcelain/ceramic</td>
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<td>D6250/51/52</td>
<td>Pontic - resin with metal</td>
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<td>D6545</td>
<td>Retainer - cast metal for resin bonded fixed prosthesis</td>
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<td>D6548</td>
<td>Ret. - porc./ceramic for resin bonded fixed prosthesis</td>
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<td>D6549</td>
<td>Resin retainer for resin bonded fixed prosthesis</td>
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<td>D6600</td>
<td>Retainer inlay - porc./ceramic, two surfaces</td>
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<td>D6601</td>
<td>Retainer inlay - porc./ceramic, &gt;=3 surfaces</td>
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<td>D6602</td>
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<tr>
<td>D6603</td>
<td>Retainer inlay - cast high noble metal, &gt;=3 surfaces</td>
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<td>D6604</td>
<td>Retainer inlay - cast predominantly base metal, two surfaces</td>
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<td>D6605</td>
<td>Retainer inlay - cast predominantly base metal, &gt;=3 surfaces</td>
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<td>D6606</td>
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<td>Retainer inlay - cast noble metal, &gt;=3 surfaces</td>
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<td>D6608</td>
<td>Retainer onlay -porc./ceramic, two surfaces</td>
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<tr>
<td>D6609</td>
<td>Retainer onlay - porc./ceramic, three or more surfaces</td>
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<td>D6610</td>
<td>Retainer onlay - cast high noble metal, two surfaces</td>
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<td>D6611</td>
<td>Retainer onlay - cast high noble metal, &gt;=3 surfaces</td>
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<td>D6612</td>
<td>Retainer onlay - cast predominantly base metal, two surfaces</td>
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<td>D6613</td>
<td>Retainer onlay - cast predominantly base metal, &gt;=3 surfaces</td>
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<td>D6614</td>
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<td>D6615</td>
<td>Retainer onlay - cast noble metal, &gt;=3 surfaces</td>
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<td>D6720/21/22</td>
<td>Retainer crown - resin with metal</td>
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<td>D6740</td>
<td>Retainer crown - porcelain/ceramic</td>
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<td>Retainer crown - porcelain fused metal</td>
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<td>D6780</td>
<td>Retainer crown - 3/4 cast high noble metal</td>
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<td>D6781</td>
<td>Retainer crown - 3/4 cast predominantly base metal</td>
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<td>D6782</td>
<td>Retainer crown - 3/4 cast noble metal</td>
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<td>D6783</td>
<td>Retainer crown - 3/4 porc./ceramic</td>
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<td>D6790/91/92</td>
<td>Retainer crown - full cast metal</td>
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ADJUNCTIVE GENERAL SERVICES

D9110 Palliative (emergency) treatment of dental pain 43
D9210/15 Local anesthesia 0
D9211/12 Regional block anesthesia 0
D9219 Evaluation for deep sedation or general anesthesia 0
D9222 Deep sedation/general anesthesia – first 15 minutes 103
D9223 Deep sedation/general anesthesia each subsequent 15 minute increment 103
D9230 Inhalation of nitrous oxide/analgesia, anxiolysis 37
D9239 IV moderate conscious sedation/analgesia – first 15 minutes 103
D9243 IV moderate conscious sedation/analgesia – each subsequent 15 minute increment 103
D9248 Non-intravenous conscious sedation 145
D9310 Consultation (diagnostic service by nontreating dentist) 43
D9410 House/extended care facility call 200
D9420 Hospital call 350
D9613 Infiltration of sustained release therapeutic drug – single or multiple sites 190
D9910 Application of desensitizing medicament 31
D9930 Treatment of complications (post-surgical) 43
D9941 Fabrication of athletic mouthguard 102
D9944 Occlusal guard – hard appliance, full arch 272
D9945 Occlusal guard – soft appliance, full arch 272
D9946 Occlusal guard – hard appliance, partial arch 272
D9950 Occlusion analysis - mounted case 104
D9951 Occlusal adjustment - limited 66
D9952 Occlusal adjustment - complete 266
D9986 Missed appointment 50
D9995 Teledentistry – synchronous; real-time encounter 20
D9996 Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review 20

ENDODONTICS

D3110/20 Pulp cap - direct/indirect (excl. final restoration) 32
D3220 Therapeutic pulpotomy (excl. final restor.) 81
D3221 Pulpal debridement, prim. and perm. teeth 94
D3230 Pulpal therapy - resorbable filling, anterior, primary tooth 160
D3240 Pulpal therapy - resorbable filling, posterior, primary tooth 164
D3310 Endodontic therapy, anterior tooth 341
D3320 Endodontic therapy, premolar tooth (excl. final restor.) 418
D3330 Endodontic therapy, molar tooth (excl. final restor.) 512
### PERIODONTICS

