

**State:** District of Columbia **Filing Company:** Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

**TOI/Sub-TOI:** HOrg03 Health - Other/HOrg03.000 Health Organizations - Other

**Product Name:** 2017 DC Mid-Large Employer Group Benefit Form - HMO Cost Share

**Project Name/Number:** /

### Filing at a Glance

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

Product Name: 2017 DC Mid-Large Employer Group Benefit Form - HMO Cost Share

State: District of Columbia

TOI: HOrg03 Health - Other

Sub-TOI: HOrg03.000 Health Organizations - Other

Filing Type: Form

Date Submitted: 11/17/2016

SERFF Tr Num: KPMA-130812612

SERFF Status: Assigned

State Tr Num:

State Status:

Co Tr Num:

Implementation: On Approval

Date Requested:

Author(s): Lynn Robinson, Zalika Murray, Nikki Bridgeforth, Veronica Green, Nikora Grooms, Stephen Chuang, John Xu, David Liebert, David Parks, Shilpa Myers, Ky Le, Scott Curran, David Rosenfeld

Reviewer(s): Andre Beard (primary)

Disposition Date:

Disposition Status:

Implementation Date:

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## General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Group Market Type: Employer, Association, Trust	Overall Rate Impact:
Filing Status Changed: 11/17/2016	
State Status Changed:	Deemer Date:
Created By: Shilpa Myers	Submitted By: Shilpa Myers
Corresponding Filing Tracking Number:	
PPACA: Not PPACA-Related	
PPACA Notes: null	
Include Exchange Intentions:	No

**Filing Description:**  
 On behalf of the Health Plan, we are resubmitting our HMO Cost Share.

## Company and Contact

### Filing Contact Information

Catherine Reifert, Manager	catherine.l.reifert@kp.org
2101 E. Jefferson	301-816-7346 [Phone]
Rockville, MD 20852	301-816-7346 [FAX]

### Filing Company Information

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	CoCode: 95639	State of Domicile: Maryland
2101 E Jefferson St.	Group Code:	Company Type: Health Maintenance Organization
Rockville, MD 20852	Group Name:	State ID Number:
(301) 816-6867 ext. [Phone]	FEIN Number: 52-0954463	

## Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	

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## Correspondence Summary

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	POS - Summary of Services and Cost Shares	Shilpa Myers	11/18/2016	11/18/2016
Supporting Document	EOV	Shilpa Myers	11/18/2016	11/18/2016
Supporting Document	Redlines	Shilpa Myers	11/18/2016	11/18/2016
Form	Section 3: Benefits	Shilpa Myers	11/17/2016	11/17/2016
Supporting Document	EOV	Shilpa Myers	11/17/2016	11/17/2016
Supporting Document	Redlines	Shilpa Myers	11/17/2016	11/17/2016
Form	Section 3: Benefits	Shilpa Myers	11/17/2016	11/17/2016
Supporting Document	EOV	Shilpa Myers	11/17/2016	11/17/2016
Supporting Document	Redlines	Shilpa Myers	11/17/2016	11/17/2016

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## Amendment Letter

Submitted Date: 11/18/2016

Comments:

The POS Cost share was updated with the same changes that were made to the HMO Cost share. Again, these changes do not effect rates.

Changed Items:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	POS - Summary of Services and Cost Shares	DCLG-POS-COST(1-17)	SCH	Revised	Previous Filing Number: KPMA-1307604 Replaced Form Number: DCLG-POS-COST(1-17)	41.600	DCLG-POS-COST(01-17).pdf	Date Submitted: 11/18/2016 By:

No Rate Schedule Items Changed.

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### Supporting Document Schedule Item Changes

<b>Satisfied - Item:</b>	EOV
<b>Comments:</b>	
<b>Attachment(s):</b>	DCLG-HMO-COST(1-17)-EOV.pdf DCLG-ALL-SEC3(01-17)-EOV.pdf DCLG-POS-COST(1-17)-EOV.pdf
<i>Previous Version</i>	
<b>Satisfied - Item:</b>	EOV
<b>Comments:</b>	
<b>Attachment(s):</b>	<i>DCLG-HMO-COST(1-17)-EOV.pdf</i> <i>DCLG-ALL-SEC3(01-17)-EOV.pdf</i>
<i>Previous Version</i>	
<b>Satisfied - Item:</b>	EOV
<b>Comments:</b>	
<b>Attachment(s):</b>	<i>DCLG-HMO-COST(1-17)-EOV.pdf</i> <i>DCLG-ALL-SEC3(01-17)-EOV.pdf</i>
<i>Previous Version</i>	
<b>Satisfied - Item:</b>	EOV
<b>Comments:</b>	
<b>Attachment(s):</b>	<i>DCLG-HMO-COST(1-17)-EOV.pdf</i>

<b>Satisfied - Item:</b>	Redlines
<b>Comments:</b>	
<b>Attachment(s):</b>	DCLG-HMO-COST(01-17)_redline.pdf DCLG-ALL-SEC3(01-17)_redline.pdf DCLG-POS-COST(01-17)_redline.pdf
<i>Previous Version</i>	
<b>Satisfied - Item:</b>	Redlines
<b>Comments:</b>	
<b>Attachment(s):</b>	<i>DCLG-HMO-COST(01-17)_redline.pdf</i> <i>DCLG-ALL-SEC3(01-17)_redline.pdf</i>
<i>Previous Version</i>	
<b>Satisfied - Item:</b>	Redlines
<b>Comments:</b>	
<b>Attachment(s):</b>	<i>DCLG-HMO-COST(01-17)_redline.pdf</i>

SERFF Tracking #:

KPMA-130812612

State Tracking #:

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Product Name:

2017 DC Mid-Large Employer Group Benefit Form - HMO Cost Share

Project Name/Number:

/

*DCLG-ALL-SEC3(01-17)\_redline.pdf*

*Previous Version*

**Satisfied - Item:**

*Redlines*

**Comments:**

**Attachment(s):**

*DCLG-HMO-COST(01-17)\_redline.pdf*

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## Amendment Letter

Submitted Date: 11/17/2016

Comments:

Section 3 revisions: #2 under Therapy and Rehabilitative Services has been updated and the second number 4. on page 3.1 has been revised.

Changed Items:

Form Schedule Item Changes									
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments	Submitted
1	Section 3: Benefits	DCLG-ALL-SEC3(01-17)	POL	Revised	Previous Filing Number:	KPMA-130636049	40.000	DCLG-ALL-SEC3(01-17).pdf	Date Submitted: 11/17/2016 By:
					Replaced Form Number:	DCLG-ALL-SEC3(01-17)			
<i>Previous Version</i>									
1	Section 3: Benefits	DCLG-ALL-SEC3(01-17)	POL	Revised	Previous Filing Number:	KPMA-130636049	40.000	DCLG-ALL-SEC3(01-17).pdf	Date Submitted: 11/17/2016 By:
					Replaced Form Number:	DCLG-ALL-SEC3(01-17)			

No Rate Schedule Items Changed.

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### Supporting Document Schedule Item Changes

<b>Satisfied - Item:</b>	EOV
<b>Comments:</b>	
<b>Attachment(s):</b>	DCLG-HMO-COST(1-17)-EOV.pdf DCLG-ALL-SEC3(01-17)-EOV.pdf
<i>Previous Version</i>	
<b>Satisfied - Item:</b>	EOV
<b>Comments:</b>	
<b>Attachment(s):</b>	<i>DCLG-HMO-COST(1-17)-EOV.pdf</i> <i>DCLG-ALL-SEC3(01-17)-EOV.pdf</i>
<i>Previous Version</i>	
<b>Satisfied - Item:</b>	EOV
<b>Comments:</b>	
<b>Attachment(s):</b>	<i>DCLG-HMO-COST(1-17)-EOV.pdf</i>

<b>Satisfied - Item:</b>	Redlines
<b>Comments:</b>	
<b>Attachment(s):</b>	DCLG-HMO-COST(01-17)_redline.pdf DCLG-ALL-SEC3(01-17)_redline.pdf
<i>Previous Version</i>	
<b>Satisfied - Item:</b>	Redlines
<b>Comments:</b>	
<b>Attachment(s):</b>	<i>DCLG-HMO-COST(01-17)_redline.pdf</i> <i>DCLG-ALL-SEC3(01-17)_redline.pdf</i>
<i>Previous Version</i>	
<b>Satisfied - Item:</b>	Redlines
<b>Comments:</b>	
<b>Attachment(s):</b>	<i>DCLG-HMO-COST(01-17)_redline.pdf</i>

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## Amendment Letter

Submitted Date: 11/17/2016

Comments:  
To whom it may concern,

Section 3 was added with spelling errors corrected and #2 under Therapy and Rehabilitative Services has been updated.

Changed Items:

Form Schedule Item Changes									
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments	Submitted
1	Section 3: Benefits	DCLG-ALL-SEC3(01-17)	POL	Revised	Previous Filing Number:	KPMA-130636049	40.000	DCLG-ALL-SEC3(01-17).pdf	Date Submitted: 11/17/2016 By:
					Replaced Form Number:	DCLG-ALL-SEC3(01-17)			

No Rate Schedule Items Changed.

SERFF Tracking #:

KPMA-130812612

State Tracking #:

Company Tracking #:

State: District of Columbia

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Product Name: 2017 DC Mid-Large Employer Group Benefit Form - HMO Cost Share

Project Name/Number: /

**Supporting Document Schedule Item Changes****Satisfied - Item:** EOV**Comments:****Attachment(s):** DCLG-HMO-COST(1-17)-EOV.pdf  
DCLG-ALL-SEC3(01-17)-EOV.pdf*Previous Version***Satisfied - Item:** *EOV***Comments:****Attachment(s):** *DCLG-HMO-COST(1-17)-EOV.pdf***Satisfied - Item:** Redlines**Comments:****Attachment(s):** DCLG-HMO-COST(01-17)\_redline.pdf  
DCLG-ALL-SEC3(01-17)\_redline.pdf*Previous Version***Satisfied - Item:** *Redlines***Comments:****Attachment(s):** *DCLG-HMO-COST(01-17)\_redline.pdf*

State: District of Columbia

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Project Name/Number: /

## Form Schedule

### Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1		HMO-Summary of Services and Cost Shares	DCLG-HMO-COST(01-17)	SCH	Revised	Previous Filing Number:	KPMA-130760412	41.600	DCLG-HMO-COST(01-17).pdf
						Replaced Form Number:	DCLG-HMO-COST(01-17)		
2		Section 3: Benefits	DCLG-ALL-SEC3(01-17)	POL	Revised	Previous Filing Number:	KPMA-130636049	40.000	DCLG-ALL-SEC3(01-17).pdf
						Replaced Form Number:	DCLG-ALL-SEC3(01-17)		
3		POS - Summary of Services and Cost Shares	DCLG-POS-COST(1-17)	SCH	Revised	Previous Filing Number:	KPMA-130760412	41.600	DCLG-POS-COST(01-17).pdf
						Replaced Form Number:	DCLG-POS-COST(1-17)		

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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## Summary of Services and Cost Shares

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

### **[DEPENDENT AGE LIMIT**

Eligible Dependent children are covered from birth to age [26 - 30], [or to age [26 – 30] if a full-time student], as defined by your Group and approved by Health Plan.

### **MEMBER COST-SHARE**

Your Cost Share is the amount of the Allowable Charge for a covered Service that you must pay through [Deductibles, ]Copayments and Coinsurance. The Cost Share, if any, is listed for each Service in this “Summary of Services and Cost Shares.” Allowable Charge is defined in the Definitions Appendix.

In addition to the monthly premium, you may be required to pay a Cost Share for some Services. You are responsible for payment of all Cost Shares. Copayments are due at the time you receive a Service. You will be billed for any Deductible and Coinsurance you owe. Failure to pay your Cost Shares may result in termination of your Membership (refer to Section 6: Termination for Nonpayment).

### **[DEDUCTIBLE**

The Deductible is the amount of Allowable Charges you must incur during a [contract] [calendar] [policy] year for certain covered Services before Health Plan will begin paying benefits for those Services. [The Deductible applies to all covered Services except Preventive Health Care Services [and post-partum home health visits] as described in Section 3, Benefits [, and outpatient Prescription Drugs]. [Preventive Health Care Services may be subject to a Copayment as shown below.]] [The Deductible applies to covered Hospital Inpatient Care, Skilled Nursing Facility Care, inpatient Chemical Dependency and Mental Health Services, and inpatient Rehabilitation Therapy Services only.] [The Deductible applies to the Services shown in the schedule below [that have a Coinsurance] [, except Durable Medical Equipment, Preventive Health Care Services and Prosthetic and Orthotic Devices].][Other Services may have a Copayment.] [Copayments do not apply toward the Deductible.]

For covered Services that are subject to a Deductible, you must pay the Allowable Charges for the Services when you receive them, until you meet your Deductible. The only amounts that count toward your Deductible are the Allowable Charges you incur for Services that are subject to the Deductible, but only if the Service would otherwise be covered. After you meet the Deductible, you pay the applicable [Copayment] [or] [Coinsurance] for these Services.

**[[Self-Only] [Individual] Coverage Deductible.** If you are covered as a Subscriber, and you do not have any Dependents covered under the plan, you must meet the [Self-Only] [Individual] Deductible shown below.]

**[Family Coverage Deductible.** If you have one or more Dependents covered under this EOC, one or more covered Members of your Family Unit together must meet the Family Deductible shown below. After one or more covered Members of your Family Unit combined have met the Family Coverage Deductible, the Deductible will be met for all Members of the Family Unit for the rest of the [contract] [calendar] [policy] year. The Individual Deductible shown below does not apply with Family Coverage.]

**[Family Coverage Deductible.** If you have one or more Dependents covered under this EOC, all covered Members of your family together can meet the Family Deductible shown below, but no one family Member’s medical expenses may contribute more than the Individual Deductible shown below. After an Individual Member of the Family Unit has met the Individual Deductible, his or her Deductible will be met for the rest of the [calendar][contract] [policy] year. Other family Members will continue to pay full charges for Services that are subject to the Deductible until the Family Deductible is met. After all Members of the Family Unit combined have met the Family Deductible, the Deductible will be met for all Members of the Family Unit for the rest of the [contract] [calendar] [policy] year.]

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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**[Individual within Family Coverage Deductible.** If you are the only Member in your Family, then you must meet the Individual within Family Deductible. If you are a Member in a Family of two or more Members, then either you must each meet the Individual within Family Deductible, or your entire Family must meet the Family Deductible. Each Individual within Family Deductible amount counts toward the Family Deductible amount. Once the Family Deductible is satisfied, no further Individual within Family Deductible will be due for the remainder of the Year. The Self-Only Deductible, Individual within Family Deductible, and Family Deductible amounts are shown below.]

**[Deductible Carryover.** Allowable Charges incurred during the last 3 months of the [contract] [calendar] [policy] year that apply toward the Deductible will also apply to the Deductible for the following [contract] [calendar] [policy] year.]

**[Deductible Credit.** If you were covered on the day immediately preceding the effective date of the Group Agreement under any other group coverage that was replaced by this EOC, then charges for covered Services incurred by you and applicable toward the individual or family Deductible under the prior coverage, will be used to satisfy all or any portion of the individual or family Deductible amounts under this EOC. This Deductible credit provision applies only to the Deductible amount wholly or partially satisfied in the same [contract][calendar][policy] year as the effective date of this EOC.]

**[Keep Your Receipts.** When you pay an amount toward your Deductible, we will give you a receipt. Keep your receipts. [If you have an HSA account, you may need to prove to the IRS that distributions from your HSA were for qualified medical expenses. Also, if] [If] you have met your Deductible, and we have not received and processed all of your claims, you can use your receipts to prove that you have met your Deductible. You can also obtain a statement of the amounts that have been applied toward your Deductible from our Member Services Department.]]

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### [Missed Appointment Fee]

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[The amount you may be required to pay if you fail to keep a scheduled appointment and you do not notify us at least one day prior to the appointment.]	[[\$10 - \$100] per missed appointment]
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### [Deductible]

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[The amount you must pay each [contract][calendar][policy] year for the Services indicated below before we provide benefits for those Services]	[No Deductible]
<b>[[Self-Only] [Individual] Deductible]</b>	[\$100 - \$10,000] per individual per [contract] [calendar] [policy] year]
<b>[Individual within Family Deductible]</b>	[\$100 - \$10,000] per individual Family Member per [contract] [calendar] [policy] year]
<b>[Family Deductible]</b>	[2x - 3x individual deductible] [\$100 - \$20,000] per Family Unit per [contract] [calendar] [policy] year]

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### Copayments and Coinsurance

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Covered Service	You Pay [after Deductible]
<b>Outpatient Care</b>	
Office visits (for other than preventive health care Services)	
Primary care office visits [For adults]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
[For children under [24 months][2 – 18] [years] of	[No charge][[\$0 - \$100] per visit] [,then]

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

**YOUR GROUP EVIDENCE OF COVERAGE (EOC)  
KAISER PERMANENTE**

<b>Copayments and Coinsurance</b>	
<b>Covered Service</b>	<b>You Pay [after Deductible]</b>
age]	[[0% - 0%] of AC*] [after Deductible] [;] [Deductible waived]
[For children [24 months][2 – 18] [years] of age or older]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Specialty care office visits [For adults]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
[For children under [24 months][2 – 18][ years] of age]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
[For children age [24 months][2 – 18] [years] of age or older]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
[Consultations and immunizations for foreign travel]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]
Outpatient surgery physician/surgical Services	[No charge] [[\$0 - \$500] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]
[Special outpatient procedures]	[No charge][[\$5 - \$500] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
[Outpatient hospital procedures]	[No charge][[\$5 - \$500] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Anesthesia	[No charge] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]
Chemotherapy and radiation therapy	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]
Respiratory therapy	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]
Medical social services	[No charge][[\$0 - \$100] per visit] [,then]

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**YOUR GROUP EVIDENCE OF COVERAGE (EOC)  
KAISER PERMANENTE**

<b>Copayments and Coinsurance</b>	
<b>Covered Service</b>	<b>You Pay [after Deductible]</b>
	[[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
House calls	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
<b>Hospital Inpatient Care</b> All charges incurred during a covered stay as an inpatient in a hospital	[No charge] [[\$100 - \$1000] per admission] [,then][Deductible, then][[0% - 50%] of AC*] [[\$100 - \$500] per day, not to exceed a total of [3x - 5x the daily amount] per admission] [after Deductible] [;] [Deductible waived] [Member payment not to exceed \$[100-10,000] [per admission] [per [contract] [calendar] [policy] year]]
<b>[Hospital Observation Services]</b>	[ [No charge] [[\$ 25 -\$500] per visit][; not to exceed the actual cost of the visit.] [,then] [0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [; Copayment waived if admitted as an inpatient] [Copayment waived if observation status in conjunction with emergency room visit]]
<b>Accidental Dental Injury Services</b> [Limited to treatment started within 6 months of the accident]	[Applicable Cost Shares will apply, based on type and place of Service] [No charge][[0% - 50%] of AC* [after Deductible] [;] [Deductible waived]]
<b>Allergy Services</b>	[Applicable Cost Shares will apply based on type and place of Service] [No charge][[0% - 50%] of AC*][after Deductible] [;] [Deductible waived]]
[Evaluations and treatment]	[[Applicable Cost Shares will apply, based on type and place of Service] [No charge][[0% - 50%] of AC*][after Deductible] [;] [Deductible waived]]
[Injection visits and serum]	[Applicable Cost Shares will apply, based on type and place of Service, not to exceed the cost of the serum plus administration] [No charge][[0% - 50%] of AC*] [[\$0 - \$100] per visit] [after Deductible] [;][Deductible waived]]
<b>Ambulance Services</b> By a licensed ambulance Service, per encounter	[No charge][[\$0 - \$500] per encounter] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Non-emergent transportation Services	[No charge][[\$0 - \$500] per encounter] [per [round] trip] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]

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

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

## Copayments and Coinsurance

Covered Service	You Pay [after Deductible]
<b>Anesthesia for Dental Services</b> Anesthesia and associated hospital or ambulatory Services for certain individuals only	[No charge] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Applicable Cost Shares will apply, based on type and place of Service]
<b>Blood, Blood Products and their Administration</b>	[No charge] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [No additional charge] [Applicable Cost Shares will apply, based on type and place of Service]
<b>Chemical Dependency and Mental Health Services</b> [Partial hospitalization is limited to 60 days per [contract] [calendar] [policy] year]	[[No charge][0% - 50%] of AC* [after Deductible] [;] [Deductible waived]]
[Inpatient psychiatric and substance abuse care, including detoxification (minimum of 12 days of detoxification per [contract][calendar][policy] year)	[Applicable inpatient Cost Shares will apply] [No charge] [[0 - \$100] per day] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Hospital alternative Services Intensive outpatient psychiatric treatment programs	[No charge] [[0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Partial hospitalization	[No charge] [[0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Outpatient psychiatric and substance abuse care <ul style="list-style-type: none"> <li>• Individual therapy</li> </ul>	[No charge] [[0 - \$35] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [waived for children under [24 months -5 years of age] ]
<ul style="list-style-type: none"> <li>• Group therapy</li> </ul>	[No charge] [[0 - \$10] per visit] [,then] [[5% - 50%] of AC*][after Deductible] [; Deductible waived] [waived for children under [24 months -5 years of age] ]
[Medication management visits]	[No charge][[0 - \$100 per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
[Residential treatment center]	[Applicable inpatient Cost Shares will apply] [No charge] [[0 - \$100] per day] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
<b>[[Chiropractic] [and] [Acupuncture] Services</b> [No limit] [Limited to [10 – 50] visits for Chiropractic Services per Member per [contract] [calendar] [policy] year]	[No charge][[0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]

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

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

## Copayments and Coinsurance

Covered Service	You Pay [after Deductible]
[No limit] [Limited to [10 – 50] visits for Acupuncture Services per Member per [contract] [calendar] [policy] year]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
<b>Cleft Lip, Cleft Palate, or Both</b>	[Applicable Cost Shares will apply, based on type and place of Service] [No charge] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
<b>Clinical Trials</b>	[Applicable Cost Shares will apply, based on type and place of Service] [No charge] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
<b>Diabetic Equipment, Supplies and Self-Management Training</b>	[[No charge][[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]]
[Diabetic equipment [and supplies]]	[[No charge] [[0% - 50%]of AC*] [after Deductible] [;] [Deductible waived]
[Diabetic supplies]	[[No charge][[\$5 - \$50 per supply][after Deductible][;][Deductible waived]]
[ <ul style="list-style-type: none"> <li>• Disposable needles and syringes</li> <li>• Glucose test strips</li> <li>• Glucose test meter <ul style="list-style-type: none"> <li>○ Additional meters</li> </ul> </li> <li>• Control solutions</li> <li>• Lancets</li> <li>• Other supplies]</li> </ul>	[[No charge][[0% - 50%]of AC*] [after Deductible] [;] [Deductible waived]  [No charge][[0% - 50%]of AC*] [after Deductible] [;] [Deductible waived]  [\$10 - \$20 per meter]  [\$10 - \$20 per meter]  [\$8 - \$15 per package]  [\$8 - \$15 per package]  [No charge][[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
[Self-management training]	[Applicable Cost Shares will apply, based on place of Service]
<b>Dialysis</b>	[No charge][[0% - 50%] of AC*][after Deductible] [;] [Deductible waived]]
[Inpatient care]	[[Applicable inpatient Cost Shares will apply] [[0% - 50%] of AC*][after Deductible] [;] [Deductible waived]
[Outpatient Care]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]

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

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

<b>Copayments and Coinsurance</b>	
Covered Service	You Pay [after Deductible]
[Dialysis Center]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
Home dialysis, including training]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
Dialysis Training	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
<b>Drugs, Supplies, and Supplements</b> Administered by or under the supervision of a Plan Provider	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ] [Applicable Cost Shares will apply, based on type and place of Service]
<b>Durable Medical Equipment (DME) - Outpatient</b>	[[No charge][[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]] [Applicable Cost Shares will apply, based on type and place of Service]
<b>[Outpatient Basic Durable Medical Equipment]</b>	[[No charge] [[0% - 50%] of AC*][after Deductible] [;] [Deductible waived]
<b>[Outpatient Supplemental Durable Medical Equipment]</b>	[Limited to use in the home for up to 3 months following: an authorized confinement in a hospital, a sub-acute facility; or a specialized rehabilitation facility; or an authorized outpatient surgical procedure.] ]
<ul style="list-style-type: none"> <li>• Oxygen and Equipment</li> </ul>	[No charge] [[0% - 50%] of AC*] [No charge for 1 <sup>st</sup> 3 months; [50% - 60%] of AC* each month thereafter][[20% - 50%]of AC* for 1 <sup>st</sup> 3 months; [50% - 70%] of AC* each month thereafter] [after Deductible] [;] [Deductible waived] [Limited to a Plan maximum payment for oxygen and equipment of [\$1,000 - \$100,000] per [contract] [calendar] [policy] year]
<ul style="list-style-type: none"> <li>• Positive Airway Pressure Equipment</li> </ul>	[No charge] [[0% - 50%] of AC*] [No charge for 1 <sup>st</sup> 3 months; [50% - 60%] of AC* each month thereafter][[20% - 50%]of AC* for 1 <sup>st</sup> 3 months; [50% - 70%] of AC* each month thereafter] [after Deductible] [;] [Deductible waived]
<ul style="list-style-type: none"> <li>• Apnea Monitors (Infants under 3, not to exceed a period of 6 months)</li> </ul>	[No charge] [[0% - 50%] of AC*][after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>• Asthma Equipment</li> </ul>	[[No charge] [[0% - 50%] of AC*][after

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

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

<b>Copayments and Coinsurance</b>	
Covered Service	You Pay [after Deductible]
	Deductible] [; Deductible waived]]
<ul style="list-style-type: none"> <li>○ [Spacers</li> <li>○ Peak-flow meters</li> <li>○ Nebulizers]</li> </ul>	<ul style="list-style-type: none"> <li>[ [\$5 - \$10] per item]</li> <li>[[ \$10 - \$15] per item]</li> <li>[\$30 - \$40] per item] ]</li> </ul>
<ul style="list-style-type: none"> <li>• [Bilirubin Lights (Infants under 3, not to exceed a period of 6 months)]</li> </ul>	[No charge] [[0% - 50%] of AC*][after Deductible] [; Deductible waived] ]
<b>Emergency Services</b>	[[No charge] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]]
[Emergency Room Visits	[ [No charge] [[ \$ 25 -\$500] per visit] [,then]
<ul style="list-style-type: none"> <li>• Inside the Service Area</li> </ul>	[[0% - 50%] of AC*] [; not to exceed the actual cost of the visit.] [after Deductible] [;] [Deductible waived] [Copayment waived if immediately admitted]
<ul style="list-style-type: none"> <li>• Outside of the Service Area</li> </ul>	[No charge] [[ \$ 25 -\$500] per visit] [,then] [[0% - 50%] of AC*] [; not to exceed the actual cost of the visit.] [after Deductible] [;] [Deductible waived] [ Copayment waived if immediately admitted.] ]
Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit copayment will not be waived.]	
Emergency Services HIV Screening Test	No charge [after Deductible]
<b>[Family Planning</b>	[[No charge] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]] [Applicable Cost Shares will apply, based on type and place of Service ]
[Women’s Preventive Services, 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 Care at no charge.]]	
[[Office visits]	[[No charge] [[ \$0 - \$100] per visit] [,then][;] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
[Tubal ligation] [, Vasectomy] [, Voluntary termination of pregnancy]]	[Applicable Cost Share will apply based on place of Service] ]
[Women’s Preventive Services, including all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity are covered under Preventive Care at no charge]	
<b>Habilitative Services</b>	[[No charge] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]] [Applicable Cost Shares will apply, based on type and place
[Limited to children up to age 21]	

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**YOUR GROUP EVIDENCE OF COVERAGE (EOC)  
KAISER PERMANENTE**

**Copayments and Coinsurance**

Covered Service	You Pay [after Deductible] of Service ]
Physical, Occupational or Speech Therapy	[Applicable Cost Share will apply based on type and place of Service] [No charge] [[ $\$0 - \$100$ ] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
[Applied Behavioral Analysis (ABA)]	[Applicable Cost Share will apply based on type and place of Service] [No charge] [[ $\$0 - \$100$ ] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
All other Services	[Applicable Cost Share will apply based on type and place of Service] [No charge] [[ $\$0 - \$100$ ] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
<b>Hearing Services</b> Hearing tests (newborn hearing screening tests are covered under preventive health care Services at no charge)	[No charge][[0% - 50%] of AC*] [Applicable office visit Cost Share will apply based on place of service] [after Deductible] [;] [Deductible waived]
<b>Home Health Care</b> See Section 3 for benefit limitations [Limited to a maximum benefit of [30 – 240 visits] per [contract] [calendar] [policy] year]	[No charge][[ $\$0 - \$100$ ] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
<b>Hospice Care</b>	[No charge] [[ $\$0 - \$100$ ] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
<b>[Infertility Services]</b>	[[No charge][0% - 50%] of AC* [after Deductible] [;] [Deductible waived]]
[Office visits [for initial diagnosis of infertility]	[[No charge] [[ $\$0 - \$100$ ] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Inpatient Hospital Care	[The applicable inpatient hospital Cost Share will apply.][No charge] [[ $\$100 - \$1000$ ] per admission] [,then] [[0% - 50%] of AC*] [[ $\$100 - \$500$ ] per day, not to exceed a total of [3x - 5x the daily amount] per admission] [after Deductible] [;] [Deductible waived] [Member payment not to exceed [ $\$100-10,000$ ] [per admission] [per [contract] [calendar] [policy] year]]
All other Services for treatment of infertility]	[No charge] [[ $\$0 - \$100$ ] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]]
[Note: Coverage for In-vitro fertilization is limited to a maximum lifetime benefit of $\$100,000$ .] ]	

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

**YOUR GROUP EVIDENCE OF COVERAGE (EOC)  
KAISER PERMANENTE**

**Copayments and Coinsurance**

Covered Service	You Pay [after Deductible]
<b>Infusion Therapy Services</b>	[Applicable Cost Shares will apply, based on type and place of Service] [No charge][[0% - 50%] of AC* [after Deductible] [;] [Deductible waived]]
<b>Maternity Services</b>	[[No charge][[0% - 50%] of AC* [after Deductible] [;] Deductible waived]]
[Prenatal and postpartum visits (after confirmation of pregnancy), including diagnostic tests	[[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] Deductible waived]
Inpatient obstetrical care and delivery, including cesarean section	[No charge] [[\$100 - \$1000] per admission] [,then] [[0% - 50%] of AC*] [[\$100 - \$500] per day, not to exceed a total of [3x - 5x the daily amount] per admission] [after Deductible] [;] [Deductible waived] [Member payment not to exceed \$[100-10,000] [per admission] [per [contract] [calendar] [policy] year] [The applicable inpatient hospital Cost Share will apply.]
Postpartum home health visits	No charge; [Deductible waived]
Breast Pumps	[[No charge] [Deductible waived]
Note: Maternity Services that are required by the Affordable Care Act are covered under Preventive Care Services at no charge]	
[Prenatal and postnatal care	[[No charge][[\$0 - \$100] per pregnancy] [,then] [[0% - 50%] of AC*] [after Deductible] [;] Deductible waived]
Inpatient obstetrical care and delivery, including cesarean section ]	[No charge] [[\$100 - \$1000] per admission] [,then] [[0% - 50%] of AC*] [[\$100 - \$500] per day, not to exceed a total of [3x - 5x the daily amount] per admission] [after Deductible] [;] [Deductible waived] [Member payment not to exceed \$[100-10,000] [per admission] [per [contract] [calendar] [policy] year]] [The applicable inpatient hospital Cost Share will apply.]
<b>Medical Foods</b>	[No charge] [[0% - 50%] of AC*] [after Deductible][;] Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]

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# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

## Copayments and Coinsurance

Covered Service	You Pay [after Deductible]
<b>Medical Nutrition Therapy &amp; Counseling</b>	[No charge] [[\$5 - \$500] per visit] [,then] [0% - 50%] of AC* [after Deductible]; Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]
<b>Morbid Obesity Services</b>	[No charge] [[\$5 - \$500] per visit] [,then] [0% - 50%] of AC* [after Deductible]; Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]
[Bariatric Surgery]	[0% - 50%] of AC*[after Deductible]
All other Services]	[Applicable Cost Shares will apply based on type and place of Service]
<b>Oral Surgery</b>	[No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible]; Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]
<b>Preventive Health Care Services</b> [Not subject to Deductible]	[No charge][[\$0 - \$100] per visit] [[0% - 50%] of AC*] [;] [Copayment waived for children under [24 months] [2 - 25][years] of age]
[Routine physical exams for adults]	[[No charge][[\$0 - \$100] per visit] [;] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Routine preventive tests for adults	[No charge][[\$0 - \$100] per visit] [;] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Well child care visits	[No charge] [[\$0 - \$100] per visit] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Copayment waived for children under [24 months][2- 25] [years] of age]
Routine immunizations for children and adults conducted in a Lab or Radiology (No additional charge for immunization agent)]	[No charge] [[\$0 - \$100] per visit] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Copayment waived for children under [24 months][2 - 25][years] of age]
<b>Prosthetic Devices</b> [Limited to internally implanted devices, ostomy and urological supplies and breast prosthetics, unless a Prosthetic and Orthotic Devices Rider is attached to this EOC.]	[[No charge][0% -50%] of AC*] [after Deductible] [;] Deductible waived]
[Internally implanted devices]	[[No charge][0% -50%] of AC*] [after Deductible] [;] Deductible waived] [Applicable inpatient Cost Shares will apply]
Ostomy and urological supplies	[No charge][[0% - 50%] of AC*] [after

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**YOUR GROUP EVIDENCE OF COVERAGE (EOC)  
KAISER PERMANENTE**

<b>Copayments and Coinsurance</b>	
<b>Covered Service</b>	<b>You Pay [after Deductible]</b>
	Deductible] [; Deductible waived]
Breast prosthetics ]	[No charge][[0% - 50%] of AC*] [after Deductible] [; Deductible waived] ]
[Hair prostheses]	[No charge][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]
<b>Reconstructive Surgery</b>	[No charge] [[0 - \$100 per visit][0% - 50%] of AC*] [after Deductible][; Deductible waived] [Applicable Cost Shares will apply based on place and type of Service.]
<b>Skilled Nursing Facility Care</b> [Limited to a maximum benefit of [60 – 240] days per [admission] [contract] [calendar] [policy] year]	[No charge] [[0 - \$1000] per admission] [then] [Deductible, then] [[0% - 50%] of AC*] [[0 - \$500] per day, not to exceed a total of [3x - 5x the daily amount] per admission] [after Deductible] [;] [Deductible waived]
<b>Telemedicine Services</b>	[[No charge] [[0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
<b>Therapy and Rehabilitation Services</b> (Refer to Section 3 for benefit maximums)	[[No charge] [[0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
[Inpatient Services	[[Applicable inpatient Cost Shares will apply]
Outpatient Services	[No charge] [[0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
<b>Note:</b> All Services received in one day for multidisciplinary rehabilitation Services at a day treatment program will be considered one visit.]	
<b>Transplants</b>	[No charge][[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Applicable Cost Shares will apply based on place and type of Service]
<b>Urgent Care</b>	[[No charge] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
[Office visit during regular office hours	[Applicable office visit Cost Share will apply]
After-Hours Urgent Care or Urgent Care Center]	[No charge] [[0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
<b>[Vision [Exam] Services</b>	[[No charge] [Applicable Cost Shares will apply, based on type and place of Service] [[0% - 50%] of AC*] [after Deductible] [;]

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# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

<b>Copayments and Coinsurance</b>	
Covered Service	You Pay [after Deductible]
	[Deductible waived] ]
<p>[[Eye exams (for adults age 19 or older)</p> <ul style="list-style-type: none"> <li>• by an Optometrist</li> </ul> <p>[Routine eye exam once per [contract] [calendar][policy] year]</p> <ul style="list-style-type: none"> <li>• by an Ophthalmologist]</li> </ul> <p>[Member may opt to have frames and lenses or contacts, but not both in a [contract] [calendar] [policy] year]</p> <p>[Eyeglass [lenses and] frames</p>	<p>[ [No charge][[\$0 - \$100] per visit] [,then] [;] [[0% - 80%] of AC*] [after Deductible] [;] [Deductible waived] [Copayment waived for children under [24 months][2 – 22] [years] of age]</p> <p>[No charge] [[\$0 - \$100] per visit] [,then] [[0% - 80%] of AC*] [after Deductible] [;] [Deductible waived]</p> <p>[You receive a 25% discount off retail price** for eyeglass lenses and for eyeglass frames [once per [contract][calendar] [policy] year].] [You receive a [\$40 - \$1,000] discount for eyeglass lenses and a [\$40 - \$500] discount for eyeglass frames [once per [contract][calendar] [policy] year].] [You receive a [\$50 - \$500] allowance on frames, lenses and/or contact lenses, combined [, once per [every 2] [contract][calendar] [policy] year[s]. ]] [[\$100 - 1,000] allowance on frames; correction lenses covered in full [once per [every 2] [contract] [calendar] [policy] year[s]. ] [You receive a maximum allowance of [\$50 - \$1000] for all covered vision Services, other than eye exams [, per [every 2] [contract][calendar] [policy] year[s]. ]] [Not covered] [No charge] [Member pays balance after Plan pays] [\$50 - \$500]] [Member pays 20% - 100% of retail price**] [You receive a [\$20 - \$500] allowance toward wholesale cost. If frame is more than allowance member pays [2] times the difference between wholesale cost and allowance] ]</p>
<p>Eyeglass lenses]</p> <ul style="list-style-type: none"> <li>• [Single Vision]</li>   <li>• [Bifocal]</li>   <li>• [Trifocal]</li>   <li>• [Lenticular]</li> </ul>	<p>[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]</p> <p>[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]</p> <p>[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]</p> <p>[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]</p>

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**YOUR GROUP EVIDENCE OF COVERAGE (EOC)  
KAISER PERMANENTE**

**Copayments and Coinsurance**

Covered Service	You Pay [after Deductible]
[Scratch Resistant] [Anti-reflective Coating (ARC)]	
<ul style="list-style-type: none"> <li>• [Standard]</li> </ul>	[Not covered] [No charge] [Member pays balance after Plan pays] [\$50 - \$500]
<ul style="list-style-type: none"> <li>• [Premium]</li> </ul>	[Not covered] [No charge] [Member pays balance after Plan pays] [\$50 - \$500]
<ul style="list-style-type: none"> <li>• [Ultra]</li> </ul>	[Not covered] [No charge] [Member pays balance after Plan pays] [\$50 - \$500]
[Contact lenses] [in lieu of frames and lenses]	
	[20% - 100% of retail price**] [ Member pays balance after Plan pays [\$50 - \$500] [You receive a [15% - 25%] discount off retail price on initial pair of contact lenses] [You receive a [\$50 - \$250] allowance on frames, lenses and/or contact lenses, combined, once per [every 2] [contract][calendar] [policy] year[s] ] [You receive a \$[50 - 500] allowance on [initial pair of ] contact lenses [once per [every 2] [contract] [calendar] [policy] year[s] ] [You receive a maximum allowance of [\$50 - \$1000] for all covered vision Services, other than eye exams, per [every 2] [contract][calendar] [policy] year[s] ]
<ul style="list-style-type: none"> <li>• [Medically Necessary]</li> </ul>	[No charge] [20% - 100% or retail price**] [with prior approval] [Member pays balance after Plan pays [\$50 - \$500]
<ul style="list-style-type: none"> <li>• [Medical Multifocal]</li> </ul>	[Not covered] [No charge] [20% - 100% of retail price**] [with prior approval] [Member pays balance after Plan pays [\$50 - \$500]
<ul style="list-style-type: none"> <li>• [Cosmetic]</li> </ul>	[Not covered] [No charge] [20% - 100% of retail price**] [with prior approval] [Member pays balance after Plan pays [\$50 - \$500]

[**Note:** A child may select any pair of glasses in lieu of, or in addition to, the eyeglasses or contact lenses available at no charge under Vision Services for children below and receive the discount at any Plan Vision Center.]

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

## Copayments and Coinsurance

Covered Service	You Pay [after Deductible]
<b>[Vision Services (for children under age 19)]</b>	
Eye exams	
<ul style="list-style-type: none"> <li>by an Optometrist</li> </ul>	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
<ul style="list-style-type: none"> <li>by an Ophthalmologist</li> </ul>	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Eyeglass lenses and frames (Limited to a select group)	No charge for one pair per [contract] [calendar] [policy] year
Contact lenses (Limited to a select group)	No charge for initial fit and first purchase per [contract] [calendar] [policy] year
Medically necessary contact lenses (Limited to a select group)	No charge
Low Vision Aids (Unlimited from available supply)	No charge]
<b>X-ray, Laboratory and Special Procedures</b>	
	[[No charge] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
[Inpatient diagnostic imaging, interventional diagnostic tests, laboratory tests, specialty imaging and special procedures	[No charge] [Applicable inpatient Cost Shares will apply]
Outpatient diagnostic imaging, interventional diagnostic tests, and laboratory tests	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Outpatient specialty imaging (including CT, MRI, PET Scans, and Nuclear Medicine); Interventional Radiology and special procedures	[No charge] [[\$0 - \$500] per test] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Sleep lab	[[No charge] [[\$5 - \$500] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ] ]
Sleep studies	[[No charge] [[\$5 - \$500] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ] ]
[Note: charges for covered outpatient diagnostic and laboratory tests performed in a Plan Physician's office are included in the office visit Copayment.] ]	

\*AC means Allowable Charge

\*\* "Retail price" means the price that would otherwise be charged for the lenses, frames or contacts at the KP Vision Care Center on the day purchased.

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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## [[Out-of-Pocket Maximum]

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[The Out-of-Pocket Maximum is the limit to the total amount of [Deductible] [,] [Copayments] [and] Coinsurance you must pay in a [contract] [policy] [calendar] year for [the Basic Health] Services covered under this EOC [as shown below]. Once you or your Family Unit have met your Out-of-Pocket Maximum, you will not be required to pay any additional [Cost Shares] [Coinsurance] for [Basic Health] [most] Services [that are subject to the out-of-pocket maximum] for the rest of the [contract] [policy] [calendar] year.

**[[Self-Only] [Individual] Coverage Out-of-Pocket Maximum.** If you are covered as a Subscriber, and you do not have any Dependents covered under this EOC, your medical expenses apply toward the [Self-Only] [Individual] Out-of-Pocket Maximum shown below.]

**[Family Coverage Out-of-Pocket Maximum.** If you have one or more Dependents covered under this EOC, the covered medical expenses incurred by all Members of the Family Unit together apply toward the Family Out-of-Pocket Maximum shown below; however no one family Member's medical expenses may contribute more than the Individual Out-of-Pocket Maximum shown below. After one member of a Family Unit has met the Individual Out-of-Pocket Maximum, his or her Out-of-Pocket Maximum will be met for the rest of the [calendar][contract][policy] year. Other family Members will continue to pay applicable Cost Shares until the Family Out-of-Pocket Maximum is met. After all Members of the Family Unit combined have met the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be met for all Members of the Family Unit for the rest of the [calendar][contract] [policy] year.]

**[Family Coverage Out-of-Pocket Maximum.** If you have one or more Dependents covered under this plan, the medical expenses of one or more Members of your Family Unit together apply towards the family Out-of-Pocket Maximum shown below. The Individual Out-of-Pocket Maximum shown below does not apply with family coverage.]

[Except as excluded below, the following Services are considered "Basic Health Services" that apply toward the Out-of-Pocket Maximum:

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

[Member payments for all Services apply to the Out-of-Pocket Maximum.]

### **[Out-of-Pocket Maximum Exclusions:**

The following Services, if covered, [are *not* considered Basic Health Services and] *do not* apply toward your Out-of-Pocket Maximum:

- [Outpatient drugs, supplies and supplements, including blood, blood products, and medical foods]
- [Outpatient durable medical equipment and prosthetic and orthotic devices]
- [Inpatient and outpatient infertility Services]
- [Eyeglass lenses and frames, contact lenses]
- [[Acupuncture] [and] [chiropractic] Services]
- [Ambulance Services]
- [Adult vision exams]

[Member payments for Services that are not subject to the Deductible (as listed above in the schedule) *do not* apply to the Out-of-Pocket Maximum.]

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

**Notice of Out-of-Pocket Maximum.** We will also keep accurate records of your out-of-pocket expenses and will notify you when you have reached the maximum. We will send you written notice no later than 30 days after we

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have received and processed your claims that the Out-of-Pocket Maximum is reached. If you have exceeded your Out-of-Pocket Maximum, we will promptly refund to you any [Copayments or] Coinsurance charged after the maximum was reached.]

<p><b>[Annual Out-Of-Pocket Maximum]</b> Combined total of [Deductible and] allowable [Copayments and] Coinsurance</p>	
<p><b>[[Self-Only] [Individual] Out-of-Pocket Maximum]</b></p>	<p>[[ \$0 - \$10,000] per individual per [contract] [calendar] [policy] year]</p>
<p><b>[Family Out-of-Pocket Maximum]</b></p>	<p>[2x - 3x individual Out-of-Pocket Maximum] [\$500 - \$30,000] per Family Unit per [contract] [calendar] [policy] year]</p>

### [[Out-of-Pocket Maximum]

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

**[[Self-Only] [Individual] Coverage Out-of-Pocket Maximum.** If you are covered as a Subscriber, and you do not have any Dependents covered under this EOC, your medical expenses apply toward the [Self-Only] [Individual] Out-of-Pocket Maximum shown below.]

**[Family Coverage Out-of-Pocket Maximum.** If you have one or more Dependents covered under this EOC, the covered medical expenses incurred by all Members of the Family Unit together apply toward the Family Out-of-Pocket Maximum shown below; however no one family Member's medical expenses may contribute more than the Individual Out-of-Pocket Maximum shown below. After one member of a Family Unit has met the Individual Out-of-Pocket Maximum, his or her Out-of-Pocket Maximum will be met for the rest of the [calendar][contract][policy] year. Other family Members will continue to pay applicable Cost Shares until the Family Out-of-Pocket Maximum is met. After all Members of the Family Unit combined have met the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be met for all Members of the Family Unit for the rest of the [calendar][contract] [policy] year.]

**[Family Coverage Out-of-Pocket Maximum.** If you have one or more Dependents covered under this EOC, the medical expenses of all Members of your Family Unit together apply towards the family Out-of-Pocket Maximum shown below. After one or more covered 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 [contract] [calendar] [policy] year. The Individual Out-of-Pocket Maximum shown below does not apply with family coverage.]

**[Individual within Family Coverage Out-of-Pocket Maximum.** There is a maximum to the total dollar amount of Copayments and Coinsurance that you must pay for covered Services that you receive within the same Year. If you are the only Member in your Family, then you must meet the Individual within Family Out-of-Pocket Maximum. If you are a Member in a Family of two or more Members, then either you must each meet the Individual within Family Out-of-Pocket Maximum, or your entire Family must meet the Family Out-of-Pocket Maximum. Each Individual within Family Out-of-Pocket Maximum amount counts toward the Family Out-of-Pocket Maximum amount. The Self-Only Out-of-Pocket Maximum, Individual within Family Out-of-Pocket Maximum, and Family Out-of-Pocket Maximum amounts are shown below.]

**[Out-of-Pocket Maximum Exclusions:**

The following Services do not apply toward your Out-of-Pocket Maximum:

- [Adult eyeglass lenses and frames, contact lenses that are available with a discount only]
- [Adult dental Services, if included by Rider attached to this plan]
- [Adult routine eye exams] ]
- [In vitro fertilization]

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# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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- [Inpatient and outpatient infertility Services and drugs]

[Member payments for Services that are not subject to the Out-of-Pocket Maximum (as listed above in the schedule) *do not* apply to the Deductible.]

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

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

<p><b>[Annual Out-Of-Pocket Maximum]</b> Combined total of [Deductible and] allowable [Copayments and] Coinsurance</p>	
<p><b>[[Self-Only] [Individual] Out-of-Pocket Maximum]</b></p>	<p>[[ \$0 - \$10,000] per individual per [contract] [calendar] [policy] year]</p>
<p><b>[Individual within Family Out-of-Pocket Maximum]</b></p>	<p>[[ \$0 - \$10,000] per individual Family member per [contract] [calendar] [policy] year]</p>
<p><b>[Family Out-of-Pocket Maximum]</b></p>	<p>[2x - 3x individual Out-of-Pocket Maximum] [\$500 - \$20,000] per Family Unit per [contract] [calendar] [policy] year]</p>

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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## SECTION 3: BENEFITS

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The Services described in this section are covered only if all of the following conditions are met:

1. You are a Member on the date the Services are rendered;
2. [You have met any Deductible requirement described in the "Deductible" section of the Summary of Services and Cost Shares Appendix.]
3. The Services are provided:
  - a. By a Plan Provider; or
  - b. By a non-Plan Provider, subject to an approved referral as described in Section 2; and
  - c. In accordance with the terms and conditions within this EOC including but not limited to the requirements, if any, for prior approval (authorization);
4. The Services are Medically Necessary; and
5. You receive the Services from a Plan Provider except as described within this EOC.

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

1. Emergency Services;
2. Urgent Care outside our Service Area;
3. Authorized referrals to non-Plan Providers (as described in Section 2: How to Obtain Services)[.]; and]
4. [Receiving care in another Kaiser Foundation Health Plan Service Area in Section 2: How to Obtain Services.]

### **Exclusions and Limitations:**

Exclusions and limitations that apply only to a particular benefit are described in this section. Other exclusions, limitations, and reductions that affect all benefits are described in Section 4: Exclusions, Limitations and Reductions .

**Note:** The “Summary of Services and Cost Shares” Appendix lists the Copayments, Coinsurances and Deductibles that apply to the following covered Services. Your Cost Share will be based on the type and place of Service.

### **A. OUTPATIENT CARE**

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We cover the following outpatient care:

1. Primary care visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics/gynecology (OB/GYN) Services (Refer to “Preventive Health Care Services” for coverage of preventive care Services);
2. Specialty care visits (Refer to “Referrals to Plan Providers” in Section 2: How to Obtain Services for information about referrals to Plan specialists);
3. [Consultations and immunizations for foreign travel;]
4. Diagnostic testing for care or treatment of an illness; or to screen for a disease for which you have been determined to be at high risk for contracting. This includes, but is not limited to:
5. Diagnostic exams, including digital rectal exams and prostate antigen (PSA) tests provided:
  - a. To persons age 40 and older who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society;

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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6. Colorectal cancer screening, specifically: screening with an annual fecal occult blood test; flexible sigmoidoscopy or colonoscopy; or, in appropriate circumstances, radiologic imaging, for persons who are at high risk of cancer. High risk is determined based on the most recently published guidelines of the American College of Gastroenterology, in consultation with the American Cancer Society;
7. Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A “qualified individual” means:
  - a. An estrogen deficient individual at clinical risk for osteoporosis;
  - b. An individual with a specific sign suggestive of spinal osteoporosis. This includes: roentgenographic osteopenia or roentgenographic evidence suggestive of collapse; wedging; or ballooning of one or more thoracic or lumbar vertebral bodies; and who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
  - c. An individual receiving long-term glucocorticoid (steroid) therapy;
  - d. An individual with primary hyper-parathyroidism; or
  - e. An individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;
8. Outpatient surgery physician/surgical Services;
9. Anesthesia, including Services of an anesthesiologist;
10. Chemotherapy and radiation therapy;
11. Respiratory therapy;
12. Medical social Services;
13. House calls when care can best be provided in your home as determined by a Plan Provider; and
14. After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to the Urgent Care provision for covered Services.