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<td>Incomp endo. Therapy-inop. or fractured tooth</td>
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<tr>
<td>D3333</td>
<td>Internal root repair of perforation defects</td>
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<td>D3346</td>
<td>Retreat of prev. root canal therapy, anterior</td>
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<td>D3347</td>
<td>Retreat of prev. root canal therapy, premolar</td>
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<td>D3348</td>
<td>Retreat of prev. root canal therapy, molar</td>
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<td>D3351</td>
<td>Apexification/recalcification - initial visit</td>
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<td>D3352</td>
<td>Apexification/recalcification - interim med. repl.</td>
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<td>D3353</td>
<td>Apexification/recalcification - final visit</td>
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<td>D3355</td>
<td>Pulpal regeneration - initial visit</td>
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<td>D3356</td>
<td>Pulpal regeneration - interim medication replacement</td>
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<td>D3357</td>
<td>Pulpal regeneration - completion of treatment</td>
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<td>D3410</td>
<td>Apicoectomy - anterior</td>
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<td>D3421</td>
<td>Apicoectomy - premolar (first root)</td>
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<td>D3425</td>
<td>Apicoectomy - molar (first root)</td>
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<td>D3426</td>
<td>Apicoectomy - (each add. root)</td>
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<td>D3427</td>
<td>Periradicular surgery w/o apicoectomy</td>
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<td>D3430</td>
<td>Retrograde filling - per root</td>
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<td>D3450</td>
<td>Root amputation - per root</td>
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<td>D3470</td>
<td>Intentional reimplantation</td>
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<td>D3920</td>
<td>Hemisection, not inc. root canal therapy</td>
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<td>D3950</td>
<td>Canal prep/fitting of preformed dowel or post</td>
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<td>D0180</td>
<td>Comp. periodontal eval - new or established patient</td>
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<td>Gingivectomy or gingivoplasty - &gt;3 cont. teeth, per quad.</td>
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<td>Gingivectomy or gingivoplasty - &lt;=3 teeth, per quad.</td>
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<td>D4230</td>
<td>Anatomical crown exposure, &gt;=4 teeth per quad.</td>
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<td>D4231</td>
<td>Anatomical crown exposure, 1-3 teeth per quad.</td>
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<td>Gingival flap proc., inc. root planing - &gt;3 cont. teeth, per quad</td>
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<td>D4241</td>
<td>Gingival flap proc., inc. root planing - &lt;=3 cont. teeth, per quad</td>
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<td>D4249</td>
<td>Clinical crown lengthening - hard tissue</td>
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<td>D4260</td>
<td>Osseous surgery - &gt;3 cont. teeth, per quad</td>
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<td>D4261</td>
<td>Osseous surgery - &lt;=3 cont. teeth, per quad</td>
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<td>D4268</td>
<td>Surgical revision proc., per tooth</td>
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<td>D4274</td>
<td>Mesial/distal wedge procedure, single tooth</td>
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<td>D4320</td>
<td>Provisional splinting - intracoronal</td>
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<td>D4321</td>
<td>Provisional splinting - extracoronal</td>
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<td>D4341</td>
<td>Perio scaling and root planing - &gt;3 cont teeth, per quad.</td>
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<td>D4342</td>
<td>Perio scaling and root planing - &lt;= 3 teeth, per quad</td>
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<tr>
<td>D4346</td>
<td>Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation</td>
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<td>D4355</td>
<td>Full mouth debridement</td>
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<tr>
<td>D4381</td>
<td>Localized delivery of antimicrobial agents</td>
<td>98</td>
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</tbody>
</table>
D4910  Periodontal maintenance  74
D4920  Unscheduled dressing change by non-treating dentist  84

ORAL SURGERY

D7111  Extraction, coronal remnants - primary tooth  56
D7140  Extraction, erupted tooth or exposed root  69
D7210  Extraction, erupted tooth req. elev., etc.  133
D7220  Removal of impacted tooth - soft tissue  151
D7230  Removal of impacted tooth - partially bony  196
D7240  Removal of impacted tooth - completely bony  241
D7241  Removal of imp. tooth - completely bony, with unusual surg.  217

complications

D7250  Removal of residual tooth roots  141
D7251  Coronectomy-intentional partial tooth removal  217
D7260  Oroantral fistula closure  578
D7270  Tooth reimplant./stabiliz. of acc. evulsed/displaced tooth  226
D7272  Tooth transplantation  615
D7280  Exposure of an unerupted tooth  153
D7285  Incisinal biopsy of oral tissue - hard (bone, tooth)  387
D7286  Incisional biopsy of oral tissue - soft (all others)  295
D7290  Surgical repositioning of teeth  407
D7291  Transseptal fiberotomy/ supra crestal fiberotomy, by report  60
D7310/20  Alveoloplasty, per quad  141
D7311/21  Alveoloplasty in conj. with/out extractions  141
D7340  Vestibuloplasty - ridge ext. sec. epithel.  923
D7350  Vestibuloplasty - ridge ext. inc. grafts, etc  1776
D7410  Excision of benign lesion up to 1.25 cm  278
D7440  Exc. of malignant tumor- lesion diam. <=1.25 cm  608
D7450  Removal of benign odon cyst/tumor - diam <=1.25 cm  354
D7451  Removal of benign odon cyst/tumor - diam >1.25 cm  543
D7460  Removal of benign nonodon cyst/tumor-diam <=1.25 cm  516
D7461  Removal of benign nonodon cyst/tumor-diam >1.25 cm  718
D7471  Removal of lateral exostosis  351
D7472/73  Removal of torus palatinus/mandibularis  480
D7510  Incision and drainage of abscess - intraoral soft tissue  96
D7520  Incision/drainage of abscess - extra. soft tiss  116
D7550  Partial ostectomy/sequestrect non-vital bone rem.  336
D7960  Frenulectomy (frenectomy/frenotomy) - separate proc.  263
D7970  Excision of hyperplastic tissue - per arch  233
D7971  Excision of pericoronal gingiva  131
D7979  Non-surgical sialolithotomy  43
**ORTHODONTICS - PRE-AUTHORIZATION REQUIRED**

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<td>D8070</td>
<td>Comp. ortho. treatment - transitional dentition</td>
<td>3304</td>
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<tr>
<td>D8080</td>
<td>Comp. ortho. treatment - adolescent dentition</td>
<td>3422</td>
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<tr>
<td>D8090</td>
<td>Comp. ortho. treatment - adult dentition</td>
<td>3658</td>
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<tr>
<td>D8660</td>
<td>Pre-orthodontic treatment visit</td>
<td>413</td>
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<tr>
<td>D8670</td>
<td>Periodic ortho. treatment visit (as part of contract)</td>
<td>118</td>
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<tr>
<td>D8680</td>
<td>Orthodontic retention (rem. of appl. and placement of retainer(s))</td>
<td>413</td>
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<tr>
<td>D8692</td>
<td>Replacement of lost or broken retainer</td>
<td>179</td>
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<tr>
<td>D8693</td>
<td>Rebonding or recementing fixed retainer</td>
<td>174</td>
</tr>
<tr>
<td>D8694</td>
<td>Repair of fixed retainers, includes reattachment</td>
<td>174</td>
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</tbody>
</table>

*All fees exclude the cost of noble and precious metals. An additional fee will be charged if these materials are used.*

Only current ADA CDT codes are considered valid by Dominion Dental Services, Inc.

*Current Dental Terminology © American Dental Association.*
Appendix – Summary of Cost Shares

Cost Share is the general term used to refer to your out-of-pocket costs (e.g. Coinsurance and Copayments) for the covered Services you receive. The Cost Shares listed here apply to Services provided to Members enrolled in this Gold Metal plan. In addition to the monthly Premium, you may be required to pay a Cost Share for some Services. The Cost Share is the Copayment, Coinsurance, and Deductible, if any, listed in this Appendix for each Service. You are responsible for payment of all Cost Shares. Copayments are due at the time you receive a Service. You will be billed for any Coinsurance you owe.

This summary does not describe benefits. For the description of benefits, including exclusions and limitations, please refer to:

1. Section 3. Benefits, Exclusions and Limitations
2. Appendix - Outpatient Prescription Drug Benefit
3. Appendix - Adult Dental Plan
4. Appendix - Pediatric Dental Plan

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>You Pay</th>
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<tbody>
<tr>
<td><strong>Outpatient Office Visits</strong></td>
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<tr>
<td>Outpatient office visit Services that are required by the Affordable Care Act are covered under Preventive Health Care Services at no charge.</td>
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<tr>
<td>Primary Care office visits</td>
<td>$20 per visit (waived for children under age 5)</td>
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<tr>
<td>(Internal medicine, family practice, pediatrics or obstetrics/gynecology)</td>
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<tr>
<td>Specialty care office visits</td>
<td>$40 per visit</td>
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<tr>
<td>(All Services provided by health care practitioners that are not Primary Care Services)</td>
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</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery facility fee</td>
<td>35% of AC*</td>
</tr>
<tr>
<td>(freestanding ambulatory surgical center or outpatient Hospital)</td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery physician Services</td>
<td>35% of AC*</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td></td>
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<tr>
<td>Hospital admission</td>
<td>35% of AC*</td>
</tr>
<tr>
<td>Services provided by physicians while a Member is in a Hospital or related institution</td>
<td>35% of AC*</td>
</tr>
<tr>
<td><strong>Acupuncture</strong></td>
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<tr>
<td>Covered when Medically Necessary</td>
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### Covered Service

<table>
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<tbody>
<tr>
<td>Acupuncture</td>
<td>$30 per visit</td>
</tr>
<tr>
<td><strong>Allergy/Injections</strong></td>
<td></td>
</tr>
<tr>
<td>Evaluation and treatment</td>
<td>The applicable Cost Share will apply based on type and place of Service.</td>
</tr>
<tr>
<td>Injection visit and serum</td>
<td>The applicable Cost Share will apply based on type and place of Service, not to exceed the cost of serum plus administration</td>
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<tr>
<td><strong>Ambulance Services</strong></td>
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<tr>
<td>By a licensed ambulance Service, per encounter</td>
<td>No charge</td>
</tr>
<tr>
<td>Non-emergent transportation Services</td>
<td>No charge</td>
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<tr>
<td>(ordered by a Plan Provider)</td>
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<tr>
<td><strong>Anesthesia for Dental Services</strong></td>
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</tr>
<tr>
<td>Anesthesia for Dental Services</td>
<td>The applicable Cost Share will apply based on type and place of Service</td>
</tr>
<tr>
<td><strong>Blood, Blood Products and Their Administration</strong></td>
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</tr>
<tr>
<td>Blood, Blood Products and Their Administration</td>
<td>35% of AC*</td>
</tr>
<tr>
<td><strong>Bone Mass Measurement</strong></td>
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</tr>
<tr>
<td>Preventive screening</td>
<td>No charge</td>
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<tr>
<td>Diagnostic</td>
<td>$65 per visit</td>
</tr>
<tr>
<td><strong>Chiropractic Services</strong></td>
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<tr>
<td>Limited to twenty (20) visits per condition per Calendar Year</td>
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</tr>
<tr>
<td>Chiropractic Services</td>
<td>$30 per visit</td>
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<tr>
<td><strong>Clinical Trials</strong></td>
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<tr>
<td>Clinical Trials</td>
<td>The applicable Cost Share will apply based on type and place of Service</td>
</tr>
<tr>
<td><strong>Diabetic Equipment, Supplies and Self-Management Training</strong></td>
<td>Refer to “Durable Medical Equipment (DME) and Prosthetic Devices” benefit below</td>
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### Covered Service