(Refer to “Preventive Health Services” for coverage of preventive care tests and screening Services);

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

### **B. HOSPITAL INPATIENT CARE**

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

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

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

### **C. ACCIDENTAL DENTAL INJURY SERVICES**

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We cover restorative Services necessary to promptly repair, but not replace, sound natural teeth that have been injured as the result of an external force. Coverage is provided when all of the following conditions have been met:

1. The accident has been reported to your primary care Plan Physician within seventy-two (72) hours of the accident.
2. A Plan Provider provides the restorative dental Services;
3. The injury occurred as the result of an external force that is defined as violent contact with an external object; not force incurred while chewing;
4. The injury was sustained to sound natural teeth;
5. The covered Services must be requested within [sixty (60) days][six (6) months] of the injury; and
6. The covered Services are provided during the twelve (12) consecutive month period commencing from the date that the injury started.

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

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

#### ***Accidental Dental Injury Services Exclusions:***

- Services provided by non-Plan Providers.
- Services provided after twelve (12) months from the date the injury occurred.
- Services for teeth that have been avulsed (knocked out) or that have been so severely damaged that in the opinion of the Plan Provider, restoration is impossible.

### **D. ALLERGY SERVICES**

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We cover the following allergy Services:

- Evaluations, and treatment ; and
- Injections and serum.

### **E. AMBULANCE SERVICES**

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We cover licensed ambulance Services only if your medical condition requires: (1) the basic life support, advanced life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer; and (2) the ambulance transportation has been ordered by a Plan Provider. Coverage is also provided for Medically Necessary transportation or Services, including Medically Necessary air ambulance transport to the nearest hospital able to provide needed Services, rendered as the result of a 911 call. Your Cost Share will apply to each encounter, whether or not transport was required.

Ambulance transportation from an emergency room to a Plan Facility or from a hospital to a Plan Facility that

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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is both Medically Necessary and ordered by a Plan Provider is covered at no charge.

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

We cover licensed ambulance and non-emergent transportation Services ordered by a Plan Provider only inside our Service Area, except as covered under the “Emergency Services” provision in this section.

### ***Ambulance Services Exclusions:***

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

## **F. ANESTHESIA FOR DENTAL SERVICES**

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

1. For whom a superior result can be expected from dental care provided under general anesthesia; and
2. For whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition.

Additionally, we provide these Services to Members age:

1. 7 or younger or are developmentally disabled.
2. 17 or younger who is extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred, and for whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.
3. 17 and older when the Member’s medical condition requires that dental service be performed in a hospital or ambulatory surgical center for the safety of the Member (e.g., heart disease and hemophilia).

General anesthesia and associated hospital and ambulatory surgical center charges will be covered only for dental care that is provided by:

1. A fully accredited specialist in pediatric dentistry; or
2. A fully accredited specialist in oral and maxillofacial surgery; and
3. For whom hospital privileges have been granted.

### ***Anesthesia for Dental Services Exclusions:***

- The dentist’s or specialist’s professional Services.
- Anesthesia and related facility charges for dental care for temporomandibular joint (TMJ) disorders.

## **G. BLOOD, BLOOD PRODUCTS AND THEIR ADMINISTRATION**

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We cover; blood and blood products, both derivatives and components, including the collection and storage of autologous blood for elective surgery; cord blood procurement and storage for approved Medically Necessary

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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care, when authorized by a Plan Provider; and the administration of prescribed whole blood and blood products.

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

### ***Blood, Blood Products and their Administration Limitations:***

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

### ***Blood, Blood Products and their Administration Exclusions:***

- Directed blood donations.

## **H. CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES**

---

We cover the treatment of treatable mental illnesses, emotional disorders, drug abuse and alcohol abuse for conditions that in the opinion of a Plan Provider, would be responsive to therapeutic management.

For the purposes of this benefit provision: “Drug and alcohol abuse” means a disease that is characterized by a pattern of pathological use of a drug and/or alcohol with repeated attempts to control its use and with significant negative consequences in at least one the following areas of life: medical; legal; financial; or psycho-social.

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

1. Individual therapy;
2. Group therapy;
3. Shock therapy;
4. Drug therapy;
5. Education;
6. Psychiatric nursing care; and
7. Appropriate hospital Services.

Medical Services for detoxification are limited to the removal of the toxic substance or substances from the system. Detoxification will be covered for a minimum of twelve (12) days annually.

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

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

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

1. Evaluations;
2. Crisis intervention;
3. Individual therapy;
4. Group therapy;

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5. Psychological testing;
6. Medical treatment for withdrawal symptoms; and
7. Visits for the purpose of monitoring drug therapy.

### ***Chemical Dependency and Mental Health Services Exclusions:***

- Services in a facility whose primary purpose is to provide treatment for alcoholism, drug abuse, or drug addiction, except as described above.
- Services provided in a psychiatric residential treatment facility, except as described above.
- Services for Members who, in the opinion of the Plan Provider, are seeking Services for non-therapeutic purposes.
- [Applied Behavior Analysis (ABA).]
- Cognitive Behavior Therapy (CBT).
- Psychological testing for ability, aptitude, intelligence, or interest.
- Services on court order or as a condition of parole or probation, unless determined by the Plan Provider to be Medically Necessary.
- Evaluations that are primarily for legal or administrative purposes, and are not Medically Necessary.

### **I. [[CHIROPRACTIC [AND] [ACUPUNCTURE] SERVICES**

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

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

#### ***Chiropractic [and] [Acupuncture] Services Limitation:***

The number of visits needed for the Member to reach the maximum level of recovery will be determined by the Plan Provider [and shall not exceed a total of [ten (10)-ninety (90)] visits per [contract][calendar][policy] year [for each type of Service][for chiropractic Services]; and] [ten (10)-ninety (90) visits per [contract][calendar][policy] year for acupuncture Services.]]

### **J. CLEFT LIP, CLEFT PALATE OR BOTH**

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

### **K. CLINICAL TRIALS**

We cover the routine patient care costs you may incur as an eligible participant in an approved clinical trial undertaken for the purposes of: the prevention, early detection, treatment; or monitoring of cancer, chronic disease, or life-threatening illness.

For the purposes of this benefit, an approved clinical trial means:

1. A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
  - a. The National Institutes of Health (NIH);
  - b. The Centers for Disease Control and Prevention (CDC);

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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- c. The Agency for Health Care Research and Quality;
  - d. The Centers for Medicare and Medicaid Services;
  - e. A bona fide clinical trial cooperative group, including: the National Cancer Institute Clinical Trials Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the AIDS Clinical Trials Group; and the Community Programs for Clinical Research in AIDS; or
  - f. The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;
2. A study or investigation approved by the United States Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA; or
  3. An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

“Routine patient care costs” mean:

1. Items, drugs, and Services that are typically provided absent a clinical trial;
2. Items, drugs, and Services required solely for the provision of the investigational item or service (such as the administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
3. Items, drugs, and Services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

### ***Clinical Trials Exclusions:***

Routine patient care costs shall not include:

- The cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or items, drugs, or Services provided solely to satisfy data collection and analysis needs; or
- Items, drugs, or Services customarily provided by the research sponsors free of charge for any qualified individual enrolled in the trial.

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

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

## **L. DIABETIC EQUIPMENT, SUPPLIES, AND SELF-MANAGEMENT**

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

1. Insulin-using diabetes;

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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

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

### ***Diabetic Equipment and Supplies Limitation:***

Diabetic equipment and supplies are limited to Health Plan preferred equipment and supplies unless the equipment or supply: (1) was prescribed by a Plan Provider and (2) (a) there is no equivalent preferred equipment or supply available or (b) an equivalent preferred equipment or supply (i) has been ineffective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member. "Health Plan preferred equipment and supplies" are those purchased from a Plan preferred vendor.

To obtain information about Plan preferred vendors, contact Member Services:

[Inside the Washington, DC Metropolitan Area: (301) 468-6000]

[Outside of the Washington, DC Metropolitan Area: 1-800-777-7902]

[TTY: 711]

## **M. DIALYSIS**

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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 Provider 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 lab tests, equipment, supplies and other Services associated with your treatment;
2. Inpatient maintenance dialysis if you are admitted to a Plan Hospital because your medical condition requires specialized hospital Services on an inpatient basis; and
3. Plan Provider Services related to inpatient and outpatient dialysis.

We cover the following self-dialysis Services:

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

We cover home dialysis, which includes:

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

Members requiring dialysis outside of the service area for a limited time period, may receive pre-planned dialysis services in accordance to prior authorization requirements.

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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### **N. DRUGS, SUPPLIES, AND SUPPLEMENTS**

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#### **Administered Drugs, Supplies and Supplements**

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

1. Oral infused or injected drugs, and radioactive materials used for therapeutic purposes, including chemotherapy;
2. Injectable devices;
3. The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
4. Medical and surgical supplies including: dressings; splints; casts; hypodermic needles; syringes; or any other Medically Necessary supplies provided at the time of treatment;
5. Vaccines and immunizations approved for use by the FDA that are not considered part of routine preventive care.

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

#### ***Drugs, Supplies and Supplements Exclusions:***

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

### **O. DURABLE MEDICAL EQUIPMENT**

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Durable Medical Equipment is defined as equipment that: (1) is intended for repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) is generally not useful to a person in the absence of illness or injury; and (4) meets the Health Plan criteria for being Medically Necessary.

Durable Medical Equipment does not include coverage for prosthetic devices, such as implants, artificial eyes or legs, or orthotic devices, such as braces or therapeutic shoes. Refer to “Prosthetic Devices” for coverage of internal prosthetic devices, ostomy and urological supplies and breast prosthesis. Additional coverage for external prosthesis and orthotic devices is only covered if a Prosthetic and Orthotic Devices Rider is attached to this EOC.

#### **Basic Durable Medical Equipment**

We cover Durable Medical Equipment as prescribed by a Plan Provider for use in your home (or an institution used as your home). We also cover Durable Medical Equipment used during a covered stay in a Plan Hospital

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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or Skilled Nursing Facility, but only if the Skilled Nursing Facility ordinarily furnishes Durable Medical Equipment.

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

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

### **Supplemental Durable Medical Equipment**

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

#### **Oxygen and Equipment**

We cover oxygen and equipment when prescribed by a Plan Provider and your medical condition meets the Health Plan’s criteria for being Medically Necessary. A Plan Provider must certify the continued medical need for oxygen and equipment.

#### **Positive Airway Pressure Equipment**

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

#### **Apnea Monitors**

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

#### **Asthma Equipment**

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

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

#### **Bilirubin Lights**

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

#### ***Durable Medical Equipment Exclusions:***

- Comfort, convenience, or luxury equipment or features.
- Exercise or hygiene equipment.
- Non-medical items such as sauna baths or elevators.
- Modifications to your home or car.
- Devices for testing blood or other body substances (except as covered under “Diabetes Equipment, Supplies and Self-Management”).
- Electronic monitors of the heart or lungs, except infant apnea monitors.
- Services not preauthorized by the Health Plan.

# **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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## **P. EMERGENCY SERVICES**

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

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

We cover Emergency Services as follows:

### **Inside our Service Area**

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

### **Outside of our Service Area**

We cover reasonable charges for Emergency Services if you are injured or become ill while temporarily outside of our Service Area.

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

### **Continuing Treatment Following Emergency Services**

#### **Inside our Service Area**

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

#### **Inside another Kaiser Permanente Region**

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

#### **Outside our Service Area**

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

#### **Transport to a Service Area**

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

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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Health Plan Region, for continuing or follow-up treatment. **Note:** All ambulance transportation is covered under the “Ambulatory Services” benefit in this section.

### **Continued Care in Non-Plan Facility Limitation**

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

### **Filing Claims for Non-Plan Emergency Services**

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

### **Emergency Services HIV Screening Test**

We cover the cost of a voluntary HIV screening test performed on a Member while the Member is receiving emergency medical Services, other than HIV screening, at a hospital emergency room. The test is covered whether or not the HIV screening test is necessary for the treatment of the medical emergency which caused the member to seek Emergency Services.

Covered Services include:

1. The costs of administering such a test;
2. All lab costs to analyze the test; and
3. The costs of telling the Member the results of the test; and any applicable follow-up instructions for obtaining health care and supportive Services.

Other than the Cost Share shown in the Summary of Services and Cost Shares for Emergency Services, no additional Cost Share will be imposed for these Services.

### ***Emergency Services Limitations:***

- **Notification:** If you receive care at a hospital emergency room or are admitted to a non-Plan Hospital, you, or someone on your behalf, must notify us as soon as possible, but not later than 48 hours or the next business day, whichever is later, of the emergency room visit or hospital admission, unless it was not reasonably possible to notify us. If you are admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us as provided herein, we will not cover the emergency room visit, or hospital care you receive after transfer would have been possible.
- **Continuing or Follow-up Treatment:** Except as provided for under “Continuing Treatment Following Emergency Surgery,” we do not cover continuing or follow-up treatment after Emergency Services unless authorized by Health Plan. We cover only the out-of-Plan emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Foundation Health Plan or allied plan service area.

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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

### **Q. [FAMILY PLANNING SERVICES]**

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We cover the following:

1. [Women’s Preventive Services (WPS), including:
  - a. Patient education and contraceptive method counseling for all women of reproductive capacity;
  - b. Coverage for: FDA-approved contraceptive devices; hormonal contraceptive methods; and the insertion or removal of contraceptive devices. This includes any Medically Necessary exams associated with the use of contraceptive drugs and devices; and
  - c. Female sterilization.
    - i. (Note: WPS are preventive care and are covered at no charge.)]
2. [Additional family planning counseling[, including pre-abortion and post-abortion counseling][.][;][; and]
3. [Vasectomies][.][;][; and]
4. [[Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (i) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (ii) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.]

#### ***Voluntary termination of pregnancy limitations:***

- We cover up to a maximum of two voluntary terminations of pregnancy during a contract year.]]
1. [[Family planning counseling [, including pre-abortion and post-abortion counseling] and information on birth control.]
  2. [Insertion and removal, and any Medically Necessary exams associated with the use of contraceptive drugs and devices. Contraceptive devices (other than diaphragms) and implantable contraceptive drugs are supplied by the provider, and are covered under this benefit. Contraceptive drugs and diaphragms are covered only under an “Outpatient Prescription Drug Rider”, if applicable.]
  3. [Tubal ligations.]
  4. [Vasectomies.]
  5. [[Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (i) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (ii) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.]

#### ***Voluntary termination of pregnancy limitations:***

- We cover up to a maximum of two (2) voluntary terminations of pregnancy during a contract year.]]

**Note:** Diagnostic procedures are covered, but not under this section (see “X-ray, Laboratory and Special Procedures”).]

### **R. HABILITATIVE SERVICES**

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#### **[Children under age 21]**

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We cover Medically Necessary Services, including speech therapy, occupational therapy and physical therapy, for children under the age of 21 years with a congenital or genetic birth defect, to enhance the child's ability to function. Medically Necessary Habilitative Services are those Services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, and shall include Services that enhance functional ability without effecting a cure. Congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. The term congenital or genetic birth defect includes: (1) autism or an autism spectrum disorder and (2) cerebral palsy.

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

### **[Adults age 21 or older]**

We cover Medically Necessary Habilitative Services that are designed to enhance a Member's functional ability, without effecting a cure, for the treatment of autism or an autism spectrum disorder, "Medically Necessary Habilitative Services" include occupational therapy, physical therapy, speech therapy, and (ABA).]

### ***Habilitative Services Exclusions:***

- Assistive technology Services and devices.
- Services provided through federal, state or local early intervention programs, including school programs.
- Services not preauthorized by Health Plan.
- Services for a Member that has plateaued and is able to demonstrate stability of skills and functioning even when Services are reduced.
- Services not provided by a licensed or certified therapist.

## **S. HEARING SERVICES**

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### **[Hearing Exams]**

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

### **[Hearing Aids]**

We cover the following:

1. Medically Necessary hearing aids for both children and adults. Hearing aid means an electronic device worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing including an ear mold, if necessary.
2. Hearing aid evaluations and diagnostic procedures to determine the hearing aid model which will best compensate for loss of hearing.
3. Visits to verify that the hearing aid conforms to the prescription.
4. Visits for fitting, counseling, adjustment, cleaning, and inspection.

### ***Hearing Aid Limitations:***

- [Your hearing aid Benefit Allowance is [\$500 – \$5,000].
- [Coverage is provided for one Hearing Aid for each hearing impaired ear every [twelve (12) – sixty (60)] months. Two Hearing Aids are covered every [twelve (12) – sixty (60)] months only if both are required to provide significant improvement that is not obtainable with only one Hearing Aid, as determined by your Plan Provider.]

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- [You are not required to obtain Hearing Aids for both ears at the same time. The [twelve (12) – sixty (60)] month benefit period extends separately for each ear, and commences at the initial point of sale for each ear.]
- [The hearing aid Benefit Allowance must be used at the initial point of sale for each hearing aid. Any part of the hearing aid Benefit Allowance that is not exhausted at the initial point of sale may not be used at a later time.]
- [The type of Hearing Aid is limited to the models provided by Kaiser Permanente or the Kaiser Permanente-designated Hearing Aid vendor.]

[You may apply the hearing aid Benefit Allowance toward a hearing aid upgrade. However, you must pay the difference in the hearing aid Benefit Allowance and the cost of the hearing aid upgrade.]]

### ***Hearing Services Exclusions:***

- [Tests to determine an appropriate hearing aid.
- Hearing aids or tests to determine their efficacy.]
- [Replacement of parts and batteries.
- Replacement of lost or broken hearing aid.
- Repair of hearing aid beyond one year.
- Comfort, convenience, or luxury equipment or features.
- Hearing aids prescribed and ordered prior to coverage or after termination of coverage]

## **T. HOME HEALTH CARE**

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

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

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

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

### **Home Health Visits Following Mastectomy or Removal of Testicle**

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

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

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### ***Home Health Care Limitations:***

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

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

Additional limitations may be stated in the “Summary of Services and Cost Share.”

### ***Home Health Care Exclusions:***

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

## **U. HOSPICE CARE**

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

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

1. Nursing care;
2. Physical, occupational, speech, and respiratory therapy;
3. Medical social Services;
4. Home health aide Services;
5. Homemaker Services;
6. Medical supplies and appliances;
7. Palliative drugs in accord with our drug formulary guidelines;
8. Physician care;
9. General hospice inpatient Services for acute symptom management including pain management;
10. Respite Care that may be limited to five (5) consecutive days for any one inpatient stay up to 4 times in any contract year;

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11. Counseling Services for the Member and his Family Members, including dietary counseling for the Member; and bereavement counseling for the Member's Family for a period of one year after the Member's death; and
12. Services of hospice volunteers.

### **Definitions:**

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

### **V. [INFERTILITY SERVICES]**

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We cover the following:

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

### **Note[s]:**

1. Involuntary infertility means the inability to conceive after one (1) year of unprotected vaginal intercourse.
2. Diagnostic procedures and any covered drugs administered by or under the direct supervision of a Plan Provider are covered under this provision. Refer to the Prescription Drug Rider, if applicable, for coverage of outpatient infertility drugs.
3. [ [In vitro fertilization, if:
  - a. [The Member's oocytes are fertilized with the Member's spouse's sperm; and]
  - b. The [Member has][Member's and the Member's spouse have] a history of infertility of at least two (2) years duration; or the infertility is associated with any of the following:
    - i. Endometriosis;
    - ii. Exposure in utero to diethylstilbestrol, commonly known as DES;
    - iii. Blockage of, or surgical removal of, one (1) or both fallopian tubes (lateral or bilateral salpingectomy); or
    - iv. Abnormal male factors, including oligospermia, contributing to the infertility;
  - c. The Member has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this EOC; and
  - d. The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or the American Fertility Society minimal standards for programs of in vitro fertilization.]
4. Intracytoplasmic Sperm Injection (ICSI) if the Member meets medical guidelines;

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5. Preimplantation Genetic Diagnosis (PGD) if the Member meets medical guidelines[.];]
6. [Gamete intrafallopian transfers (GIFT); and
7. Zygote intrafallopian transfers (ZIFT).]

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

### ***[Infertility Limitations:***

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

### ***Infertility Services Exclusions:***

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

## **W. INFUSION THERAPY SERVICES**

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

## **X. MATERNITY SERVICES**

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

Services for pre-existing conditions care related to the development of a high risk condition(s) during pregnancy, and non-routine obstetrical care are covered subject to applicable Cost Share for specialty, diagnostic, and/or treatment Services.

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

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

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

Comprehensive lactation (breastfeeding) education and counseling, by trained clinicians during pregnancy and/or postpartum period in conjunction with each birth, Breastfeeding equipment is issued, per pregnancy. The breast feeding pump (including any equipment that is required for pump functionality) is covered for six (6) months at no cost sharing to the member.

### ***Maternity Services Exclusions***

- Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.

## **Y. MEDICAL FOODS**

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

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

Low protein modified foods are food products that are (1) specially formulated to have less than one (1) gram of protein per serving, and (2) intended to be used under the direction of a Plan Provider for the dietary treatment of an inherited metabolic disease.

### ***Medical Foods Exclusions:***

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

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

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

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

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

### ***Amino Acid Based Elemental Formula Exclusions:***

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

## **Z. MORBID OBESITY**

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We cover diagnosis and treatment of morbid obesity including gastric bypass surgery or other surgical method that is recognized by the National Institutes of Health (NIH) as effective for long-term reversal of morbid obesity, and is consistent with criteria approved by the NIH.

Morbid obesity is defined as:

1. A weight that is at least one-hundred (100) pounds over or twice the ideal weight for a patients frame, age, height, and gender, as specified in the 1983 Metropolitan Life Insurance tables; or
2. A body mass index (BMI) that is equal to or greater than thirty-five (35) kilograms per meter squared with a comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary condition, sleep apnea, or diabetes; or
3. A BMI of forty (40) kilograms per meter squared without such comorbidity.

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

### ***Morbid Obesity Services Exclusions***

- Services not preauthorized by the Health Plan

## **AA. ORAL SURGERY**

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

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

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

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

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

1. Evidenced through documented medical records showing significant impairment in speech or a nutritional deficit; and

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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2. Based on examination of the Member by a Plan Provider.

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

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

### ***Oral Surgery Exclusions:***

- Oral surgery Services when the functional aspect is minimal and would not in itself warrant surgery.
- Lab fees associated with cysts that are considered dental under our standards.
- Medical and dental Services for treatment TMJ.
- Orthodontic Services.
- Dental appliances.

### **BB.PREVENTIVE HEALTH CARE SERVICES**

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

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

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

[We cover medically appropriate preventive health care Services based on your age, sex, or other factors, as determined by your primary care Plan Physician pursuant to national preventive health care standards.

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

1. Preventive care exams, including:
  - a. Routine physical examinations and health screening tests appropriate to your age and sex;

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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- b. Well-woman examinations; and
- c. Well child care examinations;
2. Routine and necessary immunizations [(travel immunizations are not preventive and are covered under Outpatient Services in this section)] for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;
3. An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
4. Low dose screening mammograms to determine the presence of breast disease is covered as follows:
  - a. One mammogram for persons age 35 through 39;
  - b. One mammogram biennially for persons age 40 through 49; and
  - c. One mammogram annually for person 50 and over;
5. Bone mass measurement to determine risk for osteoporosis;
6. Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to men who are age 40 or older;
7. Colorectal cancer screening in accordance with screening guidelines issued by the American Cancer Society including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy;
8. Cholesterol test (lipid profile);
9. Diabetes screening (fasting blood glucose test);
10. Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis and HPS), subject to the following:
  - a. Annual chlamydia screening is covered for (a) women under age of 20, if they are sexually active; and (b) women age 20 years of age or older, and men of any age, who have multiple risk factors, which include: (i) a prior history of sexually transmitted diseases; (ii) new or multiple sex partners; (iii) inconsistent use of barrier contraceptives; or (iv) cervical ectopy;
  - b. Human Papillomavirus Screening (HPS) as recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;
11. HIV tests;
12. TB tests;
13. Newborn hearing screenings that include follow up audiological examinations, as recommended by a physician or audiologist, and performed by a licensed audiologist to confirm the existence or absence of hearing loss when ordered by a Plan Provider; [and]
14. Associated preventive care radiological and lab tests not listed above[.]; [and]
15. [BRCA counseling and genetic testing is covered a no Cost Share. Any follow up Medically Necessary treatment is covered at the applicable Cost Share based upon type and place of Service][.]; [and]
16. CT scan of the Thorax when ordered as a preventive for smokers age 55 to 80 years of age.]

### ***Preventive Health Services Limitation:***

While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services. Applicable Cost Shares will apply.

- Monitoring a chronic disease;
- Follow-up Services after you have been diagnosed with a disease;

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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- Testing and diagnosis for specific diseases for which you have been determined to be at high risk for contracting based on factors determined by national standards;
- Services provided when you show signs or symptoms of a specific disease or disease process;
- Non-routine gynecological visits; and
- Treatment of a medical condition or problem identified during the course of a preventive screening exam.

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

### **CC. PROSTHETIC DEVICES**

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We cover the devices listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is ill or injured. Coverage includes fitting and adjustment of these devices, repair or replacement (unless due to loss or misuse), and Services to determine whether you need the prosthetic. If we do not cover the prosthetic, we will try to help you find facilities where you may obtain what you need at a reasonable price. Coverage is limited to the standard device that adequately meets your medical needs.

#### **Internally Implanted Devices**

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

#### **Ostomy and Urological Supplies**

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

#### **Breast Prosthetics**

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

#### ***Breast Prosthetics Limitation:***

- Coverage for mastectomy bras is limited to a maximum of two (2) per [calendar][contract] [policy] year.

#### ***Prosthetic Devices Exclusions:***

- Services not preauthorized by Health Plan.
- Internally implanted breast prosthetics for cosmetic purposes.
- External prosthetics, except as provided in this section under “Cleft-Lip, Cleft Palate, or Both”, “Hearing Services”, or as provided under a “Prosthetic and Orthotic Devices Rider”, if applicable.
- Repair or replacement of prosthetics devices due to loss or misuse.
- [Hair Prostheses.]
- Microprocessor and robotic controlled external prosthetics and orthotics that does not meet the Health Plan criteria as Medical Necessary.

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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- Multifocal intraocular lens implants.

### **DD. RECONSTRUCTIVE SURGERY**

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We cover reconstructive surgery. This shall include plastic, cosmetic and related procedures required to: (1) to correct significant disfigurement resulting from an injury or Medically Necessary surgery, (2) to correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function, and (3) to treat congenital hemangioma known as port wine stains on the face for Members age 18 or younger, (4) breast augmentation is covered only if determined to be Medical Necessary.

Following mastectomy, we cover reconstructive breast surgery and all stages of reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. Mastectomy is the surgical removal of all or part of a breast as a result of breast cancer. Reconstructive breast surgery is surgery performed as a result of a mastectomy to reestablish symmetry between the two (2) breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

#### ***Reconstructive Surgery Exclusions:***

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

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

### **EE. SKILLED NURSING FACILITY CARE**

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

We cover the following Services:

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

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

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

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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### ***Skilled Nursing Facility Care Exclusions:***

- Custodial care (see definition under “Exclusions” in Section 4: Exclusions, Limitations, and Reductions).
- Domiciliary care.

### **FF. TELEMEDICINE SERVICES**

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

Telemedicine Services means the delivery of healthcare Services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Not all medical services are conducive to telemedicine, as such the provider will make a determination whether the member should instead be seen in a face-to-face medical office setting.

### ***Telemedicine Services Exclusion:***

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

### **GG. THERAPY AND REHABILITATION SERVICES**

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#### **Physical, Occupational, and Speech Therapy Services**

If, in the judgment of a Plan Provider, significant improvement is achievable within a two (2)-month period, we cover physical, occupational and speech therapy[:

1. While you are confined in Plan Hospital; and
2. For up to [twenty (20)-ninety (90)] visits [[or] ninety (90) consecutive days] of physical therapy [whichever is longer], [twenty (20)-ninety (90)] visits [[or] ninety (90) consecutive days] of occupational therapy, and [twenty (20)-ninety (90)] visits [[or] ninety (90) consecutive days] of speech therapy per [contract] [policy] [calendar] year per injury, incident or condition in a Plan Medical Center, a Plan Provider’s medical office, a Skilled Nursing Facility or as part of home health care. [These limits do not apply to necessary treatment of cleft lip or cleft palate.]]

#### ***Physical, Occupational, and Speech Therapy Services Limitations:***

- Physical therapy is limited to treatment to restore physical function that was lost due to injury or illness. It is not covered to develop physical function, except as provided for under “Habilitative Services” in this section.
- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Speech therapy is limited to treatment for speech impairments due to injury or illness.

#### **Multidisciplinary Rehabilitation Services**

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

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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

***Multidisciplinary Rehabilitation Services Limitations:***

- The limitations listed above for physical, occupation and speech therapy also applies to those Services when provided within a multidisciplinary program.

**Cardiac Rehabilitation Services**

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

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

**[Pulmonary Rehabilitation Services**

We cover pulmonary rehabilitation Services that are Medically Necessary; limited to one (1) program per lifetime.]

***Therapy and Rehabilitation Services Exclusion:***

- Long-term rehabilitative therapy.

### **HH. TRANSPLANT SERVICES**

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

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

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

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

***Transplant Services Exclusions:***

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

### **II. URGENT CARE**

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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).

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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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 Office please call:

[Inside the Washington, DC Metropolitan Area: (301) 468-6000]

[Outside of the Washington, DC Metropolitan Area: 1-800-777-7902]

[TTY: 711]

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

### **Outside of our Service Area**

If you are injured or become ill while temporarily outside of the Service Area, we will cover reasonable charges for Urgent Care Services as defined in this section. 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 Plan Medical Office in the Service Area, or in the nearest Kaiser Foundation Health Plan Region for continuing or follow-up treatment.

### ***Urgent Care Limitations:***

We do not cover Services outside of our Service Area for conditions that, before leaving the Service Area, you should have known might require Services while outside 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 an extreme personal emergency.

### ***Urgent Care Exclusions:***

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

## **JJ. VISION [EXAM] SERVICES**

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### **Medical Treatment**

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

### ***[Vision Services Exclusions:***

- All Services related to vision correction, including but not limited to, eye exams to determine the need for vision correction and to provide a prescription for corrective lenses.
- Eyeglass lenses and eyeglass frames.
- Eye exercises.
- All Services related to contact lenses including: exams, fitting, dispensing, and follow-up visits.

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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- Orthoptic (eye training) therapy.
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism, including but not limited to radial keratotomy, photo-refractive keratectomy, and similar procedures.]

[**Note:** Discounts are available as a Value Added Service for lenses and frames.]

### **Eye Exams**

We cover routine and necessary eye exams, including:

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

### ***Vision Exam Services Exclusions:***

- Eyeglass lenses and eyeglass frames.
- Eye exercises.
- All Services related to contact lenses including: exams, fitting, dispensing, and follow-up visits.
- Orthoptic (eye training) therapy.]]

### **Pediatric Eye Exams**

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

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

### **Pediatric Lenses and Frames**

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

1. One (1) pair of lenses per year;
2. One (1) pair of frames per year from a select group of frames;
3. Regular contact lenses (in lieu of lenses and frames) for the first regular supply for that contact lens per year; or
4. Medically Necessary contact lenses up to two (2) pair per eye per year.]

[In addition, we cover the following Services:

### **Eyeglass Lenses**

[We provide a discount on the purchase of regular eyeglass lenses, including add-ons, when purchased at a Kaiser Permanente Optical Shop. Regular eyeglass lenses are any lenses with a refractive value. If only one eye needs correction, we also provide a balance lens for the other eye. ] [We cover the purchase of eyeglass lenses at no charge when purchased at a Kaiser Permanente Optical Shop.]

### **Frames**

[We provide a discount on the purchase of eyeglass frames, when purchased at a Kaiser Permanente Optical Shop. The discount includes the mounting of eyeglass lenses in the frame, original fitting of the frame, and subsequent adjustment. ] [We cover the purchase of eyeglass frames at no charge when purchased at a Kaiser Permanente Optical Shop.]

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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### **Contact Lenses**

[We cover the [initial] purchase of contact lenses at no charge when purchased at a Kaiser Permanente Optical Shop.] [We cover the initial fitting for contact lenses at no charge when purchased at a Kaiser Permanente Optical Shop.] [We provide a discount on the initial fitting for contact lenses, when purchased at a Kaiser Permanente Optical Shop. Initial fitting means the first time you have ever been examined for contact lens wear at a Plan Facility. The discount includes the following Services:

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

[You will also receive a discount on your initial purchase of contact lenses, if you choose to purchase them at the same time.] [Note: Additional contact lens Services are available without the discount from any Kaiser Permanente Optical Shop.]

### ***[Vision Exclusions:***

- Industrial and athletic safety frames.
- Eyeglass lenses and contact lenses with no refractive value.
- Sunglasses without corrective lenses unless Medically Necessary.
- Any eye surgery solely for that the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), and astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
- Eye exercises.
- Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section.
- Replacement of lost, broken, or damaged lenses frames and contact lenses.
- Plano lenses.
- Lens adornment, such as engraving, faceting, or jewellery.
- Low-vision devices.
- Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits.
- Orthoptic (eye training) therapy.]

### **KK. [VISITING MEMBER SERVICES**

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We cover the same Medically Necessary Services that are covered under this plan in our Service Area, and your Cost Share may differ, when you are temporarily a visiting member in a different Kaiser Permanente Region or Group Health Cooperative service area. .

To receive more information about visiting Member Services, including facility locations across the United States, contact Member Services:

[Inside the Washington, DC Metropolitan Area: (301) 468-6000]

[Outside of the Washington, DC Metropolitan Area: 1-800-777-7902]

[TTY: 711]

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

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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### ***Visiting Member Services Limitations:***

Access to Services in the visited service area will be subject to availability at the time you request the Service. Services may be unavailable due to temporary capacity constraints, inability to provide the Service generally, or other restrictions. If the Service is not available in the visited service area, you must call us for authorization to receive the Service.

### ***Visiting Member Service Exclusions:***

All the terms and conditions, exclusions and limitations that apply to covered Services in our Service Area, will apply to Services received as a visiting Member in a different Kaiser Permanente Region or Group Health Cooperative service area.]

## **LL. X-RAY, LABORATORY, AND SPECIAL PROCEDURES**

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

1. Diagnostic imaging;
2. Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
3. Special procedures, such as electrocardiograms and electroencephalograms;
4. Sleep lab and sleep studies; and
5. Specialty imaging: including CT, MRI, PET Scans, and Nuclear Medicine studies; and interventional radiology.

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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## Summary of Services and Cost Shares

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

### **[DEPENDENT AGE LIMIT]**

Eligible Dependent children are covered from birth to age [26 - 30], [or to age [26 – 30] if a full-time student], as defined by your Group and approved by Health Plan.

### **MEMBER COST-SHARE**

Your Cost Share is the amount of the charges for a covered Service that you must pay through Deductibles, Copayments and Coinsurance. After the Deductible is met, the Copayments and Coinsurance listed here (your Cost Share) apply to covered Services you receive, up to the Out-of-Pocket Maximum.

In addition to the monthly premium, you may be required to pay a Cost Share for some Services. The Cost Share, if any, is listed for each Service in this “Summary of Services and Cost Shares.” You are responsible for payment of all Cost Shares. Copayments are due at the time you receive a Service. You will be billed for any Deductible and Coinsurance you owe. Failure to pay your Cost Shares may result in termination of your Membership (refer to Section 6: Termination for Nonpayment).

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<b>[Missed Appointment Fee]</b>	<b>[You Pay In-Plan]</b>	<b>[You Pay Out-of-Plan]</b>
[The amount you may be required to pay if you fail to keep a scheduled appointment at a Plan Facility, and you do not notify us at least one day prior to the appointment.]	[[ \$10 - \$100] per missed appointment]	[Not Applicable]

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### **[Deductible]**

[The Deductible is the amount of charges you must incur during a [contract] [calendar] [policy] year for certain [Out-of-Plan] covered Services before the Health Plan will provide benefits for those Services.

**[[Self-Only] [Individual] Coverage Deductible.** If you are covered as a Subscriber, and you do not have any Dependents covered under the plan, you must meet the [Self-Only] [Individual] Deductible shown below.]

**[Family Coverage Deductible.** If you have one or more Dependents covered under this EOC, one or more covered Members of your Family Unit together must meet the Family Deductible shown below. After one or more covered Members of your Family Unit combined have met the Family Coverage Deductible, the Deductible will be met for all Members of the Family Unit for the rest of the [contract] [calendar] [policy] year. The Individual Deductible shown below does not apply with Family Coverage.]

**[Family Coverage Deductible.** If you have one or more Dependents covered under this EOC, all covered Members of your family together can meet the Family Deductible shown below, but no one family Member’s medical expenses may contribute more than the Individual Deductible shown below. After an Individual Member of the Family Unit has met the Individual Deductible, his or her Deductible will be met for the rest of the [calendar][contract] [policy] year. Other family Members will continue to pay full charges for Services that are subject to the Deductible until the Family Deductible is met. After all Members of the Family Unit combined have met the Family Deductible, the Deductible will be met for all Members of the Family Unit for the rest of the [contract] [calendar] [policy] year.]

**[Individual within Family Coverage Deductible.** If you are the only Member in your Family, then you must meet the Individual within Family Deductible. If you are a Member in a Family of two or more Members, then either you must each meet the Individual within Family Deductible, or your entire Family must meet the Family Deductible. Each Individual within Family Deductible amount counts toward the Family Deductible amount. Once the Family Deductible is satisfied, no further Individual within Family Deductible will be due for the remainder of the Year. The Self-Only Deductible, Individual within Family Deductible, and Family Deductible amounts are shown below.]

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

# YOUR GROUP EVIDENCE OF COVERAGE (EOC)

## KAISER PERMANENTE

**[Deductible Carryover.** Charges incurred during the last 3 months of the [contract] [calendar] [policy] year that apply toward the Deductible will also apply to the Deductible for the following [contract] [calendar] [policy] year.]

**[Deductible Credit.** If you were covered on the day immediately preceding the effective date of the Group Agreement under any other group coverage that was replaced by this plan, then charges for covered Services incurred by you and applicable toward the individual or family Deductible under the prior coverage, will be used to satisfy all or any portion of the individual or family Deductible amounts under this EOC. This Deductible credit provision applies only to the Deductible amount wholly or partially satisfied in the same [contract] [calendar] [policy] year as the effective date of this EOC.]

**Services Subject to the Deductible.** The Deductible applies to covered Services as indicated in the schedule below [for Out-of-Plan Benefits.][A separate Deductible applies for In-Plan Benefits and Out-of-Plan Benefit.] All [Out-of-Plan] Services are subject to this Deductible, except [for those covered under the "Outpatient Prescription Drug Rider" attached to this EOC, and] those indicating "Deductible waived" in the following schedule of Copayments and Coinsurance. Emergency Services and out-of-area Urgent Care Services are treated as In-Plan Services and are not subject to the Out-of-Plan Deductible.

**Payments Toward Your Deductible.** For Services that are subject to a Deductible, you must pay for the Services when you receive them, until you meet your Deductible. After you meet the Deductible, you pay the applicable Copayment or Coinsurance for the Service. The only payments that count toward this Deductible are those you make for Services that are subject to this Deductible, but only if the Service would otherwise be covered. When you pay an amount toward your Deductible, ask for and keep a copy of your receipt. If you have met your Deductible, but we have not yet received and processed all of your claims, you can use your receipts as proof that you have met the Deductible. We will send you a statement summarizing the amounts you have paid toward your Deductible. You can also request a copy of this statement from our Member Services Department.

**Excess Charges.** Excess Charges are the amount of charges that exceed the Usual, Customary and Reasonable charges paid by Health Plan to a Non-Plan Provider.]

[Deductible	You Pay In-Plan	You Pay Out-of-Plan
The amount you must pay each [contract][calendar][policy] year for the Services indicated below before we provide benefits for those Services	[No Deductible]	
<b>[[Self-Only] [Individual] Deductible]</b>	[You pay [\$100 - \$5,000] per individual per [contract] [calendar] [policy] year]	[You pay [\$100 - \$10,000] per individual per [contract] [calendar][policy] year]
<b>[Individual within Family Deductible]</b>	[You pay [\$100 - \$5,000] per individual per [contract] [calendar] [policy] year]	[You pay [\$100 - \$10,000] per individual per [contract] [calendar][policy] year]
<b>[Family Deductible]</b>	[[[\$200-\$15,000] per Family Unit per [contract] [calendar][policy] year]	[[[\$200-\$19,050] [20,000] per Family Unit per [contract] [calendar] [policy] year]
	[The Deductible is a total of combined In- and Out-of-Plan charges.]	[The Deductible is a total of combined In- and Out-of-Plan charges.] ]

Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan

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# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
<b>Outpatient Care</b>		
Office Visits (for other than preventive health care Services)		
Primary care office visits [For adults]	[No charge] [[\$0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[For children under [24 months] [2 – 18] [ years] of age]	[No charge] [[\$0 - \$60] per visit] [, then] [[0% - 60%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[For children [24 months] [2 – 18] [ years] of age or older]	[No charge] [[\$0 - \$60] per visit] [, then] [[0% - 60%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Specialty care office visits [For adults]	[No charge] [[\$0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[For children under [24 months] [2 – 18] [years] of age]	[No charge] [[\$0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[For children [24 months] [2 – 18] [years] of age or older]	[No charge] [[\$0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Consultations and immunizations for foreign travel]	[No charge] [[\$0 - \$60] per visit] [, then] [0% - 50%] of AC*] [after Deductible] [; Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Outpatient surgery physician/surgical Services	[No charge] [[\$0 - \$500] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$1,000] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Special outpatient procedures]	[No charge][[\$5 - \$500] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [;]	[10% - 60%] of UCR after Deductible

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**YOUR GROUP EVIDENCE OF COVERAGE (EOC)  
KAISER PERMANENTE**

<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
	[Deductible waived]	
[Outpatient hospital procedures]	[No charge][[\$5 - \$500] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]	[10% - 60%] of UCR after Deductible
Anesthesia	[No charge] [[0% - 50%] of AC*] [after Deductible] [;] Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Chemotherapy and radiation therapy	[No charge] [[\$0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [;] Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]	[[[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Respiratory therapy	[No charge] [[\$0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [;] Deductible waived]	[[[\$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Medical social Services	[No charge] [[\$0 - \$60] per visit] [, then] [0% - 50%] of AC*] [after Deductible] [;] Deductible waived]	[[[\$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
House calls	[No charge] [[\$0 - \$60] per visit] [, then] [[0%-50%] of AC*] [after Deductible] [;] Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
<b>Hospital Inpatient Care</b> All charges incurred for covered Services during a covered stay as an inpatient in a hospital	[No charge] [[\$100 - \$1,000] per admission] [, then] [[0% - 50%] of AC*] [[\$100 - \$500] per day, not to exceed a total of [3x - 5x] the daily amount per admission] [after Deductible] [;] Deductible waived]	[[[\$100 - \$2000] per admission] [[\$100 - \$1,500] per day, not to exceed a total of [3x - 5x] the daily amount per admission] [[10% - 60%] of UCR] [after Deductible] [;] Deductible waived]
<b>[Hospital Observation Services]</b>	[[No charge] [[\$ 25 - \$500] per visit]; not to exceed the actual cost of the visit.] [, then] [0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [;] Copayment waived if	[[[\$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]

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<b>Copayments and Coinsurance</b>		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
	admitted as an inpatient] [Copayment waived if observation status in conjunction with emergency room visit]]	
<b>Accidental Dental Injury Services</b> [Limited to treatment started within 6 months of the accident]	[Applicable Cost Share applies based on type and place of Service] [No charge] [[ \$0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[ \$5- \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>Allergy Services</b>	[Applicable Cost Share applies, based on type and place of Service]	[[ \$5- \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Allergy evaluation and treatment	[No charge] [[ \$0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[ \$5- \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Injection visit and serum]	[No charge] [[ \$0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived] [Applicable Cost Shares will apply, based on type and place of Service, not to exceed the cost of the serum plus administration]	[[ \$5- \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>Ambulance Services</b> By a licensed ambulance Service, per encounter	[No charge] [[ \$0 - \$500] per encounter] [then] [[0% - 50%] of AC*] [after Deductible][; Deductible waived]	[No charge][[ \$0 - \$500] per encounter] [[10% - 60%] of UCR [after Deductible][; Deductible waived]]
Non-emergent transportation Services	[No charge] [[ \$0 - \$500] per encounter] [,then] [[0% - 50%] of AC*] [after Deductible][; Deductible waived]	[No charge][[ \$0 - \$500] per encounter] [[10% - 60%] of UCR [after Deductible][; Deductible waived]]
<b>Anesthesia for Dental Services</b> (Limited to individuals who meet specific criteria described in the “Benefits” section)	[No charge] [[0% - 50%] of AC*] [after Deductible][; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>Blood, Blood Products and Their Administration</b>	[No charge] [[0% - 50%] of	[10% - 60%] of UCR [after

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# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
	AC*] [after Deductible]; Deductible waived] [Applicable Cost Shares will apply, based on type and place of Service]	Deductible] [;] [Deductible waived]
<b>Chemical Dependency and Mental Health Services</b>		
[Partial hospitalization is limited to 60 days per [contract][calendar][policy] year )	[[No charge][[0% - 50%] of AC*][after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [;] [Deductible waived]
[Inpatient psychiatric and substance abuse care, including detoxification	Applicable inpatient Cost Share will apply] [No charge] [[0 - \$100] per day] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]	[Applicable inpatient Cost Share will apply] [No charge] [[0 - \$100] per day] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Hospital alternative Services Intensive outpatient psychiatric treatment programs	[No charge] [[5 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [;]Deductible waived]
Partial hospitalization	[No charge] [[0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [;] Deductible waived]	[[5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [;] Deductible waived]
Outpatient psychiatric and substance abuse care <ul style="list-style-type: none"> <li>• Individual therapy</li> </ul>	[No charge] [[0 - \$35] per visit] [, then] [[0% - 50%] of AC*][after Deductible] [; Deductible waived] [waived for children under [24 months][2 -5] [years] of age]]	[[5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [;] Deductible waived]
<ul style="list-style-type: none"> <li>• Group therapy</li> </ul>	[No charge] [[0 - \$10] per visit] [, then] [[0% - 50%] of AC*][after Deductible] [; Deductible waived] [waived for children under [24 months][2 -5] [years] of age]]	[[5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [;] Deductible waived]
[Medication management visits]]	[No charge][[0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [;] Deductible waived]
[Residential treatment center]	Applicable inpatient Cost Shares will apply [No charge] [[0 - \$100] per	[10% - 60%] of UCR after Deductible

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<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
	day] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [No charge][[\$0 - \$100] per visit] [,then][[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]	
<b>Cleft Lip, Cleft Palate, or Both</b>	[No charge] [[0% - 50%] of AC*] [after Deductible] [;] Deductible waived][Applicable Cost Share applies, based on type and place of Service]	[[10% - 60%] of UCR] [after Deductible] [;] Deductible waived] [Applicable Cost Shares apply, based on type and place of Service]
<b>Clinical Trials</b>	[No charge] [[0% - 50%] of AC*] [after Deductible] [;] Deductible waived] [Applicable Cost Shares will apply, based on type and place of Service]	[[10% - 60%] of UCR] [after Deductible] [;] Deductible waived] [Applicable Cost Shares will apply, based on type and place of Service]
<b>Diabetic Equipment, Supplies and Self-Management Training</b>	[No charge] [[0% - 50%] of AC*] [after Deductible] [;] Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [;] Deductible waived]
[Diabetic equipment]	[No charge] [[0% - 50%] of AC*] [after Deductible] [;] Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [;] Deductible waived]
Diabetic supplies	[No charge] [[0% - 50%] of AC*][after Deductible] [;] Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [;] Deductible waived]
<ul style="list-style-type: none"> <li>• [Disposable needles and syringes]</li> </ul>	[No charge] [[0% - 50%] of AC*][after Deductible] [;] Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [;] Deductible waived]
<ul style="list-style-type: none"> <li>• [Glucose test strips]</li> </ul>	[No charge] [[0% - 50%] of AC*][after Deductible] [;] Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [;] Deductible waived]
<ul style="list-style-type: none"> <li>• [Glucose test meter] <ul style="list-style-type: none"> <li>○ [Replacement batteries]</li> </ul> </li> </ul>	[[ \$10 - \$20] per meter]	[[10% - 60%] of UCR] [after Deductible] [;] Deductible waived]
	[[ \$5 - \$10] per package]	[[10% - 60%] of UCR] [after Deductible] [;] Deductible waived]
		[[10% - 60%] of UCR] [after

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## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
○ [Additional meters]	[\$10 - \$20] per meter	Deductible] [; Deductible waived]
• [Control solutions]	[\$8 - \$15] per package	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
• [Lancets]	[\$8 - \$15] per package	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Self-management training]	[Applicable Cost Share applies, based on place of Service]	[Applicable Cost Share applies, based on place of Service] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>Dialysis</b>	[No charge] [[0% - 50%] of AC*][after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [;] [Deductible waived]
[Inpatient care	[Applicable inpatient Cost Share applies]	[Applicable inpatient Cost Share applies]
Outpatient Care]	[No charge] [[0 - \$60] per visit] [then][0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Dialysis Center	[No charge] [[0 - \$100] per visit] [,then] [0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60% of UCR after Deductible]
Home dialysis, including training]	[No charge] [[0 - \$100] per visit] [,then] [0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60% of UCR after Deductible]
Dialysis training]	[No charge] [[0 - \$100] per visit] [,then] [0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60% of UCR after Deductible]
<b>Drugs, Supplies, and Supplements</b> Administered by or under supervision of a physician	[No charge] [[0% - 50%] of AC*] [after Deductible][; Deductible waived] [Applicable Cost Shares will apply, based on type and place of Service]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived] [Applicable Cost Shares will apply, based on type and place of Service]

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# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
<b>Durable Medical Equipment- Outpatient</b>	[No charge] [[0% - 50%] of AC*][after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>[Basic Durable Medical Equipment</b>	No charge] [[0% - 50%] of AC*][after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Limited to use in the home for up to 3 months following: an authorized confinement in a hospital, a sub-acute facility; or a specialized rehabilitation facility; or an authorized outpatient surgical procedure.]		
<b>[Supplemental Durable Medical Equipment</b>		
<ul style="list-style-type: none"> <li>• Oxygen and Equipment</li> </ul>	[No charge] [[0% - 50%] of AC*] [[No charge][20% - 50%] for 1 <sup>st</sup> 3 months; [50% - 70%] of AC* each month thereafter] [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR for 1 <sup>st</sup> 3 months; [60% - 80%] of UCR each month thereafter] [after Deductible] [; Deductible waived]
	[Limited to [a combined In- and Out-of-Plan] benefit maximum of [\$5,000 - \$25,000] per [contract] [calendar] [policy] year]	[Limited to [a combined In- and Out-of-Plan] benefit maximum of [\$5,000 - \$25,000] per [contract] [calendar] [policy] year]
<ul style="list-style-type: none"> <li>• Positive Airway Pressure Equipment</li> </ul>	[No charge] [[0% - 50%] of AC*] [[No charge][20% - 50%] for 1 <sup>st</sup> 3 months; [50% - 70%] of AC* each month thereafter] [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR for 1 <sup>st</sup> 3 months; [60% - 80%] of UCR each month thereafter] [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>• Apnea Monitors (under 3, not to exceed a period of 6 months)</li> </ul>	[No charge] [[0% - 50%] of AC*][after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>• Asthma Equipment</li> </ul>	[ No charge] [0% - 50%] of AC*][after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>○ [Spacers</li> </ul>	[[ \$5 - \$10] per item]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>○ Peak-flow meters</li> </ul>	[[ \$10 - \$15] per item]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]