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<tr>
<td>All other diabetic equipment and supplies</td>
<td>Refer to Outpatient Prescription Drug Benefit Appendix for benefit</td>
</tr>
<tr>
<td>Diabetic test strips</td>
<td>Refer to Outpatient Prescription Drug Benefit Appendix for benefit</td>
</tr>
<tr>
<td>Self-management training</td>
<td>The applicable Cost Share will apply based on type and place of Service</td>
</tr>
</tbody>
</table>

### Dialysis

| Outpatient Services                                                           | $40 per visit |

### Durable Medical Equipment (DME) and Prosthetic Devices

| Durable Medical Equipment (DME) and Prosthetic Devices | 35% of AC* |

### Emergency Services

Transfer to an observation bed or observation status does not qualify as an admission to a Hospital and your emergency room visit Cost Share will not be waived.

| Emergency Services | $500 per visit (waived if admitted to the Hospital) |

### Family Planning Services

Women’s Preventive Services (WPS), including all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity are covered under Preventive Health Care Services at no charge.

| Male Sterilization | No charge |
| Voluntary termination of pregnancy | The applicable Cost Share will apply based on type and place of Service. |

### Fertility Services

Standard fertility preservation visits and procedures for iatrogenic infertility

| Standard fertility preservation visits and procedures for iatrogenic infertility | $40 per visit |

### Habilitative Services (for adults age 19 or older)

| Physical, Occupational or Speech Therapy | $30 per visit |
| Assistive Devices                        | 35% of AC*    |
# Kaiser Permanente for Individuals and Families/
# Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>All other Services</td>
<td>The applicable Cost Share will apply based on type and place of Service.</td>
</tr>
</tbody>
</table>

## Habilitative Services and Devices
(for children to end of the month in which the Member turns 19)

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Occupational or Speech Therapy</td>
<td>$30 per visit</td>
</tr>
<tr>
<td>Applied Behavioral Analysis (ABA)</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Assistive Devices</td>
<td>35% of AC*</td>
</tr>
<tr>
<td>All other Services</td>
<td>The applicable Cost Share will apply based on type and place of Service.</td>
</tr>
</tbody>
</table>

## Hearing Services

Newborn hearing screening tests are covered under Preventive Health Care Services at no charge.

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Tests</td>
<td>The applicable Cost Share will apply based on type and place of Service</td>
</tr>
</tbody>
</table>
| Hearing Aids | • $40 per visit  
• 35% of AC* |

## Home Health Care Services

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care Services</td>
<td>No charge</td>
</tr>
</tbody>
</table>

## Hospice Care Services

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care Services</td>
<td>No charge</td>
</tr>
</tbody>
</table>

## Infertility Services

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility Services (inpatient treatment, outpatient surgery or outpatient visits)</td>
<td>The applicable Cost Share will apply based on type and place of Service</td>
</tr>
</tbody>
</table>

## Maternity Services

Maternity Services that are required by the Affordable Care Act are covered under Preventive Health Care Services at no charge.
<table>
<thead>
<tr>
<th>Covered Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-natal and post-natal Services (includes routine and non-routine office visits, telemedicine visits, x-ray, lab and specialty tests), including:</td>
<td></td>
</tr>
<tr>
<td>• Birthing Classes (offered once per pregnancy)</td>
<td></td>
</tr>
<tr>
<td>• Breastfeeding support and equipment</td>
<td></td>
</tr>
<tr>
<td>Inpatient Delivery</td>
<td>35% of AC*</td>
</tr>
<tr>
<td>Outpatient Delivery and All Services (i.e. birthing centers, certified midwife)</td>
<td>The applicable Cost Share will apply based on type and place of Service.</td>
</tr>
<tr>
<td>Postpartum home health visits</td>
<td>No charge</td>
</tr>
</tbody>
</table>

**Medical Foods**

| Medical Foods (including amino-acid-based elemental formula)                  | 35% of AC*                                  |

**Medical Nutrition Therapy & Counseling**

Medical Nutrition Therapy & Counseling                                  $20 per visit

**Mental Health and Substance Abuse Services**

<table>
<thead>
<tr>
<th>Inpatient psychiatric and substance abuse Services, including detoxification</th>
<th>35% of AC*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Treatment Center Services</td>
<td>35% of AC*</td>
</tr>
<tr>
<td>Partial hospitalization</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Outpatient psychiatric and substance abuse Services</td>
<td></td>
</tr>
<tr>
<td>• Individual therapy</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Group therapy</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>• Intensive therapy</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Diagnostic evaluation</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• Medication evaluation and management visits</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>• All other Outpatient Services</td>
<td>$20 per visit</td>
</tr>
</tbody>
</table>

**Morbid Obesity Services, including Bariatric Surgery**

Morbid Obesity Services, including Bariatric Surgery The applicable Cost Share will apply based on type and place of Service
### Covered Service

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oral Surgery/Temporomandibular Joint Services (TMJ)</strong></td>
<td></td>
</tr>
<tr>
<td>Oral surgery, including treatment of the temporomandibular joint</td>
<td>The applicable Cost Share will apply based on type and place of Service.</td>
</tr>
<tr>
<td>TMJ appliances</td>
<td>35% of AC*</td>
</tr>
<tr>
<td><strong>Preventive Health Care Services</strong></td>
<td></td>
</tr>
<tr>
<td>Preventive Health Care Services</td>
<td>No charge</td>
</tr>
</tbody>
</table>

While treatment may be provided in the following situations, the following Services, exams and screening tests or interpretations are not considered “Preventive Health Care Services” and shall be subject to the applicable Cost Share under other sections of this Agreement:

1. Monitoring chronic disease or follow-up testing, once you have been diagnosed with a disease, except for those listed under Preventive Health Care Services in Section 3: Benefits, Exclusions and Limitations.
2. Testing for specific diseases for which you have been determined to be at high risk for contracting, except for those listed under Preventive Health Care Services in Section 3: Benefits, Exclusions and Limitations.
3. Medically Necessary Services when you show signs or symptoms of a specific disease or disease process, except for those listed under Preventive Health Care Services in Section 3: Benefits, Exclusions and Limitations.

### Radiation Therapy/Chemotherapy/Infusion Therapy - Outpatient

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Therapy</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>The applicable Cost Share will apply based on type and place of Service</td>
</tr>
</tbody>
</table>

### Reconstructive Surgery

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconstructive Surgery</td>
<td>The applicable Cost Share will apply based on type and place of Service</td>
</tr>
</tbody>
</table>

### Routine Foot Care

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Foot Care</td>
<td>$40 per visit</td>
</tr>
</tbody>
</table>

### Skilled Nursing Facility Services

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility Services</td>
<td>35% of AC*</td>
</tr>
<tr>
<td>Covered Service</td>
<td>You Pay</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Telemedicine Services</strong></td>
<td></td>
</tr>
<tr>
<td>Telemedicine Services</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Therapy and Rehabilitation Services - Outpatient</strong></td>
<td></td>
</tr>
<tr>
<td>Therapy and Rehabilitation Services – Outpatient</td>
<td>$30 per visit</td>
</tr>
<tr>
<td><strong>Transplant Services</strong></td>
<td></td>
</tr>
<tr>
<td>Transplant Services</td>
<td>The applicable Cost Share will apply based on type and place of Service</td>
</tr>
<tr>
<td><strong>Urgent Care Services</strong></td>
<td></td>
</tr>
<tr>
<td>Office visit during regular office hours</td>
<td>The applicable Cost Share will apply based on type and place of Service</td>
</tr>
<tr>
<td>After-hours Urgent Care or Urgent Care center</td>
<td>$40 per visit</td>
</tr>
<tr>
<td><strong>Vision Services</strong> (for adults age 19 or older)</td>
<td></td>
</tr>
<tr>
<td>Eye exam by an Optometrist</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Eye exam by an Ophthalmologist</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Eyeglass lenses and frames</td>
<td>You receive a 30% discount off retail price** for eyeglass lenses and eyeglass frames</td>
</tr>
<tr>
<td>Contact lenses</td>
<td>You receive a 15% discount off retail price** on the initial fit and first purchase of contact lenses</td>
</tr>
<tr>
<td><strong>Vision Services</strong> (for children until end of the month in which the Member turns age 19)</td>
<td></td>
</tr>
<tr>
<td>Eye exam by an Optometrist</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Eye exam by an Ophthalmologist</td>
<td>$40 per visit</td>
</tr>
<tr>
<td><strong>Vision Hardware</strong> (for children until end of the month in which the Member turns age 19)</td>
<td></td>
</tr>
<tr>
<td>A child may select any pair of glasses in lieu of, or in addition to, the eyeglasses or contact lenses available below at no charge and receive the discount under Vision Services (for adults age 19 or older) at any Plan vision center.</td>
<td></td>
</tr>
<tr>
<td>Covered Service</td>
<td>You Pay</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Eyeglass lenses and frames (Limited to a select group)</td>
<td>No charge for one (1) pair per Calendar Year</td>
</tr>
<tr>
<td>Elective Prescription Contact Lenses (in lieu of eyeglass lenses and frames)</td>
<td>No charge for initial fitting and first purchase based on standard packaging per Calendar Year</td>
</tr>
<tr>
<td>Limited to a select group, based on standard packaging for type of lenses.</td>
<td></td>
</tr>
<tr>
<td>Standard packaging may be:</td>
<td></td>
</tr>
<tr>
<td>• One (1) pair up to a twelve (12)-month supply for non-disposable contacts</td>
<td></td>
</tr>
<tr>
<td>• Twelve (12)-month supply for disposable contacts</td>
<td></td>
</tr>
<tr>
<td>Medically Necessary contact lenses (in lieu of eyeglass lenses and frames)</td>
<td>No charge for up to two (2) pair per eye per Calendar Year</td>
</tr>
<tr>
<td>(Limited to a select group)</td>
<td></td>
</tr>
<tr>
<td>Low vision aids (Limited to available supply at Plan Provider only)</td>
<td>No charge</td>
</tr>
</tbody>
</table>

**Wellness Benefits**

| Wellness Benefits                  | No charge |

**X-Ray, Laboratory and Special Procedures - Outpatient**

<table>
<thead>
<tr>
<th>Service</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory Outpatient and Professional Services</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>X-rays and Diagnostic Imaging</td>
<td>$65 per visit</td>
</tr>
<tr>
<td>Specialty Imaging (including CT, MRI, PET Scans and Diagnostic Nuclear Medicine)</td>
<td>$500 per test</td>
</tr>
<tr>
<td>Sleep lab</td>
<td>$500 per visit</td>
</tr>
<tr>
<td>Sleep studies</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>$500 per visit</td>
</tr>
</tbody>
</table>