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<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
<ul style="list-style-type: none"> <li>○ Nebulizers]</li> </ul>	[\$30 - \$40] per item]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>• Bilirubin Lights (under 3, not to exceed a period of 6 months)]</li> </ul>	[No charge] [[0% - 50%] of AC*][after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
<b>Emergency Services</b>		
	[No charge] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[No charge] [[10% - 50%] of AC*] [after Deductible] [; Deductible waived]
[Emergency Room Visits		
<ul style="list-style-type: none"> <li>• Inside the Service Area</li> </ul>	[[No charge] [[\$25 -\$500] per visit; not to exceed the actual cost of the visit. Waived if immediately admitted] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[No charge] [[\$25 -\$500] per visit; not to exceed the actual cost of the visit. Waived if immediately admitted] [[10% - 50%] of AC*] [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>• Outside of the Service Area]</li> </ul>	[No charge] [[\$25 -\$500] per visit; not to exceed the actual cost of the visit. Waived if immediately admitted] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[No charge] [[\$25 -\$500] per visit; not to exceed the actual cost of the visit. Waived if immediately admitted] [[10% - 50%] of AC*] [after Deductible] [; Deductible waived]
[Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit copayment will not be waived.]		
Emergency Services HIV Screening Test	No charge	No charge
<b>[Family Planning]</b>		
[Office visits]	[No charge] [[0 - \$60] per visit] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Tubal ligation] [, Vasectomy] [, Voluntary termination of pregnancy]	[No charge] [[0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived] [Applicable Cost Share applies based on place of Service]	[[5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived] [Applicable Cost Share applies based on place of Service]
[Women's Preventive Services, including all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. In-Plan Services are covered under Preventive Care at no charge.]	[No charge]	[10% - 60%] of UCR after Deductible[Applicable Cost Share applies based on place of Service]

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# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
<b>Habilitative Services</b>		
[Limited to children up to age 21]		
Physical, Speech and Occupational therapy	[No charge] [[\$0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Applied Behavioral Analysis (ABA)]	[No charge] [[\$0 - \$100] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[No charge] [[\$0 - \$100] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]
All other Services	[No charge] [[0% - \$100] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived] [The applicable cost share will apply based on type and place of service]	[No charge] [[0% - \$100] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived] [The applicable cost share will apply based on type and place of service]
<b>Hearing Services</b>		
Hearing tests	[No charge][[0% - 50%] of AC*] [Applicable office visit Cost Share applies] [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
(Note: Newborn hearing screening tests are covered under preventive health care Services at no charge In-Plan)		
<b>Home Health Care</b>		
[Limited to [a combined In- and Out-of-Plan] maximum of [30 – 240 visits] per [contract] [calendar] [policy] year]	[No charge] [[\$0 - \$60] per visit] [then][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>Hospice Care</b>		
	[No charge] [[\$0 - \$60] per visit] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>[Infertility Services</b>		
[Office visits [for initial diagnosis of infertility]	[No charge] [[\$05 - \$60] per visit] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[50% - 70%] of UCR [after Deductible] [; Deductible waived]
Inpatient Hospital Care	[No charge] [[\$0 - \$1000] per admission] [then] [[0% - 50%] of AC*] [[\$100 - \$500] per day, not to exceed a total of [3x - 5x] the daily amount per admission] [after Deductible] [; Deductible waived]	[\$100 - \$2000] per admission] [[\$100 - \$1500] per day, not to exceed a total of [3x - 5x] the daily amount per admission] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]

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<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
All other Services for treatment of infertility  [Note: Coverage for In-vitro fertilization is limited to a combined In- and Out-of-Plan maximum lifetime benefit of \$100,000.]]	[No charge] [[\$0 - \$60] per visit] [then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]	[50% - 70%] of UCR [after Deductible] [; Deductible waived]]
<b>Infusion Therapy Services</b>	[Applicable Cost Shares will apply, based on type and place of Service] [No charge][[0% - 50%] of AC* [after Deductible] [;] [Deductible waived]]	[[10% - 60%] of UCR after Deductible]] [Applicable Cost Shares will apply, based on type and place of Service]
<b>Maternity Services</b>		
[Prenatal and postpartum visits (after confirmation of pregnancy), including diagnostic tests	[No charge][Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived] [Applicable Cost Shares will apply, based on type and place of Service ]
Breast Pumps	[No charge] [[\$0 - \$60] per pump] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[ \$5 - \$70] per pump] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Postpartum home health visits	[No charge][; Deductible waived]	[10% - 60%] of UCR after Deductible
Maternity Services that are required by the Affordable Care Act are covered under Preventive Care Services at no charge]		
[Outpatient prenatal care (after confirmation of pregnancy) and first postpartum visit	[No charge] [[\$0 - \$60] per visit] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[ \$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Outpatient obstetrical or gynecological Services provided during pregnancy that are not directly related to the outpatient prenatal care ]	[No charge] [[\$0 - \$60] per visit] [then][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[ \$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Obstetrical care and delivery, including cesarean section]	[No charge] [[\$100 - \$1000] per admission] [then] [[0% - 50%] of AC*] [[\$100 - \$500] per day, not to exceed a total of [3x - 5x] the daily amount per	[[ \$100 - \$2,000] per admission] [[\$100 - \$1,500] per day, not to exceed a total of [3x - 5x] the daily amount per admission] [[10% - 60%]

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<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
	admission] [after Deductible] [; Deductible waived]	of UCR] [after Deductible] [; Deductible waived]
Newborn home visit as described in Section 3: Benefits]	[No charge]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
<b>Medical Foods</b>	[No charge] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
<b>Medical Nutrition Therapy &amp; Counseling</b>	No charge][[\$5 - \$500] per visit] [,then] [0% - 50%] of AC*] [after Deductible][; Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]	[10% - 60%] of UCR after Deductible
<b>Morbid Obesity Services</b>	[No charge] [[0% - 50%] of AC*] [Applicable Cost Share applies based on type and place of Service] [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [Applicable Cost Share applies based on type and place of Service] [after Deductible] [; Deductible waived]
<b>Oral Surgery</b>	[No charge] [Applicable Cost Share applies based on type and place of Service] [[0% - 50%] of AC*] [after Deductible] [;Deductible waived]	[[[\$5 - \$70] per visit] [Applicable Cost Share applies based on type and place of Service] [[10% - 60%] of UCR] [after Deductible] [;] [Deductible waived]
<b>Preventive Health Care Services</b> [Not subject to Deductible]	[No charge][[\$0 - \$60] per visit][;][Copayment waived for children under [24 months][2 - 25][years] of age] [then] [[0% - 50%] of AC*] [after Deductible] [;Deductible waived]	[[[\$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Routine physical exams for adults	[No charge][[\$0 - \$60] per visit] [[10% - 50%] of AC*] [after Deductible] [;Deductible waived]	[[[\$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Routine preventive tests for adults	[No charge][[\$0 - \$60] per visit] [then] [[0% - 80%] of AC*] [after Deductible] [;Deductible waived]	[[[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Well child care visits	[No charge] [[\$0 - \$60] per visit] [then] [[0% - 80%] of	[[[\$5 - \$70] per visit] [[10% - 60%] of UCR] [after

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<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
	AC*] [after Deductible] [;Deductible waived] [Copayment waived for children under [24 months] [2 – 5] [years] of age]]	Deductible] [; Deductible waived]
Immunizations for children and adults (No charge for immunization agent)]	[No charge] [[\$0 - \$60] per visit] [then] [[0% - 80%] of AC*] [after Deductible] [; Deductible waived] [Copayment waived for children under [24 months] [2 – 5] [years] of age]]	[\$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]]
<b>Prosthetic Devices</b> [Limited to internally implanted devices, ostomy and urological supplies, and breast prostheses, unless a Prosthetic and Orthotic Devices Rider is attached to this EOC.]	[No charge][0% -80%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
[Internally implanted devices	[No charge][0% -80%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
Ostomy and Urological Supplies	[No charge][[0% - 80%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
Breast Prosthetics]	[No charge][[0% - 80%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
[Hair Prostheses]	[No charge][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
<b>Reconstructive Surgery</b>	[No charge][[0% - 50%] of AC*] [Applicable Cost Share applies based on place and type of Service.] [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [Applicable Cost Share applies based on place and type of Service.] [after Deductible] [; Deductible waived]
<b>Skilled Nursing Facility Care</b> [Limited to [a combined In-and Out-of-Plan maximum of] [60 – 240] days per [admission] [contract] [calendar] [policy] year]	[No charge] [[\$100 - \$1000] per admission] [then] [[10% - 50%] of AC*] [[\$100 - \$500] per day, not to exceed a total of [3x - 5x] the daily amount per admission] [after Deductible] [; Deductible waived]	[\$100 - \$2,000] per admission] [[\$100 - \$1,500] per day, not to exceed a total of [3x - 5x] the daily amount per admission] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]

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<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
<b>Telemedicine Services</b>	[No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]	[[10% - 60%] of UCR] [Applicable Cost Share applies based on place and type of Service.] [after Deductible] [;] [Deductible waived]
<b>Therapy and Rehabilitation Services</b> Refer to Section 3 for benefit maximums-	[No charge] [[\$0 - \$60] [then] [0% - 50%] of AC*] per visit] [after Deductible] [;] [Deductible waived]	[\$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [;] [Deductible waived]
[Inpatient Services]	[Applicable inpatient Cost Share applies]	[Applicable inpatient Cost Share applies]
Outpatient Services	[No charge] [[\$0 - \$60] [then] [0% - 50%] of AC*] per visit] [after Deductible] [;] [Deductible waived]	[\$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [;] [Deductible waived]
<b>Note:</b> All Services received in one day for multidisciplinary rehabilitation Services at a day treatment program will be considered one visit.]		
<b>Transplants</b>	[No charge] [[0% - 50%] of AC*] per visit] [Applicable Cost Share applies based on place and type of Service.] [after Deductible] [;] [Deductible waived]	[[10% - 60%] of UCR] [Applicable Cost Share applies based on place and type of Service.] [after Deductible] [;] [Deductible waived]
<b>Urgent Care</b>		
[Office visit during regular office hours]	Applicable office visit cost Share applies [after Deductible] [;] [Deductible waived]	[[10% - 60%] of UCR] [Applicable office visit cost Share applies] [after Deductible] [;] [Deductible waived]
After-Hours Urgent Care or Urgent Care Center]	[No charge] [[\$0 - \$60] per visit] [then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]	[No charge] [[\$5 - \$70] per visit] [[10% - 60%] of AC*] [after Deductible] [;] [Deductible waived]



## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
	allowance toward wholesale cost. If frame is more than allowance member pays [2] times the difference between wholesale cost and allowance] ]	
Eyeglass lenses]		
• [Single Vision]	[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]	[Not covered] [Member pays full price]
• [Bifocal]	[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]	[Not covered] [Member pays full price]
• [Trifocal]	[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]	[Not covered] [Member pays full price]
• [Lenticular]	[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]	[Not covered] [Member pays full price]
[Scratch Resistant] [Anti-reflective Coating (ARC)]		
• [Standard]	[Not covered] [No charge] [Member pays balance after Plan pays] [\$50 - \$500]	[Not covered] [Member pays full price]
• [Premium]	[Not covered] [No charge] [Member pays balance after Plan pays] [\$50 - \$500]	[Not covered] [Member pays full price]
• [Ultra]	[Not covered] [No charge] [Member pays balance after Plan pays] [\$50 - \$500]	[Not covered] [Member pays full price]
[Contact lenses] [in lieu of frames and lenses]	[20% - 100% of retail price**] [ Member pays balance after Plan pays [\$50 - \$500] [You receive a [15% - 25%] discount off retail price on initial pair of contact lenses] [You receive a [\$50 - \$250] allowance on frames, lenses and/or contact lenses, combined, once per [every 2] [contract][calendar] [policy] year[s] ]	[You receive a [5% - 15%] discount off retail price on initial pair of contact lenses] [You receive a [\$20 - \$50] allowance on frames, lenses and/or contact lenses, combined, once per [every 2] [contract][calendar] [policy] year[s] ] [You receive a \$[20 - 25] allowance on [initial pair of] contact lenses [once per [every 2] [contract]

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Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
	[You receive a \$[50 - 500] allowance on [initial pair of ] contact lenses [once per [every 2] [contract] [calendar] [policy] year[s] ] [You receive a maximum allowance of [\$50 - \$1000] for all covered vision Services, other than eye exams, per [every 2] [contract][calendar] [policy] year[s] ]	[calendar] [policy] year[s] ] [You receive a maximum allowance of [\$20 - \$500] for all covered vision Services, other than eye exams, per [every 2] [contract][calendar] [policy] year[s] ]
<ul style="list-style-type: none"> <li>• [Medically Necessary]</li> </ul>	[No charge] [20% - 100% of retail price**] [with prior approval] [Member pays balance after Plan pays [\$50 - \$500]	[10% - 15% of retail price**] [with prior approval]
<ul style="list-style-type: none"> <li>• [Medical Multifocal]</li> </ul>	[Not covered] [No charge] [20% - 100% of retail price**] [with prior approval] [Member pays balance after Plan pays [\$50 - \$500]	[Not covered] [Member pays full price]
<ul style="list-style-type: none"> <li>• [Cosmetic]</li> </ul>	[Not covered] [No charge] [20% - 100% of retail price**] [with prior approval] [Member pays balance after Plan pays [\$50 - \$500]	[Not covered] [Member pays full price]
<p>[Note: A child may select any pair of glasses in lieu of, or in addition to, the eyeglasses or contact lenses available at no charge under Vision Services for children below and receive the discount at any Plan Vision Center.]</p>		
<p>[Vision Services (for children under age 19) Eye exams</p>		
<ul style="list-style-type: none"> <li>• by an Optometrist</li> </ul>	[No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR after Deductible
<ul style="list-style-type: none"> <li>• by an Ophthalmologist</li> </ul>	[No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR after Deductible
<p>Eyeglass lenses and frames (Limited to one pair of frames per calendar year from a selected group of frames; limited to one pair of polycarbonate or plastic single vision or bifocal</p>	No charge [; Deductible waived]	[10% - 60%] of UCR after Deductible

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Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
lenses (ST28) per [contract][calendar][plan] year)		
Contact lenses (Limited to the initial fit and purchase of contact lenses from a selected list per [contract][calendar][plan] year)	No charge[; Deductible waived]	[10% - 60%] of UCR after Deductible
Low Vision Aids (Unlimited low vision aids from available supply)	No charge[; Deductible waived]	Not available]

### X-ray, Laboratory and Specialty Procedures

Inpatient diagnostic imaging, interventional diagnostic tests, laboratory tests, specialty imaging and special procedures	[No Charge] [Applicable inpatient Cost Share applies]	[Applicable inpatient Cost Share applies]
Outpatient diagnostic imaging, interventional diagnostic tests, and laboratory tests	[No charge] [[\$0 - \$60] per visit] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Outpatient specialty imaging (including CT, MRI, PET Scans, Nuclear Medicine and Interventional Radiology) and special procedures	[No charge] [[\$0 - \$500] per test] [then][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$1000 per test][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Sleep lab	[No charge] [[\$0 - \$500] per visit] [then][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$1000 per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Sleep studies	[No charge] [[\$0 - \$500] per test] [then][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$1000 per test][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]

**Note:** Charges for covered outpatient diagnostic and laboratory tests performed in a Plan Physician's office are included in the office visit Copayment.

\*AC means Allowable Charges as defined in the EOC.

\*UCR means Usual, Reasonable and Customary as defined in the "Added-Choice: A Point-of-Service Amendment."

\*\* "Retail price" means the price that would otherwise be charged for the lenses, frames or contacts at the KP Vision Care Center on the day purchased.

### [ Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the limit to the total amount of Deductible, Copayments and Coinsurance you must pay in a [contract] [calendar] [policy] year for covered Services under this EOC. Once you have met your Out-of-Pocket Maximum, you will not be required to pay any additional Cost Shares for covered Services for the rest of the [contract] [policy] [calendar] year. After two or more Members of a Family Unit combined have met the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be met for all Members of the Family Unit for the rest of the [contract]

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[policy] [calendar] year.

Any amounts you pay toward the Deductible, Copayments or Coinsurance for covered Services apply toward the annual Out-of-Pocket Maximum[.], except for Deductible, Copayments or Coinsurance you pay for items covered under the “Outpatient Prescription Drug Rider.”]

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

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

Out-Of-Pocket Maximum	In-Plan	Out-of-Plan
(Combined total of [In-Plan and] Out-of-Plan Deductible, Copayment and Coinsurance)		
<b>[[Self-Only][Individual] Out-of-Pocket Maximum]</b>	[[\\$250 - \\$10,000] per individual per [contract] [calendar] [policy] year] [Not Applicable]	[\$500 - \$15,000] per individual per [contract] [calendar] [policy] year
<b>[Family Out-of-Pocket Maximum]</b>	[[\\$500 - \\$30,000] per Family Unit per [contract] [calendar] [policy] year] [Not Applicable]	[[\\$1,000 - \$45,000] per Family Unit per [contract] [calendar] [policy] year]
<b>Maximum Lifetime Benefit Amount</b>	No Limit	[No Limit] [[\\$1,000,000 - \$5,000,000] Out-of-Plan Maximum]

### [Out-of-Pocket Maximum]

The Out-of-Pocket Maximum is the limit to the total amount of Deductible, Copayments and Coinsurance you must pay in a [contract] [calendar] [policy] year for covered Services under this EOC. Once you have met your Out-of-Pocket Maximum, you will not be required to pay any additional Cost Shares for covered Services for the rest of the [contract] [policy] [calendar] year.

Any amounts you pay toward the Deductible, Copayments or Coinsurance for covered Services apply toward the annual Out-of-Pocket Maximum.

**[[Self-Only] [Individual] Coverage Out-of-Pocket Maximum.** If you are covered as a Subscriber, and you do not have any Dependents covered under this EOC, your medical expenses apply toward the [Self-Only] [Individual] Out-of-Pocket Maximum shown below.]

**[Family Coverage Out-of-Pocket Maximum.** If you have one or more Dependents covered under this EOC, the covered medical expenses incurred by all Members of the Family Unit together apply toward the Family Out-of-Pocket Maximum shown below; however no one family Member’s medical expenses may contribute more than the Individual Out-of-Pocket Maximum shown below. After one member of a Family Unit has met the Individual Out-of-Pocket Maximum, his or her Out-of-Pocket Maximum will be met for the rest of the [calendar][contract][policy] year. Other family Members will continue to pay applicable Cost Shares until the Family Out-of-Pocket Maximum is met. After all Members of the Family Unit combined have met the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be met for all Members of the Family Unit for the rest of the [calendar][contract] [policy] year.]

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**[Family Coverage Out-of-Pocket Maximum.** If you have one or more Dependents covered under this EOC, the medical expenses of all Members of your Family Unit together apply towards the family Out-of-Pocket Maximum shown below. After one or more covered 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 [contract] [calendar] [policy] year. The Individual Out-of-Pocket Maximum shown below does not apply with family coverage.]

**[Individual within Family Coverage Out-of-Pocket Maximum.** There is a maximum to the total dollar amount of Copayments and Coinsurance that you must pay for covered Services that you receive within the same Year. If you are the only Member in your Family, then you must meet the Individual within Family Out-of-Pocket Maximum. If you are a Member in a Family of two or more Members, then either you must each meet the Individual within Family Out-of-Pocket Maximum, or your entire Family must meet the Family Out-of-Pocket Maximum. Each Individual within Family Out-of-Pocket Maximum amount counts toward the Family Out-of-Pocket Maximum amount. The Self-Only Out-of-Pocket Maximum, Individual within Family Out-of-Pocket Maximum, and Family Out-of-Pocket Maximum amounts are shown below.]

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

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

<b>Out-of-Pocket Maximum</b>	<b>In-Plan</b>	<b>Out-of-Plan</b>
(Combined total of [In-Plan and] Out-of-Plan Deductible, Copayment and Coinsurance)		
<b>[[Self-Only] [Individual] Out-of-Pocket Maximum]</b>	[[ \$250 - \$10,000 ] per individual per [contract] [calendar] [policy] year] [Not Applicable]	[[ \$500 - \$15,000 ] per individual per [contract] [calendar] [policy] year]
<b>[Individual within Family Out-of-Pocket Maximum]</b>	[[ \$250 - \$10,000 ] per individual per [contract] [calendar] [policy] year] [Not Applicable]	[[ \$500 - \$15,000 ] per individual per [contract] [calendar] [policy] year]
<b>[Family Out-of-Pocket Maximum]</b>	[[ \$500 - \$20,000 ] per Family Unit per [contract] [calendar] [policy] year] [Not Applicable]	[[ \$1,000 - \$45,000 ] per Family Unit per [contract] [calendar] [policy] year]

**State:** District of Columbia **Filing Company:** Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.  
**TOI/Sub-TOI:** HOrg03 Health - Other/HOrg03.000 Health Organizations - Other  
**Product Name:** 2017 DC Mid-Large Employer Group Benefit Form - HMO Cost Share  
**Project Name/Number:** /

## Supporting Document Schedules

<b>Satisfied - Item:</b>	Cover Letter
<b>Comments:</b>	
<b>Attachment(s):</b>	Cover Letter - 11-17-16.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	EOV
<b>Comments:</b>	
<b>Attachment(s):</b>	DCLG-HMO-COST(1-17)-EOV.pdf DCLG-ALL-SEC3(01-17)-EOV.pdf DCLG-POS-COST(1-17)-EOV.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Redlines
<b>Comments:</b>	
<b>Attachment(s):</b>	DCLG-HMO-COST(01-17)_redline.pdf DCLG-ALL-SEC3(01-17)_redline.pdf DCLG-POS-COST(01-17)_redline.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	



**KAISER PERMANENTE®**

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

November 17, 2016

Department of Insurance, Securities and Banking  
Product Analysis Division  
810 First Street, N.E., Suite 701  
Washington, DC 20002

Re: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.  
NAIC Number: 95639  
Forms Submission: 2017 DC Mid-Large Employer Group Benefit Form - HMO Cost Share  
SERFF Number: KPMA-130812612

To whom it may concern:

On behalf of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), we are resubmitting our HMO Cost Share. These forms was previously filed and approved under SERFF number KPMA-130760412. The rates have already been filed and approved for this form. The changes do not impact the rates. Changes include:

1. Brackets placed around Applied Behavioral Analysis (ABA)
2. Missing end brackets added to right column to ensure every variable has a beginning and end bracket.
3. EOV was updated to reflect these changes and also language that was not filed under DME was removed from the EOV.

Please review the redline for changes that were made for the document. If you may have any questions, please feel to reach out to me via email ([Shilpa.P.Myers@kp.org](mailto:Shilpa.P.Myers@kp.org)) or telephone ((301)-816-5780).

Sincerely,

Shilpa Myers  
Contract Specialist

Enclosure

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-HMO-COST(1-17)

### VARIABLES USED ONLY IN DHMO PLANS

Page(s)	Applicable Plans	Variables	Explanations
1	DHMO	[The Deductible applies to the Services shown in the schedule below]  [that have a Coinsurance.]	This text will be included in the form when the benefit plan is a <b>grandfathered</b> DHMO that only applies the deductible to benefits that have a coinsurance.  This variable will be removed if the plan has a Deductible but have a copayment.
1	DHMO	[, except Durable Medical Equipment ... Orthotic Devices]	This text will be included in the form when the benefit plan is a <b>grandfathered</b> DHMO and durable medical equipment, preventive health care services, and prosthetic and orthotic devices do not apply to the deductible.
1	DHMO	[Other Services may have a Copayment.]	This text will be included in the form when the benefit plan is a DHMO.
1	DHMO	[Copayments do not apply toward the Deductible.]	This text will be included in the form to clarify that copayments do not apply toward the Deductible.

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-HMO-COST(1-17)

### VARIABLES USED ONLY IN HDHP PLANS

Page(s)	Applicable Plans	Variables	Explanations
2	HDHP	[Keep Your Receipts. When you pay an amount toward your Deductible, we will give you a receipt. Keep your receipts. If you have an HSA account, you may need to prove to the IRS that distributions from your HSA were for qualified medical expenses. Also, if you have met your Deductible, and we have not received and processed all of your claims, you can use your receipts to prove that you have met your Deductible. You can also obtain a statement of the amounts that have been applied toward your Deductible from our Member Services Department.]	This provision will be included in the form when the benefit plan is HDHP.
12	HDHP	Under <b>Vision [Exam] Services</b>	The covered service heading will be Vision Exam Services when plan is HDHP.
12	HDHP	Under <b>Vision [Exam] Services:</b> [[Eye exams (for adults age 19 or older) • by an Optometrist ... • by an Ophthalmologist]	This text will be omitted from the form when the cost share for all Vision Exam Services is “No charge” or a coinsurance, after deductible or deductible waived. All sub-headings will be deleted when the benefit plan is HDHP, or when an employer elects to only cover medically necessary treatment of the eye (except for pediatric vision).
13	HDHP	[Eyeglass [lenses and] frames ... Eyeglasses lenses]	This text will be omitted from the form when the benefit plan is HDHP.

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-HMO-COST(1-17)

### VARIABLES USED ONLY IN HMO & 3TPOS PLANS

Page(s)	Applicable Plans	Variables	Explanations
1	HMO & 3TPOS	[The Deductible applies to covered Hospital Inpatient Care ... Therapy Services only.]	The text will be included in the form when the benefit plan is an <b>HMO plan design with a deductible</b> that only applies to inpatient services.

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-HMO-COST(1-17)

### VARIABLES USED ONLY IN DHMO, HMO & 3TPOS PLANS

Page(s)	Applicable Plans	Variables	Explanations
2	DHMO HMO & 3TPOS	[Keep Your Receipts. When you pay an amount toward your Deductible, we will give you a receipt. Keep your receipts. If you have met your Deductible, and we have not received and processed all of your claims, you can use your receipts to prove that you have met your Deductible. You can also obtain a statement of the amounts that have been applied toward your Deductible from our Member Services Department.]	This provision will be included in the form when the benefit plan is an HMO with an inpatient only deductible or a DHMO.
13	DHMO HMO & 3TPOS	Under <b>Vision Services</b> :  [[Eye exams • by an Optometrist ... • by an Ophthalmologist]  [(for adults age 19 or older)]	The covered service heading will be Vision Services when the benefit plan is HMO or DHMO and the employer elects to cover routine eye exams and or vision hardware.  This text will be omitted from the form when the employer group elects to exclude all benefits for eyesight correction.  [(for adults age 19 or older] will be included when the Pediatric Vision benefit is included.
13	DHMO HMO & 3TPOS	[Routine eye exam once per [contract] [calendar][policy] year]	The group elects routine eye exam once per year for both Optometrist and Ophthalmologist for all lines of business.
13	DHMO HMO & 3TPOS	[Member may opt to have frames and lenses or contacts, but not both in a [contract] [calendar] [policy] year]	The group elects to cover either frames and lenses or contacts.
13	DHMO HMO & 3TPOS	[Eyeglass [lenses and] frames Eyeglass lenses]	These variables are used depending on when an employer chooses to cover lenses and frames or only lenses.
13	DHMO HMO & 3TPOS	• [Single Vision] • [Bifocal] • [Trifocal] • [Lenticular]	These variables will be include if the group offers various lenses types i.e. Single Vision, Bifocal, Trifocal and Lenticular at various benefit levels.

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-HMO-COST(1-17)

Page(s)	Applicable Plans	Variables	Explanations
14	DHMO HMO & 3TPOS	[Scratch Resistant] [Anti-reflective Coating (ARC)] • [Standard] • [Premium] • [Ultra]	These variables will be include if the group offers various scratch resistant or anti-reflective coating (ARC): standard, premium and ultra.
14	DHMO HMO & 3TPOS	[Contact lenses] [in lieu of frames and lenses]	Contact lenses are offered by the group at a certain rate. In lieu of frames and lenses is used if the employer limits to only glasses or contacts.
14	DHMO HMO & 3TPOS	• [Medically Necessary] • [Medical Multifocal] • [Cosmetic]	These variables will be include if the group offers various options for Contact lenses at a certain rate.
14	DHMO HMO & 3TPOS	[ <b>Note:</b> A child may select any pair of glasses in lieu of, or in addition to, the eyeglasses or contact lenses available at no charge under Vision Services for children below and receive the discount at any Plan Vision Center.]	The Note will be included when plan covers eyeglass hardware and lenses, and includes the pediatric vision benefit.
15	DHMO HMO & 3TPOS	[Vision Services (for children under age 19) ... Low Vision Aids]	Pediatric vision is removed if the employer requests not to cover.

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-HMO-COST(1-17)

### VARIABLES USED ONLY IN DHMO & HDHP PLANS

Page(s)	Applicable Plans	Variables	Explanations
Throughout Form	DHMO HDHP	[Deductibles,]; [Deductible,]; [Deductible and]; [Deductible]	This variable will be included in the form when the benefit plan has a deductible.
1	DHMO HDHP	[The Deductible applies to all covered Services except Preventive Health Care Services [and post-partum home health visits] as described in Section 3, Benefits [, and outpatient Prescription Drugs].	This text will be included in the form when the deductible applies to all benefits except preventive care. “And post-partum home health visits” will be included for all deductible plan designs except HDHP plans that are HSA-qualified plans.
1	DHMO HDHP	[, and outpatient Prescription Drugs].	This variable is included if prescription drugs do not apply to the deductible.
1	DHMO HDHP	Preventive Health Care Services may be subject to a Copayment as shown below.]	This text will be included in the form for <b>grandfathered</b> plans when a copayment applies to preventive health care services.
1	DHMO HDHP	[ <b>Self-Only</b> ] [ <b>Individual</b> ]	The variable Self-Only will be used for custom groups only who choose unique Ded/OOPM thresholds for self-only, individual Family Member (in a Family of 2+ Members), and entire Family (2+ Members) coverage levels.  The variable Individual will be used the plan is a traditional embedded or aggregate plan.
1	DHMO HDHP	[[ <b>Self-Only</b> ] [ <b>Individual</b> ] <b>Coverage Deductible</b> ... Self-Only Deductible shown below.]	This provision will be included in the form when the benefit plan is a DHMO or an HDHP.
1	DHMO HDHP	[ <b>Family Coverage Deductible</b> ... If you have ... Coverage].	This variable is used when the Deductible is aggregate.
1	DHMO HDHP	[ <b>Family Coverage Deductible</b> ... If you have one or more ... year].	This variable is used when the Deductible is embedded.

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-HMO-COST(1-17)

Page(s)	Applicable Plans	Variables	Explanations
1	DHMO HDHP	[ <b>Individual within Family Coverage Deductible</b> ... If you have ... shown below].	This variable is for custom groups only who choose unique Ded/OOPM thresholds for self-only, individual Family Member (in a Family of 2+ Members), and entire Family (2+ Members) coverage levels.
2	DHMO HDHP	[ <b>Deductible Carryover</b> ... following [contract] [calendar] [policy] year.]	This provision will be included in the form dependent on employer election.
2	DHMO HDHP	[ <b>Deductible Credit</b> ... the effective date of this EOC.]	This provision will be included in the form dependent on employer election and will only apply for the first contract year as of the effective date of the coverage.
2	DHMO HDHP	[[ <b>Self-Only</b> ] [ <b>Individual</b> ] <b>Deductible</b> ]	<p>This variable will be included when the plan includes an individual deductible.</p> <p><b>Note:</b> For <b>non-grandfathered</b> plan designs annual cost sharing will not exceed the IRS maximum limit for that calendar year. For 2017, the maximum cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage. The maximum family out-of-pocket limit for plans that are aggregate will never exceed the HHS maximum out-of-pocket maximum permitted for that calendar year (\$7,150 for 2017).</p>

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-HMO-COST(1-17)

Page(s)	Applicable Plans	Variables	Explanations
2	DHMO HDHP	[Individual within Family Deductible]	<p>This variable will be included when the plan includes a unique Deductible threshold for self-only, individual Family Member (in a Family of 2+ Members), and entire Family (2+ Members) coverage levels.</p> <p><b>Note:</b> For <b>non-grandfathered</b> plan designs annual cost sharing will not exceed the IRS maximum limit for that calendar year. For 2017, the maximum cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage. The maximum family out-of-pocket limit for plans that are aggregate will never exceed the HHS maximum out-of-pocket maximum permitted for that calendar year (\$7,150 for 2017).</p>
2	DHMO HDHP	[Family Deductible]	<p>This variable will be included when the plan includes a family deductible.</p> <p><b>Note:</b> For <b>non-grandfathered</b> plan designs annual cost sharing will not exceed the IRS maximum limit for that calendar year. For 2017, the maximum cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage. The maximum family out-of-pocket limit for plans that are aggregate will never exceed the HHS maximum out-of-pocket maximum permitted for that calendar year (\$7,150 for 2017).</p>

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-HMO-COST(1-17)

### VARIABLES USED IN ALL PLANS

Page(s)	Applicable Plans	Variables	Explanations
Throughout Form	DHMO HDHP HMO & 3TPOS	Telephone numbers.	To allow for change without re-filing.
Throughout Form	DHMO HDHP HMO & 3TPOS	[contract] [calendar] [policy]	The appropriate benefit plan period will be included in the form based on the employer's election. The standard employer election is contract year.
Throughout Form	DHMO HDHP HMO & 3TPOS	[Copayments or] [Coinsurance] [Coinsurance]	The correct term will be included depending on what type of plan is chosen.
1	DHMO HDHP HMO & 3TPOS	<b>[DEPENDENT AGE LIMIT]</b> Eligible Dependent children are covered from birth to age [26-30] [, or to age [26 – 30] [if a full-time student], as defined by your Group and approved by Health Plan.]	This provision will be omitted for subscriber only plans.
1	DHMO HDHP HMO & 3TPOS	[26 - 30]	The appropriate age limit will be included in the form based on the employer's election. The minimum age will be 26 except for retirement plans that are not subject to ACA requirements who want to retain age 26.
1	DHMO HDHP HMO & 3TPOS	[, or to age [26 – 30] [if a full-time student], as defined by your Group and approved by Health Plan].	This variable allows employers to cover students above the basic age requirement.
2	DHMO HDHP HMO & 3TPOS	<b>[Missed Appointment Fee]</b> [The amount you may be required to pay if you fail to keep a scheduled appointment and you do not notify us at least one day prior to the appointment.]	This portion of the schedule will be included when the benefit plan includes this provision.
2	DHMO HDHP Custom HMO	<b>[Deductible]</b>	This portion of the schedule will be included in the form when the benefit plan has a deductible.  Note: For <b>non-grandfathered</b> plan designs annual cost sharing will not exceed the IRS maximum limit for that

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-HMO-COST(1-17)

Page(s)	Applicable Plans	Variables	Explanations
			<p>calendar year.</p> <p>The family deductible for plans that do not have an individual deductible limit will not exceed the annual ACA individual cost-share limits for the applicable calendar year.</p>
1	DHMO HDHP HMO w/Deductible	[DEDUCTIBLE ... Keep Your Receipts ... Department]].	<p>This provision will be included in the form when the benefit plan has a deductible. The Deductible amounts for In-Plan and Out-of-Plan will never exceed the amounts permitted under ACA requirements for <b>non-grandfathered</b> plan designs.</p> <p>Note: For <b>non-grandfathered</b> plan designs annual cost sharing will not exceed the HHS maximum limit for that calendar year.</p>
2	DHMO HDHP HMO & 3TPOS	<p>Under Office visits (for other than preventive health care Services) – Primary care office visits and Specialty care office visits: [For adults]</p> <p>[For children under [24 months][2 – 18] [years] of age]</p> <p>[For children age [24 months][2 – 18] [years] of age or older]</p>	<p>This text will be included in the form when the primary office visit cost share for adults differs from the primary care cost share for children.</p> <p>This text will be included in the form when the primary care office visit cost share differs for children under a specific age elected by the employer group.</p> <p>This text will be included in the form when the primary care office visit cost share differs for children over a specific age elected by the employer group.</p>
3	DHMO HDHP HMO & 3TPOS	Under <b>Outpatient Care:</b> Anesthesia	The cost share for the Anesthesia benefit will be the same as for Anesthesia for Dental Services.

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-HMO-COST(1-17)

Page(s)	Applicable Plans	Variables	Explanations
4	DHMO HDHP HMO & 3TPOS	[Hospital Observation Services]	This variable will be included if the employer elects to cover the benefit.
4	DHMO HDHP HMO & 3TPOS	Under <b>Accidental Dental Injury Services</b> :  [Limited to treatment started within 6 months of the accident]	“Applicable Cost Shares will apply, based on type and place of Service” will be used when there are various cost shares options. When the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.  This variable will be included at the request of the employer.
4	DHMO HDHP HMO & 3TPOS	Under <b>Allergy Services</b> ,  [Evaluations and treatment Injection visits and serum]	The cost share for all services will be the “Applicable Cost Shares will apply, based on type and place of Service” when there are various cost shares options. When the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.  The sub-categories will be omitted from the form when the cost share for all Allergy Services is the same for all services.
5	DHMO HDHP HMO & 3TPOS	<b>Anesthesia for Dental Services</b>	“Applicable Cost Shares will apply, based on type and place of Service” will be used when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.
5	DHMO HDHP HMO & 3TPOS	<b>Blood, Blood Products and their Administration</b>	For most HMO plan designs, the cost share is “No charge”, unless the employer elects to apply a cost share based on place of service.  For all other plan designs the cost share will be the “Applicable Cost Shares will apply, based on type and place of Service” when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-HMO-COST(1-17)

Page(s)	Applicable Plans	Variables	Explanations
5	DHMO HDHP HMO & 3TPOS	<p><b>Under Chemical Dependency and Mental Health Services:</b></p> <p>[Inpatient psychiatric and ...Medication management visits]</p> <p>[Medication Management visits]</p> <p>[Residential Treatment center]</p>	<p>Only the heading is included if all services are covered at the same coinsurance.</p> <p>This section is included when the group opts to elect separate cost shares for these services.</p> <p>This variable will be excluded at the request of the employer.</p> <p>This variable will be included at the request of the employer.</p>
5	DHMO HDHP HMO & 3TPOS	<p><b>[Chiropractic] [and] [Acupuncture] Services</b></p> <p>[No limit] [Limited to [10 – 90] visits for Chiropractic Services per Member per [contract] [calendar] [policy] year]</p> <p>[No limit] [Limited to [10 – 90] visits for Acupuncture Services per Member per [contract] [calendar] [policy] year]</p>	<p>The variables Chiropractic and Acupuncture will be included or removed depending on if the employer elects the service(s). It will be included in the cost shares if the service(s) are covered under the base plan instead of by the Rider.</p> <p>[Limited to ... year] will be included when there is an annual limit; or omitted if the visits are unlimited. There is a variable for each Service so that an employer may elect to include the same or a different number of visits for each service; and the same or a different cost share for each service.</p>
6	DHMO HDHP HMO & 3TPOS	<p><b>Cleft Lip, Cleft Palate, or Both</b></p>	<p>“Applicable Cost Shares will apply, based on type and place of Service” will be used when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.</p>
6	DHMO HDHP HMO & 3TPOS	<p><b>Clinical Trials</b></p>	<p>“Applicable Cost Shares will apply, based on type and place of Service” will be used when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.</p>

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-HMO-COST(1-17)

Page(s)	Applicable Plans	Variables	Explanations
6	DHMO HDHP HMO & 3TPOS	<p>Under <b>Diabetic Equipment, Supplies and Self-Management Training:</b></p> <p>[Diabetic equipment [and supplies]]</p> <p>[Diabetic equipment]</p> <p>[Diabetic supplies]</p> <p>[Disposable needles and syringes]</p> <ul style="list-style-type: none"> <li>• Glucose test strips</li> <li>• Glucose test meter                             <ul style="list-style-type: none"> <li>○ Additional meters</li> </ul> </li> <li>• Control solutions</li> <li>• Lancets</li> <li>• Other supplies]</li> </ul> <p>[Self-management training]</p>	<p>The cost share for diabetic equipment and supplies will be the same as for DME. The cost share for self-management training will be the “Applicable Cost Shares will apply, based on type and place of Service” when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected. This text will be omitted from the form when the cost share for all Diabetic Equipment, Supplies and Self-Management Training is “No charge” or a coinsurance, after deductible or deductible waived.</p> <p>This text will be included in the form when the cost share for all Diabetic Equipment and Diabetic Supplies is the same, but differ from the cost share of Self-Management Training.</p> <p>This text will be included in the form when the cost share for Diabetic Equipment differs from the cost share for Diabetic Supplies.</p> <p>This text will be included when (a) the cost share for Diabetic Supplies differs from that of Diabetic Equipment, and (b) the cost share of all Diabetic Supplies is the same. This bulleted list will be included in the form when (a) the cost share for Diabetic Supplies differs from the cost share for Diabetic Equipment, and (b) the cost share for Diabetic Supplies varies dependent on the type of diabetic supply.</p> <p>This variable will be included when the variable “Diabetic equipment and supplies in included.</p> <p>Note: The standard employer group election is to have the same cost share for diabetic supplies and equipment.</p>

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-HMO-COST(1-17)

Page(s)	Applicable Plans	Variables	Explanations
6	DHMO HDHP HMO & 3TPOS	<p>Under <b>Dialysis</b>:</p> <p>[Inpatient care]</p> <p>[Outpatient Care ]</p> <p>[Dialysis Center Home dialysis, including training]</p>	<p>The sub-categories will be omitted from the form when the cost share for all inpatient and outpatient Dialysis services is “No charge” or a coinsurance, after deductible or deductible waived.</p> <p>Inpatient care will be included when different cost shares apply to inpatient and outpatient dialysis.</p> <p>Outpatient Care will be included when all outpatient care services are a different cost share than inpatient care.</p> <p>These variables will be used when there is a different cost share for outpatient dialysis at a dialysis center than for home dialysis.</p>
7	DHMO HDHP HMO & 3TPOS	<p>Under <b>Durable Medical Equipment</b>:</p> <p><b>[Outpatient Basic Durable Medical Equipment]</b></p> <p>[Limited to use in the home for up to 3 months ... authorized outpatient surgical procedure.]</p> <p><b>[Outpatient Supplemental Durable Medical Equipment ... (under age 3, not to exceed a period of 6 months)]</b></p> <p>[Apnea Monitors (under age 3, not to exceed a period of 6 months)]</p> <ul style="list-style-type: none"> <li>o [Spacers</li> <li>o Peak-flow meters</li> <li>o Nebulizers]</li> </ul>	<p>All sub-categories will be deleted and only the heading will be used for plan designs that have the same cost share for all DME received on an outpatient basis.</p> <p>This variable will be included in the form when Basic Durable Medical Equipment has a different cost share than Supplemental DME.</p> <p>This provision will be included in the form when the employer group elects this option.</p> <p>The Supplemental Durable Medical Equipment section will be included in the form when the cost share of Supplemental Durable Medical Equipment differs from the cost share for Basic Durable Medical Equipment.</p> <p>This provision will be omitted for subscriber only plans.</p> <p>The text will be included in the form when (a) the cost share for Supplemental Durable Medical Equipment differs from the cost share for Basic Durable Medical Equipment, and (b) the cost share for Asthma Equipment varies dependent on the type of asthma equipment.</p>

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-HMO-COST(1-17)

Page(s)	Applicable Plans	Variables	Explanations
		[Bilirubin Lights (under age 3, not to exceed a period of 6 months)]	This provision will be omitted for subscriber only plans.
8	DHMO HDHP HMO & 3TPOS	Under <b>Emergency Services</b> : [Emergency room visits ... Copayment will not be waived]	These sub-categories will be omitted and only the heading will be used when the cost share for all Emergency Services is “No charge” or a coinsurance, after deductible or deductible waived.
8	DHMO HDHP HMO & 3TPOS	<b>[Family Planning]</b>	For <b>Grandfathered</b> Plans, the cost share for all services will be “Applicable Cost Shares will apply, based on type and place of Service” when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.  For <b>non-Grandfathered</b> Plans, the cost share for all services that are considered preventive care services under ACA will be covered at “No Charge”. All other services will be the “Applicable Cost Shares will apply, based on type and place of Service” when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.
8	DHMO HDHP HMO & 3TPOS	Under <b>Family Planning</b> : [[Office visits]  [Tubal ligation] [,Vasectomy] [Voluntary termination of pregnancy]]	This text will be omitted from the form when the cost share for all Family Planning services is “No charge” or a coinsurance, after deductible or deductible waived.  Tubal ligation will only be included with a <b>grandfathered</b> plan that has this coverage. The other two procedures are variable to allow a group to elect which services to cover.
8	DHMO HDHP HMO & 3TPOS	Under <b>Family Planning</b> : [Women’s Preventive Services, including all Food and Drug Administration approved contraceptive methods,	This variable will be included for <b>non-grandfathered plans</b> . This variable will be omitted when the employer

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Page(s)	Applicable Plans	Variables	Explanations
		sterilization procedures, and patient education and counseling for all women with reproductive capacity are covered under Preventive Care at no charge.]	group requests the exclusion of family planning services as permitted under 45 CFR §147.131 for <b>non-grandfathered</b> plans.
8	DHMO HDHP HMO & 3TPOS	<b>Habilitative Services</b> [Limited to children up to age 21]  [Applied Behavioral Analysis (ABA)]	ABA will always be the same as mental health “all other.”  Bracketed to allow removal if the benefit is not covered.
9	DHMO HDHP HMO & 3TPOS	Under <b>Home Health Care:</b> [Limited to a maximum ... or postpartum home visits.]  [30 – 240 visits]	This provision will be included in the form when the employer group elects a visit limit.  The appropriate visit limit will be included in the form dependent on the employer group’s election.
9	DHMO HDHP HMO & 3TPOS	[ <b>Infertility Services</b> ]	This provision will be omitted when an employer group requests the exclusion of in vitro fertilization from coverage.
9	DHMO HDHP HMO & 3TPOS	Under <b>Infertility Services:</b> [Office visits [for initial diagnosis of infertility] ... for treatment of infertility]  Office visits [for initial diagnosis of infertility]  [Note: Coverage for in vitro fertilization is limited to a maximum of three attempts per live birth][, not to exceed a maximum lifetime benefit of \$100,000.]]	This text will be omitted when the cost share for all Infertility Services is “No charge” or a coinsurance, after deductible or deductible waived.  This text will be included when the employer group elects a cost share for office visits for initial diagnosis of infertility different than that of office visits for all other infertility services.  This text will be omitted when the employer group elects to remove the limit on in vitro fertilization. The provision will be omitted with the employer group elects to omit a maximum limit.
10	DHMO HDHP HMO & 3TPOS	Under <b>Maternity Services:</b> [Prenatal and postpartum visits ... charge]  Postpartum home health visits	These subcategories will be deleted if the same cost share applies to all non-ACA maternity services.  For the cost share, the Deductible will be waived for all

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		Breast Pumps	<p>plan designs except HSA Qualified HDHP plans.</p> <p>Breast Pumps added at no charge in accordance with the Affordable Care Act Mandate.</p> <p>Note: Cost-sharing provision for routine outpatient global maternity shall be covered at no charge under preventive care services in compliance with the Health Resources and Services Administration Supported Women’s Preventive Services Guidelines 45 CFR §147.130(a)(1)(iv).</p>
10	DHMO HDHP HMO & 3TPOS Grandfathered plans	<p>Under <b>Maternity Services:</b> [Prenatal and Postnatal care ... section]</p> <p>Postpartum home health visits</p>	<p>This provision will be included for <b>grandfathered plans</b>.</p> <p>For the cost share, the Deductible will be waived for all plan designs except HSA Qualified HDHP plans.</p>
10	DHMO HDHP HMO & 3TPOS	<p><b>Morbid Obesity Services:</b></p> <p>[Bariatric Surgery All other Services]</p>	<p>The heading will be included and all sub-headings deleted if the plan has the same cost share for all morbid obesity services.</p> <p>These variables will be included if there are different cost shares for surgery than for other morbid obesity services, such as consultations.</p> <p>The variable cost-sharing provision for Morbid Obesity surgery will be covered at the same cost shares as any other surgical procedure. All other cost shares will be the “Applicable Cost Shares will apply, based on type and place of Service” when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.</p>
10	DHMO HDHP HMO & 3TPOS	<b>Oral Surgery</b>	<p>“Applicable Cost Shares will apply, based on type and place of Service” will be used when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will</p>

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			be reflected.
10	DHMO HDHP HMO & 3TPOS	Under <b>Preventive Health Care Services:</b> [Not subject to Deductible]  [Routine physical exams...for immunization agent)]	This text will be included HDHP plans.  This text is included when a group elects to assess a copay for these services.
11	DHMO HDHP HMO & 3TPOS	Under <b>Prosthetic Devices:</b> [Limited to internally implanted devices, ostomy and urological supplies and breast prosthetics, unless a Prosthetic and Orthotic Devices Rider is attached to this EOC.]	This text will be included in the form when the cost share for all Prosthetic Devices is “No charge” or a coinsurance, after deductible or deductible waived.
11	DHMO HDHP HMO & 3TPOS	Under <b>Prosthetic Devices:</b> [Internally implanted devices ... Breast Prosthetics]        [Hair Protheses]	These variables will be omitted from the form when the cost share for all Prosthetic Devices is “No charge” or a coinsurance, after deductible or deductible waived.  The variable cost-sharing provision for breast prosthetics and hair prosthesis will be covered at the same cost shares as any other prosthetic device covered under the contract, except some HMO plans are always covered at “No charge”. The variable cost-sharing provision for ostomy and urological supplies and equipment will be covered at the same cost shares as all medical devices and supplies.  This variable will be included if the employer elects to include Hair Protheses as a base benefit.
11	DHMO HDHP HMO & 3TPOS	Under <b>Reconstructive Surgery</b>	The variable cost-sharing provision for Reconstructive Surgery will be covered at the same cost shares as any other surgical procedure, based on type and place of service.
11	DHMO HDHP HMO & 3TPOS	Under <b>Skilled Nursing Facility Care:</b>	The cost share for skilled nursing care will be the same as an inpatient stay in a hospital unless specifically requested by employer group. All requests other than the same as

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Page(s)	Applicable Plans	Variables	Explanations
		<p>[Limited to a maximum benefit ... year]</p> <p>[60 – 240][per admission]</p>	<p>inpatient must be reviewed for impact on mental health inpatient cost share.</p> <p>This text will be included in the form when the employer group elects a day limit.</p> <p>The appropriate number of days will be included in the form based on the employer group’s election.</p>
12	DHMO HDHP HMO & 3TPOS	<p>Under <b>Therapy and Rehabilitation Services:</b> [Inpatient Services ... program will be considered one visit.]</p>	<p>The sub-categories will be omitted from the form when the cost share for both inpatient and outpatient Therapy and Rehabilitation Services is “No charge” or a coinsurance, after deductible or deductible waived.</p>
12	DHMO HDHP HMO & 3TPOS	<p>Under <b>Urgent Care:</b> [Office visit during regular office hours After-Hours Urgent Care or Urgent Care Center ]</p>	<p>The sub-categories will be omitted from the form when the cost share for all Urgent Care services is “No charge” or a coinsurance, after deductible or deductible waived.</p>
15	DHMO HDHP HMO & 3TPOS	<p>Under <b>X-ray, Laboratory and Special Procedures:</b> [Inpatient diagnostic imaging ... visit Copayment]</p> <p>[Note: charges for covered..... office visit Copayment.]</p>	<p>The sub-categories will be omitted from the form when the cost share for all X-ray, Laboratory and Special Procedures is “No charge” or a coinsurance, after deductible or deductible waived.</p> <p>This text will be omitted from the form based on employer group election.</p>
15	Grandfathered plans: DHMO HDHP HMO & 3TPOS	<p><b>[Out-of-Pocket Maximum]</b> [The Out-of-Pocket Maximum ... maximum was reached.]</p> <p>[the Basic Health]</p> <p><b>[[Self-Only] [Individual] Coverage Out-of-Pocket Maximum ... shown below.]</b></p>	<p>This Out-of-Pocket Maximum provision will be included with grandfathered plans The first paragraph is included in all plan designs.</p> <p>Basic Health Services are included for grandfathered HMO and DHMO plans.</p> <p>This variable will be used with HDHP or DHMO plans.</p>

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Page(s)	Applicable Plans	Variables	Explanations
		<p>[Family Coverage Out-of-Pocket Maximum ... year.]</p> <p>[Family Coverage Out-of-Pocket Maximum ... coverage.]</p> <p>[Except as excluded... mental health Services]</p> <p>[Member payments for all Services apply to the Out-of-Pocket Maximum.]</p> <p><b>[Out-of-Pocket Maximum Exclusions:</b> The following Services, if covered, [are not considered Basic Health Services and] ... [adult vision exam] ]</p> <p>[Member payments for Services that are not subject to the Deductible (as listed above in the schedule) do not apply to the Out-of-Pocket Maximum.]</p> <p>Keep Your Receipts and Notice of Out-of-Pocket Maximum are not variable.</p> <p><b>[Annual Out-Of-Pocket Maximum]</b></p> <p>[most] [that are subject to the out-of-pocket- maximum]</p>	<p>This variable is used with an embedded OOPM.</p> <p>This variable is used with an aggregate OOPM.</p> <p>The list of basic services will only be included for HMO or DHMO plans.</p> <p>This variable will be used for HDHP plans.</p> <p>For use with HMO or DHMO that exclude certain services from the out-of-pocket maximum based on plan design. This provision will be excluded from HDHP plans.</p> <p>This provision will be included for grandfathered plan designs that do not apply services that are not subject to the deductible towards the out-of-pocket maximum. This is used for deductible HMO plan designs.</p> <p>Include with all plan designs.</p> <p>The Self-Only and Family Out-of-Pocket Maximum will be included with all grandfathered plans.</p> <p>Certain services subject to Out-of-Pocket Maximum.</p>
16	<p>Non-grandfathered plans: DHMO HDHP HMO &amp; 3TPOS</p>	<p><b>[Out-of-Pocket Maximum]</b> [The Out-of-Pocket Maximum ... maximum was reached.]</p>	<p>This Out-of-Pocket Maximum provision will be included with non-grandfathered plans The first paragraph is included in all plan designs.</p> <p>This Out-of-Pocket Maximum provision will be included with non-grandfathered plans. The first paragraph is included in all plan designs. Note: For non-grandfathered plan designs annual cost sharing will not exceed the IRS maximum limit for that calendar year. For 2017, the</p>

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Page(s)	Applicable Plans	Variables	Explanations
		<p>[[Self-Only] [Individual] Coverage Out-of-Pocket Maximum ... shown below.]</p> <p>[Family Coverage Out-of-Pocket Maximum ... year.]</p> <p>[Family Coverage Out-of-Pocket Maximum ... coverage.]</p> <p>[Individual within Family Coverage Out-of-Pocket Maximum ... shown below.]</p> <p>[Out-of-Pocket Maximum Exclusions ... eye exams]</p> <ul style="list-style-type: none"> <li>• [Adult eyeglass lenses...a discount only]</li> <li>• [Adult dental Services...to this plan]</li> <li>• [Adult routine eye exams]</li> </ul> <p>[Member payments for Services that are not subject to the Out-of-Pocket Maximum (as listed above in the schedule) do not apply to the Deductible.]</p>	<p>maximum cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage. The maximum family out-of-pocket limit for plans that are aggregate will never exceed the HHS maximum out-of-pocket maximum permitted for that calendar year (\$7,150 for 2017).</p> <p>This variable is included for a deductible plan with an embedded Self-Only deductible. – HMO/DHMO</p> <p>This variable is used with an embedded OOPM.</p> <p>This variable is used with an aggregate OOPM.</p> <p>This variable is for custom groups only who choose unique Ded/OOPM thresholds for self-only, individual Family Member (in a Family of 2+ Members), and entire Family (2+ Members) coverage levels.</p> <p>These out-of-pocket maximum exclusions may be deleted at employer request or the entire provision may be removed if the plan does not include routine vision or adult dental benefits.</p> <p>Removed for HDHP. May be removed for HMO/DHMO custom plans that do not cover vision hardware.</p> <p>Generally included, but may be removed for a custom plan that does not include adult dental.</p> <p>Removed for HDHP. May be removed for HMO/DHMO custom plans that do not cover vision hardware.</p> <p>Included at employer request.</p>

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Page(s)	Applicable Plans	Variables	Explanations
		Keep Your Receipts and Notice of Out-of-Pocket Maximum are not variable. <b>[Annual Out-Of-Pocket Maximum]</b> [Deductible and] [Copayments and]	Include with all plan designs.  Note: For non-grandfathered plan designs annual cost sharing will not exceed the IRS maximum limit for that calendar year. For 2017, the maximum cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage. The maximum family out-of-pocket limit for plans that are aggregate will never exceed the HHS maximum out-of-pocket maximum permitted for that calendar year (\$7,150 for 2017).
17	DHMO HDHP HMO & 3TPOS	<b>[[Self-Only] [Individual] Out-of-Pocket Maximum]</b>	This variable will be included when the plan includes an individual maximum. Note: For non-grandfathered plan designs annual cost sharing will not exceed the IRS maximum limit for that calendar year. For 2017, the maximum cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage. The maximum family out-of-pocket limit for plans that are aggregate will never exceed the HHS maximum out-of-pocket maximum permitted for that calendar year (\$7,150 for 2017).
17	DHMO HDHP HMO & 3TPOS	<b>[Individual within Family Out-of-Pocket Maximum]</b>	This variable will be included when the plan includes a unique Deductible threshold for self-only, individual Family Member (in a Family of 2+ Members), and entire Family (2+ Members) coverage levels. Note: For non-grandfathered plan designs annual cost sharing will not exceed the IRS maximum limit for that calendar year. For 2017, the maximum cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage. The maximum family out-of-pocket limit for plans that are aggregate will never exceed the HHS maximum out-of-pocket maximum permitted for that calendar year (\$7,150 for 2017).



## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Section 3: Benefits

Form Number: DCLG-ALL-SEC3(1-17)

Page(s)	Applicable Products	Variables	Explanations
Throughout Section 3	DHMO HDHP HMO & 3TPOS	<a href="http://www.kp.org">[www.kp.org]</a> [Inside the Washington, DC Metropolitan Area: (301) 468-6000] [Outside of the Washington, DC Metropolitan Area: 1-800-777-7902] [TTY: 711] [1-800-677-1112] [7:30 a.m. until 9 p.m. ET.] [1-866-530-8778]	Telephone numbers, Web site addresses, and hours of operation are bracketed to allow Health Plan to change without refiling.
Throughout Section 3	DHMO HDHP HMO & 3TPOS	[contract] [calendar] [policy]	The appropriate benefit plan period will be included in the form based on the employer's election. The standard employer election is contract year.
3.1	HMO & 3TPOS	[You have met any Deductible requirement described in the "Deductibles" section of the Summary of Services and Cost Shares Appendix;]	This variable will be removed for plans without a deductible.
3.1	DHMO HDHP HMO & 3TPOS	Authorized referrals to non-Plan Providers, as described in Section 2: How to Obtain Services under "Getting a Referral," including referrals for Clinical Trials as described in this section[.]; and]	The variable [.] will be used when the plan is HDHP and does not include "Visiting Member Services as described in Section 2: How to Obtain Services."  The variable [; and] will be used when the plan is HMO or DHMO and includes "Visiting Member Services as described in Section 2: How to Obtain Services."
3.1	DHMO HHMO & 3TPOS	[Receiving care in another Kaiser Foundation Health Plan Service Area in Section 2: How to Obtain Services.]	This text will be omitted from the form when the benefit plan is a HDHP.

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Form Name: Section 3: Benefits

Form Number: DCLG-ALL-SEC3(1-17)

Page(s)	Applicable Products	Variables	Explanations
3.1	DHMO HDHP HMO & 3TPOS	[Consultations and immunizations for foreign travel;]	This variable option are may be omitted separately at the request of the employer.
3.3	DHMO HDHP HMO & 3TPOS	[sixty (60) days][six (6) months]	The amount of days or months will be chosen by the employer.
3.6	DHMO HDHP HMO & 3TPOS	[Applied Behavior Analysis (ABA).]	This benefit will be included at the request of the employer.
3.6	DHMO HDHP HMO & 3TPOS	<b>[Chiropractic] [and] [Acupuncture] Services</b> <b>[[Chiropractic] [and] [Acupuncture] Services ... Services.]</b>	This provision will be included for custom plans that provide either chiropractic or chiropractic and acupuncture coverage as part of the base plan instead of by Rider.
3.6	DHMO HDHP HMO & 3TPOS	Under <b>Chiropractic and Acupuncture Services:</b> [We cover Medically Necessary outpatient acupuncture Services for chronic pain management or chronic illness management.]	This benefit will be included at the request of the employer.
3.6	DHMO HDHP HMO & 3TPOS	Under <b>Chiropractic and Acupuncture Services:</b> [and shall not exceed a total of [ten (10)-ninety (90)] visits per [contract][calendar][policy] year [for each type of Service][for chiropractic Services; and [ten (10)-ninety (90) visits per [contract][calendar][policy] year for acupuncture Services.]	These variables will be included for plans that limit the number of visits per year for each type of service.  These variables will be removed for plans that have unlimited visit, or that have a different visit limit for each service.
3.9	DHMO HDHP HMO & 3TPOS	Under <b>Drugs, Supplies and Supplements:</b> [and] [.]	These variables will be included if the group requests the exclusion of family planning services.

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Form Name: Section 3: Benefits

Form Number: DCLG-ALL-SEC3(1-17)

Page(s)	Applicable Products	Variables	Explanations
3.9	DHMO HDHP HMO & 3TPOS	Under <b>Drugs, Supplies and Supplements</b> : [; and “Family Planning Services” for the insertion and removal of contraceptive drugs and devices.]	This text will be omitted when the employer group requests the exclusion of family planning services as permitted under 45 CFR §147.131 for non-Grandfathered plans.
3.9	DHMO HDHP HMO & 3TPOS	Under <b>Drugs, Supplies and Supplements</b> : [Refer to Infertility Services for coverage of administered drugs necessary for in vitro fertilization.]	This text will be omitted when an employer group requests the exclusion of in vitro fertilization from coverage.
3.13	DHMO HDHP HMO & 3TPOS	[ <b>Family Planning Services</b> ... see “X-ray, Laboratory and Special Procedures”).]	This entire benefit will be omitted when the employer group requests the exclusion of family planning services as permitted under 45 CFR §147.131.
3.13	DHMO HDHP HMO & 3TPOS	Under <b>Family Planning Services</b> : [Women’s Preventive Services ... no charge.])	This provision will be used for non-grandfathered plans.  The entire WPS benefit description will be omitted when the employer group requests the exclusion of family planning services as permitted under 45 CFR §147.131.
3.9	All Non-Grandfathered Plans	Under <b>Family Planning Services</b> : 2. [Additional family planning counseling[, including pre-abortion and post-abortion counseling][.][;][; and] 3. [Vasectomies][.][;][; and] 4. [[Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (1) the fetus suffers from a chromosomal, major metabolic or anatomic defect or (2) the maintenance of the pregnancy would seriously	This provision will be used for non-grandfathered plans.  Each of these variable options are may be omitted separately at the request of the employer.

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		<p>jeopardize the life or health of the mother.]</p> <p><b><i>Voluntary Termination of Pregnancy Limitations:</i></b></p> <ul style="list-style-type: none"> <li>• We cover up to a maximum of two (2) voluntary terminations of pregnancy during a contract year.]</li> </ul>	
3.13	All grandfathered plans	<p>Under <b>Family Planning Services:</b></p> <ol style="list-style-type: none"> <li>1. [[Family planning counseling[, including pre-abortion and post-abortion counseling] and information on birth control.]</li> <li>2. [Insertion and removal and any Medically Necessary examination associated with the use of contraceptive drugs and devices. Contraceptive devices (other than diaphragms) and implantable contraceptive drugs are supplied by the provider, and are covered under this benefit. Contraceptive drug and diaphragms are covered only under an “Outpatient Prescription Drug Rider,” if applicable.]</li> <li>3. [Tubal ligations.]</li> <li>4. [Vasectomies.]</li> <li>5. [[Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (1) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (2) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.]</li> </ol>	<p>This provision will be used for grandfathered plans.</p> <p>These benefits are bracketed to be omitted from the form if an employer group decides to exclude any one or all of the benefits.</p>

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Page(s)	Applicable Products	Variables	Explanations
		<i>Voluntary Termination of Pregnancy Limitations:</i> We cover up to a maximum of two (2) voluntary terminations of pregnancy during a contract year.]	
3.13	DHMO HDHP HMO & 3TPOS	Under <b>Habilitative Services:</b> <u>[Children under age (21)]</u>	This variable will be included if Habilitative services are covered for Children under 21 years of age will be included if elected by employer.
3.14	DHMO HDHP HMO & 3TPOS	Under <b>Habilitative Services:</b> [Medical Necessary Services to treat autism and autism spectrum disorders shall include Applied Behavioral Analysis (ABA).]	This variable will be included if the employer elects to cover Medical Necessary Services to treat autism and autism spectrum disorders.
3.14	DHMO HDHP HMO & 3TPOS	Under <b>Family Planning Services:</b> <u>[Adults age 21 or older]</u> We cover Medically Necessary habilitative Services that are designed to enhance a Member's functional ability, without effecting a cure, for the treatment of autism or an autism spectrum disorder, "Medically Necessary habilitative Services" include occupational therapy, physical therapy, speech therapy and Applied Behavioral Analysis (ABA).]	This variable will be included if Habilitative services are covered for Adults age 21 or older in accordance with the Applied Behavioral Analysis (ABA).
3.14	DHMO HDHP HMO & 3TPOS	Under <b>Hearing Services:</b> <u>[Hearing Exams]</u> <u>[Hearing Aids ... upgrade.]</u>	These variables will be included when hearing tests and/or hearing aids are selected by the employer.
3.14	DHMO HDHP HMO & 3TPOS	Under <b>Hearing Services:</b> [twelve (12)-sixty (60)] months	This variable allows the group to select how frequently the Member is covered for additional hearing aids.

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Page(s)	Applicable Products	Variables	Explanations
3.14	DHMO HDHP HMO & 3TPOS	<p><b><i>Hearing Aid Limitations:</i></b></p> <ul style="list-style-type: none"> <li>• [Your hearing aid Benefit Allowance is [\$500 – \$5,000]].</li> <li>• [Coverage is provided for one Hearing Aid for each hearing impaired ear every [twelve (12) – sixty (60)] months. Two Hearing Aids are covered every [twelve (12) – sixty (60)] months only if both are required to provide significant improvement that is not obtainable with only one Hearing Aid, as determined by your Plan Provider.]</li> <li>• [You are not required to obtain Hearing Aids for both ears at the same time. The [twelve (12) – sixty (60)] month benefit period extends separately for each ear, and commences at the initial point of sale for each ear.]</li> <li>• [The hearing aid Benefit Allowance must be used at the initial point of sale for each hearing aid. Any part of the hearing aid Benefit Allowance that is not exhausted at the initial point of sale may not be used at a later time.]</li> <li>• [The type of Hearing Aid is limited to the models provided by Kaiser Permanente or the Kaiser Permanente-designated Hearing Aid vendor.]</li> </ul> <p>[You may apply the hearing aid Benefit Allowance toward a hearing aid upgrade. However, you must pay the difference in the hearing aid Benefit Allowance</p>	<p>Each of these variable options are may be omitted separately at the request of the employer.</p> <p>The dollar amount ranges and allowable month’s ranges will depend on the amount chosen by the employer.</p>

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Page(s)	Applicable Products	Variables	Explanations
		and the cost of the hearing aid upgrade.]	
3.15	DHMO HDHP HMO & 3TPOS	Under <b>Hearing Services</b> : [Tests to determine ... their efficacy.]	This variable will be included when hearing tests and hearings aids are selected by the employer.
3.15	DHMO HDHP HMO & 3TPOS	Under <b>Hearing Services</b> : [Replacement of ... coverage.]	This variable will be included when hearings aids are selected by the employer.
3.15	DHMO HDHP HMO & 3TPOS	Under <b>Home Health Care</b> : [Except as provided for under Visiting Member Services, we]  [We]	This text will be omitted from the EOC when the benefit plan is a HDHP and included in EOC when the benefit plan is HMO, DHMO, or POS.  The variable [We] will be used when the benefit plan is HDHP.
3.16	DHMO HDHP HMO & 3TPOS	[The visit maximum does not apply to home visits following mastectomy or testicle removal; or postpartum home visits.]	This variable will be used for custom groups that include a visit limit.
3.17	DHMO HDHP HMO & 3TPOS	[ <b>Infertility Services</b> ... to such procedures.]]	This entire benefit may be omitted from the form when an employer group requests the exclusion of in vitro fertilization from coverage.
3.17	DHMO HDHP HMO & 3TPOS	Under <b>Infertility Services</b> : [; and Artificial insemination[.]	This provision will be included if the employer elects to cover artificial insemination.
3.17	DHMO HDHP HMO & 3TPOS	Under <b>Infertility Services</b> : 3. [In vitro fertilization ... fertilization]	An employer who meets the exemption criteria may elect to only cover infertility and exclude in vitro fertilization.  This provision will be excluded if the employer elects

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			to cover only artificial insemination.
3.18	DHMO HDHP HMO & 3TPOS	<p>Under <b>Infertility Services:</b>  <i>[Infertility Limitations:</i></p> <ul style="list-style-type: none"> <li>• Coverage for in-vitro fertilization embryo transfer cycles[, including frozen embryo transfer (FET) procedure,] is limited to three attempts per live birth[, not to exceed a maximum lifetime benefit of \$100,000]].</li> </ul>	<p>The three attempts per live birth and/or the \$100,000 maximum benefit will be omitted at the request of the employer.</p> <p>This service is bracketed to allow an employer group to exclude coverage.</p>
3.18	DHMO HDHP HMO & 3TPOS	<p>Under <b>Infertility Services:</b></p> <ul style="list-style-type: none"> <li>• [Services to reverse voluntary, surgically induced infertility.]</li> <li>• [Infertility Services when the infertility is the result of an elective male or female sterilization surgical procedure.]</li> <li>• [Assisted reproductive technologies and procedures[ other than those described above], including, but not limited to: [[artificial insemination;] in vitro fertilization; ][ gamete intrafallopian transfers (GIFT); ][zygote intrafallopian transfers (ZIFT);] and prescription drugs related to such procedures.]]</li> </ul>	<p>The exclusions provisions will be omitted from the form when an employer group chooses not to limit coverage of in vitro fertilization for one or more of the variable options.</p> <p>These services are bracketed to allow an employer group to exclude coverage.</p>
3.21	DHMO HDHP HMO & 3TPOS	<p>Under <b>Preventive Health Care Services:</b>            [In addition ... Services.]</p>	<p>This provision will be included in the form for non-grandfathered employer group benefit plans and grandfathered employer group benefit plans that elect the Patient Protection and Affordable Care Act preventive care package.</p>

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3.21	DHMO HDHP HMO & 3TPOS	Under <b>Preventive Health Care Services</b> : [www.uspreventiveservicestaskforce.org]); [http://www.cdc.gov/vaccines/acip/index.html]; [http://mchb.hrsa.gov]);	The URLs are variable so they can be changed without refiling.
3.21	DHMO HDHP HMO & 3TPOS	Under <b>Preventive Health Care Services</b> : [We cover medically ... age.]	This provision will be included in the form for non-grandfathered employer group benefit plans and grandfathered employer group benefit plans that elect the Patient Protection and Affordable Care Act preventive care package.
3.22	DHMO HDHP HMO & 3TPOS	Under <b>Preventive Health Care Services</b> : [BRCA ... Service.]	This benefit will be included or removed at the request of the employer.
3.23	DHMO HDHP HMO & 3TPOS	Under <b>Prosthetic Devices</b> : [Hair Prosthesis]	This variable will be included if the employer does not cover Hair Prosthesis.
3.25	DHMO HDHP HMO & 3TPOS	Under <b>Therapy and Rehabilitation Services</b> : therapy[: ... or cleft palate.]	All limits may be excluded at the request of the employer.
3.25	DHMO HDHP HMO & 3TPOS	Under <b>Therapy and Rehabilitation Services</b> : 2. For up to [twenty (20)-ninety (90)] visits [[or] ninety (90) consecutive days] of physical therapy [whichever is longer], [twenty (20)-ninety (90)] visits [[or] ninety (90) consecutive days] of occupational therapy, and [twenty (20)-ninety (90)] visits [[or] ninety (90) consecutive days] of speech therapy per [contract] [policy] [calendar]	The appropriated visit limit will be included in the form based on the employer group's election.

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		year per injury, incident or condition in a Plan Medical Center, a Plan Provider’s medical office, a Skilled Nursing Facility or as part of home health care. [These limits do not apply to necessary treatment of cleft lip or cleft palate.]	
3.26	DHMO HDHP HMO & 3TPOS	Under <b>Therapy and Rehabilitation Services:</b> <b><u>Cardiac Rehabilitation Services</u></b> [for up to twelve (12) weeks, or thirty-six (36) sessions, whichever occurs first]	The limit may be removed at the request of the employer.
3.26	DHMO HDHP HMO & 3TPOS	Under <b>Therapy and Rehabilitation Services:</b> <b><u>Pulmonary Rehabilitation Services</u></b> We cover pulmonary rehabilitation Services that are Medically Necessary; limited to one (1) program per lifetime.]	This benefit will be included at the request of the employer.
3.27	HDHP	<b>Vision [Exam] Services</b>	This variable is included for HDHP plans and omitted for HMO, DHMO and POS plans.
3.27	HDHP	Under <b>Vision Exam Services:</b> <b><i>[Vision Exam Services Exclusions:</i></b> <ul style="list-style-type: none"> <li>• All services related to vision correction, including but not limited to, eye examinations to determine the need for vision correction and to provide a prescription for corrective lenses.</li> <li>• Eyeglass lenses and eyeglass frames.</li> <li>• Eye exercises.</li> <li>• All Services related to contact lenses including examinations, fitting and dispensing, and follow-up visits.</li> </ul>	This variable is included for HDHP plans and omitted for HMO, DHMO and POS plans.

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		<ul style="list-style-type: none"> <li>• Orthoptic (eye training) therapy.</li> <li>• Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism, including but not limited to, radial keratotomy, photo-refractive keratectomy and similar procedures.]</li> </ul>	
3.27	DHMO HDHP HMO & 3TPOS	Under <b>Vision Exam Services</b> : [Note: Discounts are available for lenses and frames.]	The first instance of this variable will be omitted for HDHP plans. The second instance of this variable will be included for HMO, DHMO and POS plans.
3.27	DHMO HMO & 3TPOS	[ <b>Eye Exams</b> ... therapy.]	This provision is included if the employer elects to include coverage for routine eye exams for adults.
3.28	DHMO HMO & 3TPOS	Under <b>Vision Exam Services</b> : [ <b>Vision Exam Services Exclusions</b> : <ul style="list-style-type: none"> <li>• Eyeglass lenses and eyeglass frames.</li> <li>• Eye exercises.</li> <li>• All Services related to contact lenses including examinations, fitting and dispensing, and follow-up visits.</li> <li>• Orthoptic (eye training) therapy.]</li> </ul>	This exclusion is included if the employer elects not to cover lenses, frames and contact lenses. It is omitted if coverage is included for lenses, frames and contact lenses.
3.28	DHMO HMO & 3TPOS	[ <b>Pediatric Eye Exams</b> ... corrective lenses.]	This provision can be removed at the employer's request if they would like to make vision benefits available separately.
3.28	DHMO HMO & 3TPOS	[ <b>Pediatric Lenses and Frames</b> ... year.]	This provision can be removed at the employer's request if they would like to make vision benefits available separately.

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3.28	DHMO HMO & 3TPOS	[In addition, we cover the following Services: ... therapy.]	Lenses, Frames and Contact Lenses are included unless the employer elects to exclude this coverage.
3.28	DHMO HMO & 3TPOS	Under <b>Eyeglass Lenses:</b> [We provide a discount ... other eye.]	This provision will be included if the employer elects to cover eyeglass lenses and add-ons with a discount.
3.28	DHMO HMO & 3TPOS	Under <b>Eyeglass Lenses:</b> [We cover ... Optical Shop.]	This provision will be included if the employer elects to cover eyeglass lenses at no charge.
3.28	DHMO HMO & 3TPOS	Under <b>Frames:</b> [We provide a discount ... Optical Shop.]	This provision will be included if the employer elects to cover frames with a discount.
3.28	DHMO HMO & 3TPOS	Under <b>Frames:</b> [We cover the purchase... Optical Shop.]	This provision will be included if the employer elects to cover eyeglass frames at no charge.
3.28	DHMO HMO & 3TPOS	Under <b>Contact Lenses:</b> [We cover the [initial] purchase ... Optical Shop.]	This provision will be included if the employer elects to cover the purchase of contact lenses at no charge.  The variable [initial] will be included if the employer elects to cover only the initial purchase of contact lenses at no charge.
3.28	DHMO HMO & 3TPOS	Under <b>Contact Lenses:</b> [We cover the initial fitting ... Optical Shop.]	This provision will be included if the employer elects to cover the initial fitting of contact lenses at no charge.
3.28	DHMO HMO & 3TPOS	Under <b>Contact Lenses:</b> [We provide a discount ... Optical Shop.]	This provision will be included if the employer elects to cover contact lenses with a discount.
3.29	DHMO HMO & 3TPOS	Under <b>Contact Lenses:</b> [You will ... same time.]	This provision will be included if the employer covers contact lenses with a discount.

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3.29	DHMO HMO & 3TPOS	Under <b>Contact Lenses</b> : [Note: Additional ... Optical Shop.]	This note will be included if the employer covers contact lenses with a discount.
3.29	DHMO HMO & 3TPOS	<p><b>[Vision Exclusions:</b></p> <ul style="list-style-type: none"> <li>• Industrial and athletic safety frames.</li> <li>• Eyeglass lenses and contact lenses with no refractive value.</li> <li>• Sunglasses without corrective lenses unless Medically Necessary.</li> <li>• Any eye surgery solely for that the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), and astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).</li> <li>• Eye exercises.</li> <li>• Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section.</li> <li>• Replacement of lost, broken, or damaged lenses frames and contact lenses.</li> <li>• Plano lenses.</li> <li>• Lens adornment, such as engraving, faceting, or jewellery.</li> <li>• Low-vision devices.</li> <li>• Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits.</li> <li>• Orthoptic (eye training) therapy.]</li> </ul>	This exclusion is included if the employer elects not to cover lenses, frames and contact lenses. It is omitted if coverage is included for lenses, frames and contact lenses.

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3.29	DHMO HMO & 3TPOS	[Visiting Member Services ... Group Health Cooperative service area.]	<p>This benefit will be included if the employer elects to cover visiting member services subject to the same terms and conditions as benefit in the home service area. If elected the visiting member service benefit in Section 2 will be omitted.</p> <p>This benefit will always be omitted from the form when the benefit plan is a HDHP.</p>

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Throughout Form	Telephone numbers.	To allow for change without re-filing.
Throughout Form	[contract] [calendar] [policy]	The appropriate benefit plan period will be included in the form based on the employer's election. The standard employer election is contract year.
1	Under <b>DEPENDENT AGE LIMIT</b> , [26-31] [26-30] [if a full-time student]	The appropriate age limit will be included in the form based on the employer's election.
1	[Deductibles,]; [Deductible,]; [Deductible]; [After the Deductible is met,]	These variables will be included in the form when the benefit plan has a deductible.
1	<b>[Missed Appointment Fee]</b>	This chart will be omitted from the form when the employer group elects not to apply a missed appointment fee.
1	<b>[DEDUCTIBLE]</b> [The Deductible ... to a Non-Plan Provider.]	<p>This provision will be included in the form when the benefit plan has a deductible. The Deductible amounts for In-Plan and Out-of-Plan will never exceed the amounts permitted under ACA requirements for non-grandfathered plan designs.</p> <p>Note: For non-grandfathered plan designs annual cost sharing will not exceed the HHS maximum limit for that calendar year.</p> <p>The family deductible for plans that do not have an individual deductible limit will not exceed the annual ACA individual cost-share limits for the applicable calendar year.</p>
1	Under <b>Deductible:</b> [Out-of-Plan]	This text will be included in the form when the In-Plan services do not have a deductible.
1	<b>[Self-Only]</b> <b>[Individual]</b>	The variable Self-Only will be used for custom groups only who choose unique Ded/OOPM thresholds for self-only, individual Family Member (in a Family of 2+ Members), and entire Family (2+ Members) coverage levels.

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		The variable Individual will be used the plan is a traditional embedded or aggregate plan.
1	[[ <b>Self-Only</b> ] [ <b>Individual Coverage Deductible</b> ... Self-Only Deductible shown below.]	This provision will be included in the form when the benefit plan is a DHMO or an HDHP.
1	[ <b>Family Coverage Deductible</b> ... If you have ... Coverage].	This variable is used when the Deductible is aggregate.
1	[ <b>Family Coverage Deductible</b> ... If you have one or more ... year].	This variable is used when the Deductible is embedded.
1	[ <b>Individual within Family Coverage Deductible</b> ... If you have ... shown below].	This variable is for custom groups only who choose unique Ded/OOPM thresholds for self-only, individual Family Member (in a Family of 2+ Members), and entire Family (2+ Members) coverage levels.
1	[ <b>Deductible Carryover</b> ... following year.]	This provision will be included in the form dependent on employer election.
1	[ <b>Deductible Credit</b> ... the effective date of this EOC.]	This provision will be included in the form dependent on employer election and will only apply for the first contract year as of the effective date of the coverage.
2	<p><b>Under Services Subject to the Deductible:</b> [for Out-of-Plan Benefits.]</p> <p>[A separate Deductible applies for In-Plan Benefits and Out-of-Plan Benefit.]</p> <p>All [Out-of-Plan]</p>	<p>Variable included when Deductible only applies to Out-of-Plan benefits.</p> <p>This variable will be included when a separate deductible applies to In- and Out-of Plan benefits.</p> <p>Variable included when Deductible only applies to Out-of-Plan benefits.</p>

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	Services are subject to this Deductible, except [for those covered under the "Outpatient Prescription Drug Rider" attached to this EOC, and]	This text will be included in the form when the benefit plan includes an Outpatient Prescription Drug Rider.
2	<b>[Deductible]</b>	<p>This chart will be included in the form when the benefit plan has a deductible. Note: For non-grandfathered plan designs annual cost sharing for In-Plan and Out-of-Plan will not exceed the IRS maximum limit for that calendar year.</p> <p>The family deductible for plans that do not have a Self-Only deductible limit will not exceed the annual ACA individual cost-share limits for the applicable calendar year.</p>
2	<b>[[Self-Only] [Individual Deductible]</b>	<p>This variable will be included when the plan includes an individual deductible.</p> <p><b>Note:</b> For <b>non-grandfathered</b> plan designs annual cost sharing will not exceed the IRS maximum limit for that calendar year. For 2017, the maximum cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage. The maximum family out-of-pocket limit for plans that are aggregate will never exceed the HHS maximum out-of-pocket maximum permitted for that calendar year (\$7,150 for 2017).</p>
2	<b>[Individual within Family Deductible]</b>	<p>This variable will be included when the plan includes a unique Deductible threshold for self-only, individual Family Member (in a Family of 2+ Members), and entire Family (2+ Members) coverage levels.</p> <p><b>Note:</b> For <b>non-grandfathered</b> plan designs annual cost sharing will not exceed the IRS maximum limit for that calendar year. For 2017, the maximum cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage. The maximum family out-of-pocket limit for plans that are aggregate will never exceed the HHS</p>

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		maximum out-of-pocket maximum permitted for that calendar year (\$7,150 for 2017).
2	<b>[Family Deductible]</b>	<p>This variable will be included when the plan includes a family deductible.</p> <p><b>Note:</b> For <b>non-grandfathered</b> plan designs annual cost sharing will not exceed the IRS maximum limit for that calendar year. For 2017, the maximum cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage. The maximum family out-of-pocket limit for plans that are aggregate will never exceed the HHS maximum out-of-pocket maximum permitted for that calendar year (\$7,150 for 2017).</p>
<b>Copayments and Coinsurance – You Pay (Right-hand column)</b>		
3-18	<p>The cost share for each covered service will be included in the form based on the benefit plan design elected by the employer group. The In-Plan cost share options are: (a) copayment; (b) coinsurance; or (c) a combination of a copayment and then coinsurance. The Out-of-Plan cost share is a coinsurance.</p> <p>The cost share options for the vision hardware benefit (i.e. eyeglass lenses, eyeglass frames, and contact lenses) are: (a) a discounted percentage off of the retail price, (b) a flat dollar amount discount, or (c) a flat dollar amount allowance toward the cost of the hardware. Option c is only available to grandfathered plans; and only apply to adult vision. The limitation “once per [every 2] ...year[s].]” applies to optical hardware (i.e. lenses and frames). Routine eye exams and vision hardware are not included with HDHP plan designs.</p> <p>Additionally, the “deductible waived” and “after deductible” options will be included in the form for each covered service dependent on the benefit plan design elected by the employer group.</p>	
13	<p>Under <b>Preventive Health Care Services:</b> [Not subject to Deductible]</p> <p>[(The Deductible ... screening)]</p> <p><b>You Pay In-Plan:</b> [No charge], <b>You Pay Out-of-Plan:</b> [10% - 60%] of UCR after Deductible</p>	<p>Will be included for all non-grandfathered plan designs.</p> <p>This variable will be included for grandfathered plans.</p> <p>The variable In-Plan variable “[No charge]” will be included in the form for non-grandfathered benefit plans and for grandfathered benefit</p>

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	<p><b>You Pay In-Plan:</b> [No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;Deductible waived] [Copayment waived for children under [24 months] [2 – 25] [years] of age], <b>You Pay Out-of-Plan:</b> [10% - 60%] of UCR after Deductible</p>	<p>plans that have elected the Patient Protection and Affordable Care Act (PPACA) preventive package. The Out-of-Plan variable will be based on the Plan Coinsurance.</p> <p>These variables will be used for grandfathered benefit plans that elect to maintain their existing preventive care package at the existing cost-share. The Out-of-Plan variable will be based on the Plan Coinsurance.</p>
<b>Copayments and Coinsurance – Covered Service (Left-hand column)</b>		
3	<p>Under <b>Office visits (for other than preventive health care Services) – Primary care office visits and Specialty care office visits:</b> [For adults]</p> <p>[For children under [24 months][2 – 18] [years] of age]</p> <p>[For children [24 months][2 – 18] [years] of age or older]</p>	<p>This text will be included in the form when the primary office visit cost share for adults differs from the primary care cost share for children.</p> <p>This text will be included in the form when the primary care office visit cost share differs for children under a specific age elected by the employer group.</p> <p>This text will be included in the form when the primary care office visit cost share differs for children over a specific age elected by the employer group.</p>
4	<p><b>Under Outpatient Services:</b> <b>Anesthesia</b></p>	<p>The cost share for the Anesthesia benefit will be the same as for Anesthesia for Dental Services</p>

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4	<p><b>Accidental Dental Injury Services:</b></p> <p>[Limited to treatment started within 6 months of the accident]</p>	<p>“Applicable Cost Shares will apply, based on type and place of Service” will be used when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.</p> <p>This variable will be included at the request of the employer.</p>
4	<p><b>Allergy Services</b></p> <p>[Allergy Evaluations and treatment Injection visits and serum]</p>	<p>“Applicable Cost Shares will apply, based on type and place of Service” will be used when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.</p> <p>The sub-categories will be omitted from the form when the cost share for all Allergy Services is the same for all services.</p>
5	<p><b>Anesthesia for Dental Services</b></p>	<p>“Applicable Cost Shares will apply, based on type and place of Service” will be used when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected in place of this revision.</p>
5	<p><b>Blood, Blood Products and Their Administration</b></p>	<p>For most HMO plan designs, the cost share is “No charge”, unless the employer elects to apply a cost share based on place of service. For all other plan designs the cost share will be “Applicable Cost Shares will apply, based on type and place of Service” when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.</p>
6	<p><b>Under Chemical Dependency and Mental Health Services:</b></p> <p>[Partial hospitalization is limited to 60 days per [contract][calendar][policy] year) ]</p> <p>[Inpatient psychiatric and substance ... Management visits]</p>	<p>Note: The variable cost-sharing provision for all mental health and substance abuse treatment, including all inpatient and outpatient benefits, residential crisis services, partial hospitalization, medication management visits, and methadone treatment shall comply with federal Mental Health Parity requirements under 45 CFR §146.136.</p>

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	[Residential treatment center]	<p>“Inpatient, residential treatment centers and residential crisis services will be subject to the predominant cost share of that type applied to substantially all medical/surgical benefits in the inpatient services benefit classification.”</p> <p>Office visits for individual therapy and medication management will be based on the primary care office visit. Note: The same primary office visit cost share is applied to all primary physician services within a given plan.</p> <p>Group therapy may be equal to the primary care office visit, or will be ½ of that amount, but not less than \$5 unless primary care is \$0, in which case group therapy will be \$0.</p> <p>All other outpatient services will be based on the predominant cost share of the type applied to substantially all medical/ surgical benefits in the “all other outpatient services” benefit classification– either copay or coinsurance, or, if there is no type of cost share that applies to substantially all medical/surgical benefits, the cost share will be \$0. We may also choose to include a \$0 cost share for all other outpatient services in plans that are predominantly coinsurance rather than the plan coinsurance.</p> <p>If there is any question concerning the applicable cost share we will have the plan tested by our Actuaries to assure compliance with the Mental Health Parity requirements.</p>
7	<p><b>[Chiropractic [and Acupuncture] Services</b> [Limited to [10 – 90] visits for Chiropractic Services per Member per year]</p> <p>[Limited to [10 – 90] visits for Acupuncture Services per Member per year]</p>	<p>Chiropractic Services [and Acupuncture if elected by employer] will be included here if covered under the base plan instead of by Rider.</p> <p>[Limited to... year] will be included when there is an annual limit; or omitted if the visits are unlimited. There is a variable for each Service so that an employer may elect to include the same or a different number of visits for each service; and the same or a different cost</p>

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		share for each service.
7	<b>Cleft Lip, Cleft Palate, or Both</b>	“Applicable Cost Shares will apply, based on type and place of Service” will be used when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.
7	<b>Clinical Trials</b>	“Applicable Cost Shares will apply, based on type and place of Service” will be used when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.
7	<p><b>Under Diabetic Equipment, Supplies and Self-Management Training:</b></p> <p>[Diabetic equipment..... Self-management training]</p> <p>[Diabetic equipment [and supplies]</p> <p>[Diabetic supplies]</p>	<p>The cost share for diabetic equipment and supplies will be the same as for DME. The cost share for self-management training will be “Applicable Cost Shares will apply, based on type and place of Service” when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.</p> <p>This text will be omitted from the form when the In-Plan cost share for all Diabetic Equipment, Supplies and Self-Management Training is “No charge” or a coinsurance, after deductible or deductible waived.</p> <p>This text will be included in the form when the In-Plan cost share for all Diabetic Equipment and Diabetic Supplies is the same, but differ from the cost share of Self-Management Training.</p> <p>This text will be included in the form when the In-Plan cost share for Diabetic Equipment differs from the cost share for Diabetic Supplies.</p> <p>This text will be included when (a) the In-Plan cost share for Diabetic Supplies differs from that of Diabetic Equipment, and (b) the In-Plan cost share of all Diabetic Supplies is the same.</p>

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

Form Name: Summary of Services and Cost Shares

Form Number: DCLG-POS-COST(1-17)

Page(s)	Variables	Explanations
	<p>[</p> <ul style="list-style-type: none"> <li>• Disposable needles and syringes....</li> <li>• Other supplies]</li> </ul>	<p>This bulleted list will be included in the form when (a) the In-Plan cost share for Diabetic Supplies differs from the cost share for Diabetic Equipment, and (b) the In-Plan cost share for Diabetic Supplies varies dependent on the type of diabetic supply.</p> <p>Note: The standard employer group election is to have the same cost share for diabetic supplies and equipment.</p>
8	<p>Under <b>Dialysis:</b></p> <p>[Inpatient care]</p> <p>[Outpatient Care]</p> <p>[Dialysis Center Home dialysis, including training]</p>	<p>The sub-categories will be omitted from the form when the cost share for all inpatient and outpatient Dialysis services is “No charge” or a coinsurance, after deductible or deductible waived.</p> <p>Inpatient care will be included when different cost shares apply to inpatient and outpatient dialysis.</p> <p>Outpatient Care will be included when all outpatient care is subject to the same Cost Share.</p> <p>These variables will be used when there is a different cost share for outpatient dialysis at a dialysis center than for home dialysis.</p>
8	<p>Under <b>Durable Medical Equipment:</b> [Limited to use in the..... authorized outpatient surgical procedure.]</p>	<p>This provision will be included in the form when the employer group elects this option.</p>
9	<p>Under <b>Durable Medical Equipment:</b></p> <p>[<b>Basic Durable Medical Equipment</b>]</p>	<p>All sub-categories will be deleted and only the heading will be used for plan designs that have the same cost share for all DME received on an outpatient basis.</p> <p>This variable will be included in the form when Basic Durable Medical Equipment has a different cost share than Supplemental</p>

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Page(s)	Variables	Explanations
	<p>[Limited to use in the..... authorized outpatient surgical procedure.]</p> <p><b>[Supplemental Durable Medical Equipment.....(under age 3, not to exceed a period of 6 months)]</b></p> <p>Apnea Monitors... 6 months)]</p> <p>[Spacers Peak-flow meters Nebulizers]</p> <p>[Bilirubin Lights... 6 months)]]</p>	<p>DME.</p> <p>This provision will be included in the form when the employer group elects this option.</p> <p>The Supplemental Durable Medical Equipment section will be included in the form when the cost share of Supplemental Durable Medical Equipment differs from the cost share for Basic Durable Medical Equipment.</p> <p>This provision will be omitted for subscriber only plans.</p> <p>The text will be included in the form when (a) the cost share for Supplemental Durable Medical Equipment differs from the cost share for Basic Durable Medical Equipment, and (b) the cost share for Asthma Equipment varies dependent on the type of asthma equipment.</p> <p>This provision will be omitted for subscriber only plans.</p>
9	<p>Under <b>Durable Medical Equipment:</b></p> <p>[Spacers</p> <p>Peak-flow meters</p> <p>Nebulizers]</p>	<p>The text will be included in the form when the In-Plan cost share for Asthma Equipment varies dependent on the type of asthma equipment.</p>
10	<p>Under <b>Emergency Services:</b></p> <p>[Emergency Room Visits..... Copayment will not be waived.]</p> <p>[Transfer to an observation bed .....Copayment will not be waived.]</p>	<p>These sub-categories will be omitted and only the heading will be used when the cost share for all Emergency Services is “No charge” or a coinsurance, after deductible or deductible waived.</p> <p>This provision will be included in the form when the employer group elects to waive the emergency room cost share if the patient is</p>

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		immediately admitted as inpatient.
10	<p>Under <b>Family Planning</b>:                      [Women’s Preventive ... at no charge]</p>	<p>For Grandfathered Plans, the cost share for all services will be the “Applicable Cost Shares will apply, based on type and place of Service” when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.</p> <p>For non-Grandfathered Plans, the cost share for all services that are considered preventive care services under ACA will be covered at “No Charge”. All other services will be “Applicable Cost Shares will apply, based on type and place of Service” when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.</p> <p>This provision will be omitted when the employer group requests the exclusion of family planning services.</p>
10	<p>Under <b>Family Planning</b>:                      [[Office visits]..... [,Voluntary termination of pregnancy]]</p> <p>[Tubal ligation] [, Vasectomy] [,Voluntary termination of pregnancy]</p> <p>[Women’s...at no charge.]</p>	<p>These procedures are variable to allow a group to elect which services to cover or omit.</p> <p>Tubal ligation will only be included with a grandfathered plan that has this coverage. The other two procedures are variable to allow a group to elect which services to cover.</p> <p>This variable will be included for non-grandfathered plans. This variable will be omitted when the employer group requests the exclusion of family planning services as permitted under 45 CFR §147.131 for non-grandfathered plans.</p>

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11	<p><b>Habilitative Services</b></p> <p>[Limited to children up to age 21]</p> <p>[Applied Behavioral Analysis (ABA)]</p>	<p>“Applicable Cost Shares will apply, based on type and place of Service” will be used when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.</p> <p>ABA will always be the same as mental health “all other.”</p> <p>Bracketed to allow removal if the benefit is not covered.</p>
11	<p>Under <b>Home Health Care:</b></p> <p>[Limited to ... year.]</p> <p>[a combined In- and Out-of-Plan]</p> <p>[30 – 240 visits]</p>	<p>This provision will be included in the form when the employer group elects a visit limit.</p> <p>This text will be included in the form when the employer group elects a visit limit and the visit limit applies to both In-Plan and Out-of-Plan combined.</p> <p>The appropriate visit limit will be included in the form dependent on the employer group’s election.</p>
11	<p><b>[Infertility Services ]</b></p>	<p>This provision will be omitted when an employer group requests the exclusion of in vitro fertilization from coverage.</p>
11	<p>Under <b>Infertility Services:</b></p> <p>Office visits for [initial diagnosis of infertility]</p> <p><b>[Note:</b> Coverage for In-vitro fertilization is limited to a combined In- and Out-of-Plan maximum benefit of three attempts per live birth, not to exceed a maximum lifetime benefit of \$100,000.]</p>	<p>This text will be included when the employer group elects a cost share for office visits for initial diagnosis of infertility different than that of office visits for all other infertility services.</p> <p>This text will be omitted when the employer group elects to remove the limit on in vitro fertilization.</p>

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12	<p>Under <b>Maternity Services:</b> [Prenatal...at no charge]</p> <p>[Outpatient Prenatal ... Section 3: Benefits]</p> <p>Breast Pumps</p>	<p>The first set of variables will be included for all non-grandfathered plan designs.</p> <p>The second set of variables will be included for all grandfathered plan designs.</p> <p>Coverage for Breast Pumps added at no charge. For non-grandfathered plans the cost share will always be no charge.</p>
13	<b>Morbid Obesity Services</b>	“Applicable Cost Shares will apply, based on type and place of Service” will be used when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.
13	<b>Oral Surgery</b>	“Applicable Cost Shares will apply, based on type and place of Service” will be used when there are various cost shares options, and when the benefit plan design has the same cost share for all benefits, that cost share amount will be reflected.
13	<p>Under <b>Preventive Health Care Services:</b> [Not subject to Deductible]</p>	This text will be omitted from the form for grandfathered employer group benefit plans that elect a deductible for preventive health care services.
13	<p>Under <b>Prosthetic Devices:</b> [Limited to internally implanted devices..... Rider is attached to this EOC.]</p> <p>[Internally implanted devices ... Breast prosthetics]</p>	<p>This text will be included in the form when the cost share for all Prosthetic Devices is “No charge” or a coinsurance, after deductible or deductible waived.</p> <p>These prosthetic devices will be omitted from the form and benefit plan when requested by the employer group.</p> <p>These variables will be omitted from the form when the cost share for</p>

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	[Hair Prostheses]	<p>all Prosthetic Devices is “No charge” or a coinsurance, after deductible or deductible waived.</p> <p>The variable cost-sharing provision for breast prosthetics and hair prosthesis will be covered at the same cost shares as any other prosthetic device covered under the contract, except for some HMO plan designs, which are always covered at “No charge.”</p> <p>This variable will be included if the employer elects to include Hair Prostheses as a base benefit.</p>
14	<b>Reconstructive Surgery</b>	The variable cost-sharing provision for Reconstructive Surgery will be covered at the same cost shares as any other surgical procedure, based on type and place of service.
15	<p><b>Skilled Nursing Facility Care,</b></p> <p>[Limited to a maximum..... year]</p> <p>[a combined In- and Out-of-Plan maximum of]</p> <p>[60 – 240]</p> <p>[admission]</p>	<p>The cost share for skilled nursing care will be the same as an inpatient stay in a hospital unless specifically requested by employer group. All requests other than the same as inpatient must be reviewed for impact on mental health inpatient cost share.</p> <p>This text will be included in the form when the employer group elects a day limit.</p> <p>This text will be included in the form when the employer group elects a visit limit and the visit limit applies to both In-Plan and Out-of-Plan combined.</p> <p>The appropriate number of days will be included in the form based on the employer group’s election.</p> <p>This text will be included in the form when the employer elects a benefit visit limitation that operates on a per admission basis.</p>
15	<b>Under Vision Services:</b>	

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	[[Eye exams • by an Optometrist ... • by an Ophthalmologist]  [(for adults age 19 or older)]	This text will be omitted from the form when the employer group elects to exclude all benefits for eyesight correction.  [(for adults age 19 or older)] will be included when the Pediatric Vision benefit is included.
15	[Routine eye exam once per [contract] [calendar][policy] year]	The group elects routine eye exam once per year for both Optometrist and Ophthalmologist for all lines of business.
16	[Member may opt to have frames and lenses or contacts, but not both in a [contract] [calendar] [policy] year]	The group elects to cover either frames and lenses or contacts.
16	[Eyeglass [lenses and] frames Eyeglass lenses]	These variables are used depending on when an employer chooses to cover lenses and frames or only lenses.
17	• [Single Vision] • [Bifocal] • [Trifocal] • [Lenticular]	These variables will be include if the group offers various lenses types i.e. Single Vision, Bifocal, Trifocal and Lenticular at various benefit levels.
17	[Scratch Resistant] [Anti-reflective Coating (ARC)] • [Standard] • [Premium] • [Ultra]	These variables will be include if the group offers various scratch resistant or anti-reflective coating (ARC): standard, premium and ultra.
17	[Contact lenses] [in lieu of frames and lenses]	Contact lenses are offered by the group at a certain rate. In lieu of frames and lenses is used if the employer limits to only glasses or contacts.
18	• [Medically Necessary] • [Medical Multifocal] • [Cosmetic]	These variables will be include if the group offers various options for Contact lenses at a certain rate.
18	[ <b>Note:</b> A child may select any pair of glasses in lieu of, or in addition to, the eyeglasses or contact lenses available at no charge under Vision Services for children below and receive	The Note will be included when plan covers eyeglass hardware and lenses, and includes the pediatric vision benefit.

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	the discount at any Plan Vision Center.]	
18	[Vision Services (for children under age 19) ... Low Vision Aids]	Pediatric vision is removed if the employer requests not to cover.
20	[ <b>Out-of-Pocket Maximum</b> ...year]  [, except for Deductible, Copayments or Coinsurance you pay for items covered under the “Outpatient Prescription Drug Rider.”]  (Combined total of [In-Plan and]	This Out-of-Pocket Maximum version will be included for grandfathered plans.  This text will be included in the form when the benefit plan includes an Outpatient Prescription Drug Rider.  This provision will be included when employer elects to combine both In-Plan and Out-of-Plan toward the out-of-pocket maximum.
20	[Out-of-Pocket Maximum... year]  [[ <b>Self-Only</b> ]    [ <b>Individual</b> ] <b>Coverage</b> <b>Out-of-Pocket Maximum</b> ... shown below.]  [ <b>Family Coverage Out-of-Pocket Maximum</b> ... year.]  [ <b>Family Coverage Out-of-Pocket Maximum</b> ... coverage.]  [ <b>Individual within Family Coverage Out-of-Pocket Maximum</b> ... shown below.]  <b>Out-Of-Pocket Maximum</b> (Combined total of [In-Plan and]...	This Out-of-Pocket Maximum version will be included with non-grandfathered plans  This variable is used if the Out-of-Pocket (OOP) Maximum is aggregate. It is omitted if embedded.  This variable is used with an embedded OOPM.  This variable is used with an aggregate OOPM.  This variable is for custom groups only who choose unique Ded/OOPM thresholds for self-only, individual Family Member (in a Family of 2+ Members), and entire Family (2+ Members) coverage levels.  This variable is included for an embedded OOP Maximum. When this variable is omitted, the family out-of-pocket maximum will not have a Self-Only out-of-pocket maximum.