**“AC” means Allowable Charge as defined in the Important Terms You Should Know section of this Agreement.**

**“Retail price” means the price that would otherwise be charged for the lenses, frames or contacts at the Plan vision center on the day purchased.**
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

Out-of-Pocket Maximum

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Only Out-of-Pocket Maximum</td>
<td>$6,850 per individual per Calendar Year</td>
<td></td>
</tr>
<tr>
<td>Family Out-of-Pocket Maximum</td>
<td>$13,700 per Family Unit per Calendar Year</td>
<td></td>
</tr>
</tbody>
</table>

The Out-of-Pocket Maximum is the maximum amount of Copayments and Coinsurance that an individual or family is obligated to pay for covered Services, except as excluded below, per Calendar Year. Once you or your Family Unit together have met your Out-of-Pocket Maximum, you will not be required to pay any additional Cost Shares for covered Services that apply toward the Out-of-Pocket Maximum for the rest of the Calendar Year.

Self-Only Out-of-Pocket Maximum

If you are covered as a Subscriber, and you do not have any Dependents covered under the plan, your medical expenses for covered Services apply toward the Self-Only Out-of-Pocket Maximum indicated above.

Family Out-of-Pocket Maximum

If you have one or more Dependents covered under this Agreement, the covered medical expenses incurred by all family members together apply toward the Family Out-of-Pocket Maximum indicated above. No one family member’s medical expenses may contribute more than the Self-Only Out-of-Pocket Maximum shown above. After one member of a Family Unit has met the Self-Only Out-of-Pocket Maximum, this Member will not be required to pay any additional Cost Shares for covered Services for the rest of the Calendar Year. Other family members will continue to pay Cost Shares until the Family Out-of-Pocket Maximum is met. After two or more members of your Family Unit combined have met the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be met for all members of the Family Unit for the rest of the Calendar Year.

Out-of-Pocket Maximum Exclusions

The following Services do not apply toward your Out-of-Pocket Maximum:

- Adult eyeglass lenses and frames; contact lenses that are available with a discount only;
- Adult routine eye exams; and
- Dental Services under the Adult Dental Plan Appendix.
Appendix: Outpatient Prescription Drug Benefit
The Health Plan will provide coverage for prescription drugs as follows:

Definitions

**Allowable Charge:** Has the same meaning as defined in the *Important Terms You Should Know* section of your Membership Agreement and Evidence of Coverage.

**Authorized Representative:** Has the same meaning as defined in the *Important Terms You Should Know* section of your Membership Agreement and Evidence of Coverage.

**Brand Name Drug:** A prescription drug that has been patented and is produced by only one (1) manufacturer.

**Coinsurance:** A percentage of the Allowable Charge that you must pay for each prescription or prescription refill.

**Complex or Chronic Medical Condition:** A physical, behavioral or developmental condition that:

1. May have no known cure;
2. Is progressive; or
3. Can be debilitating or fatal if left untreated or undertreated.

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

**Contraceptive Drug:** A drug or device that is approved by the Food & Drug Administration for use as a contraceptive with or without a prescription.

**Copayment:** The specific dollar amount that you must pay for each prescription or prescription refill.

**Food & Drug Administration/FDA:** The United States Food & Drug Administration.

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

**Health Care Provider:** Has the same meaning as defined in the *Important Terms You Should Know* section in your Membership Agreement and Evidence of Coverage.

**Limited Distribution Drug (LDD):** A prescription drug that is limited in distribution by the manufacturer or Food & Drug Administration.

**Mail Service Delivery Program:** A program operated or arranged by the Health Plan that distributes prescription drugs to Members via postal mail. Some medications are not eligible for the Mail Service Delivery Program. These may include, but are not limited to, drugs that are time or temperature sensitive, drugs that cannot legally be sent by U.S. Mail and drugs that require professional administration or observation. The Mail Service Delivery Program can mail to addresses in Maryland, Virginia and Washington, D.C., and certain locations outside of the Service Area.
**Maintenance Medication:** A covered drug anticipated to be required for six (6) months or more to treat a chronic condition.

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

**Nicotine Replacement Therapy:** A product that:
1. Is used to deliver nicotine to an individual attempting to cease the use of tobacco products; and
2. Can be obtained only by a written prescription.

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

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

**Oral Chemotherapy Drug:** A drug that can be taken by mouth that is prescribed by a licensed physician to kill or slow the growth of cancer cells.

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

**Preferred Brand Drug:** A Brand Name Drug that is on the Preferred Drug List.

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

**Rare Medical Condition:** A disease or condition that affects fewer than 200,000 individuals in the United States or approximately one (1) in 1,500 individuals worldwide. Rare Medical Conditions include, but are not limited to: Cystic Fibrosis, Hemophilia and Multiple Myeloma.

**Smoking Cessation Drugs:** Over-the-counter and prescription drugs approved by the Food & Drug Administration to treat tobacco dependence.

**Specialty Drugs:** A prescription drug that:
1. Is prescribed for an individual with a Complex or Chronic Medical Condition or a Rare Medical Condition;
2. Costs $600 or more for up to a thirty (30)-day supply;
3. Is not typically stocked at retail pharmacies; and
4. Requires a difficult or unusual process of delivery to the Member in the:
   a. Preparation;
   b. Handling;
   c. Storage;
   d. Inventory;
   e. Distribution of the drug; or
Kaiser Permanente for Individuals and Families/
Kaiser Permanente Child Only Membership Agreement and Evidence of Coverage

f. Requires enhanced patient education, management or support, beyond those required for traditional dispensing, before or after administration of the drug.

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

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

Benefits

Except as provided in Section 3: Benefits, Exclusions and Limitations, we cover drugs described below when prescribed by a Plan Physician, a non-Plan Physician to whom you have an approved referral, a non-Plan Physician consulted due to an emergency or for out-of-area Urgent Care, or a dentist. Each prescription refill is subject to the same conditions as the original prescription. Over-the-counter contraceptives do not require a prescription. A Plan Provider prescribes drugs in accordance with Health Plan’s Preferred Drug List. If the price of the drug is less than the Copayment, you will pay the price of the drug. You must obtain covered drugs from a Plan Pharmacy; however, you may obtain covered drugs from a non-Plan Pharmacy for out-of-area Urgent Care Services and Emergency Services. You may also obtain prescription drugs using our Mail Service Delivery Program; ask for details at a Plan Pharmacy.

We cover the following:

1. Food & Drug Administration-approved drugs for which a prescription is required by law.
2. Compounded preparations that contain at least one ingredient requiring a prescription.
3. Insulin.
4. Oral chemotherapy drugs.
5. Drugs that are Food & Drug Administration-approved for use as contraceptives and diaphragms, including those that are over-the-counter. For coverage of other types of contraception, including contraceptive injections, implants and devices, refer to “Family Planning Services” in Section 3: Benefits, Exclusions and Limitations.
6. Any prescription drug approved by the Food & Drug Administration as an aid for the cessation of the use of tobacco products. Tobacco products include cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco.
7. Nicotine replacement prescription drugs for courses of Nicotine Replacement Therapy and drugs that are approved by the Food & Drug Administration as an aid for the cessation of the use of tobacco products.
8. Off label use of drugs when a drug is recognized in Standard Reference Compendia or certain Medical Literature as appropriate in the treatment of the diagnosed condition.
9. Non-prescription drugs when they are prescribed by a Plan Provider and are listed on the Preferred Drug List.
10. Growth hormone therapy for treatment of children under age 18 with a growth hormone deficiency; or when prescribed by a Plan Physician, pursuant to clinical guidelines for adults.

11. Limited Distribution Drugs, regardless of where they are purchased, will be covered on the same basis as if they were purchased at a Plan Pharmacy.

12. Prescription eye drops and refills in accordance with guidance for early refills of topical ophthalmic products provided by the Centers for Medicare and Medicaid Services if the:
   a. Original prescription indicates additional quantities are needed; and
   b. Refill requested does not exceed the number of refills indicated on the original prescription.

The Health Plan Pharmacy and Therapeutics Committee sets dispensing limitations in accordance with therapeutic guidelines based on the Medical Literature and research. The Committee also meets periodically to consider adding and removing prescribed drugs on the Preferred Drug List. If you would like information about whether a particular drug is included in our Preferred Drug List, please visit us online at:

https://healthy.kaiserpermanente.org/static/health/pdfs/formulary/mid/mid_exchange_formulary.pdf

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

Exclusions

Except as specifically covered under this Outpatient Prescription Drug Benefit, the Health Plan does not cover a drug:

1. That can be obtained without a prescription, except for over-the-counter contraceptive drugs; or
2. For which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to the prescription drug, unless otherwise prohibited by federal or state laws governing essential health benefits.

Where to Purchase Covered Drugs

Except for Emergency Services and Urgent Care Services, you must obtain prescribed drugs from a Plan Pharmacy or through Health Plan’s Mail Service Delivery Program. Prescribed drugs are subject to the Cost Shares listed under “Copayment/Coinsurance.” Most non-refrigerated prescription medications ordered through the Health Plan’s Mail Service Delivery Program can be delivered to addresses in Maryland, Virginia and Washington, D.C., and certain locations outside the Service Area.

Generic and Preferred Drug Requirements

Generic vs. Brand Name Drugs
Plan Pharmacies will substitute a generic equivalent for a Brand Name Drug when a generic equivalent is on our Preferred Drug List unless one of the following conditions is met:

1. The Plan Provider has prescribed a Brand Name Drug and has indicated “dispense as written” or “DAW” on the prescription;
2. The Brand Name Drug is listed on our Preferred Drug List;
3. The Brand Name Drug is:
   a. Prescribed by a Plan Physician, a non-Plan Physician to whom you have an approved referral, a non-Plan Physician consulted due to an emergency or for out-of-area urgent care, or a dentist; and
   b. There is no equivalent Generic Drug, or an equivalent Generic Drug has:
      i. Been ineffective in treating the disease or condition of the Member; or
      ii. Caused or is likely to cause an adverse reaction or other harm to the Member.

4. For a contraceptive prescription drug or device, the prescription drug or device that is not on the Preferred Drug List is Medically Necessary for the Member to adhere to the appropriate use of the prescription drug or device.

The Health Plan will treat the drug(s) obtained as prescribed above as an Essential Health Benefit, including by counting any Cost Sharing towards the health benefit plan's Out-of-Pocket Maximum described in Summary of Cost Shares Appendix of this Agreement.

If you request a Brand Name Drug for which none of the above conditions has been met, you will be responsible for the Non-Preferred Brand Drug cost share.