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	Out-of-Pocket maximums	<p>This provision will be included when employer elects to combine both In-Plan and Out-of-Plan total amounts.</p> <p><b>Note:</b> For <b>non-grandfathered</b> plan designs annual cost sharing will not exceed the IRS maximum limit for that calendar year. For 2017, the maximum cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage. The maximum family out-of-pocket limit for plans that are aggregate will never exceed the HHS maximum out-of-pocket maximum permitted for that calendar year (\$7,150 for 2017).</p>
21	<b>[[Self-Only] [Individual Out-of-Pocket Maximum]</b>	<p>This variable will be included when the plan includes an individual maximum.</p> <p><b>Note:</b> For <b>non-grandfathered</b> plan designs annual cost sharing will not exceed the IRS maximum limit for that calendar year. For 2017, the maximum cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage. The maximum family out-of-pocket limit for plans that are aggregate will never exceed the HHS maximum out-of-pocket maximum permitted for that calendar year (\$7,150 for 2017).</p>
21	<b>[Individual within Family Out-of-Pocket Maximum]</b>	<p>This variable will be included when the plan includes a unique Deductible threshold for self-only, individual Family Member (in a Family of 2+ Members), and entire Family (2+ Members) coverage levels.</p> <p><b>Note:</b> For <b>non-grandfathered</b> plan designs annual cost sharing will not exceed the IRS maximum limit for that calendar year. For 2017, the maximum cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage. The maximum family out-of-pocket limit for plans that are aggregate will never exceed the HHS maximum out-of-pocket maximum permitted for that calendar year (\$7,150 for 2017).</p>
21	<b>[Family Out-of-Pocket Maximum]</b>	<p>This variable will be included when the plan includes a family deductible.</p>

## EXPLANATION OF VARIABLES – DISTRICT OF COLUMBIA MID-LARGE GROUPS

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Page(s)	Variables	Explanations
		<p><b>Note:</b> For <b>non-grandfathered</b> plan designs annual cost sharing will not exceed the IRS maximum limit for that calendar year. For 2017, the maximum cost sharing is \$7,150 for individual coverage and \$14,300 for family coverage. The maximum family out-of-pocket limit for plans that are aggregate will never exceed the HHS maximum out-of-pocket maximum permitted for that calendar year (\$7,150 for 2017).</p>

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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## Summary of Services and Cost Shares

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

### **[DEPENDENT AGE LIMIT**

Eligible Dependent children are covered from birth to age [26 - 30], [or to age [26 – 30] if a full-time student], as defined by your Group and approved by Health Plan.

### **MEMBER COST-SHARE**

Your Cost Share is the amount of the Allowable Charge for a covered Service that you must pay through [Deductibles, ]Copayments and Coinsurance. The Cost Share, if any, is listed for each Service in this “Summary of Services and Cost Shares.” Allowable Charge is defined in the Definitions Appendix.

In addition to the monthly premium, you may be required to pay a Cost Share for some Services. You are responsible for payment of all Cost Shares. Copayments are due at the time you receive a Service. You will be billed for any Deductible and Coinsurance you owe. Failure to pay your Cost Shares may result in termination of your Membership (refer to Section 6: Termination for Nonpayment).

### **[DEDUCTIBLE**

The Deductible is the amount of Allowable Charges you must incur during a [contract] [calendar] [policy] year for certain covered Services before Health Plan will ~~provide~~begin paying benefits for those Services. [The Deductible applies to all covered Services except Preventive Health Care Services [and post-partum home health visits] as described in Section 3, Benefits [, and outpatient Prescription Drugs]. [Preventive Health Care Services may be subject to a Copayment as shown below.]] [The Deductible applies to covered Hospital Inpatient Care, Skilled Nursing Facility Care, inpatient Chemical Dependency and Mental Health Services, and inpatient Rehabilitation Therapy Services only.] [The Deductible applies to the Services shown in the schedule below [that have a Coinsurance] ~~[,except, except~~ Durable Medical Equipment, Preventive Health Care Services and Prosthetic and Orthotic Devices].][Other Services may have a Copayment.] [Copayments do not apply toward the Deductible.]

For covered Services that are subject to a Deductible, you must pay the ~~full charge~~Allowable Charges for the Services when you receive them, until you meet your Deductible. The only amounts that count toward your Deductible are the Allowable Charges you incur for Services that are subject to the Deductible, but only if the Service would otherwise be covered. After you meet the Deductible, you pay the applicable ~~Cost Share~~Copayment [or] [Coinsurance] for these Services.

**[Self-Only] [Individual] Coverage Deductible.** If you are covered as a Subscriber, and you do not have any Dependents covered under the plan, you must meet the ~~[Self-Only] [Individual]~~Individual Deductible shown below.]

**[Family Coverage Deductible.** If you have one or more Dependents covered under this EOC, one or more covered Members of your Family Unit together must meet the Family Deductible shown below. After one or more covered Members of your Family Unit combined have met the Family Coverage Deductible, the Deductible will be met for all Members of the Family Unit for the rest of the [contract] [calendar] [policy] year. The ~~Self-Only~~Individual Deductible shown below does not apply with Family Coverage.-]

**[Family Coverage Deductible.** If you have one or more Dependents covered under this EOC, ~~you must meet either a Self-Only or a Family Deductible.~~ All covered Members of your family together can meet the Family Deductible shown below, but no one family Member’s medical expenses may contribute more than the ~~Self-Only~~Individual Deductible shown below. After an Individual Member of the Family Unit has met the ~~Self-Only~~Individual Deductible, his or her Deductible will be met for the rest of the [calendar][contract] [policy] year. Other family Members will continue to pay full charges for Services that are subject to the Deductible until the Family Deductible is met. After all Members of the Family Unit combined have met the Family Deductible, the Deductible will be met for all Members of the Family Unit for the rest of the [contract] [calendar] [policy] year.]

## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

**[Individual within Family Coverage Deductible.** If you are the only Member in your Family, then you must meet the Individual within Family Deductible. If you are a Member in a Family of two or more Members, then either you must each meet the Individual within Family Deductible, or your entire Family must meet the Family Deductible. Each Individual within Family Deductible amount counts toward the Family Deductible amount. Once the Family Deductible is satisfied, no further Individual within Family Deductible will be due for the remainder of the Year. The Self-Only Deductible, Individual within Family Deductible, and Family Deductible amounts are shown below.]

**[Deductible Carryover.** Allowable Charges incurred during the last 3 months of the [contract] [calendar] [policy] year that apply toward the Deductible will also apply to the Deductible for the following [contract] [calendar] [policy] year.]

**[Deductible Credit.** If you were covered on the day immediately preceding the effective date of the Group Agreement under any other group coverage that was replaced by this EOC, then charges for covered Services incurred by you and applicable toward the individual or family Deductible under the prior coverage, will be used to satisfy all or any portion of the individual or family Deductible amounts under this EOC. This Deductible credit provision applies only to the Deductible amount wholly or partially satisfied in the same [contract][calendar][policy] year as the effective date of this EOC.]

**[Keep Your Receipts.** When you pay an amount toward your Deductible, we will give you a receipt. Keep your receipts. [If you have an HSA account, you may need to prove to the IRS that distributions from your HSA were for qualified medical expenses. Also, if] [If] you have met your Deductible, and we have not received and processed all of your claims, you can use your receipts to prove that you have met your Deductible. You can also obtain a statement of the amounts that have been applied toward your Deductible from our Member Services Department.]]

### [Missed Appointment Fee]

[The amount you may be required to pay if you fail to keep a scheduled appointment and you do not notify us at least one day prior to the appointment.]	[[ \$10 - \$100 ] per missed appointment]
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### [Deductible]

<u>[The amount you must pay each [contract][calendar][policy] year for the Services indicated below before we provide benefits for those Services]</u>	<u>[No Deductible]</u>
<u>[[Self-Only] [Individual] Deductible]</u>	<u>[\$100 - \$10,000] per individual per [contract] [calendar] [policy] year]</u>
<u>[Individual within Family Deductible]</u>	<u>[\$100 - \$10,000] per individual Family Member per [contract] [calendar] [policy] year]</u>
<u>[Family Deductible]</u>	<u>[2x - 3x individual deductible] [\$100 - \$20,000] per Family Unit per [contract] [calendar] [policy] year]</u>
<del>[The amount you must pay each [contract][calendar][policy] year for the Services indicated below before we provide benefits for those Services]</del>	<del>{No Deductible}</del> <del><b>[Individual Deductible]</b></del> <del>[\$100 - \$10,000] per individual per [contract] [calendar] [policy] year]</del>
	<del><b>[Family Deductible]</b></del> <del>{2x - 3x individual deductible} [\$100 - \$20,000] per Family Unit per [contract] [calendar] [policy] year]</del>
<del>[Self Only]</del>	<del>[\$0 - \$5,000] per [contract] [calendar] [policy]</del>

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

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

## [Missed Appointment Fee]

[Self + Spouse] [or Domestic Partner]	<del>year</del> <del>[\$100 – \$6,000] per [contract] [calendar]</del> <del>[policy] year</del>
[Self + Children]	<del>[\$100 – \$6,000] per [contract] [calendar]</del> <del>[policy] year</del>
[Self + Spouse] [or Domestic Partner] + [Children]	<del>[\$100 – \$10,000] per [contract] [calendar]</del> <del>[policy] year</del>

## Copayments and Coinsurance

Covered Service	You Pay [after Deductible]
<b>Outpatient Care</b>	
Office visits (for other than preventive health care Services)	
Primary care office visits	
[For adults]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
[For children under [24 months][2 – <del>5</del> 18] [years] of age]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - <del>5</del> 0%] of AC*] [after Deductible] [;] [Deductible waived]
[For children [24 months][2 – <del>5</del> 18] [years] of age or older]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Specialty care office visits	
[For adults]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
[For children under [24 months][2 – <del>5</del> 18][ years] of age]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
[For children age [24 months][2 – <del>5</del> 18] [years] of age or older]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
[Consultations and immunizations for foreign travel]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]
Outpatient <a href="#">surgery physician/surgical Services</a>	[No charge] [[\$ <del>5</del> 0 - \$500] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]
[Special outpatient procedures]	[No charge][[\$5 - \$500] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]

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

**YOUR GROUP EVIDENCE OF COVERAGE (EOC)  
KAISER PERMANENTE**

<b>Copayments and Coinsurance</b>	
<b>Covered Service</b>	<b>You Pay [after Deductible]</b>
[Outpatient hospital procedures]	[No charge][[\$5 - \$500] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Anesthesia	[No charge] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]
Chemotherapy and radiation therapy	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]
Respiratory therapy	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]
Medical social services	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
House calls	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
<b>Hospital Inpatient Care</b> All charges incurred during a covered stay as an inpatient in a hospital	[No charge] [[\$100 - \$1000] per admission] [,then][Deductible, then] [[0% - 50%] of AC*] [[\$100 - \$500] per day, not to exceed a total of [3x - 5x the daily amount] per admission] [after Deductible] [;] [Deductible waived] [Member payment not to exceed \$[100-10,000] [per admission] [per [contract] [calendar] [policy] year]]
<b>[Hospital Observation Services]</b>	[ [No charge] [[\$ 25 -\$500] per visit][; not to exceed the actual cost of the visit.] [,then] [0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [; Copayment waived if admitted as an inpatient] [Copayment waived if observation status in conjunction with emergency room visit]]
<b>Accidental Dental Injury Services</b> [Limited to treatment started within 6 months of the accident]	[Applicable Cost Shares will apply, based on type and place of Service] [No charge][[0% - 50%] of AC* [after Deductible] [;] [Deductible waived]]
<b>Allergy Services</b>	[Applicable Cost Shares will apply based on type and place of Service] [No charge][[0% - 50%] of AC*][after Deductible] [;] [Deductible

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

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

<b>Copayments and Coinsurance</b>	
Covered Service	You Pay [after Deductible]
	waived]]
[Evaluations and treatment	[[Applicable Cost Shares will apply, based on type and place of Service] [No charge][[0% - 50%] of AC*][after Deductible] [;] [Deductible waived]]
Injection visits and serum]	[Applicable Cost Shares will apply, based on type and place of Service, not to exceed the cost of the serum plus administration] [No charge][[0% - 50%] of AC*] [[\$0 - \$100] per visit] [after Deductible] [;][Deductible waived]]
<hr/>	
<b>Ambulance Services</b> By a licensed ambulance Service, per encounter	[No charge][[\$0 - \$500] per encounter] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Non-emergent transportation Services	[No charge][[\$0 - \$500] per encounter] [per [round] trip] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
<hr/>	
<b>Anesthesia for Dental Services</b> Anesthesia and associated hospital or ambulatory Services for certain individuals only	[No charge] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Applicable Cost Shares will apply, based on type and place of Service]
<hr/>	
<b>Blood, Blood Products and their Administration</b>	[No charge] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [No additional charge] [Applicable Cost Shares will apply, based on type and place of Service]
<hr/>	
<b>Chemical Dependency and Mental Health Services</b> [Partial hospitalization is limited to 60 days per [contract] [calendar] [policy] year]	[[No charge][0% - 50%] of AC* [after Deductible] [;] [Deductible waived]]
[Inpatient psychiatric and substance abuse care, including detoxification (minimum of 12 days of detoxification per [contract][calendar][policy] year)	[Applicable inpatient Cost Shares will apply] [No charge] [[\$0 - \$100] per day] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Hospital alternative Services Intensive outpatient psychiatric treatment programs	[No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Partial hospitalization	[No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Outpatient psychiatric and substance abuse care <ul style="list-style-type: none"> <li>• Individual therapy</li> </ul>	[No charge] [[\$0 - \$35] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;]

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

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

## Copayments and Coinsurance

Covered Service	You Pay [after Deductible]
	[Deductible waived] [waived for children under [24 months -5 years of age] ]
<ul style="list-style-type: none"> <li>• Group therapy</li> </ul>	[No charge] [[\$0 - \$10] per visit] [,then] [[5% - 50%] of AC*][after Deductible] [; Deductible waived] [waived for children under [24 months -5 years of age] ]
[Medication management visits]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
[Residential treatment center]	[Applicable inpatient Cost Shares will apply] [No charge] [[\$0 - \$100] per day] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
<b>[[Chiropractic] [and] [Acupuncture] Services</b> [No limit] [Limited to [10 – 50] visits for Chiropractic Services per Member per [contract] [calendar] [policy] year]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
[No limit] [Limited to [10 – 50] visits for Acupuncture Services per Member per [contract] [calendar] [policy] year]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
<b>Cleft Lip, Cleft Palate, or Both</b>	[Applicable Cost Shares will apply, based on type and place of Service] [No charge] [,then][[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
<b>Clinical Trials</b>	[Applicable Cost Shares will apply, based on type and place of Service] [No charge] [,then][[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
<b>Diabetic Equipment, Supplies and Self-Management Training</b>	[[No charge][[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]]
[Diabetic equipment [and supplies]]	[[No charge] [[0% - 50%]of AC*] [after Deductible] [;] [Deductible waived]
[Diabetic supplies]	[[No charge][[\$5 - \$50] per supply][after Deductible][;][Deductible waived]]
[ <ul style="list-style-type: none"> <li>• Disposable needles and syringes</li> </ul>	[[No charge][[0% - 50%]of AC*] [after Deductible] [;] [Deductible waived]
<ul style="list-style-type: none"> <li>• Glucose test strips</li> </ul>	[No charge][[0% - 50%]of AC*] [after Deductible] [;] [Deductible waived]
<ul style="list-style-type: none"> <li>• Glucose test meter</li> </ul>	[\$10 - \$20 per meter]
<ul style="list-style-type: none"> <li>○ Additional meters</li> </ul>	[\$10 - \$20 per meter]

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

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

<b>Copayments and Coinsurance</b>	
Covered Service	You Pay [after Deductible]
<ul style="list-style-type: none"> <li>• Control solutions</li> <li>• Lancets</li> <li>• Other supplies]</li> </ul>	<p>[\$8 - \$15 per package]</p> <p>[\$8 - \$15 per package]</p> <p>[No charge][[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]</p>
[Self-management training]	[Applicable Cost Shares will apply, based on place of Service]
<b>Dialysis</b>	
[Inpatient care]	[No charge][[0% - 50%] of AC*][after Deductible] [;] [Deductible waived]]
[Outpatient Care]	[[Applicable inpatient Cost Shares will apply] [[0% - 50%] of AC*][after Deductible] [;] [Deductible waived]
[Dialysis Center]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
Home dialysis, including training]	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
Dialysis Training	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
<b>Drugs, Supplies, and Supplements</b>	
Administered by or under the supervision of a Plan Provider	[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ] <a href="#">[Applicable Cost Shares will apply, based on type and place of Service]</a>
<b>Durable Medical Equipment (DME) - Outpatient</b>	
[Outpatient Basic Durable Medical Equipment]	[[No charge][[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]] <a href="#">[Applicable Cost Shares will apply, based on type and place of Service]</a>
[Outpatient Supplemental Durable Medical Equipment	[Limited to use in the home for up to 3 months following: an authorized confinement in a hospital, a sub-acute facility; or a specialized rehabilitation facility; or an authorized outpatient surgical procedure.] ]

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# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

## Copayments and Coinsurance

Covered Service	You Pay [after Deductible]
<ul style="list-style-type: none"> <li>• Oxygen and Equipment</li> </ul>	[No charge] [[0% - 50%] of AC*] [No charge for 1 <sup>st</sup> 3 months; [50% - 60%] of AC* each month thereafter] [[20% - 50%] of AC* for 1 <sup>st</sup> 3 months; [50% - 70%] of AC* each month thereafter] [after Deductible] [;] [Deductible waived] [Limited to a Plan maximum payment for oxygen and equipment of [\$1,000 - \$100,000] per [contract] [calendar] [policy] year]
<ul style="list-style-type: none"> <li>• Positive Airway Pressure Equipment</li> </ul>	[No charge] [[0% - 50%] of AC*] [No charge for 1 <sup>st</sup> 3 months; [50% - 60%] of AC* each month thereafter] [[20% - 50%] of AC* for 1 <sup>st</sup> 3 months; [50% - 70%] of AC* each month thereafter] [after Deductible] [;] [Deductible waived]
<ul style="list-style-type: none"> <li>• Apnea Monitors (Infants under 3, not to exceed a period of 6 months)</li> </ul>	[No charge] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
<ul style="list-style-type: none"> <li>• Asthma Equipment                             <ul style="list-style-type: none"> <li>○ [Spacers</li> <li>○ Peak-flow meters</li> <li>○ Nebulizers]</li> </ul> </li> </ul>	[[No charge] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]] [ [\$5 - \$10] per item] [ [\$10 - \$15] per item] [ \$30 - \$40] per item ]
<ul style="list-style-type: none"> <li>• [Bilirubin Lights (Infants under 3, not to exceed a period of 6 months)]</li> </ul>	[No charge] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
<b>Emergency Services</b>	[[No charge] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]]
[Emergency Room Visits	[ [No charge] [[\$ 25 -\$500] per visit] [,then]
<ul style="list-style-type: none"> <li>• Inside the Service Area</li> </ul>	[[0% - 50%] of AC*] [;] [not to exceed the actual cost of the visit.] [after Deductible] [;] [Deductible waived] [Copayment waived if immediately admitted]
<ul style="list-style-type: none"> <li>• Outside of the Service Area]</li> </ul>	[No charge] [[\$ 25 -\$500] per visit] [,then] [[0% - 50%] of AC*] [;] [not to exceed the actual cost of the visit.] [after Deductible] [;] [Deductible waived] [ Copayment waived if immediately admitted.] ]
<a href="#">Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit copayment will not be waived.</a>	No charge [after Deductible]
Emergency Services HIV Screening Test	

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

## Copayments and Coinsurance

Covered Service	You Pay [after Deductible]
<p><b>[Family Planning]</b></p> <p>[Women’s Preventive Services, 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 Care at no charge.]</p>	<p>[[No charge][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]] [Applicable Cost Shares will apply, based on type and place of Service ]</p>
<p>[[Office visits]</p> <p>[Tubal ligation] [, Vasectomy] [,Voluntary termination of pregnancy]]</p> <p>[Women’s Preventive Services, including all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity are covered under Preventive Care at no charge]</p>	<p>[[No charge] [[\$0 - \$100] per visit] [,then][;] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]</p> <p>[Applicable Cost Share will apply based on place of Service] ]</p>
<p><b>Habilitative Services</b></p> <p>[Limited to children up to age 21]</p>	<p>[[No charge][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]] [Applicable Cost Shares will apply, based on type and place of Service ]</p>
<p><a href="#">Physical, Occupational or Speech Therapy</a></p> <p><a href="#">[Applied Behavioral Analysis (ABA)]</a></p> <p><a href="#">All other Services</a></p>	<p><a href="#">[Applicable Cost Share will apply based on type and place of Service] [No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]</a></p> <p><a href="#">[Applicable Cost Share will apply based on type and place of Service] [No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]</a></p> <p><a href="#">[Applicable Cost Share will apply based on type and place of Service] [No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]</a></p>
<p><b>Hearing Services</b></p> <p>Hearing tests (newborn hearing screening tests are covered under preventive health care Services at no charge)</p>	<p>[No charge][[0% - 50%] of AC*] [Applicable office visit Cost Share will apply based on place of service] [after Deductible] [; Deductible waived]</p>
<p><b>Home Health Care</b></p> <p>See Section 3 for benefit limitations [Limited to a maximum benefit of [30 – 240 visits] per [contract] [calendar] [policy] year]</p>	<p>[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]</p>
<p><b>Hospice Care</b></p>	<p>[No charge] [[\$0 - \$100] per visit] [,then]</p>

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# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

<b>Copayments and Coinsurance</b>	
Covered Service	You Pay [after Deductible]
	[[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
<b>[Infertility Services</b>	[[No charge][0% - 50%] of AC* [after Deductible] [;] [Deductible waived]]
[Office visits [for initial diagnosis of infertility]	[[No charge] [[0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Inpatient Hospital Care	[The applicable inpatient hospital Cost Share will apply.] [[No charge] [[0 - \$100] per admission] [,then] [[0% - 50%] of AC*] [[0 - \$500] per day, not to exceed a total of [3x - 5x the daily amount] per admission] [after Deductible] [;] [Deductible waived] [Member payment not to exceed \$[100-10,000] [per admission] [per [contract] [calendar] [policy] year]]
All other Services for treatment of infertility]	[No charge] [[0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]]
[Note: Coverage for In-vitro fertilization is limited to a maximum lifetime benefit of \$100,000.] ]	
<b><u>Infusion Therapy Services</u></b>	<u>[[Applicable Cost Shares will apply, based on type and place of Service] [No charge][0% - 50%] of AC* [after Deductible] [;] [Deductible waived]]</u>
<b>Maternity Services</b>	[[No charge][0% - 50%] of AC* [after Deductible] [;] Deductible waived]]
[Prenatal and postpartum visits (after confirmation of pregnancy), including diagnostic tests	[[No charge][0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] Deductible waived]
<u>Inpatient obstetrical care and delivery, including cesarean section</u>	<u>[[No charge] [[0 - \$100] per admission] [,then] [[0% - 50%] of AC*] [[0 - \$500] per day, not to exceed a total of [3x - 5x the daily amount] per admission] [after Deductible] [;] [Deductible waived] [Member payment not to exceed \$[100-10,000] [per admission] [per [contract] [calendar] [policy] year] [The applicable inpatient hospital Cost Share will apply.]</u>
<del>Non-routine maternity care, including diagnostic tests]</del>	<del>[[Applicable Cost Shares will apply, based on type and place of Service]</del>
Postpartum home health visits	No charge; [Deductible waived]
Breast Pumps	[[No charge] [Deductible waived]

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# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

## Copayments and Coinsurance

Covered Service	You Pay [after Deductible]
<p>Note: Maternity Services that are required by the Affordable Care Act are covered under Preventive Care Services at no charge]</p>	
<del>[Routine global maternity care]</del> Prenatal and postnatal care	[[No charge][[\$0 - \$100] per pregnancy] [,then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]
<del>Non-routine outpatient obstetrical care</del>  Inpatient obstetrical care and delivery, including cesarean section ]	<p><del>[[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]</del></p> <p>[No charge] [[\$100 - \$1000] per admission] [,then] [[0% - 50%] of AC*] [[\$100 - \$500] per day, not to exceed a total of [3x - 5x the daily amount] per admission] [after Deductible] [;] [Deductible waived] [Member payment not to exceed \$[100-10,000] [per admission] [per [contract] [calendar] [policy] year]] [<a href="#">The applicable inpatient hospital Cost Share will apply.</a>]</p>
<b>Medical Foods</b>	[No charge] [[0% - 50%] of AC*] [after Deductible][; Deductible waived] [ <a href="#">Applicable Cost Shares will apply based on type and place of Service</a> ]
<a href="#">Medical Nutrition Therapy &amp; Counseling</a>	<a href="#">[No charge] [[\$5 - \$500] per visit] [,then] [0% - 50%] of AC*] [after Deductible][; Deductible waived] [<a href="#">Applicable Cost Shares will apply based on type and place of Service</a>]</a>
<b>Morbid Obesity Services</b>	[No charge][ [[\$5 - \$500] per visit] [,then] [0% - 50%] of AC*] [after Deductible][; Deductible waived] [ <a href="#">Applicable Cost Shares will apply based on type and place of Service</a> ]
[Bariatric Surgery]	[0% - 50%] of AC*[after Deductible]
All other Services]	[Applicable Cost Shares will apply based on type and place of Service]
<b>Oral Surgery</b>	[No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible][; Deductible waived] [ <a href="#">Applicable Cost Shares will apply based on type and place of Service</a> ]
<b>Preventive Health Care Services</b> [Not subject to Deductible]	[No charge][[\$0 - \$100] per visit] [[0% - 50%] of AC*] [;] [Copayment waived for children under [24 months] [2 - 25][years] of age]
[Routine physical exams for adults]	[[No charge][[\$0 - \$100] per visit] [;] [[0% - 50%] of AC*] [after Deductible] [;]

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# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

<b>Copayments and Coinsurance</b>	
Covered Service	You Pay [after Deductible]
	[Deductible waived]
Routine preventive tests for adults	[No charge][[\$0 - \$100] per visit] [;] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Well child care visits	[No charge] [[\$0 - \$100] per visit] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Copayment waived for children under [24 months][2- 25] [years] of age]
Routine immunizations for children and adults conducted in a Lab or Radiology (No additional charge for immunization agent)]	[No charge] [[\$0 - \$100] per visit] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Copayment waived for children under [24 months][2 - 25][years] of age]
<b>Prosthetic Devices</b> [Limited to internally implanted devices, ostomy and urological supplies and breast prosthetics, unless a Prosthetic and Orthotic Devices Rider is attached to this EOC.]	[[No charge][0% -50%] of AC*] [after Deductible] [; Deductible waived]
[Internally implanted devices	[[No charge][0% -50%] of AC*] [after Deductible] [; Deductible waived] [Applicable inpatient Cost Shares will apply]
Ostomy and urological supplies	[No charge][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]
Breast prosthetics ]	[No charge][[0% - 50%] of AC*] [after Deductible] [; Deductible waived] ]
<a href="#">[Hair prostheses]</a>	<a href="#">[No charge][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]</a>
<b>Reconstructive Surgery</b>	[No charge] [[\$0 - \$100] per visit][0% - 50%] of AC*] [after Deductible][; Deductible waived] [Applicable Cost Shares will apply based on place and type of Service.]
<b>Skilled Nursing Facility Care</b> [Limited to a maximum benefit of [60 – 240] days per [admission] [contract] [calendar] [policy] year]	[No charge] [[\$100 - \$\$1000] per admission] [,then] [Deductible, then] [[0% - 50%] of AC*] [[[\$100 - \$500] per day, not to exceed a total of [3x - 5x the daily amount] per admission] [after Deductible] [;] [Deductible waived]
<b>Telemedicine Services</b>	[[No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
<b>Therapy and Rehabilitation Services</b>	[[No charge] [[\$0 - \$100] per visit] [,then]

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## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

<b>Copayments and Coinsurance</b>	
Covered Service	You Pay [after Deductible]
(Refer to Section 3 for benefit maximums)	[[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
[Inpatient Services	[[Applicable inpatient Cost Shares will apply]
Outpatient Services	[No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
<b>Note:</b> All Services received in one day for multidisciplinary rehabilitation Services at a day treatment program will be considered one visit.]	
<b>Transplants</b>	[No charge] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [Applicable Cost Shares will apply based on place and type of Service]
<b>Urgent Care</b>	[[No charge] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
[Office visit during regular office hours	[Applicable office visit Cost Share will apply]
After-Hours Urgent Care or Urgent Care Center]	[No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
<b>[Vision [Exam] Services</b>	[[No charge] [Applicable Cost Shares will apply, based on type and place of Service] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ]
[[Eye exams (for adults age 19 or older)	
• by an Optometrist	[ [No charge] [[\$0 - \$100] per visit] [,then] [;] [[0% - 80%] of AC*] [after Deductible] [;] [Deductible waived] [Copayment waived for children under [24 months][2 – 22] [years] of age]
[Routine eye exam once per [contract] [calendar][policy] year]	
• by an Ophthalmologist]	[No charge] [[\$0 - \$100] per visit] [,then] [[0% - 80%] of AC*] [after Deductible] [;] [Deductible waived]
[Member may opt to have frames and lenses or contacts, but not both in a [contract] [calendar] [policy] year]	
[Eyeglass [lenses and] frames	[You receive a 25% discount off retail price** for eyeglass lenses and for eyeglass frames [once per [contract][calendar] [policy] year].] [You receive a [\$40 - \$1,000] discount for eyeglass lenses and a [\$40 - \$500] discount for eyeglass frames [once per [contract][calendar] [policy] year].] [You receive a [\$50 - \$500] allowance on frames, lenses and/or contact lenses, combined [, once per [every 2] [contract][calendar]

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# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

## Copayments and Coinsurance

Covered Service	You Pay [after Deductible]
	[policy] year[s]. ] [\$100 - 1,000] allowance on frames; correction lenses covered in full [once per [every 2] [contract] [calendar] [policy] year[s] . ] [You receive a maximum allowance of [\$50 - \$1000] for all covered vision Services, other than eye exams [, per [every 2] [contract][calendar] [policy] year[s]. ] [Not covered] [No charge] [Member pays balance after Plan pays] [\$50 - \$500]] [Member pays 20% - 100% of retail price**] [You receive a [\$20 - \$500] allowance toward wholesale cost. If frame is more than allowance member pays [2] times the difference between wholesale cost and allowance] ]
Eyeglass lenses]	
• [Single Vision]	[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]
• [Bifocal]	[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]
• [Trifocal]	[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]
• [Lenticular]	[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]
[Scratch Resistant] [Anti-reflective Coating (ARC)]	
• [Standard]	[Not covered] [No charge] [Member pays balance after Plan pays] [\$50 - \$500]
• [Premium]	[Not covered] [No charge] [Member pays balance after Plan pays] [\$50 - \$500]
• [Ultra]	[Not covered] [No charge] [Member pays balance after Plan pays] [\$50 - \$500]
[Contact lenses] [in lieu of frames and lenses]	[20% - 100% of retail price**] [ Member pays balance after Plan pays [\$50 - \$500] [You receive a [15% - 25%] discount off retail price on initial pair of contact lenses] [You receive a [\$50 - \$250] allowance on frames, lenses and/or contact lenses, combined, once per [every 2] [contract][calendar] [policy] year[s] ] [You receive a \$[50 - 500] allowance on [initial pair of ] contact lenses [once per [every 2] [contract] [calendar] [policy] year[s] ] [You receive a maximum allowance of [\$50 - \$1000] for all covered vision Services, other than eye exams, per [every 2]

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# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

## Copayments and Coinsurance

Covered Service	You Pay [after Deductible]
	[contract][calendar] [policy] year[s] ]
<ul style="list-style-type: none"> <li>• [Medically Necessary]</li> </ul>	[No charge] [20% - 100% or retail price**] [with prior approval] [Member pays balance after Plan pays [\$50 - \$500]
<ul style="list-style-type: none"> <li>• [Medical Multifocal]</li> </ul>	[Not covered] [No charge] [20% - 100% of retail price**] [with prior approval] [Member pays balance after Plan pays [\$50 - \$500]
<ul style="list-style-type: none"> <li>• [Cosmetic]</li> </ul>	[Not covered] [No charge] [20% - 100% of retail price**] [with prior approval] [Member pays balance after Plan pays [\$50 - \$500]

[Note: A child may select any pair of glasses in lieu of, or in addition to, the eyeglasses or contact lenses available at no charge under Vision Services for children below and receive the discount at any Plan Vision Center.]

### Vision Services (for children under age 19)

Eye exams

- by an Optometrist  
[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC\*] [after Deductible] [;] [Deductible waived]
- by an Ophthalmologist  
[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC\*] [after Deductible] [;] [Deductible waived]

Eyeglass lenses and frames  
(Limited to a select group)

No charge for one pair per [contract] [calendar] [policy] year

Contact lenses  
(Limited to a select group)

No charge for initial fit and first purchase per [contract] [calendar] [policy] year

Medically necessary contact lenses  
(Limited to a select group)

No charge

Low Vision Aids  
(Unlimited from available supply)

No charge

### X-ray, Laboratory and Special Procedures

[[No charge] [[0% - 50%] of AC\*] [after Deductible] [;] [Deductible waived] ]

[Inpatient diagnostic imaging, interventional diagnostic tests, laboratory tests, specialty imaging and special procedures

[No charge] [Applicable inpatient Cost Shares will apply]

Outpatient diagnostic imaging, interventional diagnostic tests, and laboratory tests

[No charge][[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC\*] [after Deductible] [;] [Deductible waived]

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# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

## Copayments and Coinsurance

Covered Service	You Pay [after Deductible]
Outpatient specialty imaging (including CT, MRI, PET Scans, and Nuclear Medicine); Interventional Radiology and special procedures	[No charge] [[0 - \$500] per test] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]
Sleep lab	[[No charge] [[5 - \$500] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ] ]
Sleep studies	[[No charge] [[5 - \$500] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] ] ]

[Note: charges for covered outpatient diagnostic and laboratory tests performed in a Plan Physician's office are included in the office visit Copayment.] ]

\*AC means Allowable Charge

\*\* "Retail price" means the price that would otherwise be charged for the lenses, frames or contacts at the KP Vision Care Center on the day purchased.

### [[Out-of-Pocket Maximum]

[The Out-of-Pocket Maximum is the limit to the total amount of [Deductible] [,] [Copayments] [and] Coinsurance you must pay in a [contract] [policy] [calendar] year for [the Basic Health] Services covered under this EOC [as shown below]. Once you or your Family Unit have met your Out-of-Pocket Maximum, you will not be required to pay any additional [Cost Shares] [Coinsurance] for [Basic Health] [most] Services [that are subject to the out-of-pocket maximum] for the rest of the [contract] [policy] [calendar] year.

**[[Self-Only] [Individual] Coverage Out-of-Pocket Maximum.** If you are covered as a Subscriber, and you do not have any Dependents covered under this EOC, your medical expenses apply toward the [\[Self-Only\] \[Individual\]](#) Out-of-Pocket Maximum shown below.]

**[Family Coverage Out-of-Pocket Maximum.** If you have one or more Dependents covered under this EOC, the covered medical expenses incurred by all Members of the Family Unit together apply toward the Family Out-of-Pocket Maximum shown below; however no one family Member's medical expenses may contribute more than the [Self-Only Individual](#) Out-of-Pocket Maximum shown below.} After one member of a Family Unit has met the [Self-Only Individual](#) Out-of-Pocket Maximum, his or her Out-of-Pocket Maximum will be met for the rest of the [calendar][contract][policy] year. Other family Members will continue to pay applicable Cost Shares until the Family Out-of-Pocket Maximum is met. After all Members of the Family Unit combined have met the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be met for all Members of the Family Unit for the rest of the [calendar][contract] [policy] year.]

**[Family Coverage Out-of-Pocket Maximum.** If you have one or more Dependents covered under this plan, the medical expenses of one or more Members of your Family Unit together apply towards the family Out-of-Pocket Maximum shown below. The [Self-Only Individual](#) Out-of-Pocket Maximum shown below does not apply with family coverage.]

[[Except as excluded below, the following Services are considered "Basic Health Services" that apply toward the Out-of-Pocket Maximum:

- Inpatient and outpatient physician Services
- Inpatient hospital Services
- Outpatient medical Services
- Preventive health care Services
- Emergency Services

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- X-ray, laboratory and special procedures
- Inpatient and outpatient chemical dependency and mental health Services]

[Member payments for all Services apply to the Out-of-Pocket Maximum.]

**[Out-of-Pocket Maximum Exclusions:**

The following Services, if covered, [are *not* considered Basic Health Services and] *do not* apply toward your Out-of-Pocket Maximum:

- [Outpatient drugs, supplies and supplements, including blood, blood products, and medical foods]
- [Outpatient durable medical equipment and prosthetic and orthotic devices]
- [Inpatient and outpatient infertility Services]
- [Eyeglass lenses and frames, contact lenses]
- [[Acupuncture] [and] [chiropractic] Services]
- [Ambulance Services]
- -[A]adult vision exams]

[Member payments for Services that are not subject to the Deductible (as listed above in the schedule) *do not* apply to the Out-of-Pocket Maximum.]

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

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

<p><b>[Annual Out-Of-Pocket Maximum]</b>  <u>Combined total of [Deductible and] allowable [Copayments and] Coinsurance</u></p> <p><u>[[Self-Only] [Individual] Out-of-Pocket Maximum]</u></p> <p><u>[Family Out-of-Pocket Maximum]</u></p>	<p><u>[[ \$0 - \$10,000] per individual per [contract] [calendar] [policy] year]</u></p> <p><u>[2x - 3x individual Out-of-Pocket Maximum] [ \$500 - \$30,000] per Family Unit per [contract] [calendar] [policy] year]</u></p>
<p><del>Combined total of [Deductible and] allowable [Copayments and] Coinsurance</del></p>	<p><del>[[<b>Individual Out-of-Pocket Maximum</b>] [ \$0 - \$10,000] per individual per [contract] [calendar] [policy] year]]</del></p> <p><del><b>Family Out-of-Pocket Maximum</b> [2x - 3x individual Out-of-Pocket Maximum] [ \$500 - \$30,000] per Family Unit per [contract] [calendar] [policy] year]]</del></p>

## [[Out-of-Pocket Maximum]

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

**[[Self-Only] [Individual] Coverage Out-of-Pocket Maximum.** If you are covered as a Subscriber, and you do

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## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

not have any Dependents covered under this EOC, your medical expenses apply toward the [\[Self-Only/Individual\]](#) Out-of-Pocket Maximum shown below.]

**[Family Coverage Out-of-Pocket Maximum.** If you have one or more Dependents covered under this EOC, the covered medical expenses incurred by all Members of the Family Unit together apply toward the Family Out-of-Pocket Maximum shown below; however no one family Member’s medical expenses may contribute more than the ~~Self-Only/Individual~~ Out-of-Pocket Maximum shown below. After one member of a Family Unit has met the ~~Self-Only/Individual~~ Out-of-Pocket Maximum, his or her Out-of-Pocket Maximum will be met for the rest of the [calendar][contract][policy] year. Other family Members will continue to pay applicable Cost Shares until the Family Out-of-Pocket Maximum is met. After all Members of the Family Unit combined have met the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be met for all Members of the Family Unit for the rest of the [calendar][contract] [policy] year.]

**[Family Coverage Out-of-Pocket Maximum.** If you have one or more Dependents covered under this EOC, the medical expenses of all Members of your Family Unit together apply towards the family Out-of-Pocket Maximum shown below. After one or more covered 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 [contract] [calendar] [policy] year. The ~~Self-Only/Individual~~ Out-of-Pocket Maximum shown below does not apply with family coverage.]

**[Individual within Family Coverage Out-of-Pocket Maximum.** There is a maximum to the total dollar amount of Copayments and Coinsurance that you must pay for covered Services that you receive within the same Year. If you are the only Member in your Family, then you must meet the Individual within Family Out-of-Pocket Maximum. If you are a Member in a Family of two or more Members, then either you must each meet the Individual within Family Out-of-Pocket Maximum, or your entire Family must meet the Family Out-of-Pocket Maximum. Each Individual within Family Out-of-Pocket Maximum amount counts toward the Family Out-of-Pocket Maximum amount. The Self-Only Out-of-Pocket Maximum, Individual within Family Out-of-Pocket Maximum, and Family Out-of-Pocket Maximum amounts are shown below.]

**[Out-of-Pocket Maximum Exclusions:**

The following Services do not apply toward your Out-of-Pocket Maximum:

- [Adult eyeglass lenses and frames, contact lenses that are available with a discount only]
- [Adult dental Services, if included by Rider attached to this plan]
- [Adult routine eye exams] ]
- [\[In vitro fertilization\]](#)
- [Inpatient and outpatient infertility Services and drugs]

[Member payments for Services that are not subject to the Out-of-Pocket Maximum (as listed above in the schedule) *do not* apply to the Deductible.]

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

**Notice of Out-of-Pocket Maximum.** We will also keep accurate records of your out-of-pocket expenses and will notify you when you have reached the maximum. We will send you written notice no later than 30 days after we have received and processed your claims that the Out-of-Pocket Maximum is reached. If you have exceeded your Out-of-Pocket Maximum, we will promptly refund to you any [Copayments or] [\[Coinsurance\]](#) charged after the maximum was reached.]

<p><b>[Annual Out-Of-Pocket Maximum]</b>  <a href="#">Combined total of [Deductible and] allowable [Copayments and] Coinsurance</a></p> <p><a href="#">[[Self-Only] [Individual] Out-of-Pocket Maximum]</a></p>	<p><a href="#">[[\$0 - \$10,000] per individual per [contract] [calendar] [policy] year]</a></p>
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<u>[Individual within Family Out-of-Pocket Maximum]</u>	[[ <del>\$0 - \$10,000</del> ] per individual Family member per [contract] [calendar] [policy] year]
<u>[Family Out-of-Pocket Maximum]</u>	[2x - 3x individual Out-of-Pocket Maximum] [500 - 20,000] per Family Unit per [contract] [calendar] [policy] year]
Combined total of [ <del>Deductible and</del> ] allowable [ <del>Copayments and</del> ] Coinsurance	<p><b>[Individual Out-of-Pocket Maximum]</b>  <del>[[<del>\$0 - \$10,000</del>] per individual per [contract] [calendar] [policy] year]]</del></p> <p><b>Family Out-of-Pocket Maximum</b>  <del>[2x - 3x individual Out-of-Pocket Maximum] [500 - 20,000] per Family Unit per [contract] [calendar] [policy] year]]</del></p>
{Self Only}	<del>[\$0 - \$10,000] [\$0 - \$10,000]</del>
{Self + Spouse} [ <del>or Domestic Partner</del> ]	<del>[\$0 - \$10,000]</del>
{Self + Children}	<del>[\$0 - \$10,000]</del>
{Self + Spouse} [ <del>or Domestic Partner</del> ] + {Children}	

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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## SECTION 3: BENEFITS

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The Services described in this “Benefits” section are covered only if all of the following conditions are met:

1. You are a Member on the date the Services are rendered;
2. [You have met any Deductible requirement described in the "Deductible" section of the Summary of Services and Cost Shares Appendix.]
3. The Services are provided:
  - a. By a Plan Provider; or
  - b. By a non-Plan Provider-, subject to an approved referral as described in Section 2; and
  - c. In accordance with the terms and conditions ~~of this~~ within this EOC including but not limited to the requirements, if any, for prior approval (authorization);
4. The Services are Medically Necessary; and
5. You receive the Services from a Plan Provider except as described within this EOC.

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

1. Emergency Services;
2. Urgent Care outside our Service Area;
3. Authorized referrals to non-Plan Providers (as described in Section 2: [How to Obtain Services](#))~~[.]; and]~~
4. [\[Receiving care in another Kaiser Foundation Health Plan Service Area](#)~~Visiting Member Services as described~~ in Section 2: [How to Obtain Services.](#)]

### Exclusions and Limitations:

Exclusions and limitations that apply only to a particular benefit are described in this section. Other exclusions, limitations, and reductions that affect all benefits are described in ~~the~~ [Section 4: “Exclusions, Limitations, and Reductions”](#) ~~section of this EOC.~~

**Note:** The “Summary of Services and Cost Shares” Appendix lists the Copayments, Coinsurances and Deductibles that apply to the following covered Services. Your Cost Share will be based on the type and place of Service.

### A. OUTPATIENT CARE

---

We cover the following outpatient care:

1. Primary care visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics/gynecology ([OB/GYN](#)) Services (~~R~~Refer to “Preventive Health Care Services” for coverage of preventive care Services);
2. Specialty care visits (~~R~~Refer to “Referrals to Plan Providers” in ~~the~~ [Section 2: “How to Obtain Services”](#) ~~section~~ for information about referrals to Plan specialists);
3. [Consultations and immunizations for foreign travel;]
4. Diagnostic testing for care or treatment of an illness; or to screen for a disease for which you have been determined to be at high risk for contracting. This includes, but is not limited to:
5. Diagnostic exams, including digital rectal exams and prostate antigen (PSA) tests provided:
  - a. To persons age 40 and ~~over~~ older who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society;

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6. Colorectal cancer screening, specifically: screening with an annual fecal occult blood test; flexible sigmoidoscopy or colonoscopy; or, ~~when appropriate~~ in appropriate circumstances, radiologic imaging, for persons; who are at high risk of cancer. High risk is determined based on the most recently published guidelines of the American College of Gastroenterology, in consultation with the American Cancer Society;
7. Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A “qualified individual” means:
  - a. An estrogen deficient ~~person~~ individual at clinical risk for osteoporosis;
  - b. ~~a person~~ An individual with a specific sign suggestive of spinal osteoporosis. This includes: roentgeno-graphic osteopenia or roentgen-ographic evidence suggestive of collapse; wedging; or ballooning of one or more thoracic or lumbar vertebral bodies; and who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
  - c. ~~a person~~ An individual receiving long-term gluco-corticoid (steroid) therapy;
  - d. An individual ~~a person~~ with primary hyper-parathyroidism; or
  - e. An individual ~~a person~~ being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;
8. Outpatient surgery physician/surgical Services;
9. Anesthesia, including Services of an anesthesiologist;
10. Chemotherapy and radiation therapy;
11. Respiratory therapy;
12. Medical social Services;
13. House calls when care can best be provided in your home as determined by a Plan Provider; and
14. After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to the Urgent Care provision for covered Services.

(Refer to “Preventive Health Services” for coverage of preventive care tests and screening Services);

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

### **B. HOSPITAL INPATIENT CARE**

---

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

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

## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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10. Medical social Services and discharge planning.

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

### **C. ACCIDENTAL DENTAL INJURY SERVICES**

---

We cover restorative Services necessary to promptly repair, but not replace, ~~s~~Sound ~~n~~Natural ~~T~~Teeth that have been injured as the result of an external force. Coverage is provided when all of the following conditions have been met:

1. The accident has been reported to your primary care Plan Physician within seventy-two (72) hours of the accident.
2. A Plan Provider provides the restorative dental Services;
3. The injury occurred as the result of an external force; ~~“External force” is~~ that is defined as violent contact with an external object; not force incurred while chewing;
4. The injury was sustained to ~~s~~Sound ~~N~~Natural ~~T~~Teeth;
5. The covered Services must be requested within [sixty (60) days]~~[six (6) months]~~ of the injury; and
6. The covered Services are provided during the twelve (12) consecutive month period commencing from the date that the injury ~~occurred~~started.

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

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

#### ***Accidental Dental Injury Services Exclusions:***

- Services provided by non-Plan Providers.
- Services provided after twelve (12) months from the date the injury occurred.
- Services for teeth that have been avulsed (knocked out) or that have been so severely damaged that in the opinion of the Plan Provider, restoration is impossible.

### **D. ALLERGY SERVICES**

---

We cover the following allergy Services:

- Evaluations, and treatment ; and
- Injections and serum.

### **E. AMBULANCE SERVICES**

---

We cover licensed ambulance Services only if your medical condition requires: (1) the basic life support, advanced life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer; and (2) the ambulance transportation has been ordered by a Plan Provider. Coverage is also provided for Medically Necessary transportation or Services, including Medically Necessary air ambulance transport to the nearest hospital able to provide needed Services, rendered as the result of a 911 call. Your Cost Share will apply to each encounter, whether or not transport was required.

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

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

We cover licensed ambulance and non-emergent transportation Services ordered by a Plan Provider only inside our Service Area, except as covered under the “Emergency Services” provision in this section, ~~of the EOC.~~

### ***Ambulance Services Exclusions:***

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

## **F. ANESTHESIA FOR DENTAL SERVICES**

---

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

1. For whom a superior result can be expected from dental care provided under general anesthesia; and
2. For whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition.

Additionally, we provide these Services to Members age:

1. 7 or younger or are developmentally disabled.
2. 17 or younger who is extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred, and for whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.
3. 17 and older when the Member’s medical condition requires that dental service be performed in a hospital or ambulatory surgical center for the safety of the Member (e.g., heart disease and hemophilia).

~~We cover general anesthesia and associated hospital or ambulatory surgical center Services for dental care provided to Members:~~

- ~~1. Who are 7 years of age or younger or are developmentally disabled;~~
- ~~2. For whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition; and~~
- ~~3. For whom a superior result can be expected from dental care provided under general anesthesia; or~~
- ~~4. Who are 17 years of age or younger who is extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred; and~~
- ~~5. Whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity; or~~
- ~~6. For adults age 17 and older when the Member’s medical condition requires that dental service be performed in a hospital or ambulatory surgical center for the safety of the Member (e.g., heart disease~~

## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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~~and hemophilia).~~

General anesthesia and associated hospital and ambulatory surgical center charges will be covered only for dental care that is provided by:

1. A fully accredited specialist in pediatric dentistry; or
2. A fully accredited specialist in oral and maxillofacial surgery; and
3. For whom hospital privileges ~~has~~<sup>ye</sup> been granted.

### ***Anesthesia for Dental Services Exclusions:***

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

## **G. BLOOD, BLOOD PRODUCTS AND THEIR ADMINISTRATION**

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We cover; blood ~~and~~ ,—blood ~~products, both derivatives and components~~<sup>products, both derivatives and components</sup>, ~~i~~ including the collection and storage of autologous blood for elective surgery; cord blood procurement and storage for approved Medically Necessary care, when authorized by a Plan Provider; and the administration of prescribed whole blood and blood products.

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

### ***Blood, Blood Products and their Administration Limitations:***

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

### ***Blood, Blood Products and their Administration Exclusions:***

- Directed blood donations.

## **H. CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES**

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We cover the treatment of treatable mental illnesses, emotional disorders, drug abuse and alcohol abuse for conditions that in the opinion of a Plan Provider, would be responsive to therapeutic management.

For the purposes of this benefit provision: "Drug and alcohol abuse" means a disease that is characterized by a pattern of pathological use of a drug and/or alcohol with repeated attempts to control its use and with significant negative consequences in at least one the following areas of life: medical; legal; financial; or psycho-social.

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

1. Individual therapy;
2. Group therapy;
3. Shock therapy;
4. Drug therapy;
5. Education;
6. Psychiatric nursing care; and
7. Appropriate hospital Services.