**Dispensing Limitations**

Except for Maintenance Medications and contraceptive drugs as described below, Members may obtain up to a 30-day supply and will be charged the applicable Copayment or Coinsurance based on:

1. The prescribed dosage;
2. Standard Manufacturers Package Size; and
3. Specified dispensing limits.

Drugs that have a short shelf life may require dispensing in smaller quantities to assure that the quality is maintained. Such drugs will be limited to a thirty (30)-day supply. If a drug is dispensed in several smaller quantities (for example, three (3) ten (10)-day supplies), you will be charged only one Cost Share at the initial dispensing for each thirty (30)-day supply.

Members may obtain a partial supply of a prescription drug and will be charged a prorated daily copayment or coinsurance, if the following conditions are met:

1. The prescribing physician or pharmacist determines dispensing a partial supply of a prescription drug to be in the best interest of the member;
2. The prescription drug is anticipated to be required for more than three (3) months;
3. The Member requests or agrees to a partial supply for the purpose of synchronizing the dispensing of the Member’s prescription drugs;
4. The prescription drug is not a Schedule II controlled dangerous substance; and
5. The supply and dispensing of the prescription drug meets all prior authorization and utilization management requirements specific to the prescription drug at the time of the synchronized dispensing.
Except for Maintenance Medications and contraceptive drugs as described below, injectable drugs that are self-administered and dispensed from the pharmacy are limited to a thirty (30)-day supply.

**Maintenance Medication Dispensing Limitations**

Members may obtain up to a ninety (90)-day supply of Maintenance Medications in a single prescription, when authorized by the prescribing Plan Provider or by a dentist or a referral physician. This does not apply to the first prescription or change in a prescription. The day supply is based on:

1. The prescribed dosage;
2. Standard Manufacturer’s Package Size; and
3. Specified dispensing limits.

**Contraceptive Drug Dispensing Limitations**

For prescribed contraceptives, you may obtain up to a twelve (12)-month supply for a single dispense at a Plan Pharmacy or through our Mail Service Delivery Program.

**Prescriptions Covered Outside the Service Area: Obtaining Reimbursement**

The Health Plan covers drugs purchased at non-Plan Pharmacies when the drug was prescribed during the course of an emergency care visit or an urgent care visit (see *Emergency Services* and *Urgent Care Services* in Section 3: Benefits, Exclusions and Limitations), or associated with a covered, authorized referral inside or outside Health Plan’s Service Area. To obtain reimbursement, Members must submit a copy of the itemized receipts for their prescriptions to the Health Plan. We may require proof that Emergency Services or Urgent Care Services were provided. Reimbursement will be made at the Allowable Charge less the applicable Copayment as shown below. Claims should be submitted to:

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

**Copayment/Coinsurance**

You pay the Copayment or Coinsurance amounts set forth below when purchasing covered outpatient prescription drugs from the Kaiser Permanente Plan Pharmacy. If the price of the drug is less than the Copayment, you will pay the price of the drug.

The following Copayments and Coinsurance apply to all covered prescription drugs purchased at a Kaiser Permanente Plan Pharmacy or through Kaiser Permanente’s Mail Service Delivery Program. These Copayments and Coinsurance amounts also apply to covered prescription drugs offered at non-Plan Pharmacies in connection with Emergency Services and Urgent Care Services.

<table>
<thead>
<tr>
<th>Thirty (30)-Day Supply</th>
<th>Plan Pharmacy and Mail Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs</td>
<td>$10</td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>$50</td>
</tr>
<tr>
<td>Non-Preferred Brand Drugs</td>
<td>35% of AC*</td>
</tr>
</tbody>
</table>
## Specialty Drugs
35% of AC* but not to exceed $150

## Oral Chemotherapy Drugs
No charge

## Preventive Care Drugs**
No charge

## Smoking Cessation Drugs
No charge

## Diabetic Equipment and Supplies (not including Insulin Pumps, Glucose Monitoring Equipment and Test Strips)
35% of AC*

## Diabetic Test Strips
No charge

## Ninety (90)-Day Supply

<table>
<thead>
<tr>
<th>Generic Drugs</th>
<th>Plan Pharmacy and Mail Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preferred Brand Drugs</th>
<th>$100</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Non-Preferred Brand Drugs</th>
<th>35% of AC*</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Specialty Drugs</th>
<th>35% of AC* but not to exceed $300</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Oral Chemotherapy Drugs</th>
<th>No charge</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Preventive Care Drugs**</th>
<th>No charge</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Smoking Cessation Drugs</th>
<th>No charge</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Diabetic Equipment and Supplies (not including Insulin Pumps, Glucose Monitoring Equipment and Test Strips)</th>
<th>35% of AC*</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Diabetic Test Strips</th>
<th>No charge</th>
</tr>
</thead>
</table>

## Twelve (12)-Month Supply

<table>
<thead>
<tr>
<th>Contraceptive Drugs**</th>
<th>Plan Pharmacy and Mail Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No charge</td>
</tr>
</tbody>
</table>

*Allowable Charge (AC) is defined in the Important Terms You Should Know section in your Membership Agreement and Evidence of Coverage, to which this Appendix is attached.

**Preventive Care Drugs and Contraceptive Drugs required to be covered by the Affordable Care Act, including over-the-counter contraceptives, are covered at no charge. You can find a list of these drugs at:

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

### Out-of-Pocket Maximum

All Cost Shares for outpatient prescription drugs apply toward the Out-of-Pocket Maximum set forth in the Summary of Cost Shares Appendix of this Agreement.