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Medical Services for detoxification are limited to the removal of the toxic substance or substances from the system. Detoxification will be covered for a minimum of [twelve \(12\)](#) days annually.

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

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

In an outpatient setting, we cover all ~~necessary~~ [Medically Necessary](#) Services of physicians and other health care professionals as performed, prescribed, or directed by a physician including, but not limited to:

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

### ***Chemical Dependency and Mental Health Services Exclusions:***

- Services in a facility whose primary purpose is to provide treatment for alcoholism, drug abuse, or drug addiction, except as described above.
- Services provided in a psychiatric residential treatment facility, except as described above.
- Services for Members who, in the opinion of the Plan Provider, are seeking Services for non-therapeutic purposes.
- [Applied Behavior Analysis (ABA).]
- Cognitive Behavior Therapy (CBT).
- Psychological testing for ability, aptitude, intelligence, or interest.
- Services on court order or as a condition of parole or probation, unless determined by the Plan Provider to be Medically Necessary.
- Evaluations that are primarily for legal or administrative purposes, and are not Medically Necessary.

### **I. [\[CHIROPRACTIC \[AND\] \[ACUPUNCTURE\] SERVICES](#)**

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

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

### ***Chiropractic [\[and\] \[Acupuncture\] Services Limitation:](#)***

The number of visits needed for the Member to reach the maximum level of recovery will be determined by the Plan Provider [and shall not exceed a total of [\[ten \(10\)-ninety \(950\)\]](#) visits per [contract][calendar][policy] year [\[for each type of Service\]\[for chiropractic Services\]; and \[ten \(10\)-ninety \(90\) visits per \[contract\]\[calendar\]\[policy\] year for acupuncture Services.\]](#)

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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### **J. CLEFT LIP, CLEFT PALATE OR BOTH**

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

### **K. CLINICAL TRIALS**

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We cover the routine patient care costs you may incur as an eligible participant in an approved clinical trial undertaken for the purposes of: the prevention, early detection, treatment; or monitoring of cancer, chronic disease, or life-threatening illness.

For the purposes of this benefit, an approved clinical trial means:

1. A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
  - a. The National Institutes of Health ([NIH](#));
  - b. The Centers for Disease Control and Prevention ([CDC](#));
  - c. The Agency for Health Care Research and Quality;
  - d. The Centers for Medicare and Medicaid Services;
  - e. A bona fide clinical trial cooperative group, including: the National Cancer Institute Clinical Trials Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the AIDS Clinical Trials Group; and the Community Programs for Clinical Research in AIDS; or
  - f. The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;
2. A study or investigation approved by the [United States](#) Food and Drug Administration (“FDA”), including those conducted under an investigational new drug or device application reviewed by the FDA; or
3. An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

“Routine patient care costs” mean:

1. Items, drugs, and Services that are typically provided absent a clinical trial;
2. Items, drugs, and Services required solely for the provision of the investigational item or service (such as the administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
3. Items, drugs, and Services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

#### ***Clinical Trials Exclusions:***

Routine patient care costs shall not include:

- The cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or items, drugs, or Services provided solely to satisfy data collection and analysis needs; or
- Items, drugs, or Services customarily provided by the research sponsors free of charge for any qualified individual enrolled in the trial.

## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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**Note:** Coverage will not be restricted solely because the Member received the Service outside [of](#) the Service Area or the Service was provided by a non-Plan Provider.

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

### **L. DIABETIC EQUIPMENT, SUPPLIES, AND SELF-MANAGEMENT**

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

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

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

***Diabetic Equipment and Supplies Limitation:***

Diabetic equipment and supplies are limited to Health Plan preferred equipment and supplies unless the equipment or supply: (1) was prescribed by a Plan Provider; and (2) (a) there is no equivalent preferred equipment or supply available; or (b) an equivalent preferred equipment or supply (i) has been ineffective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member. "Health Plan preferred equipment and supplies" are those purchased from a Plan preferred vendor.

[To obtain information about Plan preferred vendors, contact Member Services:](#)

[\[Inside the Washington, DC Metropolitan Area: \(301\) 468-6000\]](#)

[\[Outside of the Washington, DC Metropolitan Area: 1-800-777-7902\]](#)

[\[TTY: 711\]](#)

### **M. DIALYSIS**

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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 Provider 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 lab tests, equipment, supplies and other Services associated with your treatment; ~~and~~
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~~

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3. Plan Provider Services related to inpatient and outpatient dialysis.

We cover the following self-dialysis Services:

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

We cover home dialysis, which includes:

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

[Members requiring dialysis outside of the service area for a limited time period, may receive pre-planned dialysis services in accordance to prior authorization requirements.](#)

### **N. DRUGS, SUPPLIES, AND SUPPLEMENTS**

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#### **Administered Drugs, Supplies and Supplements**

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

1. Oral infused or injected drugs, and radioactive materials used for therapeutic purposes, including chemotherapy;
2. Injectable devices;
3. The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
4. Medical and surgical supplies including: dressings; splints; casts; hypodermic needles; syringes; or any other Medically Necessary supplies provided at the time of treatment;
5. Vaccines and immunizations approved for use by the ~~federal Food and Drug Administration (FDA)~~ that are not considered part of routine preventive care.

**Note:** Additional Services that require administration or observation by medical personnel are covered. See the “Outpatient Prescription Drugs Rider,”<sup>2</sup> if applicable, for coverage of self-administered outpatient prescription drugs; “Preventive Health Care Services” for coverage of vaccines and immunizations that are part of routine preventive care; [and] “Allergy Services” for coverage of allergy test and treatment materials[.]; and “Family Planning Services” for the insertion and removal of contraceptive drugs and devices, if applicable.]

#### ***Drugs, Supplies and Supplements Exclusions:***

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

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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## **O. DURABLE MEDICAL EQUIPMENT**

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

Durable Medical Equipment does not include coverage for prosthetic devices, such as implants, artificial eyes or legs, or orthotic devices, such as braces or therapeutic shoes. Refer to “Prosthetic Devices” for coverage of internal prosthetic devices, ostomy and urological supplies and breast prosthesis. Additional coverage for external prosthesis and orthotic devices is only covered if a Prosthetic and Orthotic Devices Rider is attached to this EOC.

### **Basic Durable Medical Equipment**

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

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

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

### **Supplemental Durable Medical Equipment**

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

#### **Oxygen and Equipment**

We cover oxygen and equipment when prescribed by a Plan Provider and your medical condition meets the Health Plan’s criteria for being Medically Necessary. A Plan Provider must certify the continued medical need for oxygen and equipment ~~every 30 days~~.

#### **Positive Airway Pressure Equipment**

We cover continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BIPAP) equipment when prescribed by a Plan Provider and your medical condition meets the Health Plan’s criteria for being Medically Necessary. A Plan Provider must certify the continued medical need ~~every 30 days~~ [for positive airway pressure equipment](#).

#### **Apnea Monitors**

We cover apnea monitors for infants who are under age 3, for a period not to exceed ~~six~~ [\(6\)](#) months.

#### **Asthma Equipment**

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

1. Spacers
2. Peak-flow meters

## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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### 3. Nebulizers

#### **Bilirubin Lights**

We cover bilirubin lights for infants, who are under age 3, for a period not to exceed [six \(6\)](#) months.

#### ***Durable Medical Equipment Exclusions:***

- Comfort, convenience, or luxury equipment or features.
- Exercise or hygiene equipment.
- Non-medical items such as sauna baths or elevators.
- Modifications to your home or car.
- Devices for testing blood or other body substances (except as covered under “Diabetes Equipment, Supplies and Self-Management”).
- Electronic monitors of the heart or lungs, except infant apnea monitors.
- Services not preauthorized by the Health Plan.

### **P. EMERGENCY SERVICES**

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

If you think you are experiencing an Emergency Medical Condition you should call 911 immediately. If you are not sure whether you are experiencing an Emergency Medical Condition, please contact us at the number listed on the reverse side of your ID card for immediate medical advice. You or your representative must notify the Health Plan as soon as possible, [and](#) not to exceed forty-eight (48) hours or the ~~next-1<sup>st</sup>~~ business day, whichever is later, if you receive care at a hospital emergency room (ER) to ensure coverage. If the emergency room visit was not due to an “Emergency Medical Condition,” as defined in the [“Definitions”<sup>2</sup>](#) Appendix ~~of this EOC~~, and was not authorized by [the](#) Health Plan, you will be responsible for all charges.

We cover Emergency Services as follows:

#### **Inside our Service Area**

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

#### **Outside [of](#) our Service Area**

We cover reasonable charges for Emergency Services if you are injured or become ill while temporarily outside [of](#) our Service Area.

We do not cover Services for conditions that, before leaving the Service Area, you should have known might require Services while you are away, such as: dialysis for ~~end-stage renal disease~~ [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.

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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## **Continuing Treatment Following Emergency Services**

### **Inside our Service Area**

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

### **Inside another Kaiser Permanente Region**

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

### **Outside our Service Area**

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

### **Transport to a Service Area**

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

## **Continued Care in Non-Plan Facility Limitation**

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

## **Filing Claims for Non-Plan Emergency Services**

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

## **Emergency Services HIV Screening Test**

We cover the cost of a voluntary HIV screening test performed on a Member while the Member is receiving emergency medical Services, other than HIV screening, at a hospital emergency room. The test is covered whether or not the HIV screening test is necessary for the treatment of the medical emergency which caused the member to seek Emergency Services.

Covered Services include:

1. The costs of administering such a test;
2. All lab costs to analyze the test; and
3. The costs of telling the Member the results of the test; and any applicable follow-up instructions for obtaining health care and supportive Services.

Other than the Cost Share shown in the Summary of Services and Cost Shares for Emergency Services, no additional Cost Share will be imposed for these Services.

## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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### *Emergency Services Limitations:*

- **Notification:** If you receive care at a hospital emergency room or are admitted to a non-Plan Hospital, you, or someone on your behalf, must notify us as soon as possible, but not later than 48 hours or the next business day, whichever is later, of the emergency room visit or hospital admission, unless it was not reasonably possible to notify us. If you are admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us as provided herein, we will not cover the emergency room visit, or hospital care you receive after transfer would have been possible.
- **Continuing or Follow-up Treatment:** Except as provided for under “Continuing Treatment Following Emergency Surgery,” we do not cover continuing or follow-up treatment after Emergency Services unless authorized by Health Plan. We cover only the out-of-Plan emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Foundation Health Plan or allied plan service area.
- **Hospital Observation:** Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit copayment will not be waived.

### **Q. [FAMILY PLANNING SERVICES**

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We cover the following:

1. [Women’s Preventive Services (WPS), including:
  - a. Patient education and contraceptive method counseling for all women of reproductive capacity;
  - b. Coverage for: FDA-approved contraceptive devices; hormonal contraceptive methods; and the insertion or removal of contraceptive devices. This includes any Medically Necessary exams associated with the use of contraceptive drugs and devices; and
  - c. Female sterilization.
    - i. (Note: WPS are preventive care and are covered at no charge.)]
2. [Additional family planning counseling[, including pre-abortion and post-abortion counseling][.];[; and]
3. [Vasectomies][.];[; and]
4. [[Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (i) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (ii) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.]

### *Voluntary termination of pregnancy limitations:*

- We cover up to a maximum of two voluntary terminations of pregnancy during a contract year.]]
- 1. [[Family planning counseling [, including pre-abortion and post-abortion counseling] and information on birth control.]
- 2. [Insertion and removal, and any Medically Necessary exams associated with the use of contraceptive drugs and devices. Contraceptive devices (other than diaphragms) and implantable contraceptive drugs are supplied by the provider, and are covered under this benefit. Contraceptive drugs and diaphragms are covered only under an “Outpatient Prescription Drug Rider”, if applicable.]

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3. [Tubal ligations.]
4. [Vasectomies.]
5. [[Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (i) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (ii) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.]

### ***Voluntary termination of pregnancy limitations:***

- We cover up to a maximum of two (2) voluntary terminations of pregnancy during a contract year.]]

**Note:** Diagnostic procedures are covered, but not under this section (see “X-ray, Laboratory and Special Procedures”).]

## **R. HABILITATIVE SERVICES**

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### **[Children under age 21]**

We cover Medically Necessary Services, including speech therapy, occupational therapy and physical therapy, for children under the age of 21 years with a congenital or genetic birth defect, to enhance the child’s ability to function. Medically Necessary Habilitative Services are those Services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, and shall include Services that enhance functional ability without effecting a cure. Congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. The term congenital or genetic birth defect includes: (1) autism or an autism spectrum disorder and (2) cerebral palsy.

[Medical ~~Necessity~~-Necessary Services to treat autism and autism spectrum disorders shall include Applied Behavioral Analysis (ABA).]

### **[Adults age 21 or older]**

We cover Medically Necessary Habilitative Services that are designed to enhance a Member's functional ability, without effecting a cure, for the treatment of autism or an autism spectrum disorder, "Medically Necessary Habilitative Services" include occupational therapy, physical therapy, speech therapy, and (ABA).]

### ***Habilitative Services Exclusions:***

- Assistive technology Services and devices.
- Services provided through federal, state or local early intervention programs, including school programs.
- Services not preauthorized by Health Plan.
- Services for a Member that has plateaued and is able to demonstrate stability of skills and functioning even when Services are reduced.
- Services not provided by a licensed or certified therapist.

## **S. HEARING SERVICES**

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### **[Hearing Exams]**

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

## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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### **Hearing Aids**

We cover the following:

1. Medically Necessary hearing aids for both children and adults. Hearing aid means an electronic device worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing including an ear mold, if necessary.
2. Hearing aid evaluations and diagnostic procedures to determine the hearing aid model which will best compensate for loss of hearing.
3. Visits to verify that the hearing aid conforms to the prescription.
4. Visits for fitting, counseling, adjustment, cleaning, and inspection.

### ***Hearing Aid Limitations:***

- [Your hearing aid Benefit Allowance is [\$500 – \$5,000].
- [Coverage is provided for one Hearing Aid for each hearing impaired ear every [~~twelve (12)~~ – ~~sixty (60)~~] months. Two Hearing Aids are covered every [~~twelve (12)~~ – ~~sixty (60)~~] months only if both are required to provide significant improvement that is not obtainable with only one Hearing Aid, as determined by your Plan Provider.]
- [You are not required to obtain Hearing Aids for both ears at the same time. The [~~twelve (12)~~ – ~~sixty (60)~~] month benefit period extends separately for each ear, and commences at the initial point of sale for each ear.]
- [The hearing aid Benefit Allowance must be used at the initial point of sale for each hearing aid. Any part of the hearing aid Benefit Allowance that is not exhausted at the initial point of sale may not be used at a later time.]
- [The type of Hearing Aid is limited to the models provided by Kaiser Permanente or the Kaiser Permanente-designated Hearing Aid vendor.]

[You may apply the hearing aid Benefit Allowance toward a hearing aid upgrade. However, you must pay the difference in the hearing aid Benefit Allowance and the cost of the hearing aid upgrade.]]

### ***Hearing Services Exclusions:***

- [Tests to determine an appropriate hearing aid; ~~and~~
- Hearing aids or tests to determine their efficacy.]
- [Replacement of parts and batteries.]
- Replacement of lost or broken hearing aid.]
- Repair of hearing aid beyond one year.]
- Comfort, convenience, or luxury equipment or features.]
- Hearing aids prescribed and ordered prior to coverage or after termination of coverage]

## **T. HOME HEALTH CARE**

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

1. Skilled nursing care
2. Home health aide Services: and
3. Medical social Services.]

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

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

### **Home Health Visits Following Mastectomy or Removal of Testicle**

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

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

### ***Home Health Care Limitations:***

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

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

Additional limitations may be stated in the "Summary of Services and Cost Share."

### ***Home Health Care Exclusions:***

- Custodial care (see definition in ~~the Section 4: "Exclusions, Limitations, and Reductions"~~ section of this EOC).
- Routine administration of oral medications, eye drops, and/or ointments.
- General maintenance care of colostomy, ileostomy, and ureterostomy.
- Medical supplies or dressings applied by a Member or family caregiver.
- Corrective appliances, artificial aids, and orthopedic devices.
- Homemaker Services.
- Care that a Plan Provider determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, and we provide or offer to provide that care in one of these facilities.
- Services not preauthorized by the Health Plan.
- Transportation and delivery service costs of Durable Medical Equipment, medications, drugs, medical supplies and supplements to the home.

## **U. HOSPICE CARE**

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

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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the home if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

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

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

### **Definitions:**

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

## **V. [INFERTILITY SERVICES]**

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We cover the following:

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

### **Note[s]:**

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

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3. [ [In vitro fertilization, if:
  - a. [The Member's oocytes are fertilized with the Member's spouse's sperm; and]
  - b. The [Member has][Member's and the Member's spouse have] a history of infertility of at least two (2) years duration; or the infertility is associated with any of the following:
    - i. Endometriosis;
    - ii. Exposure in utero to diethylstilbestrol, commonly known as DES;
    - iii. Blockage of, or surgical removal of, one (1) or both fallopian tubes (lateral or bilateral salpingectomy); or
    - iv. Abnormal male factors, including oligospermia, contributing to the infertility;
  - c. The Member has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this EOC; and
  - d. The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or the American Fertility Society minimal standards for programs of in vitro fertilization.]
4. Intracytoplasmic Sperm Injection (ICSI) if the Member meets medical guidelines;
5. Preimplantation Genetic Diagnosis (PGD) if the Member meets medical guidelines[.];]
6. [Gamete intrafallopian transfers (GIFT); and
7. Zygote intrafallopian transfers (ZIFT).]

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

### ***[Infertility Limitations:***

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

### ***Infertility Services Exclusions:***

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

## **W. INFUSION THERAPY SERVICES**

We cover Services for infusion therapy, which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion Services also include enteral nutrition, which

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is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parentally. Infusion services may be received at multiple sites of service, including facilities, professional provider offices, and ambulatory infusion centers and from home infusion providers. The Cost Share amount will apply based on the place and type of Service provided.

### **W.X. MATERNITY SERVICES**

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We cover obstetrical Services for pre-and post-natal services, which includes routine and non-routine office visits, x-ray, lab and specialty tests. The Health Plan covers birthing classes and breastfeeding support, supplies, and counseling from trained providers during pregnancy and/or in the postpartum period.~~routine global maternity care; care for conditions that existed prior to pregnancy; care for high risk conditions that develop during pregnancy; and non-routine obstetrical care.~~

~~“Routine global maternity” means care provided after the first visit where pregnancy is confirmed, and includes all of the following Services, subject to a Cost Share: (a) the normal series of regularly scheduled preventive prenatal care exams; (b) physician charges for labor and delivery, including cesarean section; and (c) routine postpartum follow up consultations and exams.~~

Services for pre-existing conditions care related to the development of a high risk condition(s) during pregnancy, and non-routine obstetrical care are covered subject to applicable Cost Share for specialty, diagnostic, and/or treatment Services.

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

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

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

Comprehensive lactation (breastfeeding) education and counseling, by trained clinicians during pregnancy and/or postpartum period in conjunction with each birth, Breastfeeding equipment is issued, per pregnancy. The breast feeding pump (including any equipment that is required for pump functionality) is covered for six (6) months at no cost sharing to the member.

#### **Maternity Services Exclusions**

- Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.

### **X.Y. MEDICAL FOODS**

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We cover medical foods and low protein modified food products for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry including a disease for which the State screens newborn babies. Coverage is provided if the medical foods and low protein food products are prescribed as

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Medically Necessary for the therapeutic treatment of inherited metabolic diseases, and are administered under the direction of a Plan Provider.

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

Low protein modified foods are food products that are (1) specially formulated to have less than one (1) gram of protein per serving, and (2) intended to be used under the direction of a Plan Provider for the dietary treatment of an inherited metabolic disease.

### **Medical Foods Exclusions:**

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

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

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

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

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

### **Amino Acid Based Elemental Formula Exclusions:**

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

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

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

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

### ~~**Medical Foods Exclusions:**~~

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

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### ~~Y.Z.~~ MORBID OBESITY

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We cover diagnosis and treatment of morbid obesity including gastric bypass surgery or other surgical method that is recognized by the National Institutes of Health ([NIH](#)) as effective for long-term reversal of morbid obesity, and is consistent with criteria approved by the ~~National Institutes of Health~~[NIH](#).

Morbid obesity is defined as:

1. A weight that is at least [one-hundred \(100\)](#) pounds over or twice the ideal weight for a patients frame, age, height, and gender, as specified in the 1983 Metropolitan Life Insurance tables; or
2. A body mass index (BMI) that is equal to or greater than [thirty-five \(35\)](#) kilograms per meter squared with a comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary condition, sleep apnea, or diabetes; or
3. A BMI of [forty \(40\)](#) kilograms per meter squared without such comorbidity.

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

#### *Morbid Obesity Services Exclusions*

- Services not preauthorized by [the Health Plan](#)

### ~~Z.AA.~~ ORAL SURGERY

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

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

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

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

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

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

[Note:](#) Functional impairment refers to an anatomical function as opposed to a psychological function.

[The Health Plan](#) provides coverage for cleft lip, ~~and~~ cleft palate [or both](#) under a separate benefit. Please see ~~the "Cleft Lip, Cleft Palate, or Both" section of this EOC for coverage~~ [in this section](#).

#### *Oral Surgery Exclusions:*

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

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- Medical and dental Services for treatment ~~of the condition commonly referred to as~~ TMJ ~~(temporomandibular joint syndrome)~~.
- Orthodontic Services.
- Dental appliances.

### AA.BB. PREVENTIVE HEALTH CARE SERVICES

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

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

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

[We cover medically appropriate preventive health care Services based on your age, sex, or other factors, as determined by your primary care Plan Physician pursuant to national preventive health care standards.

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

1. Preventive care exams, including:
  - a. Routine physical examinations and health screening tests appropriate to your age and sex;
  - b. Well-woman examinations; and
  - c. Well child care examinations;
2. Routine and necessary immunizations [(travel immunizations are not preventive and are covered under Outpatient Services in this section)] for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;

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3. An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
4. Low dose screening mammograms to determine the presence of breast disease is covered as follows:
  - a. One mammogram for persons age 35 through 39;
  - b. One mammogram biennially for persons age 40 through 49; and
  - c. One mammogram annually for person 50 and over;
5. Bone mass measurement to determine risk for osteoporosis;
6. Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to men who are age 40 or older;
7. Colorectal cancer screening in accordance with screening guidelines issued by the American Cancer Society including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy;
8. Cholesterol test (lipid profile);
9. Diabetes screening (fasting blood glucose test);
10. Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis and HPS), subject to the following:
  - a. Annual chlamydia screening is covered for ~~(1a)~~ women under ~~the~~ age of 20, if they are sexually active; and ~~(2b)~~ women age 20 years of age or older, and men of any age, who have multiple risk factors, which include: ~~(i)~~ a prior history of sexually transmitted diseases; (ii) new or multiple sex partners; (iii) inconsistent use of barrier contraceptives; or (iv) cervical ectopy;
  - b. Human Papillomavirus Screening (HPS) as recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;
11. HIV tests;
12. TB tests;
13. Newborn hearing screenings that include follow up audiological examinations, as recommended by a physician or audiologist, and performed by a licensed audiologist to confirm the existence or absence of hearing loss when ordered by a Plan Provider; [and]
14. Associated preventive care radiological and lab tests not listed above[.]; and]
15. [BRCA counseling and genetic testing is covered a no Cost Share. Any follow up Medically Necessary treatment is covered at the applicable Cost Share based upon type and place of Service-][.]; and]
16. CT scan of the Thorax when ordered as a preventive for smokers age 55 to 80 years of age.]

### ***Preventive Health Services Limitation:***

While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services. Applicable Cost Shares will apply.

- Monitoring a chronic disease;
- Follow-up Services after you have been diagnosed with a disease;
- Testing and diagnosis for specific diseases for which you have been determined to be at high risk for contracting based on factors determined by national standards;
- Services provided when you show signs or symptoms of a specific disease or disease process;
- Non-routine gynecological visits; and
- Treatment of a medical condition or problem identified during the course of a preventive screening exam.

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

### **BB.CC. PROSTHETIC DEVICES**

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We cover the devices listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is ill or injured. Coverage includes fitting and adjustment of these devices, repair or replacement (unless due to loss or misuse), and Services to determine whether you need the prosthetic. If we do not cover the prosthetic, we will try to help you find facilities where you may obtain what you need at a reasonable price. Coverage is limited to the standard device that adequately meets your medical needs.

#### **Internally Implanted Devices**

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

#### **Ostomy and Urological Supplies**

We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets [the](#) Health Plan’s criteria for Medical Necessity.

#### **Breast Prosthetics**

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

#### ***Breast Prosthetics Limitation:***

- Coverage for mastectomy bras is limited to a maximum of two (2) per [calendar][contract] [policy] year.

#### ***Prosthetic Devices Exclusions:***

- Services not preauthorized by Health Plan.
- Internally implanted breast prosthetics for cosmetic purposes.
- External prosthetics, except as provided in this ~~S~~ection under “Cleft-Lip, Cleft Palate, or Both”, “Hearing Services”, or as provided under a “Prosthetic and Orthotic Devices Rider”, if applicable.
- Repair or replacement of prosthetics devices due to loss or misuse.
- [\[Hair Prostheses.\]](#)
- Microprocessor and robotic controlled external prosthetics and orthotics that does not meet [the](#) Health Plan criteria ~~as for Medical Necessity~~[Necessary](#).
- Multifocal intraocular lens implants.

### **CC.DD. RECONSTRUCTIVE SURGERY**

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We cover reconstructive surgery. This shall include plastic, cosmetic and related procedures required to: ~~(a1)~~ to correct significant disfigurement resulting from an injury or Medically Necessary surgery, ~~(b2)~~ to correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function, and

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(e3) to treat congenital hemangioma known as port wine stains on the face for Members age 18 or younger, (d4) breast augmentation is covered only if determined to be ~~a medical necessity~~ [Medical Necessary](#).

Following mastectomy, we ~~also~~ cover reconstructive breast surgery and all stages of reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. Mastectomy is the surgical removal of all or part of a breast as a result of breast cancer. Reconstructive breast surgery is surgery performed as a result of a mastectomy to reestablish symmetry between the two [\(2\)](#) breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

### ***Reconstructive Surgery Exclusions:***

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

- Removal of moles or other benign skin growths for appearance only;
- Chemical Peels; [and](#)
- Pierced earlobe repairs, except for the repair of an acute bleeding laceration.

### **~~DD.EE.~~ SKILLED NURSING FACILITY CARE**

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

We cover the following Services:

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

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

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

### ***Skilled Nursing Facility Care Exclusions:***

- Custodial care (see definition under “Exclusions” in ~~the~~ [Section 4: “Exclusions, Limitations, and Reductions”](#) ~~section of this EOC~~).
- Domiciliary care.

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## EE.FF. – TELEMEDICINE SERVICES

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

Telemedicine Services means the delivery of healthcare Services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Not all medical services are conducive to telemedicine, as such the provider will make a determination whether the member should instead be seen in a face-to-face medical office setting.

### *Telemedicine Services Exclusion:*

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

## FF.GG. THERAPY AND REHABILITATION SERVICES

### Physical, Occupational, and Speech Therapy Services

If, in the judgment of a Plan Provider, significant improvement is achievable within a two (2)-month period, we cover physical, occupational and speech therapy[:

1. While you are confined in Plan Hospital; and
2. For up to [twenty (20)-ninety (90)] visits [[or] ninety (90) consecutive days] of physical therapy [whichever is longer], [twenty (20)-ninety (90)] visits [[or] ninety (90) consecutive days] of occupational therapy, and [twenty (20)-ninety (90)] visits [[or] ninety (90) consecutive days] of speech therapy per [contract] [policy] [calendar] year per injury, incident or condition in a Plan Medical Center, a Plan Provider’s medical office, a Skilled Nursing Facility or as part of home health care. [These limits do not apply to necessary treatment of cleft lip or cleft palate.]]
- ~~2. For up to [20-90 visits] [90 consecutive days of treatment] per injury, incident or condition for each therapy in a Plan Medical Center, a Plan Provider’s medical office, or a Skilled Nursing Facility, or as part of home health care. This limit does not apply to necessary treatment of cleft lip or cleft palate.]~~

### *Physical, Occupational, and Speech Therapy Services Limitations:*

- Physical therapy is limited to treatment to restore physical function that was lost due to injury or illness. It is not covered to develop physical function, except as provided for under “Habilitation Services” in this section.
- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Speech therapy is limited to treatment for speech impairments due to injury or illness.

### Multidisciplinary Rehabilitation Services

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

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

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## *Multidisciplinary Rehabilitation Services Limitations:*

- The limitations listed above for physical, occupation and speech therapy also applies to those Services when provided within a multidisciplinary program.

## **Cardiac Rehabilitation Services**

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

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

## **Pulmonary Rehabilitation Services**

We cover pulmonary rehabilitation Services that are Medically Necessary; limited to one [\(1\)](#) program per lifetime.]

## *Therapy and Rehabilitation Services Exclusions:*

- Long-term rehabilitative therapy.

## **GG.HH. TRANSPLANT SERVICES**

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

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

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

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

## *Transplant Services Exclusions:*

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

## **HH.II. URGENT CARE**

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As described below you are covered for Urgent Care Services anywhere in the world. ~~“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.”~~ 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, ~~as shown in the Summary of Services and Cost Shares section~~).

[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.](#)

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### **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 Office please call:

[\[Inside the Washington, DC Metropolitan Area: \(301\) 468-6000\]](#)

[\[Outside of the Washington, DC Metropolitan Area: 1-800-777-7902\]](#)

[\[TTY: 711\]](#)

~~Inside the Washington, D.C. Metropolitan Area~~

~~[(703) 359-7878]~~

~~[TTY 711]~~

~~Outside the Washington, D.C. Metropolitan Area [1-800-777-7904]~~

~~[TTY 711]~~

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

### **Outside of our Service Area**

If you are injured or become ill while temporarily ~~outside~~ [outside of](#) the Service Area, we will cover reasonable charges for Urgent Care Services as defined in this section. 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 Plan Medical Office in the Service Area, or in the nearest Kaiser Foundation Health Plan Region for continuing or follow-up treatment.

### ***Urgent Care Limitations:***

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

### ***Urgent Care Exclusions:***

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

## **H.J.J. VISION [EXAM] SERVICES**

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### **Medical Treatment**

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

### ***[Vision Services Exclusions:***

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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

[**Note:** Discounts are available as a Value Added Service for lenses and frames.]

### **Eye Exams**

[We cover routine and necessary eye exams, including:

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

### ***Vision Exam Services Exclusions:***

- Eyeglass lenses and eyeglass frames.
- Eye exercises.
- All Services related to contact lenses including: exams, fitting, dispensing, and follow-up visits.
- Orthoptic (eye training) therapy.]]

### **Pediatric Eye Exams**

We cover the following for children [until the end of the month in which the child turns age 19](#)~~under age 19~~:

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

### **Pediatric Lenses and Frames**

We cover the following for children [until the end of the month in which the child turns age 19](#)~~under age 19~~ at no charge:

1. One [\(1\)](#) pair of lenses per year;
2. One [\(1\)](#) pair of frames per year from a select group of frames;
3. Regular contact lenses (in lieu of lenses and frames) for the first regular supply for that contact lens per year; or
4. Medically Necessary contact lenses up to two [\(2\)](#) pair per eye per year.]

[In addition, we cover the following Services:

### **Eyeglass Lenses**

[We provide a discount on the purchase of regular eyeglass lenses, including add-ons, when purchased at a Kaiser Permanente Optical Shop. Regular eyeglass lenses are any lenses with a refractive value. If only one eye needs correction, we also provide a balance lens for the other eye. ] [\[We cover the purchase of eyeglass lenses at no charge when purchased at a Kaiser Permanente Optical Shop.\]](#)

## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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### **Frames**

[We provide a discount on the purchase of eyeglass frames, when purchased at a Kaiser Permanente Optical Shop. The discount includes the mounting of eyeglass lenses in the frame, original fitting of the frames, and subsequent adjustment.] [[We cover the purchase of eyeglass frames at no charge when purchased at a Kaiser Permanente Optical Shop.](#)]

### **Contact Lenses**

[[We cover the \[initial\] purchase of contact lenses at no charge when purchased at a Kaiser Permanente Optical Shop.](#)] [[We cover the initial fitting for contact lenses at no charge when purchased at a Kaiser Permanente Optical Shop.](#)] [We provide a discount on the initial fitting for contact lenses, when purchased at a Kaiser Permanente Optical Shop. Initial fitting means the first time you have ever been examined for contact lens wear at a Plan Facility. The discount includes the following Services:

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

[You will also receive a discount on your initial purchase of contact lenses, if you choose to purchase them at the same time.] [Note: Additional contact lens Services are available without the discount from any Kaiser Permanente Optical Shop.]

### **Vision Exclusions:**

- Industrial and athletic safety frames.
- Eyeglass lenses and contact lenses with no refractive value.
- Sunglasses without corrective lenses unless Medically Necessary.
- Any eye surgery solely for that the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), and astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
- Eye exercises.
- Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section.
- Replacement of lost, broken, or damaged lenses frames and contact lenses.
- Plano lenses.
- Lens adornment, such as engraving, faceting, or jewellery.
- Low-vision devices.
- Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits.
- Orthoptic (eye training) therapy.]

### **JJ.KK. [VISITING MEMBER SERVICES**

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We cover the same Medically Necessary Services that are covered under this plan in our Service Area, and your Cost Share may differ, when you are temporarily a visiting member in a different Kaiser Permanente Region or Group Health Cooperative service area. .

To receive more information about ~~V~~visiting Member Services, including facility locations across the United States, ~~you may call~~[contact](#) ~~our~~ Member Services ~~Department~~:

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## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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[\[Inside the Washington, DC Metropolitan Area: \(301\) 468-6000\]](#)

[\[Outside of the Washington, DC Metropolitan Area: 1-800-777-7902\]](#)

[\[TTY: 711\]](#)

~~Inside the Washington, D.C. Metropolitan Area~~

~~[(301) 468 6000]~~

~~[TTY 711]~~

~~Outside the Washington, D.C. Metropolitan Area~~

~~[1 800 777 7902]~~

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

### ***Visiting Member Services Limitations:***

Access to Services in the visited service area will be subject to availability at the time you request the Service. Services may be unavailable due to temporary capacity constraints, inability to provide the Service generally, or other restrictions. If the Service is not available in the visited service area, you must call us for authorization to receive the Service.

### ***Visiting Member Service Exclusions:***

All the terms and conditions, exclusions and limitations that apply to covered Services in our Service Area, will apply to Services received as a visiting Member in a different Kaiser Permanente Region or Group Health Cooperative service area.]

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## **~~KK.LL.~~ – X-RAY, LABORATORY, AND SPECIAL PROCEDURES**

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

1. Diagnostic imaging;
2. Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
3. Special procedures, such as electrocardiograms and electroencephalograms;
4. Sleep lab and sleep studies; and
5. Specialty imaging: including CT, MRI, PET Scans, and Nuclear Medicine studies; and interventional radiology.

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## Summary of Services and Cost Shares

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

### **[DEPENDENT AGE LIMIT]**

Eligible Dependent children are covered from birth to age [26 - 30], [or to age [26 – 30] if a full-time student], as defined by your Group and approved by Health Plan.

### **MEMBER COST-SHARE**

Your Cost Share is the amount of the charges for a covered Service that you must pay through Deductibles, Copayments and Coinsurance. After the Deductible is met, the Copayments and Coinsurance listed here (your Cost Share) apply to covered Services you receive, up to the Out-of-Pocket Maximum.

In addition to the monthly premium, you may be required to pay a Cost Share for some Services. The Cost Share, if any, is listed for each Service in this “Summary of Services and Cost Shares.” You are responsible for payment of all Cost Shares. Copayments are due at the time you receive a Service. You will be billed for any Deductible and Coinsurance you owe. Failure to pay your Cost Shares may result in termination of your Membership (refer to Section 6: Termination for Nonpayment).

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<b>[Missed Appointment Fee]</b>	<b>[You Pay In-Plan]</b>	<b>[You Pay Out-of-Plan]</b>
[The amount you may be required to pay if you fail to keep a scheduled appointment at a Plan Facility, and you do not notify us at least one day prior to the appointment.]	[[ \$10 - \$100] per missed appointment]	[Not Applicable]

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### **[Deductible]**

[The Deductible is the amount of charges you must incur during a [contract] [calendar] [policy] year for certain [Out-of-Plan] covered Services before the Health Plan will provide benefits for those Services.

**[[Self-Only] [Individual] Coverage Deductible.** If you are covered as a Subscriber, and you do not have any Dependents covered under the plan, you must meet the [\[Self-Only\] \[Individual\] Deductible](#) shown below.]

**[Family Coverage Deductible.** If you have one or more Dependents covered under this EOC, one or more covered Members of your Family Unit together must meet the Family Deductible shown below. After one or more covered Members of your Family Unit combined have met the Family Coverage Deductible, the Deductible will be met for all Members of the Family Unit for the rest of the [contract] [calendar] [policy] year. The Individual Deductible shown below does not apply with Family Coverage.]

**[Family Coverage Deductible.** If you have one or more Dependents covered under this EOC, all covered Members of your family together can meet the Family Deductible shown below, but no one family Member’s medical expenses may contribute more than the Individual Deductible shown below. After an Individual Member of the Family Unit has met the Individual Deductible, his or her Deductible will be met for the rest of the [calendar][contract] [policy] year. Other family Members will continue to pay full charges for Services that are subject to the Deductible until the Family Deductible is met. After all Members of the Family Unit combined have met the Family Deductible, the Deductible will be met for all Members of the Family Unit for the rest of the [contract] [calendar] [policy] year.]

**[Individual within Family Coverage Deductible.** If you are the only Member in your Family, then you must meet the [Individual within Family Deductible](#). If you are a Member in a Family of two or more Members, then either you must each meet the [Individual within Family Deductible](#), or your entire Family must meet the [Family Deductible](#). Each [Individual within Family Deductible](#) amount counts toward the [Family Deductible](#) amount. Once the [Family Deductible](#) is satisfied, no further [Individual within Family Deductible](#) will be due for the remainder of the Year. The [Self-Only Deductible](#), [Individual within Family Deductible](#), and [Family Deductible](#) amounts are shown below.]

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## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

**[Deductible Carryover.** Charges incurred during the last 3 months of the [contract] [calendar] [policy] year that apply toward the Deductible will also apply to the Deductible for the following [contract] [calendar] [policy] year.]

**[Deductible Credit.** If you were covered on the day immediately preceding the effective date of the Group Agreement under any other group coverage that was replaced by this plan, then charges for covered Services incurred by you and applicable toward the individual or family Deductible under the prior coverage, will be used to satisfy all or any portion of the individual or family Deductible amounts under this EOC. This Deductible credit provision applies only to the Deductible amount wholly or partially satisfied in the same [contract] [calendar] [policy] year as the effective date of this EOC.]

**Services Subject to the Deductible.** The Deductible applies to covered Services as indicated in the schedule below [for Out-of-Plan Benefits.][A separate Deductible applies for In-Plan Benefits and Out-of-Plan Benefit.] All [Out-of-Plan] Services are subject to this Deductible, except [for those covered under the "Outpatient Prescription Drug Rider" attached to this EOC, and] those indicating "Deductible waived" in the following schedule of Copayments and Coinsurance. Emergency Services and out-of-area Urgent Care Services are treated as In-Plan Services and are not subject to the Out-of-Plan Deductible.

**Payments Toward Your Deductible.** For Services that are subject to a Deductible, you must pay for the Services when you receive them, until you meet your Deductible. After you meet the Deductible, you pay the applicable Copayment or Coinsurance for the Service. The only payments that count toward this Deductible are those you make for Services that are subject to this Deductible, but only if the Service would otherwise be covered. When you pay an amount toward your Deductible, ask for and keep a copy of your receipt. If you have met your Deductible, but we have not yet received and processed all of your claims, you can use your receipts as proof that you have met the Deductible. We will send you a statement summarizing the amounts you have paid toward your Deductible. You can also request a copy of this statement from our Member Services Department.

**Excess Charges.** Excess Charges are the amount of charges that exceed the Usual, Customary and Reasonable charges paid by Health Plan to a Non-Plan Provider.]

<b>[Deductible</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
<u>The amount you must pay each [contract][calendar][policy] year for the Services indicated below before we provide benefits for those Services</u>	<u>[No Deductible]</u>	
<u>[[Self-Only] [Individual] Deductible]</u>	<u>[You pay [\$100 - \$5,000] per individual per [contract] [calendar] [policy] year]</u>	<u>[You pay [\$100 - \$10,000] per individual per [contract] [calendar][policy] year]</u>
<u>[Individual within Family Deductible]</u>	<u>[You pay [\$100 - \$5,000] per individual per [contract] [calendar] [policy] year]</u>	<u>[You pay [\$100 - \$10,000] per individual per [contract] [calendar][policy] year]</u>
<u>[Family Deductible]</u>	<u>[[ \$200-\$15,000] per Family Unit per [contract] [calendar][policy] year]</u>	<u>[[ \$200-\$19,050] [20,000] per Family Unit per [contract] [calendar] [policy] year]</u>
	<u>[The Deductible is a total of combined In- and Out-of-Plan charges.]</u>	<u>[The Deductible is a total of combined In- and Out-of-Plan charges.]</u>
<del>The amount you must pay each [contract][calendar][policy] year for the Services indicated below before we provide benefits for those Services</del>	<del>[No Deductible] <b>[Individual Deductible]</b> You pay [\$100 - \$5,000] per individual per [contract] [calendar] [policy] year</del>	<del><b>Individual Deductible</b> You pay [\$100 - \$10,000] per individual per [contract] [calendar][policy] year</del>

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	<b>Family Deductible</b> [ <del>\$200 - \$15,000</del> ] per Family Unit per [contract] [calendar] [policy] year	<b>Family Deductible</b> [ <del>\$200 - \$19,050</del> ] [ <del>20,000</del> ] per Family Unit per [contract] [calendar] [policy] year
	[ <del>The Deductible is a total of combined In- and Out-of-Plan charges.</del> ]	[ <del>The Deductible is a total of combined In- and Out-of-Plan charges.</del> ]
[Self Only]	[\$0 - \$5,000] per [contract] [calendar] [policy] year	[\$50 - \$15,000] per [contract] [calendar] [policy] year
[Self + Spouse] [or Domestic Partner]	[\$100 - \$6,000] per [contract] [calendar] [policy] year	[\$200 - \$16,000] per [contract] [calendar] [policy] year
[Self + Children]	[\$100 - \$6,000] per [contract] [calendar] [policy] year	
[Self + Spouse] [or Domestic Partner] + [Children]	[\$100 - \$10,000] per [contract] [calendar] [policy] Year	[\$200 - \$16,000] per [contract] [calendar] [policy] year
		[\$400 - \$20,000] per [contract] [calendar] [policy] year

### Copayments and Coinsurance

Covered Service	You Pay In-Plan	You Pay Out-of-Plan
<b>Outpatient Care</b>		
Office Visits (for other than preventive health care Services)		
Primary care office visits		
[For adults]	[No charge] [[\$0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[For children under [24 months] [2 - <del>5</del> 18] [ years] of age]	[No charge] [[\$0 - \$60] per visit] [, then] [[0% - 60%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[For children [24 months] [2 - <del>5</del> 18] [ years] of age or older]	[No charge] [[\$0 - \$60] per visit] [, then] [[0% - 60%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Specialty care office visits		
[For adults]	[No charge] [[\$0 - \$60] per	[\$5 - \$70] per visit][[10% -

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## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
	visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]]	60%] of UCR] [after Deductible] [; Deductible waived]
[For children under [24 months] [2 - <del>5</del> 18] [years] of age]	[No charge] [[0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[0 - \$60] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[For children [24 months] [2 - <del>5</del> 18] [years] of age or older]	[No charge] [[0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[0 - \$60] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Consultations and immunizations for foreign travel]	[No charge] [[0 - \$60] per visit] [, then] [0% - 50%] of AC*] [after Deductible] [; Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]	[[0 - \$60] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Outpatient surgery <a href="#">physician/surgical Services</a>	[No charge] [[0 - \$500] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[0 - \$500] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Special outpatient procedures]	[No charge] [[0 - \$500] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR after Deductible
[Outpatient hospital procedures]	[No charge] [[0 - \$500] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR after Deductible
Anesthesia	[No charge] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Chemotherapy and radiation therapy	[No charge] [[0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]	[[0 - \$60] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]

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<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
Respiratory therapy	[No charge] [[0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Medical social Services	[No charge] [[0 - \$60] per visit] [, then] [0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
House calls	[No charge] [[0 - \$60] per visit] [, then] [[0%-50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
<b>Hospital Inpatient Care</b> All charges incurred for covered Services during a covered stay as an inpatient in a hospital	[No charge] [[100 - \$1,000] per admission] [, then] [[0% - 50%] of AC*] [[100 - \$500] per day, not to exceed a total of [3x - 5x] the daily amount per admission] [after Deductible] [; Deductible waived]	[[100 - \$2000] per admission] [[100 - \$1,500] per day, not to exceed a total of [3x - 5x] the daily amount per admission] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>[Hospital Observation Services]</b>	[[No charge] [[25 - \$500] per visit][; not to exceed the actual cost of the visit.] [, then] [0% - 50%] of AC*] [after Deductible] [; Deductible waived] [; Copayment waived if admitted as an inpatient] [Copayment waived if observation status in conjunction with emergency room visit]]	[[5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>Accidental Dental Injury Services</b> [Limited to treatment started within 6 months of the accident]	[Applicable Cost Share applies based on type and place of Service] [No charge] [[0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>Allergy Services</b>	[Applicable Cost Share applies, based on type and place of Service]	[[5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Allergy evaluation and treatment]	[No charge] [[0 - \$60] per	[[5 - \$70] per visit] [[10% -

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<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
	visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	60%] of UCR] [after Deductible] [; Deductible waived]
Injection visit and serum]	[No charge] [[0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived] [Applicable Cost Shares will apply, based on type and place of Service, not to exceed the cost of the serum plus administration]	[\$5- \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>Ambulance Services</b> By a licensed ambulance Service, per encounter	[No charge] [[0 - \$500] per encounter] [then] [[0% - 50%] of AC*] [after Deductible][; Deductible waived]	[No charge][[0 - \$500] per encounter] [[10% - 60%] of UCR [after Deductible][; Deductible waived]]
Non-emergent transportation Services	[No charge] [[0 - \$500] per encounter] [,then] [[0% - 50%] of AC*] [after Deductible][; Deductible waived]	[No charge][[0 - \$500] per encounter] [[10% - 60%] of UCR [after Deductible][; Deductible waived]]
<b>Anesthesia for Dental Services</b> (Limited to individuals who meet specific criteria described in the “Benefits” section)	[No charge] [[0% - 50%] of AC*] [after Deductible][; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>Blood, Blood Products and Their Administration</b>	[No charge] [[0% - 50%] of AC*] [after Deductible][; Deductible waived] [Applicable Cost Shares will apply, based on type and place of Service]	[10% - 60%] of UCR [after Deductible] [;] [Deductible waived]
<b>Chemical Dependency and Mental Health Services</b> [Partial hospitalization is limited to 60 days per [contract][calendar][policy] year) ]	[[No charge][[0% - 50%] of AC*][after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [;] [Deductible waived]
[Inpatient psychiatric and substance abuse care, including detoxification	Applicable inpatient Cost Share will apply] [No charge] [[0 - \$100] per day] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]	[Applicable inpatient Cost Share will apply] [No charge] [[0 - \$100] per day] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]

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Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
Hospital alternative Services Intensive outpatient psychiatric treatment programs	[No charge] [[ $\$5$ - $\$60$ ] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[ $\$5$ - $\$70$ ] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Partial hospitalization	[No charge] [[ $\$0$ - $\$60$ ] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[ $\$5$ - $\$70$ ] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Outpatient psychiatric and substance abuse care <ul style="list-style-type: none"> <li>• Individual therapy</li> </ul>	[No charge] [[ $\$0$ - $\$35$ ] per visit] [, then] [[0% - 50%] of AC*][after Deductible] [; Deductible waived] [waived for children under [24 months][2 -5] [years] of age]]	[[ $\$5$ - $\$70$ ] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>• Group therapy</li> </ul>	[No charge] [[ $\$0$ - $\$10$ ] per visit] [, then] [[0% - 50%] of AC*][after Deductible] [; Deductible waived] [waived for children under [24 months][2 -5] [years] of age]]	[[ $\$5$ - $\$70$ ] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Medication management visits]	[No charge] [[ $\$0$ - $\$60$ ] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[ $\$5$ - $\$70$ ] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Residential treatment center]	Applicable inpatient Cost Shares will apply [No charge] [[ $\$0$ - $\$100$ ] per day] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived] [No charge] [[ $\$0$ - $\$100$ ] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]	[10% - 60%] of UCR after Deductible
<b>Cleft Lip, Cleft Palate, or Both</b>	[No charge] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived][Applicable Cost Share applies, based on type and place of Service]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived] [Applicable Cost Shares apply, based on type and place of Service]
<b>Clinical Trials</b>	[No charge] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived] [Applicable Cost Shares will	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived] [Applicable Cost Shares will apply, based on

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<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
	apply, based on type and place of Service]	type and place of Service]
<b>Diabetic Equipment, Supplies and Self-Management Training</b>	[No charge] [[0% - 50%]of AC*] [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Diabetic equipment]	[No charge] [[0% - 50%]of AC*] [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Diabetic supplies	[No charge] [[0% - 50%]of AC*][after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>• [Disposable needles and syringes]</li> </ul>	[No charge] [[0% - 50%]of AC*][after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>• [Glucose test strips]</li> </ul>	[No charge] [[0% - 50%]of AC*][after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>• [Glucose test meter] <ul style="list-style-type: none"> <li>○ [Replacement batteries]</li> <li>○ [Additional meters]</li> </ul> </li> </ul>	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>• [Control solutions]</li> </ul>	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>• [Lancets]</li> </ul>	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Self-management training]	[Applicable Cost Share applies, based on place of Service]	[Applicable Cost Share applies, based on place of Service] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>Dialysis</b>	[No charge] [[0% - 50%]of AC*][after Deductible] [;	[[10% - 60%] of UCR] [after Deductible] [;] [Deductible

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## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
	Deductible waived]	waived]
[Inpatient care	[Applicable inpatient Cost Share applies]	[Applicable inpatient Cost Share applies]
Outpatient Care]	[No charge] [[\$0 - \$60] per visit] [then][0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[ \$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Dialysis Center	[No charge] [[\$0 - \$100] per visit] [,then] [0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60% of UCR after Deductible
Home dialysis, including training]	[No charge] [[\$0 - \$100] per visit] [,then] [0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60% of UCR after Deductible
Dialysis training]	[No charge] [[\$0 - \$100] per visit] [,then] [0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60% of UCR after Deductible
<b>Drugs, Supplies, and Supplements</b> Administered by or under supervision of a physician	[No charge] [[0% - 50%] of AC*] [after Deductible]; Deductible waived] <a href="#">[Applicable Cost Shares will apply, based on type and place of Service]</a>	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived] <a href="#">[Applicable Cost Shares will apply, based on type and place of Service]</a>
<b>Durable Medical Equipment- Outpatient</b>	[No charge] [[0% - 50%] of AC*][after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>[Basic Durable Medical Equipment</b>	No charge] [[0% - 50%] of AC*][after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Limited to use in the home for up to 3 months following: an authorized confinement in a hospital, a sub-acute facility; or a specialized rehabilitation facility; or an authorized outpatient surgical procedure.]		
<b>[Supplemental Durable Medical Equipment</b>		
<ul style="list-style-type: none"> <li>Oxygen and Equipment <del>(Must be certified every 30 days)</del></li> </ul>	[No charge] [[0% - 50%] of AC*] [[No charge][20% - 50%] for 1 <sup>st</sup> 3 months; [50% - 70%] of AC* each month	[[10% - 60%] of UCR for 1 <sup>st</sup> 3 months; [60% - 80%] of UCR each month thereafter] [after Deductible] [;

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Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
	thereafter] [after Deductible] [; Deductible waived]	Deductible waived]
	[Limited to [a combined In- and Out-of-Plan] benefit maximum of [\$5,000 - \$25,000] per [contract] [calendar] [policy] year]	[Limited to [a combined In- and Out-of-Plan] benefit maximum of [\$5,000 - \$25,000] per [contract] [calendar] [policy] year]
<ul style="list-style-type: none"> <li>• Positive Airway Pressure Equipment <del>(Must be certified every 30 days)</del></li> </ul>	[No charge] [[0% - 50%] of AC*] [[No charge][20% - 50%] for 1 <sup>st</sup> 3 months; [50% - 70%] of AC* each month thereafter] [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR for 1 <sup>st</sup> 3 months; [60% - 80%] of UCR each month thereafter] [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>• Apnea Monitors (under 3, not to exceed a period of 6 months)</li> </ul>	[No charge] [[0% - 50%] of AC*][after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>• Asthma Equipment               <ul style="list-style-type: none"> <li>○ [Spacers</li> <li>○ Peak-flow meters</li> <li>○ Nebulizers]</li> </ul> </li> </ul>	[ No charge] [0% - 50%] of AC*][after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
	[\$5 - \$10] per item]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
	[\$10 - \$15] per item]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
	[\$30 - \$40] per item]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>• Bilirubin Lights (under 3, not to exceed a period of 6 months)]</li> </ul>	[No charge] [[0% - 50%] of AC*][after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]]
<b>Emergency Services</b>	[No charge] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[No charge] [[10% - 50%] of AC*] [after Deductible] [; Deductible waived]
[Emergency Room Visits	[[No charge] [[25 -\$500] per visit; not to exceed the actual cost of the visit. Waived if immediately admitted] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[No charge] [[25 -\$500] per visit; not to exceed the actual cost of the visit. Waived if immediately admitted] [[10% - 50%] of AC*] [after Deductible] [; Deductible waived]
<ul style="list-style-type: none"> <li>• Inside the Service Area</li> </ul>		

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Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
<ul style="list-style-type: none"> <li>• Outside of the Service Area]</li> </ul> <p>[Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit copayment will not be waived.]</p> <p>Emergency Services HIV Screening Test</p>	<p>[No charge] [[\$25 -\$500] per visit; not to exceed the actual cost of the visit. Waived if immediately admitted] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]</p> <p>No charge</p>	<p>[No charge] [[\$25 -\$500] per visit; not to exceed the actual cost of the visit. Waived if immediately admitted] [[10% - 50%] of AC*] [after Deductible] [; Deductible waived]]</p> <p>No charge</p>
<b>[Family Planning]</b>		
<p>[Office visits]</p> <p>[Tubal ligation] [, Vasectomy] [, Voluntary termination of pregnancy]</p>	<p>[No charge] [[\$0 - \$60] per visit] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]</p> <p>[No charge] [[\$0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived] [Applicable Cost Share applies based on place of Service]</p> <p>[No charge]</p>	<p>[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]</p> <p>[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived] [Applicable Cost Share applies based on place of Service]]</p> <p>[10% - 60%] of UCR after Deductible[Applicable Cost Share applies based on place of Service]]</p>
<p>[Women's Preventive Services, including all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. In-Plan Services are covered under Preventive Care at no charge.]</p>		

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<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
<b>Habilitative Services</b> [Limited to children up to age 21]		
Physical, Speech and Occupational therapy	[No charge] [[\$0 - \$60] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Applied Behavioral Analysis (ABA)]	[No charge] [[\$0 - \$100] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[No charge] [[\$0 - \$100] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]
All other Services	[No charge] [[0% - \$100] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived] [The applicable cost share will apply based on type and place of service]	[No charge] [[0% - \$100] per visit] [, then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived] [The applicable cost share will apply based on type and place of service]
<b>Hearing Services</b>		
Hearing tests  (Note: Newborn hearing screening tests are covered under preventive health care Services at no charge In-Plan)	[No charge][[0% - 50%] of AC*] [Applicable office visit Cost Share applies] [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>Home Health Care</b> [Limited to [a combined In- and Out-of-Plan] maximum of [30 – 240 visits] per [contract] [calendar] [policy] year]		
	[No charge] [[\$0 - \$60] per visit] [then][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>Hospice Care</b>		
	[No charge] [[\$0 - \$60] per visit] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>[Infertility Services</b>		
[Office visits [for initial diagnosis of infertility]	[No charge] [[\$05 - \$60] per visit] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[50% - 70%] of UCR [after Deductible] [; Deductible waived]
Inpatient Hospital Care	[No charge] [[\$0 - \$1000] per admission] [then] [[0% - 50%] of AC*] [[\$100 - \$500] per day, not to exceed a total of [3x - 5x] the daily amount per admission] [after Deductible] [; Deductible waived]	[\$100 - \$2000] per admission] [[\$100 - \$1500] per day, not to exceed a total of [3x - 5x] the daily amount per admission] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]

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Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
All other Services for treatment of infertility  [Note: Coverage for In-vitro fertilization is limited to a combined In- and Out-of-Plan maximum lifetime benefit of \$100,000.]]	[No charge] [[\$0 - \$60] per visit] [then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]	[50% - 70%] of UCR [after Deductible] [; Deductible waived]]
<u>Infusion Therapy Services</u>	<u>[Applicable Cost Shares will apply, based on type and place of Service]</u> <u>[No charge] [[0% - 50%] of AC* [after Deductible] [;] [Deductible waived]]</u>	<u>[[10% - 60%] of UCR after Deductible] [Applicable Cost Shares will apply, based on type and place of Service]</u>
<b>Maternity Services</b>		
<del>[Routine p]</del> Prenatal and postpartum visits (after confirmation of pregnancy), including diagnostic tests	[No charge][Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived] [Applicable Cost Shares will apply, based on type and place of Service ]
<del>Non-routine maternity care, including diagnostic tests]</del>	<del>[Applicable Cost Shares will apply, based on type and place of Service ]</del>	<del>[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived] [Applicable Cost Shares will apply, based on type and place of Service ]</del>
Breast Pumps	[No charge] [[\$0 - \$60] per pump] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[5 - \$70] per pump] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Postpartum home health visits	[No charge][; Deductible waived]	[10% - 60%] of UCR after Deductible
Maternity Services that are required by the Affordable Care Act are covered under Preventive Care Services at no charge]		
[Outpatient <del>routine</del> prenatal care (after confirmation of pregnancy) and first postpartum visit	[No charge] [[\$0 - \$60] per visit] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Outpatient obstetrical or gynecological Services provided during pregnancy that are not directly	[No charge] [[\$0 - \$60] per visit] [then][[0% - 50%] of	[[5 - \$70] per visit][[10% - 60%] of UCR] [after

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<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
related to the outpatient prenatal care ]	AC*] [after Deductible] [; Deductible waived]	Deductible] [; Deductible waived]
Obstetrical care and delivery, including cesarean section]	[No charge] [[\$100 - \$1000] per admission] [then] [[0% - 50%] of AC*] [[\$100 - \$500] per day, not to exceed a total of [3x - 5x] the daily amount per admission] [after Deductible] [; Deductible waived]	[[ \$100 - \$2,000] per admission] [[\$100 - \$1,500] per day, not to exceed a total of [3x - 5x] the daily amount per admission] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Newborn home visit as described in <a href="#">Section 3: Benefits</a> <del>the “Benefits” section</del>	[No charge]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
<b>Medical Foods</b>	[No charge] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
<b><u>Medical Nutrition Therapy &amp; Counseling</u></b>	<u>No charge] [[\$5 - \$500] per visit] [, then] [0% - 50%] of AC*] [after Deductible] [; Deductible waived] [Applicable Cost Shares will apply based on type and place of Service]</u>	<u>[10% - 60%] of UCR after Deductible</u>
<b>Morbid Obesity Services</b>	[No charge] [[0% - 50%] of AC*] [Applicable Cost Share applies based on type and place of Service] [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [Applicable Cost Share applies based on type and place of Service] [after Deductible] [; Deductible waived]
<b>Oral Surgery</b>	[No charge] [Applicable Cost Share applies based on type and place of Service] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[ \$5 - \$70] per visit] [Applicable Cost Share applies based on type and place of Service] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>Preventive Health Care Services</b> [Not subject to Deductible]	[No charge] [[\$0 - \$60] per visit] [; Copayment waived for children under [24 months] [2 - 25] [years] of age] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[ \$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Routine physical exams for adults	[No charge] [[\$0 - \$60] per visit] [[10% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[ \$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]

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<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
Routine preventive tests for adults	[No charge][[\$0 - \$60] per visit] [then] [[0% - 80%] of AC*] [after Deductible] [;Deductible waived]	[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Well child care visits	[No charge] [[\$0 - \$60] per visit] [then] [[0% - 80%] of AC*] [after Deductible] [;Deductible waived] [Copayment waived for children under [24 months] [2 - 5] [years] of age]]	[\$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Immunizations for children and adults (No charge for immunization agent)	[No charge] [[\$0 - \$60] per visit] [then] [[0% - 80%] of AC*] [after Deductible] [; Deductible waived] [Copayment waived for children under [24 months] [2 - 5] [years] of age]]	[\$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]]
<b>Prosthetic Devices</b> [Limited to internally implanted devices, ostomy and urological supplies, and breast prostheses, unless a Prosthetic and Orthotic Devices Rider is attached to this EOC.]	[No charge][0% -80%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
[Internally implanted devices	[No charge][0% -80%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
Ostomy and Urological Supplies	[No charge][[0% - 80%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
Breast Prosthetics]	[No charge][[0% - 80%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR [after Deductible] [; Deductible waived]
<a href="#">[Hair Prostheses]</a>	<a href="#">[No charge][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]</a>	<a href="#">[10% - 60%] of UCR [after Deductible] [; Deductible waived]</a>
<b>Reconstructive Surgery</b>	[No charge][[0% - 50%] of AC*] [Applicable Cost Share applies based on place and type of Service.] [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [Applicable Cost Share applies based on place and type of Service.] [after Deductible] [; Deductible waived]
<b>Skilled Nursing Facility Care</b>	[No charge] [[\$100 - \$1000]	[\$100 - \$2,000] per

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## KAISER PERMANENTE

<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
[Limited to [a combined In-and Out-of-Plan maximum of] [60 – 240] days per [admission] [contract] [calendar] [policy] year]	per admission] [then] [[10% - 50%] of AC*] [[\$100 - \$500] per day, not to exceed a total of [3x - 5x] the daily amount per admission] [after Deductible] [; Deductible waived]	admission] [[\$100 - \$1,500] per day, not to exceed a total of [3x - 5x] the daily amount per admission] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>Telemedicine Services</b>	[No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [;] [Deductible waived]	[[10% - 60%] of UCR] [Applicable Cost Share applies based on place and type of Service.] [after Deductible] [; Deductible waived]
<b>Therapy and Rehabilitation Services</b> Refer to Section 3 for benefit maximums-	[No charge] [[\$0 - \$60] [then] [0% - 50%] of AC*] per visit] [after Deductible] [; Deductible waived]	[[\$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
[Inpatient Services	[Applicable inpatient Cost Share applies]	[Applicable inpatient Cost Share applies]
Outpatient Services	[No charge] [[\$0 - \$60] [then] [0% - 50%] of AC*] per visit] [after Deductible] [; Deductible waived]	[[\$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
<b>Note:</b> All Services received in one day for multidisciplinary rehabilitation Services at a day treatment program will be considered one visit.]		
<b>Transplants</b>	[No charge] [[0% - 50%] of AC*] per visit] [Applicable Cost Share applies based on place and type of Service.] [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [Applicable Cost Share applies based on place and type of Service.] [after Deductible] [; Deductible waived]
<b>Urgent Care</b>		
[Office visit during regular office hours	Applicable office visit cost Share applies [after Deductible] [; Deductible waived]	[[10% - 60%] of UCR] [Applicable office visit cost Share applies] [after Deductible] [; Deductible waived]
After-Hours Urgent Care or Urgent Care Center]	[No charge] [[\$0 - \$60] per visit] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[No charge] [[\$5 - \$70] per visit] [[10% - 60%] of AC*] [after Deductible] [; Deductible waived]
<b>Vision Services</b>		
[[Eye exams [(for adults age 19 or older)]		
[Routine eye exam once per [contract]		
[calendar][policy] year]		

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# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
<ul style="list-style-type: none"> <li>• by an Optometrist</li> </ul>	<p>[No charge] [[\$0 - \$60] per visit] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived] [Copayment waived for children under [24 months] [2 – 5] [years] of age]]</p>	<p>[\$5 - \$70] per visit] [[10% - 60%] of UCR] [after Deductible] [; Deductible waived]</p>
<ul style="list-style-type: none"> <li>• by an Ophthalmologist]</li> </ul>	<p>[No charge] [[\$0 - \$60 per visit] [then] [0% - 50%] of AC*] [after Deductible] [; Deductible waived]</p>	<p>[\$5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]</p>
<p>[Eyeglass [lenses and] frames [and Contact Lenses]]</p> <p>[Member may opt to have frames and lenses or contacts, but not both in a [contract] [calendar] [policy] year]</p>	<p>[You receive a [25%][[\$40 - \$250] discount off retail price** for eyeglass lenses and frames [once per [contract][calendar] [policy] year].] [You receive a [\$40 - \$150] discount off retail price** for eyeglass lenses and a [\$40 - \$100] discount off retail price** for eyeglass frames [once per [contract] [calendar] [policy] year].] [You receive a [\$50 - \$250] allowance on frames, lenses and/or contact lenses combined [, once per [every 2] [contract][calendar] [policy] year[s].] [\$250 allowance on frames; correction lenses covered in full [, once [every 2] year[s].] [You receive a maximum allowance of [\$50 - \$1000] for all covered vision Services, other than eye exams [, per [every 2] [contract] [calendar] [policy] year[s] .]]</p> <p>Not covered] [No charge] [Member pays balance after Plan pays] [\$50 - \$500]] [Member pays 20% - 100% of retail price**] [You receive a [\$20 - \$500] allowance toward wholesale</p>	<p>[You receive a [10%][[\$20 - \$125] discount off retail price** for eyeglass lenses and frames [once per [contract] [calendar] [policy] year].] [You receive a [\$20 - \$75] discount off retail price** for eyeglass lenses and a [\$20 - \$50] discount off retail price** for eyeglass frames [once per [contract] [calendar] [policy] year].] [You receive a [\$25 - \$125] allowance on frames, lenses and/or contact lenses combined [, once per [every 2] [contract] [calendar] [policy] year[s].] [You receive a maximum allowance of [\$50 - \$1000] for all covered vision Services, other than eye exams [, per [every 2] [contract] [calendar] [policy] year[s] . ]]</p>

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

## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
	cost. If frame is more than allowance member pays [2] times the difference between wholesale cost and allowance] ]	
Eyeglass lenses]		
• [Single Vision]	[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]	[Not covered] [Member pays full price]
• [Bifocal]	[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]	[Not covered] [Member pays full price]
• [Trifocal]	[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]	[Not covered] [Member pays full price]
• [Lenticular]	[Not covered] [No charge] [Member pays balance after Plan pays [\$50 - \$500]	[Not covered] [Member pays full price]
[Scratch Resistant] [Anti-reflective Coating (ARC)]		
• [Standard]	[Not covered] [No charge] [Member pays balance after Plan pays] [\$50 - \$500]	[Not covered] [Member pays full price]
• [Premium]	[Not covered] [No charge] [Member pays balance after Plan pays] [\$50 - \$500]	[Not covered] [Member pays full price]
• [Ultra]	[Not covered] [No charge] [Member pays balance after Plan pays] [\$50 - \$500]	[Not covered] [Member pays full price]
[Contact lenses] [in lieu of frames and lenses]	[20% - 100% of retail price**] [ Member pays balance after Plan pays [\$50 - \$500] [You receive a [15% - 25%] discount off retail price on initial pair of contact lenses] [You receive a [\$50 - \$250] allowance on frames, lenses and/or contact lenses, combined, once per [every 2] [contract][calendar] [policy] year[s] ] [You receive a \$[50 - 500]	[You receive a [5% - 15%] Idiscount off retail price on initial pair of contact lenses] [You receive a [\$20 - \$50] allowance on frames, lenses and/or contact lenses, combined, once per [every 2] [contract][calendar] [policy] year[s] ] [You receive a \$[20 - 25] allowance on [initial pair of ] contact lenses [once per [every 2] [contract] [calendar] [policy] year[s] ]

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

## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

Copayments and Coinsurance		
Covered Service	You Pay In-Plan	You Pay Out-of-Plan
	allowance on [initial pair of ] contact lenses [once per [every 2] [contract] [calendar] [policy] year[s] ] [You receive a maximum allowance of [\$50 - \$1000] for all covered vision Services, other than eye exams, per [every 2] [contract][calendar] [policy] year[s] ]	[You receive a maximum allowance of [\$20 - \$500] for all covered vision Services, other than eye exams, per [every 2] [contract][calendar] [policy] year[s] ]
<ul style="list-style-type: none"> <li>• [Medically Necessary]</li> </ul>	<p>[No charge] [20% - 100% of retail price**] [with prior approval] [Member pays balance after Plan pays [\$50 - \$500]</p>	<p>[10% - 15% of retail price**] [with prior approval]</p>
<ul style="list-style-type: none"> <li>• [Medical Multifocal]</li> </ul>	<p>[Not covered] [No charge] [20% - 100% of retail price**] [with prior approval] [Member pays balance after Plan pays [\$50 - \$500]</p>	<p>[Not covered] [Member pays full price]</p>
<ul style="list-style-type: none"> <li>• [Cosmetic]</li> </ul>	<p>[Not covered] [No charge] [20% - 100% of retail price**] [with prior approval] [Member pays balance after Plan pays [\$50 - \$500]</p>	<p>[Not covered] [Member pays full price]</p>

[Note: A child may select any pair of glasses in lieu of, or in addition to, the eyeglasses or contact lenses available at no charge under Vision Services for children below and receive the discount at any Plan Vision Center.]

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[Vision Services (for children under age 19)]

Eye exams

- by an Optometrist
 

	[No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR after Deductible
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- by an Ophthalmologist
 

	[No charge] [[\$0 - \$100] per visit] [,then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[10% - 60%] of UCR after Deductible
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Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

<b>Copayments and Coinsurance</b>		
<b>Covered Service</b>	<b>You Pay In-Plan</b>	<b>You Pay Out-of-Plan</b>
Eyeglass lenses and frames (Limited to one pair of frames per calendar year from a selected group of frames; limited to one pair of polycarbonate or plastic single vision or bifocal lenses (ST28) per [contract][calendar][plan] year)	No charge [; Deductible waived]	[10% - 60%] of UCR after Deductible
Contact lenses (Limited to the initial fit and purchase of contact lenses from a selected list per [contract][calendar][plan] year)	No charge[; Deductible waived]	[10% - 60%] of UCR after Deductible
Low Vision Aids (Unlimited low vision aids from available supply)	No charge[; Deductible waived]	Not available]

### **X-ray, Laboratory and Specialty Procedures**

Inpatient diagnostic imaging, interventional diagnostic tests, laboratory tests, specialty imaging and special procedures	[No Charge] [Applicable inpatient Cost Share applies]	[Applicable inpatient Cost Share applies]
Outpatient diagnostic imaging, interventional diagnostic tests, and laboratory tests	[No charge] [[0 - \$60] per visit] [then] [[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[[5 - \$70] per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Outpatient specialty imaging (including CT, MRI, PET Scans, Nuclear Medicine and Interventional Radiology) and special procedures	[No charge] [[0 - \$500] per test] [then][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$1000 per test][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Sleep lab	[No charge] [[0 - \$500] per visit] [then][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$1000 per visit][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]
Sleep studies	[No charge] [[0 - \$500] per test] [then][[0% - 50%] of AC*] [after Deductible] [; Deductible waived]	[\$5 - \$1000 per test][[10% - 60%] of UCR] [after Deductible] [; Deductible waived]

**Note:** Charges for covered outpatient diagnostic and laboratory tests performed in a Plan Physician's office are included in the office visit Copayment.

\*AC means Allowable Charges as defined in the EOC.

\*UCR means Usual, Reasonable and Customary as defined in the "Added-Choice: A Point-of-Service Amendment."

\*\* "Retail price" means the price that would otherwise be charged for the lenses, frames or contacts at the KP Vision Care Center on the day purchased.

### **[ Out-of-Pocket Maximum**

The Out-of-Pocket Maximum is the limit to the total amount of Deductible, Copayments and Coinsurance you must pay in a [contract] [calendar] [policy] year for covered Services under this EOC. Once you have met your Out-of-Pocket

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

## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

Maximum, you will not be required to pay any additional Cost Shares for covered Services for the rest of the [contract] [policy] [calendar] year. After two or more Members of a Family Unit combined have met the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be met for all Members of the Family Unit for the rest of the [contract] [policy] [calendar] year.

Any amounts you pay toward the Deductible, Copayments or Coinsurance for covered Services apply toward the annual Out-of-Pocket Maximum[.], except for Deductible, Copayments or Coinsurance you pay for items covered under the “Outpatient Prescription Drug Rider.”]

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

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

<b>Out-Of-Pocket Maximum</b>	<b>In-Plan</b>	<b>Out-of-Plan</b>
<u>(Combined total of [In-Plan and] Out-of-Plan Deductible, Copayment and Coinsurance)</u>		
<u>[[Self-Only][Individual] Out-of-Pocket Maximum]</u>	<u>[[ \$250 - \$10,000 ] per individual per [contract] [calendar] [policy] year] [Not Applicable]</u>	<u>[\$500 - \$15,000] per individual per [contract] [calendar] [policy] year]</u>
<u>[Family Out-of-Pocket Maximum]</u>	<u>[[ \$500 - \$30,000 ] per Family Unit per [contract] [calendar] [policy] year] [Not Applicable]</u>	<u>[[ \$1,000 - \$45,000 ] per Family Unit per [contract] [calendar] [policy] year]</u>
<del>(Combined total of [In-Plan and] Out-of-Plan Deductible, Copayment and Coinsurance)</del>		
	<del><b>Individual Out-of-Pocket Maximum</b> [[ \$250 - \$10,000 ] per individual per [contract] [calendar] [policy] year] [Not Applicable]</del>	<del><b>Individual Out-of-Pocket Maximum</b> [\$500 - \$15,000] per individual per [contract] [calendar] [policy] year</del>
	<del><b>Family Out-of-Pocket Maximum</b> [[ \$500 - \$30,000 ] per Family Unit per [contract] [calendar] [policy] year] [Not Applicable]</del>	<del><b>Family Out-of-Pocket Maximum</b> [\$1,000 - \$45,000] per Family Unit per [contract] [calendar] [policy] year ]</del>
<b>Maximum Lifetime Benefit Amount</b>	No Limit	[No Limit] [[ \$1,000,000 - \$5,000,000 ] Out-of-Plan Maximum]

### [Out-of-Pocket Maximum]

The Out-of-Pocket Maximum is the limit to the total amount of Deductible, Copayments and Coinsurance you must pay in a [contract] [calendar] [policy] year for covered Services under this EOC. Once you have met your Out-of-Pocket Maximum, you will not be required to pay any additional Cost Shares for covered Services for the rest of the [contract]

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

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

[policy] [calendar] year.

Any amounts you pay toward the Deductible, Copayments or Coinsurance for covered Services apply toward the annual Out-of-Pocket Maximum.

**[[Self-Only] [Individual] Coverage Out-of-Pocket Maximum.** If you are covered as a Subscriber, and you do not have any Dependents covered under this EOC, your medical expenses apply toward the [Self-Only] [Individual] Out-of-Pocket Maximum shown below.]

**Family Coverage Out-of-Pocket Maximum.** If you have one or more Dependents covered under this EOC, the covered medical expenses incurred by all Members of the Family Unit together apply toward the Family Out-of-Pocket Maximum shown below; however no one family Member's medical expenses may contribute more than the Individual Out-of-Pocket Maximum shown below. After one member of a Family Unit has met the Individual Out-of-Pocket Maximum, his or her Out-of-Pocket Maximum will be met for the rest of the [calendar][contract][policy] year. Other family Members will continue to pay applicable Cost Shares until the Family Out-of-Pocket Maximum is met. After all Members of the Family Unit combined have met the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be met for all Members of the Family Unit for the rest of the [calendar][contract] [policy] year.]

**Family Coverage Out-of-Pocket Maximum.** If you have one or more Dependents covered under this EOC, the medical expenses of all Members of your Family Unit together apply towards the family Out-of-Pocket Maximum shown below. After one or more covered 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 [contract] [calendar] [policy] year. The Individual Out-of-Pocket Maximum shown below does not apply with family coverage.]

Individual within Family Coverage Out-of-Pocket Maximum. There is a maximum to the total dollar amount of Copayments and Coinsurance that you must pay for covered Services that you receive within the same Year. If you are the only Member in your Family, then you must meet the Individual within Family Out-of-Pocket Maximum. If you are a Member in a Family of two or more Members, then either you must each meet the Individual within Family Out-of-Pocket Maximum, or your entire Family must meet the Family Out-of-Pocket Maximum. Each Individual within Family Out-of-Pocket Maximum amount counts toward the Family Out-of-Pocket Maximum amount. The Self-Only Out-of-Pocket Maximum, Individual within Family Out-of-Pocket Maximum, and Family Out-of-Pocket Maximum amounts are shown below.]

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

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

Out-of-Pocket Maximum	In-Plan	Out-of-Plan
<u>(Combined total of [In-Plan and] Out-of-Plan Deductible, Copayment and Coinsurance)</u>		
<u>[[Self-Only] [Individual] Out-of-Pocket Maximum]</u>	<u>[[ \$250 - \$10,000] per individual per [contract] [calendar] [policy] year]</u> <u>[Not Applicable]</u>	<u>[[ \$500 - \$15,000] per individual per [contract] [calendar] [policy] year]</u>
<u>[Individual within Family Out-of-Pocket Maximum]</u>	<u>[[ \$250 - \$10,000] per individual per [contract] [calendar] [policy] year]</u> <u>[Not Applicable]</u>	<u>[[ \$500 - \$15,000] per individual per [contract] [calendar] [policy] year]</u>

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

## YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

<u>[Family Out-of-Pocket Maximum]</u>	<u>[[ \$500 - \$20,000 ] per Family Unit per [contract] [calendar] [policy] year] [Not Applicable]</u>	<u>[[ \$1,000 - \$45,000 ] per Family Unit per [contract] [calendar] [policy] year]</u>
(Combined total of [In-Plan and] Out-of-Plan Deductible, Copayment and Coinsurance)	<b>Individual Out-of-Pocket Maximum</b> [[ \$250 - \$10,000 ] per individual per [contract] [calendar] [policy] year]	<b>Individual Out-of-Pocket Maximum</b> [[ \$500 - \$15,000 ] per individual per [contract] [calendar] [policy] year]
	<b>Family Out-of-Pocket Maximum</b> [[ \$500 - \$20,000 ] per Family Unit per [contract] [calendar] [policy] year]	<b>Family Out-of-Pocket Maximum</b> [[ \$1,000 - \$45,000 ] per Family Unit per [contract] [calendar] [policy] year]
[Self-Only]	[[ \$0 - \$5,000 ] per [contract] [calendar] [policy] year]	[[ \$50 - \$15,000 ] per [contract] [calendar] [policy] year]
[Self + Spouse] [or Domestic Partner]		
[Self + Children]	[[ \$100 - \$6,000 ] per [contract] [calendar] [policy] year [[ \$100 - \$6,000 ] per [contract] [calendar] [policy] year]	[[ \$200 - \$16,000 ] per [contract] [calendar] [policy] year [[ \$200 - \$16,000 ] per [contract] [calendar] [policy] year]
[Self + Spouse] [or Domestic Partner] + [Children]	[[ \$100 - \$10,000 ] per [contract] [calendar] [policy] year]	[[ \$400 - \$20,000 ] per [contract] [calendar] [policy] year]

State: District of Columbia

Filing Company:

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

TOI/Sub-TOI: HOrg03 Health - Other/HOrg03.000 Health Organizations - Other

Product Name: 2017 DC Mid-Large Employer Group Benefit Form - HMO Cost Share

Project Name/Number: /

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/17/2016		Supporting Document	EOV	11/18/2016	DCLG-HMO-COST(1-17)-EOV.pdf DCLG-ALL-SEC3(01-17)-EOV.pdf
11/17/2016		Supporting Document	Redlines	11/18/2016	DCLG-HMO-COST(01-17)_redline.pdf DCLG-ALL-SEC3(01-17)_redline.pdf
11/17/2016		Form	Section 3: Benefits	11/17/2016	DCLG-ALL-SEC3(01-17).pdf (Superseded)
11/17/2016		Supporting Document	EOV	11/17/2016	DCLG-HMO-COST(1-17)-EOV.pdf DCLG-ALL-SEC3(01-17)-EOV.pdf (Superseded)
11/17/2016		Supporting Document	Redlines	11/17/2016	DCLG-HMO-COST(01-17)_redline.pdf DCLG-ALL-SEC3(01-17)_redline.pdf (Superseded)
11/17/2016		Supporting Document	EOV	11/17/2016	DCLG-HMO-COST(1-17)-EOV.pdf
11/17/2016		Supporting Document	Redlines	11/17/2016	DCLG-HMO-COST(01-17)_redline.pdf

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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## SECTION 3: BENEFITS

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The Services described in this section are covered only if all of the following conditions are met:

1. You are a Member on the date the Services are rendered;
2. [You have met any Deductible requirement described in the "Deductible" section of the Summary of Services and Cost Shares Appendix.]
3. The Services are provided:
  - a. By a Plan Provider; or
  - b. By a non-Plan Provider, subject to an approved referral as described in Section 2; and
  - c. In accordance with the terms and conditions within this EOC including but not limited to the requirements, if any, for prior approval (authorization);
4. The Services are Medically Necessary; and
5. You receive the Services from a Plan Provider except as described within this EOC.

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

1. Emergency Services;
2. Urgent Care outside our Service Area;
3. Authorized referrals to non-Plan Providers (as described in Section 2: How to Obtain Services)[.]; and]
4. [Visiting Member Services as described in Section 2: How to Obtain Services.]

### **Exclusions and Limitations:**

Exclusions and limitations that apply only to a particular benefit are described in this section. Other exclusions, limitations, and reductions that affect all benefits are described in Section 4: Exclusions, Limitations and Reductions.

**Note:** The “Summary of Services and Cost Shares” Appendix lists the Copayments, Coinsurances and Deductibles that apply to the following covered Services. Your Cost Share will be based on the type and place of Service.

### **A. OUTPATIENT CARE**

---

We cover the following outpatient care:

1. Primary care visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics/gynecology (OB/GYN) Services (Refer to “Preventive Health Care Services” for coverage of preventive care Services);
2. Specialty care visits (Refer to “Referrals to Plan Providers” in Section 2: How to Obtain Services for information about referrals to Plan specialists);
3. [Consultations and immunizations for foreign travel;]
4. Diagnostic testing for care or treatment of an illness; or to screen for a disease for which you have been determined to be at high risk for contracting. This includes, but is not limited to:
5. Diagnostic exams, including digital rectal exams and prostate antigen (PSA) tests provided:
  - a. To persons age 40 and older who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society;
6. Colorectal cancer screening, specifically: screening with an annual fecal occult blood test; flexible sigmoidoscopy or colonoscopy; or, in appropriate circumstances, radiologic imaging, for persons who

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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are at high risk of cancer. High risk is determined based on the most recently published guidelines of the American College of Gastroenterology, in consultation with the American Cancer Society;

7. Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A “qualified individual” means:
  - a. An estrogen deficient individual at clinical risk for osteoporosis;
  - b. An individual with a specific sign suggestive of spinal osteoporosis. This includes: roentgenographic osteopenia or roentgenographic evidence suggestive of collapse; wedging; or ballooning of one or more thoracic or lumbar vertebral bodies; and who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
  - c. An individual receiving long-term glucocorticoid (steroid) therapy;
  - d. An individual with primary hyper-parathyroidism; or
  - e. An individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;
8. Outpatient surgery physician/surgical Services;
9. Anesthesia, including Services of an anesthesiologist;
10. Chemotherapy and radiation therapy;
11. Respiratory therapy;
12. Medical social Services;
13. House calls when care can best be provided in your home as determined by a Plan Provider; and
14. After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to the Urgent Care provision for covered Services.

(Refer to “Preventive Health Services” for coverage of preventive care tests and screening Services);

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

### **B. HOSPITAL INPATIENT CARE**

---

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

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

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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

### **C. ACCIDENTAL DENTAL INJURY SERVICES**

---

We cover restorative Services necessary to promptly repair, but not replace, sound natural teeth that have been injured as the result of an external force. Coverage is provided when all of the following conditions have been met:

1. The accident has been reported to your primary care Plan Physician within seventy-two (72) hours of the accident.
2. A Plan Provider provides the restorative dental Services;
3. The injury occurred as the result of an external force that is defined as violent contact with an external object; not force incurred while chewing;
4. The injury was sustained to sound natural teeth;
5. The covered Services must be requested within [sixty (60) days][six (6) months] of the injury; and
6. The covered Services are provided during the twelve (12) consecutive month period commencing from the date that the injury started.

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

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

#### ***Accidental Dental Injury Services Exclusions:***

- Services provided by non-Plan Providers.
- Services provided after twelve (12) months from the date the injury occurred.
- Services for teeth that have been avulsed (knocked out) or that have been so severely damaged that in the opinion of the Plan Provider, restoration is impossible.

### **D. ALLERGY SERVICES**

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We cover the following allergy Services:

- Evaluations, and treatment ; and
- Injections and serum.

### **E. AMBULANCE SERVICES**

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We cover licensed ambulance Services only if your medical condition requires: (1) the basic life support, advanced life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer; and (2) the ambulance transportation has been ordered by a Plan Provider. Coverage is also provided for Medically Necessary transportation or Services, including Medically Necessary air ambulance transport to the nearest hospital able to provide needed Services, rendered as the result of a 911 call. Your Cost Share will apply to each encounter, whether or not transport was required.

Ambulance transportation from an emergency room to a Plan Facility or from a hospital to a Plan Facility that

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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is both Medically Necessary and ordered by a Plan Provider is covered at no charge.

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

We cover licensed ambulance and non-emergent transportation Services ordered by a Plan Provider only inside our Service Area, except as covered under the “Emergency Services” provision in this section.

### ***Ambulance Services Exclusions:***

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

## **F. ANESTHESIA FOR DENTAL SERVICES**

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

1. For whom a superior result can be expected from dental care provided under general anesthesia; and
2. For whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition.

Additionally, we provide these Services to Members age:

1. 7 or younger or are developmentally disabled.
2. 17 or younger who is extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred, and for whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.
3. 17 and older when the Member’s medical condition requires that dental service be performed in a hospital or ambulatory surgical center for the safety of the Member (e.g., heart disease and hemophilia).

General anesthesia and associated hospital and ambulatory surgical center charges will be covered only for dental care that is provided by:

1. A fully accredited specialist in pediatric dentistry; or
2. A fully accredited specialist in oral and maxillofacial surgery; and
3. For whom hospital privileges have been granted.

### ***Anesthesia for Dental Services Exclusions:***

- The dentist’s or specialist’s professional Services.
- Anesthesia and related facility charges for dental care for temporomandibular joint (TMJ) disorders.

## **G. BLOOD, BLOOD PRODUCTS AND THEIR ADMINISTRATION**

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We cover; blood and blood products, both derivatives and components, including the collection and storage of autologous blood for elective surgery; cord blood procurement and storage for approved Medically Necessary

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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care, when authorized by a Plan Provider; and the administration of prescribed whole blood and blood products.

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

### ***Blood, Blood Products and their Administration Limitations:***

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

### ***Blood, Blood Products and their Administration Exclusions:***

- Directed blood donations.

## **H. CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES**

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We cover the treatment of treatable mental illnesses, emotional disorders, drug abuse and alcohol abuse for conditions that in the opinion of a Plan Provider, would be responsive to therapeutic management.

For the purposes of this benefit provision: “Drug and alcohol abuse” means a disease that is characterized by a pattern of pathological use of a drug and/or alcohol with repeated attempts to control its use and with significant negative consequences in at least one the following areas of life: medical; legal; financial; or psycho-social.

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

1. Individual therapy;
2. Group therapy;
3. Shock therapy;
4. Drug therapy;
5. Education;
6. Psychiatric nursing care; and
7. Appropriate hospital Services.

Medical Services for detoxification are limited to the removal of the toxic substance or substances from the system. Detoxification will be covered for a minimum of twelve (12) days annually.

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

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

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

1. Evaluations;
2. Crisis intervention;
3. Individual therapy;
4. Group therapy;

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5. Psychological testing;
6. Medical treatment for withdrawal symptoms; and
7. Visits for the purpose of monitoring drug therapy.

### ***Chemical Dependency and Mental Health Services Exclusions:***

- Services in a facility whose primary purpose is to provide treatment for alcoholism, drug abuse, or drug addiction, except as described above.
- Services provided in a psychiatric residential treatment facility, except as described above.
- Services for Members who, in the opinion of the Plan Provider, are seeking Services for non-therapeutic purposes.
- [Applied Behavior Analysis (ABA).]
- Cognitive Behavior Therapy (CBT).
- Psychological testing for ability, aptitude, intelligence, or interest.
- Services on court order or as a condition of parole or probation, unless determined by the Plan Provider to be Medically Necessary.
- Evaluations that are primarily for legal or administrative purposes, and are not Medically Necessary.

### **I. [[CHIROPRACTIC [AND] [ACUPUNCTURE] SERVICES**

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

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

### ***Chiropractic [and] [Acupuncture] Services Limitation:***

The number of visits needed for the Member to reach the maximum level of recovery will be determined by the Plan Provider [and shall not exceed a total of [ten (10)-ninety (90)] visits per [contract][calendar][policy] year [for each type of Service][for chiropractic Services]; and] [ten (10)-ninety (90) visits per [contract][calendar][policy] year for acupuncture Services.]

### **J. CLEFT LIP, CLEFT PALATE OR BOTH**

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

### **K. CLINICAL TRIALS**

We cover the routine patient care costs you may incur as an eligible participant in an approved clinical trial undertaken for the purposes of: the prevention, early detection, treatment; or monitoring of cancer, chronic disease, or life-threatening illness.

For the purposes of this benefit, an approved clinical trial means:

1. A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
  - a. The National Institutes of Health (NIH);
  - b. The Centers for Disease Control and Prevention (CDC);

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- c. The Agency for Health Care Research and Quality;
  - d. The Centers for Medicare and Medicaid Services;
  - e. A bona fide clinical trial cooperative group, including: the National Cancer Institute Clinical Trials Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the AIDS Clinical Trials Group; and the Community Programs for Clinical Research in AIDS; or
  - f. The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;
2. A study or investigation approved by the United States Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA; or
  3. An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

“Routine patient care costs” mean:

1. Items, drugs, and Services that are typically provided absent a clinical trial;
2. Items, drugs, and Services required solely for the provision of the investigational item or service (such as the administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
3. Items, drugs, and Services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

### ***Clinical Trials Exclusions:***

Routine patient care costs shall not include:

- The cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or items, drugs, or Services provided solely to satisfy data collection and analysis needs; or
- Items, drugs, or Services customarily provided by the research sponsors free of charge for any qualified individual enrolled in the trial.

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

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

## **L. DIABETIC EQUIPMENT, SUPPLIES, AND SELF-MANAGEMENT**

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

1. Insulin-using diabetes;
2. Insulin-dependent diabetes;

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

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

### ***Diabetic Equipment and Supplies Limitation:***

Diabetic equipment and supplies are limited to Health Plan preferred equipment and supplies unless the equipment or supply: (1) was prescribed by a Plan Provider and (2) (a) there is no equivalent preferred equipment or supply available or (b) an equivalent preferred equipment or supply (i) has been ineffective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member. "Health Plan preferred equipment and supplies" are those purchased from a Plan preferred vendor.

To obtain information about Plan preferred vendors, contact Member Services:

[Inside the Washington, DC Metropolitan Area: (301) 468-6000]

[Outside of the Washington, DC Metropolitan Area: 1-800-777-7902]

[TTY: 711]

## **M. DIALYSIS**

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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 Provider 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 lab tests, equipment, supplies and other Services associated with your treatment;
2. Inpatient maintenance dialysis if you are admitted to a Plan Hospital because your medical condition requires specialized hospital Services on an inpatient basis; and
3. Plan Provider Services related to inpatient and outpatient dialysis.

We cover the following self-dialysis Services:

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

We cover home dialysis, which includes:

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

Members requiring dialysis outside of the service area for a limited time period, may receive pre-planned dialysis services in accordance to prior authorization requirements.

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### **N. DRUGS, SUPPLIES, AND SUPPLEMENTS**

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#### **Administered Drugs, Supplies and Supplements**

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

1. Oral infused or injected drugs, and radioactive materials used for therapeutic purposes, including chemotherapy;
2. Injectable devices;
3. The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
4. Medical and surgical supplies including: dressings; splints; casts; hypodermic needles; syringes; or any other Medically Necessary supplies provided at the time of treatment;
5. Vaccines and immunizations approved for use by the FDA that are not considered part of routine preventive care.

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

#### ***Drugs, Supplies and Supplements Exclusions:***

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

### **O. DURABLE MEDICAL EQUIPMENT**

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Durable Medical Equipment is defined as equipment that: (1) is intended for repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) is generally not useful to a person in the absence of illness or injury; and (4) meets the Health Plan criteria for being Medically Necessary.

Durable Medical Equipment does not include coverage for prosthetic devices, such as implants, artificial eyes or legs, or orthotic devices, such as braces or therapeutic shoes. Refer to “Prosthetic Devices” for coverage of internal prosthetic devices, ostomy and urological supplies and breast prosthesis. Additional coverage for external prosthesis and orthotic devices is only covered if a Prosthetic and Orthotic Devices Rider is attached to this EOC.

#### **Basic Durable Medical Equipment**

We cover Durable Medical Equipment as prescribed by a Plan Provider for use in your home (or an institution used as your home). We also cover Durable Medical Equipment used during a covered stay in a Plan Hospital

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or Skilled Nursing Facility, but only if the Skilled Nursing Facility ordinarily furnishes Durable Medical Equipment.

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

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

### **Supplemental Durable Medical Equipment**

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

#### **Oxygen and Equipment**

We cover oxygen and equipment when prescribed by a Plan Provider and your medical condition meets the Health Plan’s criteria for being Medically Necessary. A Plan Provider must certify the continued medical need for oxygen and equipment.

#### **Positive Airway Pressure Equipment**

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

#### **Apnea Monitors**

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

#### **Asthma Equipment**

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

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

#### **Bilirubin Lights**

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

#### ***Durable Medical Equipment Exclusions:***

- Comfort, convenience, or luxury equipment or features.
- Exercise or hygiene equipment.
- Non-medical items such as sauna baths or elevators.
- Modifications to your home or car.
- Devices for testing blood or other body substances (except as covered under “Diabetes Equipment, Supplies and Self-Management”).
- Electronic monitors of the heart or lungs, except infant apnea monitors.
- Services not preauthorized by the Health Plan.

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## **P. EMERGENCY SERVICES**

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

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

We cover Emergency Services as follows:

### **Inside our Service Area**

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

### **Outside of our Service Area**

We cover reasonable charges for Emergency Services if you are injured or become ill while temporarily outside of our Service Area.

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

### **Continuing Treatment Following Emergency Services**

#### **Inside our Service Area**

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

#### **Inside another Kaiser Permanente Region**

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

#### **Outside our Service Area**

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

#### **Transport to a Service Area**

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

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Health Plan Region, for continuing or follow-up treatment. **Note:** All ambulance transportation is covered under the “Ambulatory Services” benefit in this section.

### **Continued Care in Non-Plan Facility Limitation**

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

### **Filing Claims for Non-Plan Emergency Services**

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

### **Emergency Services HIV Screening Test**

We cover the cost of a voluntary HIV screening test performed on a Member while the Member is receiving emergency medical Services, other than HIV screening, at a hospital emergency room. The test is covered whether or not the HIV screening test is necessary for the treatment of the medical emergency which caused the member to seek Emergency Services.

Covered Services include:

1. The costs of administering such a test;
2. All lab costs to analyze the test; and
3. The costs of telling the Member the results of the test; and any applicable follow-up instructions for obtaining health care and supportive Services.

Other than the Cost Share shown in the Summary of Services and Cost Shares for Emergency Services, no additional Cost Share will be imposed for these Services.

### ***Emergency Services Limitations:***

- **Notification:** If you receive care at a hospital emergency room or are admitted to a non-Plan Hospital, you, or someone on your behalf, must notify us as soon as possible, but not later than 48 hours or the next business day, whichever is later, of the emergency room visit or hospital admission, unless it was not reasonably possible to notify us. If you are admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us as provided herein, we will not cover the emergency room visit, or hospital care you receive after transfer would have been possible.
- **Continuing or Follow-up Treatment:** Except as provided for under “Continuing Treatment Following Emergency Surgery,” we do not cover continuing or follow-up treatment after Emergency Services unless authorized by Health Plan. We cover only the out-of-Plan emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Foundation Health Plan or allied plan service area.

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

### **Q. [FAMILY PLANNING SERVICES]**

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We cover the following:

1. [Women’s Preventive Services (WPS), including:
  - a. Patient education and contraceptive method counseling for all women of reproductive capacity;
  - b. Coverage for: FDA-approved contraceptive devices; hormonal contraceptive methods; and the insertion or removal of contraceptive devices. This includes any Medically Necessary exams associated with the use of contraceptive drugs and devices; and
  - c. Female sterilization.
    - i. (Note: WPS are preventive care and are covered at no charge.)]
2. [Additional family planning counseling[, including pre-abortion and post-abortion counseling][.][;][; and]
3. [Vasectomies][.][;][; and]
4. [[Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (i) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (ii) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.]

#### ***Voluntary termination of pregnancy limitations:***

- We cover up to a maximum of two voluntary terminations of pregnancy during a contract year.]]
1. [[Family planning counseling [, including pre-abortion and post-abortion counseling] and information on birth control.]
  2. [Insertion and removal, and any Medically Necessary exams associated with the use of contraceptive drugs and devices. Contraceptive devices (other than diaphragms) and implantable contraceptive drugs are supplied by the provider, and are covered under this benefit. Contraceptive drugs and diaphragms are covered only under an “Outpatient Prescription Drug Rider”, if applicable.]
  3. [Tubal ligations.]
  4. [Vasectomies.]
  5. [[Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (i) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (ii) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.]

#### ***Voluntary termination of pregnancy limitations:***

- We cover up to a maximum of two (2) voluntary terminations of pregnancy during a contract year.]]

**Note:** Diagnostic procedures are covered, but not under this section (see “X-ray, Laboratory and Special Procedures”).]

### **R. HABILITATIVE SERVICES**

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#### **[Children under age 21]**

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

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We cover Medically Necessary Services, including speech therapy, occupational therapy and physical therapy, for children under the age of 21 years with a congenital or genetic birth defect, to enhance the child's ability to function. Medically Necessary Habilitative Services are those Services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, and shall include Services that enhance functional ability without effecting a cure. Congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. The term congenital or genetic birth defect includes: (1) autism or an autism spectrum disorder and (2) cerebral palsy.

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

### **Adults age 21 or older**

We cover Medically Necessary Habilitative Services that are designed to enhance a Member's functional ability, without effecting a cure, for the treatment of autism or an autism spectrum disorder, "Medically Necessary Habilitative Services" include occupational therapy, physical therapy, speech therapy, and (ABA).]

### ***Habilitative Services Exclusions:***

- Assistive technology Services and devices.
- Services provided through federal, state or local early intervention programs, including school programs.
- Services not preauthorized by Health Plan.
- Services for a Member that has plateaued and is able to demonstrate stability of skills and functioning even when Services are reduced.
- Services not provided by a licensed or certified therapist.

## **S. HEARING SERVICES**

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### **Hearing Exams**

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

### **Hearing Aids**

We cover the following:

1. Medically Necessary hearing aids for both children and adults. Hearing aid means an electronic device worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing including an ear mold, if necessary.
2. Hearing aid evaluations and diagnostic procedures to determine the hearing aid model which will best compensate for loss of hearing.
3. Visits to verify that the hearing aid conforms to the prescription.
4. Visits for fitting, counseling, adjustment, cleaning, and inspection.

### ***Hearing Aid Limitations:***

- [Your hearing aid Benefit Allowance is [\$500 – \$5,000].
- [Coverage is provided for one Hearing Aid for each hearing impaired ear every [twelve (12) – sixty (60)] months. Two Hearing Aids are covered every [twelve (12) – sixty (60)] months only if both are required to provide significant improvement that is not obtainable with only one Hearing Aid, as determined by your Plan Provider.]

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- [You are not required to obtain Hearing Aids for both ears at the same time. The [twelve (12) – sixty (60)] month benefit period extends separately for each ear, and commences at the initial point of sale for each ear.]
- [The hearing aid Benefit Allowance must be used at the initial point of sale for each hearing aid. Any part of the hearing aid Benefit Allowance that is not exhausted at the initial point of sale may not be used at a later time.]
- [The type of Hearing Aid is limited to the models provided by Kaiser Permanente or the Kaiser Permanente-designated Hearing Aid vendor.]

[You may apply the hearing aid Benefit Allowance toward a hearing aid upgrade. However, you must pay the difference in the hearing aid Benefit Allowance and the cost of the hearing aid upgrade.]]

### ***Hearing Services Exclusions:***

- [Tests to determine an appropriate hearing aid.
- Hearing aids or tests to determine their efficacy.]
- [Replacement of parts and batteries.
- Replacement of lost or broken hearing aid.
- Repair of hearing aid beyond one year.
- Comfort, convenience, or luxury equipment or features.
- Hearing aids prescribed and ordered prior to coverage or after termination of coverage]

## **T. HOME HEALTH CARE**

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

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

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

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

### **Home Health Visits Following Mastectomy or Removal of Testicle**

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

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

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### ***Home Health Care Limitations:***

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

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

Additional limitations may be stated in the “Summary of Services and Cost Share.”

### ***Home Health Care Exclusions:***

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

## **U. HOSPICE CARE**

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

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

1. Nursing care;
2. Physical, occupational, speech, and respiratory therapy;
3. Medical social Services;
4. Home health aide Services;
5. Homemaker Services;
6. Medical supplies and appliances;
7. Palliative drugs in accord with our drug formulary guidelines;
8. Physician care;
9. General hospice inpatient Services for acute symptom management including pain management;
10. Respite Care that may be limited to five (5) consecutive days for any one inpatient stay up to 4 times in any contract year;

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11. Counseling Services for the Member and his Family Members, including dietary counseling for the Member; and bereavement counseling for the Member's Family for a period of one year after the Member's death; and
12. Services of hospice volunteers.

### **Definitions:**

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

### **V. [INFERTILITY SERVICES]**

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We cover the following:

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

### **Note[s]:**

1. Involuntary infertility means the inability to conceive after one (1) year of unprotected vaginal intercourse.
2. Diagnostic procedures and any covered drugs administered by or under the direct supervision of a Plan Provider are covered under this provision. Refer to the Prescription Drug Rider, if applicable, for coverage of outpatient infertility drugs.
3. [ [In vitro fertilization, if:
  - a. [The Member's oocytes are fertilized with the Member's spouse's sperm; and]
  - b. The [Member has][Member's and the Member's spouse have] a history of infertility of at least two (2) years duration; or the infertility is associated with any of the following:
    - i. Endometriosis;
    - ii. Exposure in utero to diethylstilbestrol, commonly known as DES;
    - iii. Blockage of, or surgical removal of, one (1) or both fallopian tubes (lateral or bilateral salpingectomy); or
    - iv. Abnormal male factors, including oligospermia, contributing to the infertility;
  - c. The Member has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this EOC; and
  - d. The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or the American Fertility Society minimal standards for programs of in vitro fertilization.]
4. Intracytoplasmic Sperm Injection (ICSI) if the Member meets medical guidelines;

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5. Preimplantation Genetic Diagnosis (PGD) if the Member meets medical guidelines[.];]
6. [Gamete intrafallopian transfers (GIFT); and
7. Zygote intrafallopian transfers (ZIFT).]

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

***[Infertility Limitations:***

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

***Infertility Services Exclusions:***

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

### **W. INFUSION THERAPY SERVICES**

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

### **X. MATERNITY SERVICES**

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

Services for pre-existing conditions care related to the development of a high risk condition(s) during pregnancy, and non-routine obstetrical care are covered subject to applicable Cost Share for specialty, diagnostic, and/or treatment Services.

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

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

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

Comprehensive lactation (breastfeeding) education and counseling, by trained clinicians during pregnancy and/or postpartum period in conjunction with each birth, Breastfeeding equipment is issued, per pregnancy. The breast feeding pump (including any equipment that is required for pump functionality) is covered for six (6) months at no cost sharing to the member.

### ***Maternity Services Exclusions***

- Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.

## **Y. MEDICAL FOODS**

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

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

Low protein modified foods are food products that are (1) specially formulated to have less than one (1) gram of protein per serving, and (2) intended to be used under the direction of a Plan Provider for the dietary treatment of an inherited metabolic disease.

### ***Medical Foods Exclusions:***

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

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

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

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

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

### ***Amino Acid Based Elemental Formula Exclusions:***

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

## **Z. MORBID OBESITY**

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We cover diagnosis and treatment of morbid obesity including gastric bypass surgery or other surgical method that is recognized by the National Institutes of Health (NIH) as effective for long-term reversal of morbid obesity, and is consistent with criteria approved by the NIH.

Morbid obesity is defined as:

1. A weight that is at least one-hundred (100) pounds over or twice the ideal weight for a patients frame, age, height, and gender, as specified in the 1983 Metropolitan Life Insurance tables; or
2. A body mass index (BMI) that is equal to or greater than thirty-five (35) kilograms per meter squared with a comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary condition, sleep apnea, or diabetes; or
3. A BMI of forty (40) kilograms per meter squared without such comorbidity.

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

### ***Morbid Obesity Services Exclusions***

- Services not preauthorized by the Health Plan

## **AA. ORAL SURGERY**

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

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

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

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

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

1. Evidenced through documented medical records showing significant impairment in speech or a nutritional deficit; and

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2. Based on examination of the Member by a Plan Provider.

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

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

### ***Oral Surgery Exclusions:***

- Oral surgery Services when the functional aspect is minimal and would not in itself warrant surgery.
- Lab fees associated with cysts that are considered dental under our standards.
- Medical and dental Services for treatment TMJ.
- Orthodontic Services.
- Dental appliances.

### **BB. PREVENTIVE HEALTH CARE SERVICES**

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

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

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

[We cover medically appropriate preventive health care Services based on your age, sex, or other factors, as determined by your primary care Plan Physician pursuant to national preventive health care standards.

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

1. Preventive care exams, including:
  - a. Routine physical examinations and health screening tests appropriate to your age and sex;

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- b. Well-woman examinations; and
- c. Well child care examinations;
2. Routine and necessary immunizations [(travel immunizations are not preventive and are covered under Outpatient Services in this section)] for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;
3. An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
4. Low dose screening mammograms to determine the presence of breast disease is covered as follows:
  - a. One mammogram for persons age 35 through 39;
  - b. One mammogram biennially for persons age 40 through 49; and
  - c. One mammogram annually for person 50 and over;
5. Bone mass measurement to determine risk for osteoporosis;
6. Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to men who are age 40 or older;
7. Colorectal cancer screening in accordance with screening guidelines issued by the American Cancer Society including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy;
8. Cholesterol test (lipid profile);
9. Diabetes screening (fasting blood glucose test);
10. Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis and HPS), subject to the following:
  - a. Annual chlamydia screening is covered for (a) women under age of 20, if they are sexually active; and (b) women age 20 years of age or older, and men of any age, who have multiple risk factors, which include: (i) a prior history of sexually transmitted diseases; (ii) new or multiple sex partners; (iii) inconsistent use of barrier contraceptives; or (iv) cervical ectopy;
  - b. Human Papillomavirus Screening (HPS) as recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;
11. HIV tests;
12. TB tests;
13. Newborn hearing screenings that include follow up audiological examinations, as recommended by a physician or audiologist, and performed by a licensed audiologist to confirm the existence or absence of hearing loss when ordered by a Plan Provider; [and]
14. Associated preventive care radiological and lab tests not listed above[.]; [and]
15. [BRCA counseling and genetic testing is covered a no Cost Share. Any follow up Medically Necessary treatment is covered at the applicable Cost Share based upon type and place of Service] [.]; [and]
16. CT scan of the Thorax when ordered as a preventive for smokers age 55 to 80 years of age.]

### ***Preventive Health Services Limitation:***

While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services. Applicable Cost Shares will apply.

- Monitoring a chronic disease;
- Follow-up Services after you have been diagnosed with a disease;

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- Testing and diagnosis for specific diseases for which you have been determined to be at high risk for contracting based on factors determined by national standards;
- Services provided when you show signs or symptoms of a specific disease or disease process;
- Non-routine gynecological visits; and
- Treatment of a medical condition or problem identified during the course of a preventive screening exam.

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

### **CC. PROSTHETIC DEVICES**

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We cover the devices listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is ill or injured. Coverage includes fitting and adjustment of these devices, repair or replacement (unless due to loss or misuse), and Services to determine whether you need the prosthetic. If we do not cover the prosthetic, we will try to help you find facilities where you may obtain what you need at a reasonable price. Coverage is limited to the standard device that adequately meets your medical needs.

#### **Internally Implanted Devices**

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

#### **Ostomy and Urological Supplies**

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

#### **Breast Prosthetics**

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

#### ***Breast Prosthetics Limitation:***

- Coverage for mastectomy bras is limited to a maximum of two (2) per [calendar][contract] [policy] year.

#### ***Prosthetic Devices Exclusions:***

- Services not preauthorized by Health Plan.
- Internally implanted breast prosthetics for cosmetic purposes.
- External prosthetics, except as provided in this section under “Cleft-Lip, Cleft Palate, or Both”, “Hearing Services”, or as provided under a “Prosthetic and Orthotic Devices Rider”, if applicable.
- Repair or replacement of prosthetics devices due to loss or misuse.
- [Hair Prostheses.]
- Microprocessor and robotic controlled external prosthetics and orthotics that does not meet the Health Plan criteria as Medical Necessary.

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- Multifocal intraocular lens implants.

### **DD. RECONSTRUCTIVE SURGERY**

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We cover reconstructive surgery. This shall include plastic, cosmetic and related procedures required to: (1) to correct significant disfigurement resulting from an injury or Medically Necessary surgery, (2) to correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function, and (3) to treat congenital hemangioma known as port wine stains on the face for Members age 18 or younger, (4) breast augmentation is covered only if determined to be Medical Necessary.

Following mastectomy, we cover reconstructive breast surgery and all stages of reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. Mastectomy is the surgical removal of all or part of a breast as a result of breast cancer. Reconstructive breast surgery is surgery performed as a result of a mastectomy to reestablish symmetry between the two (2) breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

#### ***Reconstructive Surgery Exclusions:***

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

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

### **EE. SKILLED NURSING FACILITY CARE**

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

We cover the following Services:

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

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

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

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### ***Skilled Nursing Facility Care Exclusions:***

- Custodial care (see definition under “Exclusions” in Section 4: Exclusions, Limitations, and Reductions).
- Domiciliary care.

### **FF. TELEMEDICINE SERVICES**

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

Telemedicine Services means the delivery of healthcare Services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Not all medical services are conducive to telemedicine, as such the provider will make a determination whether the member should instead be seen in a face-to-face medical office setting.

### ***Telemedicine Services Exclusion:***

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

### **GG. THERAPY AND REHABILITATION SERVICES**

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#### **Physical, Occupational, and Speech Therapy Services**

If, in the judgment of a Plan Provider, significant improvement is achievable within a two (2)-month period, we cover physical, occupational and speech therapy[:

1. While you are confined in Plan Hospital; and
2. For up to [twenty (20)-ninety (90)] visits [or] ninety (90) consecutive days] of physical therapy [whichever is longer], and [twenty (20)-ninety (90)] visits [or] ninety (90) consecutive days] of occupational or speech therapy per [contract] [policy] [calendar] year per injury, incident or condition in a Plan Medical Center, a Plan Provider’s medical office, a Skilled Nursing Facility or as part of home health care. [These limits do not apply to necessary treatment of cleft lip or cleft palate.]

#### ***Physical, Occupational, and Speech Therapy Services Limitations:***

- Physical therapy is limited to treatment to restore physical function that was lost due to injury or illness. It is not covered to develop physical function, except as provided for under “Habilitative Services” in this section.
- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Speech therapy is limited to treatment for speech impairments due to injury or illness.

#### **Multidisciplinary Rehabilitation Services**

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

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

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## ***Multidisciplinary Rehabilitation Services Limitations:***

- The limitations listed above for physical, occupation and speech therapy also applies to those Services when provided within a multidisciplinary program.

## **Cardiac Rehabilitation Services**

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

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

## **Pulmonary Rehabilitation Services**

We cover pulmonary rehabilitation Services that are Medically Necessary; limited to one (1) program per lifetime.]

## ***Therapy and Rehabilitation Services Exclusion:***

- Long-term rehabilitative therapy.

## **HH. TRANSPLANT SERVICES**

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

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

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

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

## ***Transplant Services Exclusions:***

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

## **II. URGENT CARE**

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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.

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### **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 Office please call:

[Inside the Washington, DC Metropolitan Area: (301) 468-6000]

[Outside of the Washington, DC Metropolitan Area: 1-800-777-7902]

[TTY: 711]

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

### **Outside of our Service Area**

If you are injured or become ill while temporarily outside of the Service Area, we will cover reasonable charges for Urgent Care Services as defined in this section. 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 Plan Medical Office in the Service Area, or in the nearest Kaiser Foundation Health Plan Region for continuing or follow-up treatment.

### ***Urgent Care Limitations:***

We do not cover Services outside of our Service Area for conditions that, before leaving the Service Area, you should have known might require Services while outside 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 an extreme personal emergency.

### ***Urgent Care Exclusions:***

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

## **JJ. VISION [EXAM] SERVICES**

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### **Medical Treatment**

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

### ***[Vision Services Exclusions:***

- All Services related to vision correction, including but not limited to, eye exams to determine the need for vision correction and to provide a prescription for corrective lenses.
- Eyeglass lenses and eyeglass frames.
- Eye exercises.
- All Services related to contact lenses including: exams, fitting, dispensing, and follow-up visits.
- Orthoptic (eye training) therapy.

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- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism, including but not limited to radial keratotomy, photo-refractive keratectomy, and similar procedures.]

[**Note:** Discounts are available as a Value Added Service for lenses and frames.]

### **Eye Exams**

We cover routine and necessary eye exams, including:

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

### ***Vision Exam Services Exclusions:***

- Eyeglass lenses and eyeglass frames.
- Eye exercises.
- All Services related to contact lenses including: exams, fitting, dispensing, and follow-up visits.
- Orthoptic (eye training) therapy.]]

### **Pediatric Eye Exams**

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

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

### **Pediatric Lenses and Frames**

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

1. One (1) pair of lenses per year;
2. One (1) pair of frames per year from a select group of frames;
3. Regular contact lenses (in lieu of lenses and frames) for the first regular supply for that contact lens per year; or
4. Medically Necessary contact lenses up to two (2) pair per eye per year.]

[In addition, we cover the following Services:

### **Eyeglass Lenses**

[We provide a discount on the purchase of regular eyeglass lenses, including add-ons, when purchased at a Kaiser Permanente Optical Shop. Regular eyeglass lenses are any lenses with a refractive value. If only one eye needs correction, we also provide a balance lens for the other eye. ] [We cover the purchase of eyeglass lenses at no charge when purchased at a Kaiser Permanente Optical Shop.]

### **Frames**

[We provide a discount on the purchase of eyeglass frames, when purchased at a Kaiser Permanente Optical Shop. The discount includes the mounting of eyeglass lenses in the frame, original fitting of the frame, and subsequent adjustment. ] [We cover the purchase of eyeglass frames at no charge when purchased at a Kaiser Permanente Optical Shop.]

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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### **Contact Lenses**

[We cover the [initial] purchase of contact lenses at no charge when purchased at a Kaiser Permanente Optical Shop.] [We cover the initial fitting for contact lenses at no charge when purchased at a Kaiser Permanente Optical Shop.] [We provide a discount on the initial fitting for contact lenses, when purchased at a Kaiser Permanente Optical Shop. Initial fitting means the first time you have ever been examined for contact lens wear at a Plan Facility. The discount includes the following Services:

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

[You will also receive a discount on your initial purchase of contact lenses, if you choose to purchase them at the same time.] [Note: Additional contact lens Services are available without the discount from any Kaiser Permanente Optical Shop.]

### ***[Vision Exclusions:***

- Industrial and athletic safety frames.
- Eyeglass lenses and contact lenses with no refractive value.
- Sunglasses without corrective lenses unless Medically Necessary.
- Any eye surgery solely for that the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), and astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
- Eye exercises.
- Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section.
- Replacement of lost, broken, or damaged lenses frames and contact lenses.
- Plano lenses.
- Lens adornment, such as engraving, faceting, or jewellery.
- Low-vision devices.
- Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits.
- Orthoptic (eye training) therapy.]

### **KK. [VISITING MEMBER SERVICES**

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We cover the same Medically Necessary Services that are covered under this plan in our Service Area, and your Cost Share may differ, when you are temporarily a visiting member in a different Kaiser Permanente Region or Group Health Cooperative service area. .

To receive more information about visiting Member Services, including facility locations across the United States, contact Member Services:

[Inside the Washington, DC Metropolitan Area: (301) 468-6000]

[Outside of the Washington, DC Metropolitan Area: 1-800-777-7902]

[TTY: 711]

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

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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### ***Visiting Member Services Limitations:***

Access to Services in the visited service area will be subject to availability at the time you request the Service. Services may be unavailable due to temporary capacity constraints, inability to provide the Service generally, or other restrictions. If the Service is not available in the visited service area, you must call us for authorization to receive the Service.

### ***Visiting Member Service Exclusions:***

All the terms and conditions, exclusions and limitations that apply to covered Services in our Service Area, will apply to Services received as a visiting Member in a different Kaiser Permanente Region or Group Health Cooperative service area.]

## **LL. X-RAY, LABORATORY, AND SPECIAL PROCEDURES**

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

1. Diagnostic imaging;
2. Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
3. Special procedures, such as electrocardiograms and electroencephalograms;
4. Sleep lab and sleep studies; and
5. Specialty imaging: including CT, MRI, PET Scans, and Nuclear Medicine studies; and interventional radiology.

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Page(s)	Applicable Products	Variables	Explanations
Throughout Section 3	DHMO HDHP HMO & 3TPOS	<a href="http://www.kp.org">[www.kp.org]</a> [Inside the Washington, DC Metropolitan Area: (301) 468-6000] [Outside of the Washington, DC Metropolitan Area: 1-800-777-7902] [TTY: 711] [1-800-677-1112] [7:30 a.m. until 9 p.m. ET.] [1-866-530-8778]	Telephone numbers, Web site addresses, and hours of operation are bracketed to allow Health Plan to change without refiling.
Throughout Section 3	DHMO HDHP HMO & 3TPOS	[contract] [calendar] [policy]	The appropriate benefit plan period will be included in the form based on the employer's election. The standard employer election is contract year.
3.1	HMO & 3TPOS	[You have met any Deductible requirement described in the "Deductibles" section of the Summary of Services and Cost Shares Appendix;]	This variable will be removed for plans without a deductible.
3.1	DHMO HDHP HMO & 3TPOS	Authorized referrals to non-Plan Providers, as described in Section 2: How to Obtain Services under "Getting a Referral," including referrals for Clinical Trials as described in this section[.]; and]	The variable [.] will be used when the plan is HDHP and does not include "Visiting Member Services as described in Section 2: How to Obtain Services."  The variable [; and] will be used when the plan is HMO or DHMO and includes "Visiting Member Services as described in Section 2: How to Obtain Services."
3.1	DHMO HHMO & 3TPOS	[Visiting Member Services as described in Section 2: How to Obtain Services.]	This text will be omitted from the form when the benefit plan is a HDHP.

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Page(s)	Applicable Products	Variables	Explanations
3.1	DHMO HDHP HMO & 3TPOS	[Consultations and immunizations for foreign travel;]	This variable option are may be omitted separately at the request of the employer.
3.3	DHMO HDHP HMO & 3TPOS	[sixty (60) days][six (6) months]	The amount of days or months will be chosen by the employer.
3.6	DHMO HDHP HMO & 3TPOS	[Applied Behavior Analysis (ABA).]	This benefit will be included at the request of the employer.
3.6	DHMO HDHP HMO & 3TPOS	<b>[Chiropractic] [and] [Acupuncture] Services</b> <b>[[Chiropractic] [and] [Acupuncture] Services ... Services.]</b>	This provision will be included for custom plans that provide either chiropractic or chiropractic and acupuncture coverage as part of the base plan instead of by Rider.
3.6	DHMO HDHP HMO & 3TPOS	Under <b>Chiropractic and Acupuncture Services:</b> [We cover Medically Necessary outpatient acupuncture Services for chronic pain management or chronic illness management.]	This benefit will be included at the request of the employer.
3.6	DHMO HDHP HMO & 3TPOS	Under <b>Chiropractic and Acupuncture Services:</b> [and shall not exceed a total of [ten (10)-ninety (90)] visits per [contract][calendar][policy] year [for each type of Service][for chiropractic Services; and [ten (10)-ninety (90) visits per [contract][calendar][policy] year for acupuncture Services.]	These variables will be included for plans that limit the number of visits per year for each type of service.  These variables will be removed for plans that have unlimited visit, or that have a different visit limit for each service.
3.9	DHMO HDHP HMO & 3TPOS	Under <b>Drugs, Supplies and Supplements:</b> [and] [.]	These variables will be included if the group requests the exclusion of family planning services.

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3.9	DHMO HDHP HMO & 3TPOS	Under <b>Drugs, Supplies and Supplements</b> : [; and “Family Planning Services” for the insertion and removal of contraceptive drugs and devices.]	This text will be omitted when the employer group requests the exclusion of family planning services as permitted under 45 CFR §147.131 for non-Grandfathered plans.
3.9	DHMO HDHP HMO & 3TPOS	Under <b>Drugs, Supplies and Supplements</b> : [Refer to Infertility Services for coverage of administered drugs necessary for in vitro fertilization.]	This text will be omitted when an employer group requests the exclusion of in vitro fertilization from coverage.
3.13	DHMO HDHP HMO & 3TPOS	[ <b>Family Planning Services</b> ... see “X-ray, Laboratory and Special Procedures”).]	This entire benefit will be omitted when the employer group requests the exclusion of family planning services as permitted under 45 CFR §147.131.
3.13	DHMO HDHP HMO & 3TPOS	Under <b>Family Planning Services</b> : [Women’s Preventive Services ... no charge.)]	This provision will be used for non-grandfathered plans.  The entire WPS benefit description will be omitted when the employer group requests the exclusion of family planning services as permitted under 45 CFR §147.131.
3.9	All Non-Grandfathered Plans	Under <b>Family Planning Services</b> : 2. [Additional family planning counseling[, including pre-abortion and post-abortion counseling][.][;][; and] 3. [Vasectomies][.][;][; and] 4. [[Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (1) the fetus suffers from a chromosomal, major metabolic or anatomic defect or (2) the maintenance of the pregnancy would seriously	This provision will be used for non-grandfathered plans.  Each of these variable options are may be omitted separately at the request of the employer.

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		<p>jeopardize the life or health of the mother.]</p> <p><b><i>Voluntary Termination of Pregnancy Limitations:</i></b></p> <ul style="list-style-type: none"> <li>• We cover up to a maximum of two (2) voluntary terminations of pregnancy during a contract year.]</li> </ul>	
3.13	All grandfathered plans	<p>Under <b>Family Planning Services:</b></p> <ol style="list-style-type: none"> <li>1. [[Family planning counseling[, including pre-abortion and post-abortion counseling] and information on birth control.]</li> <li>2. [Insertion and removal and any Medically Necessary examination associated with the use of contraceptive drugs and devices. Contraceptive devices (other than diaphragms) and implantable contraceptive drugs are supplied by the provider, and are covered under this benefit. Contraceptive drug and diaphragms are covered only under an “Outpatient Prescription Drug Rider,” if applicable.]</li> <li>3. [Tubal ligations.]</li> <li>4. [Vasectomies.]</li> <li>5. [[Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (1) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (2) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.]</li> </ol>	<p>This provision will be used for grandfathered plans.</p> <p>These benefits are bracketed to be omitted from the form if an employer group decides to exclude any one or all of the benefits.</p>

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		<i>Voluntary Termination of Pregnancy Limitations:</i> We cover up to a maximum of two (2) voluntary terminations of pregnancy during a contract year.]	
3.13	DHMO HDHP HMO & 3TPOS	Under <b>Habilitative Services:</b> <u>[Children under age (21)]</u>	This variable will be included if Habilitative services are covered for Children under 21 years of age will be included if elected by employer.
3.14	DHMO HDHP HMO & 3TPOS	Under <b>Habilitative Services:</b> [Medical Necessary Services to treat autism and autism spectrum disorders shall include Applied Behavioral Analysis (ABA).]	This variable will be included if the employer elects to cover Medical Necessary Services to treat autism and autism spectrum disorders.
3.14	DHMO HDHP HMO & 3TPOS	Under <b>Family Planning Services:</b> <u>[Adults age 21 or older]</u> We cover Medically Necessary habilitative Services that are designed to enhance a Member's functional ability, without effecting a cure, for the treatment of autism or an autism spectrum disorder, "Medically Necessary habilitative Services" include occupational therapy, physical therapy, speech therapy and Applied Behavioral Analysis (ABA).]	This variable will be included if Habilitative services are covered for Adults age 21 or older in accordance with the Applied Behavioral Analysis (ABA).
3.14	DHMO HDHP HMO & 3TPOS	Under <b>Hearing Services:</b> <u>[Hearing Exams]</u> <u>[Hearing Aids ... upgrade.]</u>	These variables will be included when hearing tests and/or hearings aids are selected by the employer.
3.14	DHMO HDHP HMO & 3TPOS	Under <b>Hearing Services:</b> [twelve (12)-sixty (60)] months	This variable allows the group to select how frequently the Member is covered for additional hearing aids.

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3.14	DHMO HDHP HMO & 3TPOS	<p><b><i>Hearing Aid Limitations:</i></b></p> <ul style="list-style-type: none"> <li>• [Your hearing aid Benefit Allowance is [\$500 – \$5,000]].</li> <li>• [Coverage is provided for one Hearing Aid for each hearing impaired ear every [twelve (12) – sixty (60)] months. Two Hearing Aids are covered every [twelve (12) – sixty (60)] months only if both are required to provide significant improvement that is not obtainable with only one Hearing Aid, as determined by your Plan Provider.]</li> <li>• [You are not required to obtain Hearing Aids for both ears at the same time. The [twelve (12) – sixty (60)] month benefit period extends separately for each ear, and commences at the initial point of sale for each ear.]</li> <li>• [The hearing aid Benefit Allowance must be used at the initial point of sale for each hearing aid. Any part of the hearing aid Benefit Allowance that is not exhausted at the initial point of sale may not be used at a later time.]</li> <li>• [The type of Hearing Aid is limited to the models provided by Kaiser Permanente or the Kaiser Permanente-designated Hearing Aid vendor.]</li> </ul> <p>[You may apply the hearing aid Benefit Allowance toward a hearing aid upgrade. However, you must pay the difference in the hearing aid Benefit Allowance</p>	<p>Each of these variable options are may be omitted separately at the request of the employer.</p> <p>The dollar amount ranges and allowable month’s ranges will depend on the amount chosen by the employer.</p>

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		and the cost of the hearing aid upgrade.]	
3.15	DHMO HDHP HMO & 3TPOS	Under <b>Hearing Services</b> : [Tests to determine ... their efficacy.]	This variable will be included when hearing tests and hearings aids are selected by the employer.
3.15	DHMO HDHP HMO & 3TPOS	Under <b>Hearing Services</b> : [Replacement of ... coverage.]	This variable will be included when hearings aids are selected by the employer.
3.15	DHMO HDHP HMO & 3TPOS	Under <b>Home Health Care</b> : [Except as provided for under Visiting Member Services, we]  [We]	This text will be omitted from the EOC when the benefit plan is a HDHP and included in EOC when the benefit plan is HMO, DHMO, or POS.  The variable [We] will be used when the benefit plan is HDHP.
3.16	DHMO HDHP HMO & 3TPOS	[The visit maximum does not apply to home visits following mastectomy or testicle removal; or postpartum home visits.]	This variable will be used for custom groups that include a visit limit.
3.17	DHMO HDHP HMO & 3TPOS	[ <b>Infertility Services</b> ... to such procedures.]]	This entire benefit may be omitted from the form when an employer group requests the exclusion of in vitro fertilization from coverage.
3.17	DHMO HDHP HMO & 3TPOS	Under <b>Infertility Services</b> : [; and Artificial insemination[.]	This provision will be included if the employer elects to cover artificial insemination.
3.17	DHMO HDHP HMO & 3TPOS	Under <b>Infertility Services</b> : 3. [In vitro fertilization ... fertilization]	An employer who meets the exemption criteria may elect to only cover infertility and exclude in vitro fertilization.  This provision will be excluded if the employer elects

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			to cover only artificial insemination.
3.18	DHMO HDHP HMO & 3TPOS	<p>Under <b>Infertility Services:</b>  <i>[Infertility Limitations:</i></p> <ul style="list-style-type: none"> <li>• Coverage for in-vitro fertilization embryo transfer cycles[, including frozen embryo transfer (FET) procedure,] is limited to three attempts per live birth[, not to exceed a maximum lifetime benefit of \$100,000]].</li> </ul>	<p>The three attempts per live birth and/or the \$100,000 maximum benefit will be omitted at the request of the employer.</p> <p>This service is bracketed to allow an employer group to exclude coverage.</p>
3.18	DHMO HDHP HMO & 3TPOS	<p>Under <b>Infertility Services:</b></p> <ul style="list-style-type: none"> <li>• [Services to reverse voluntary, surgically induced infertility.]</li> <li>• [Infertility Services when the infertility is the result of an elective male or female sterilization surgical procedure.]</li> <li>• [Assisted reproductive technologies and procedures[ other than those described above], including, but not limited to: [[artificial insemination;] in vitro fertilization; ][ gamete intrafallopian transfers (GIFT); ][zygote intrafallopian transfers (ZIFT);] and prescription drugs related to such procedures.]]</li> </ul>	<p>The exclusions provisions will be omitted from the form when an employer group chooses not to limit coverage of in vitro fertilization for one or more of the variable options.</p> <p>These services are bracketed to allow an employer group to exclude coverage.</p>
3.21	DHMO HDHP HMO & 3TPOS	<p>Under <b>Preventive Health Care Services:</b>                      [In addition ... Services.]</p>	<p>This provision will be included in the form for non-grandfathered employer group benefit plans and grandfathered employer group benefit plans that elect the Patient Protection and Affordable Care Act preventive care package.</p>

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3.21	DHMO HDHP HMO & 3TPOS	Under <b>Preventive Health Care Services</b> : [www.uspreventiveservicestaskforce.org]; [http://www.cdc.gov/vaccines/acip/index.html]; [http://mchb.hrsa.gov];	The URLs are variable so they can be changed without refiling.
3.21	DHMO HDHP HMO & 3TPOS	Under <b>Preventive Health Care Services</b> : [We cover medically ... age.]	This provision will be included in the form for non-grandfathered employer group benefit plans and grandfathered employer group benefit plans that elect the Patient Protection and Affordable Care Act preventive care package.
3.22	DHMO HDHP HMO & 3TPOS	Under <b>Preventive Health Care Services</b> : [BRCA ... Service.]	This benefit will be included or removed at the request of the employer.
3.23	DHMO HDHP HMO & 3TPOS	Under <b>Prosthetic Devices</b> : [Hair Prostheses]	This variable will be included if the employer does not cover Hair Prostheses.
3.25	DHMO HDHP HMO & 3TPOS	Under <b>Therapy and Rehabilitation Services</b> : therapy[: ... or cleft palate.]	All limits may be excluded at the request of the employer.
3.25	DHMO HDHP HMO & 3TPOS	Under <b>Therapy and Rehabilitation Services</b> : 2. For up to [twenty (20)-ninety (90)] visits [or ninety (90) consecutive days] of physical therapy [whichever is longer], and [twenty (20)-ninety (90)] visits [or ninety (90) consecutive days] of occupational or speech therapy per [contract] [policy] [calendar] year per injury, incident or condition in a Plan Medical Center, a Plan	The appropriated visit limit will be included in the form based on the employer group's election.

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		Provider’s medical office, a Skilled Nursing Facility or as part of home health care. [These limits do not apply to necessary treatment of cleft lip or cleft palate.]	
3.26	DHMO HDHP HMO & 3TPOS	Under <b>Therapy and Rehabilitation Services:</b> <b><u>Cardiac Rehabilitation Services</u></b> [for up to twelve (12) weeks, or thirty-six (36) sessions, whichever occurs first]	The limit may be removed at the request of the employer.
3.26	DHMO HDHP HMO & 3TPOS	Under <b>Therapy and Rehabilitation Services:</b> <b><u>Pulmonary Rehabilitation Services</u></b> We cover pulmonary rehabilitation Services that are Medically Necessary; limited to one (1) program per lifetime.]	This benefit will be included at the request of the employer.
3.27	HDHP	<b>Vision [Exam] Services</b>	This variable is included for HDHP plans and omitted for HMO, DHMO and POS plans.
3.27	HDHP	Under <b>Vision Exam Services:</b> <b><i>[Vision Exam Services Exclusions:</i></b> <ul style="list-style-type: none"> <li>• All services related to vision correction, including but not limited to, eye examinations to determine the need for vision correction and to provide a prescription for corrective lenses.</li> <li>• Eyeglass lenses and eyeglass frames.</li> <li>• Eye exercises.</li> <li>• All Services related to contact lenses including examinations, fitting and dispensing, and follow-up visits.</li> </ul>	This variable is included for HDHP plans and omitted for HMO, DHMO and POS plans.

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		<ul style="list-style-type: none"> <li>• Orthoptic (eye training) therapy.</li> <li>• Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism, including but not limited to, radial keratotomy, photo-refractive keratectomy and similar procedures.]</li> </ul>	
3.27	DHMO HDHP HMO & 3TPOS	Under <b>Vision Exam Services:</b> [Note: Discounts are available for lenses and frames.]	The first instance of this variable will be omitted for HDHP plans. The second instance of this variable will be included for HMO, DHMO and POS plans.
3.27	DHMO HMO & 3TPOS	[ <b>Eye Exams</b> ... therapy.]	This provision is included if the employer elects to include coverage for routine eye exams for adults.
3.28	DHMO HMO & 3TPOS	Under <b>Vision Exam Services:</b> [ <b>Vision Exam Services Exclusions:</b> <ul style="list-style-type: none"> <li>• Eyeglass lenses and eyeglass frames.</li> <li>• Eye exercises.</li> <li>• All Services related to contact lenses including examinations, fitting and dispensing, and follow-up visits.</li> <li>• Orthoptic (eye training) therapy.]</li> </ul>	This exclusion is included if the employer elects not to cover lenses, frames and contact lenses. It is omitted if coverage is included for lenses, frames and contact lenses.
3.28	DHMO HMO & 3TPOS	[ <b>Pediatric Eye Exams</b> ... corrective lenses.]	This provision can be removed at the employer's request if they would like to make vision benefits available separately.
3.28	DHMO HMO & 3TPOS	[ <b>Pediatric Lenses and Frames</b> ... year.]	This provision can be removed at the employer's request if they would like to make vision benefits available separately.

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3.28	DHMO HMO & 3TPOS	[In addition, we cover the following Services: ... therapy.]	Lenses, Frames and Contact Lenses are included unless the employer elects to exclude this coverage.
3.28	DHMO HMO & 3TPOS	Under <b>Eyeglass Lenses:</b> [We provide a discount ... other eye.]	This provision will be included if the employer elects to cover eyeglass lenses and add-ons with a discount.
3.28	DHMO HMO & 3TPOS	Under <b>Eyeglass Lenses:</b> [We cover ... Optical Shop.]	This provision will be included if the employer elects to cover eyeglass lenses at no charge.
3.28	DHMO HMO & 3TPOS	Under <b>Frames:</b> [We provide a discount ... Optical Shop.]	This provision will be included if the employer elects to cover frames with a discount.
3.28	DHMO HMO & 3TPOS	Under <b>Frames:</b> [We cover the purchase... Optical Shop.]	This provision will be included if the employer elects to cover eyeglass frames at no charge.
3.28	DHMO HMO & 3TPOS	Under <b>Contact Lenses:</b> [We cover the [initial] purchase ... Optical Shop.]	This provision will be included if the employer elects to cover the purchase of contact lenses at no charge.  The variable [initial] will be included if the employer elects to cover only the initial purchase of contact lenses at no charge.
3.28	DHMO HMO & 3TPOS	Under <b>Contact Lenses:</b> [We cover the initial fitting ... Optical Shop.]	This provision will be included if the employer elects to cover the initial fitting of contact lenses at no charge.
3.28	DHMO HMO & 3TPOS	Under <b>Contact Lenses:</b> [We provide a discount ... Optical Shop.]	This provision will be included if the employer elects to cover contact lenses with a discount.
3.29	DHMO HMO & 3TPOS	Under <b>Contact Lenses:</b> [You will ... same time.]	This provision will be included if the employer covers contact lenses with a discount.

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3.29	DHMO HMO & 3TPOS	Under <b>Contact Lenses</b> : [Note: Additional ... Optical Shop.]	This note will be included if the employer covers contact lenses with a discount.
3.29	DHMO HMO & 3TPOS	<p><b>[Vision Exclusions:</b></p> <ul style="list-style-type: none"> <li>• Industrial and athletic safety frames.</li> <li>• Eyeglass lenses and contact lenses with no refractive value.</li> <li>• Sunglasses without corrective lenses unless Medically Necessary.</li> <li>• Any eye surgery solely for that the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), and astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).</li> <li>• Eye exercises.</li> <li>• Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section.</li> <li>• Replacement of lost, broken, or damaged lenses frames and contact lenses.</li> <li>• Plano lenses.</li> <li>• Lens adornment, such as engraving, faceting, or jewellery.</li> <li>• Low-vision devices.</li> <li>• Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits.</li> <li>• Orthoptic (eye training) therapy.]</li> </ul>	This exclusion is included if the employer elects not to cover lenses, frames and contact lenses. It is omitted if coverage is included for lenses, frames and contact lenses.

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<b>Page(s)</b>	<b>Applicable Products</b>	<b>Variables</b>	<b>Explanations</b>
3.29	DHMO HMO & 3TPOS	[Visiting Member Services ... Group Health Cooperative service area.]	<p>This benefit will be included if the employer elects to cover visiting member services subject to the same terms and conditions as benefit in the home service area. If elected the visiting member service benefit in Section 2 will be omitted.</p> <p>This benefit will always be omitted from the form when the benefit plan is a HDHP.</p>

# YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE

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## SECTION 3: BENEFITS

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The Services described in this “Benefits” section are covered only if all of the following conditions are met:

1. You are a Member on the date the Services are rendered;
2. [You have met any Deductible requirement described in the "Deductible" section of the Summary of Services and Cost Shares Appendix.]
3. The Services are provided:
  - a. By a Plan Provider; or
  - b. By a non-Plan Provider, subject to an approved referral as described in Section 2; and
  - c. In accordance with the terms and conditions ~~of this~~ within this EOC including but not limited to the requirements, if any, for prior approval (authorization);
4. The Services are Medically Necessary; and
5. You receive the Services from a Plan Provider except as described within this EOC.

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

1. Emergency Services;
2. Urgent Care outside our Service Area;
3. Authorized referrals to non-Plan Providers (as described in Section 2: [How to Obtain Services](#)) ~~[.]~~; and
4. [Visiting Member Services as described in Section 2: [How to Obtain Services](#).]

### Exclusions and Limitations:

Exclusions and limitations that apply only to a particular benefit are described in this section. Other exclusions, limitations, and reductions that affect all benefits are described in ~~the~~ [Section 4: “Exclusions, Limitations; and Reductions”](#) ~~section of this EOC~~.

**Note:** The “Summary of Services and Cost Shares” Appendix lists the Copayments, Coinsurances and Deductibles that apply to the following covered Services. Your Cost Share will be based on the type and place of Service.

## A. OUTPATIENT CARE

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We cover the following outpatient care:

1. Primary care visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics/gynecology ([OB/GYN](#)) Services (~~R~~Refer to “Preventive Health Care Services” for coverage of preventive care Services);
2. Specialty care visits (~~R~~Refer to “Referrals to Plan Providers” in ~~the~~ [Section 2: “How to Obtain Services”](#) ~~section~~ for information about referrals to Plan specialists);
3. [Consultations and immunizations for foreign travel;]
4. Diagnostic testing for care or treatment of an illness; or to screen for a disease for which you have been determined to be at high risk for contracting. This includes, but is not limited to:
5. Diagnostic exams, including digital rectal exams and prostate antigen (PSA) tests provided:
  - a. To persons age 40 and ~~over~~ older who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society;
6. Colorectal cancer screening, specifically: screening with an annual fecal occult blood test; flexible sigmoidoscopy or colonoscopy; or, ~~when appropriate~~ in appropriate circumstances, radiologic

## **YOUR GROUP EVIDENCE OF COVERAGE (EOC) KAISER PERMANENTE**

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imaging, for persons, who are at high risk of cancer. High risk is determined based on the most recently published guidelines of the American College of Gastroenterology, in consultation with the American Cancer Society;

7. Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A “qualified individual” means:
  - a. An estrogen deficient ~~person~~ individual at clinical risk for osteoporosis;
  - b. ~~a person~~ An individual with a specific sign suggestive of spinal osteoporosis. This includes: roentgeno-graphic osteopenia or roentgen-ographic evidence suggestive of collapse; wedging; or ballooning of one or more thoracic or lumbar vertebral bodies; and who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
  - c. ~~a person~~ An individual receiving long-term gluco-corticoid (steroid) therapy;
  - d. An individual ~~a person~~ with primary hyper-parathyroidism; or
  - e. An individual ~~a person~~ being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;
8. Outpatient surgery physician/surgical Services;
9. Anesthesia, including Services of an anesthesiologist;
10. Chemotherapy and radiation therapy;
11. Respiratory therapy;
12. Medical social Services;
13. House calls when care can best be provided in your home as determined by a Plan Provider; and
14. After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to the Urgent Care provision for covered Services.

(Refer to “Preventive Health Services” for coverage of preventive care tests and screening Services);

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

### **B. HOSPITAL INPATIENT CARE**

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

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

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

### C. ACCIDENTAL DENTAL INJURY SERVICES

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We cover restorative Services necessary to promptly repair, but not replace, ~~s~~Sound ~~n~~Natural ~~T~~Teeth that have been injured as the result of an external force. Coverage is provided when all of the following conditions have been met:

1. The accident has been reported to your primary care Plan Physician within seventy-two (72) hours of the accident.
2. A Plan Provider provides the restorative dental Services;
3. The injury occurred as the result of an external force: ~~“External force” is~~ that is defined as violent contact with an external object; not force incurred while chewing;
4. The injury was sustained to ~~s~~Sound ~~N~~natural ~~T~~Teeth;
5. The covered Services must be requested within [sixty (60) days][six (6) months] of the injury; and
6. The covered Services are provided during the twelve (12) consecutive month period commencing from the date that the injury ~~occurred~~started.

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

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

#### *Accidental Dental Injury Services Exclusions:*

- Services provided by non-Plan Providers.
- Services provided after twelve (12) months from the date the injury occurred.
- Services for teeth that have been avulsed (knocked out) or that have been so severely damaged that in the opinion of the Plan Provider, restoration is impossible.

### D. ALLERGY SERVICES

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We cover the following allergy Services:

- Evaluations, and treatment ; and
- Injections and serum.

### E. AMBULANCE SERVICES

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We cover licensed ambulance Services only if your medical condition requires: (1) the basic life support, advanced life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer; and (2) the ambulance transportation has been ordered by a Plan Provider. Coverage is also provided for Medically Necessary transportation or Services, including Medically Necessary air ambulance transport to the nearest hospital able to provide needed Services, rendered as the result of a 911 call. Your Cost Share will apply to each encounter, whether or not transport was required.

Ambulance transportation from an emergency room to a Plan Facility or from a hospital to a Plan Facility that

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is both Medically Necessary and ordered by a Plan Provider is covered at no charge.

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

We cover licensed ambulance and non-emergent transportation Services ordered by a Plan Provider only inside our Service Area, except as covered under the “Emergency Services” provision in this section. ~~of the EOC.~~

### *Ambulance Services Exclusions:*

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

## **F. ANESTHESIA FOR DENTAL SERVICES**

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

1. For whom a superior result can be expected from dental care provided under general anesthesia; and
2. For whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual or other medically compromising condition.

Additionally, we provide these Services to Members age:

1. 7 or younger or are developmentally disabled.
2. 17 or younger who is extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred, and for whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.
3. 17 and older when the Member’s medical condition requires that dental service be performed in a hospital or ambulatory surgical center for the safety of the Member (e.g., heart disease and hemophilia).

~~We cover general anesthesia and associated hospital or ambulatory surgical center Services for dental care provided to Members:~~

- ~~1. Who are 7 years of age or younger or are developmentally disabled;~~
- ~~2. For whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition; and~~
- ~~3. For whom a superior result can be expected from dental care provided under general anesthesia; or~~
- ~~4. Who are 17 years of age or younger who is extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred; and~~
- ~~5. Whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity; or~~
- ~~6. For adults age 17 and older when the Member’s medical condition requires that dental service be performed in a hospital or ambulatory surgical center for the safety of the Member (e.g., heart disease and hemophilia).~~

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General anesthesia and associated hospital and ambulatory surgical center charges will be covered only for dental care that is provided by:

1. A fully accredited specialist in pediatric dentistry; or
2. A fully accredited specialist in oral and maxillofacial surgery; and
3. For whom hospital privileges has~~ve~~ been granted.

***Anesthesia for Dental Services Exclusions:***

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

### **G. BLOOD, BLOOD PRODUCTS AND THEIR ADMINISTRATION**

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We cover; blood ~~and~~ ~~blood~~ ~~products, both derivatives and components~~ ~~products, both derivatives and components, i~~ including the collection and storage of autologous blood for elective surgery; cord blood procurement and storage for approved Medically Necessary care, when authorized by a Plan Provider; and the administration of prescribed whole blood and blood products.

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

***Blood, Blood Products and their Administration Limitations:***

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

***Blood, Blood Products and their Administration Exclusions:***

- Directed blood donations.

### **H. CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES**

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We cover the treatment of treatable mental illnesses, emotional disorders, drug abuse and alcohol abuse for conditions that in the opinion of a Plan Provider, would be responsive to therapeutic management.

For the purposes of this benefit provision: "Drug and alcohol abuse" means a disease that is characterized by a pattern of pathological use of a drug and/or alcohol with repeated attempts to control its use and with significant negative consequences in at least one the following areas of life: medical; legal; financial; or psycho-social.

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

1. Individual therapy;
2. Group therapy;
3. Shock therapy;
4. Drug therapy;
5. Education;
6. Psychiatric nursing care; and
7. Appropriate hospital Services.

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Medical Services for detoxification are limited to the removal of the toxic substance or substances from the system. Detoxification will be covered for a minimum of [twelve \(12\)](#) days annually.

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

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

In an outpatient setting, we cover all ~~necessary~~ [Medically Necessary](#) Services of physicians and other health care professionals as performed, prescribed, or directed by a physician including, but not limited to:

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

### ***Chemical Dependency and Mental Health Services Exclusions:***

- Services in a facility whose primary purpose is to provide treatment for alcoholism, drug abuse, or drug addiction, except as described above.
- Services provided in a psychiatric residential treatment facility, except as described above.
- Services for Members who, in the opinion of the Plan Provider, are seeking Services for non-therapeutic purposes.
- [Applied Behavior Analysis (ABA).]
- Cognitive Behavior Therapy (CBT).
- Psychological testing for ability, aptitude, intelligence, or interest.
- Services on court order or as a condition of parole or probation, unless determined by the Plan Provider to be Medically Necessary.
- Evaluations that are primarily for legal or administrative purposes, and are not Medically Necessary.

### **I. [\[CHIROPRACTIC \[AND\] \[ACUPUNCTURE\] SERVICES](#)**

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

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

### ***Chiropractic [\[and\] \[Acupuncture\] Services Limitation:](#)***

The number of visits needed for the Member to reach the maximum level of recovery will be determined by the Plan Provider [and shall not exceed a total of [\[ten \(10\)-ninety \(950\)\]](#) visits per [contract][calendar][policy] year [\[for each type of Service\]\[for chiropractic Services\]; and \[ten \(10\)-ninety \(90\) visits per \[contract\]\[calendar\]\[policy\] year for acupuncture Services.\]](#)

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### **J. CLEFT LIP, CLEFT PALATE OR BOTH**

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

### **K. CLINICAL TRIALS**

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We cover the routine patient care costs you may incur as an eligible participant in an approved clinical trial undertaken for the purposes of: the prevention, early detection, treatment; or monitoring of cancer, chronic disease, or life-threatening illness.

For the purposes of this benefit, an approved clinical trial means:

1. A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
  - a. The National Institutes of Health ([NIH](#));
  - b. The Centers for Disease Control and Prevention ([CDC](#));
  - c. The Agency for Health Care Research and Quality;
  - d. The Centers for Medicare and Medicaid Services;
  - e. A bona fide clinical trial cooperative group, including: the National Cancer Institute Clinical Trials Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the AIDS Clinical Trials Group; and the Community Programs for Clinical Research in AIDS; or
  - f. The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;
2. A study or investigation approved by the [United States](#) Food and Drug Administration (“FDA”), including those conducted under an investigational new drug or device application reviewed by the FDA; or
3. An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

“Routine patient care costs” mean:

1. Items, drugs, and Services that are typically provided absent a clinical trial;
2. Items, drugs, and Services required solely for the provision of the investigational item or service (such as the administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
3. Items, drugs, and Services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

#### ***Clinical Trials Exclusions:***

Routine patient care costs shall not include:

- The cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or items, drugs, or Services provided solely to satisfy data collection and analysis needs; or
- Items, drugs, or Services customarily provided by the research sponsors free of charge for any qualified individual enrolled in the trial.

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**Note:** Coverage will not be restricted solely because the Member received the Service outside [of](#) the Service Area or the Service was provided by a non-Plan Provider.

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

### **L. DIABETIC EQUIPMENT, SUPPLIES, AND SELF-MANAGEMENT**

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

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

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

#### ***Diabetic Equipment and Supplies Limitation:***

Diabetic equipment and supplies are limited to Health Plan preferred equipment and supplies unless the equipment or supply: (1) was prescribed by a Plan Provider; and (2) (a) there is no equivalent preferred equipment or supply available; or (b) an equivalent preferred equipment or supply (i) has been ineffective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member. "Health Plan preferred equipment and supplies" are those purchased from a Plan preferred vendor.

[To obtain information about Plan preferred vendors, contact Member Services:](#)

[\[Inside the Washington, DC Metropolitan Area: \(301\) 468-6000\]](#)

[\[Outside of the Washington, DC Metropolitan Area: 1-800-777-7902\]](#)

[\[TTY: 711\]](#)

### **M. DIALYSIS**

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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 Provider 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 lab tests, equipment, supplies and other Services associated with your treatment; ~~and~~
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~~

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3. Plan Provider Services related to inpatient and outpatient dialysis.

We cover the following self-dialysis Services:

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

We cover home dialysis, which includes:

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

[Members requiring dialysis outside of the service area for a limited time period, may receive pre-planned dialysis services in accordance to prior authorization requirements.](#)

### **N. DRUGS, SUPPLIES, AND SUPPLEMENTS**

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#### **Administered Drugs, Supplies and Supplements**

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

1. Oral infused or injected drugs, and radioactive materials used for therapeutic purposes, including chemotherapy;
2. Injectable devices;
3. The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
4. Medical and surgical supplies including: dressings; splints; casts; hypodermic needles; syringes; or any other Medically Necessary supplies provided at the time of treatment;
5. Vaccines and immunizations approved for use by the ~~federal Food and Drug Administration (FDA)~~ that are not considered part of routine preventive care.

**Note:** Additional Services that require administration or observation by medical personnel are covered. See the “Outpatient Prescription Drugs Rider,”<sup>2</sup> if applicable, for coverage of self-administered outpatient prescription drugs; “Preventive Health Care Services” for coverage of vaccines and immunizations that are part of routine preventive care; [and] “Allergy Services” for coverage of allergy test and treatment materials[.]; and “Family Planning Services” for the insertion and removal of contraceptive drugs and devices, if applicable.]

#### ***Drugs, Supplies and Supplements Exclusions:***

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

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## **O. DURABLE MEDICAL EQUIPMENT**

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

Durable Medical Equipment does not include coverage for prosthetic devices, such as implants, artificial eyes or legs, or orthotic devices, such as braces or therapeutic shoes. Refer to “Prosthetic Devices” for coverage of internal prosthetic devices, ostomy and urological supplies and breast prosthesis. Additional coverage for external prosthesis and orthotic devices is only covered if a Prosthetic and Orthotic Devices Rider is attached to this EOC.

### **Basic Durable Medical Equipment**

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

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

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

### **Supplemental Durable Medical Equipment**

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

#### **Oxygen and Equipment**

We cover oxygen and equipment when prescribed by a Plan Provider and your medical condition meets the Health Plan’s criteria for being Medically Necessary. A Plan Provider must certify the continued medical need for oxygen and equipment ~~every 30 days~~.

#### **Positive Airway Pressure Equipment**

We cover continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BIPAP) equipment when prescribed by a Plan Provider and your medical condition meets the Health Plan’s criteria for being Medically Necessary. A Plan Provider must certify the continued medical need ~~every 30 days~~ [for positive airway pressure equipment](#).

#### **Apnea Monitors**

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

#### **Asthma Equipment**

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

1. Spacers
2. Peak-flow meters

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### 3. Nebulizers

#### **Bilirubin Lights**

We cover bilirubin lights for infants, who are under age 3, for a period not to exceed [six \(6\)](#) months.

#### ***Durable Medical Equipment Exclusions:***

- Comfort, convenience, or luxury equipment or features.
- Exercise or hygiene equipment.
- Non-medical items such as sauna baths or elevators.
- Modifications to your home or car.
- Devices for testing blood or other body substances (except as covered under “Diabetes Equipment, Supplies and Self-Management”).
- Electronic monitors of the heart or lungs, except infant apnea monitors.
- Services not preauthorized by the Health Plan.

### **P. EMERGENCY SERVICES**

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

If you think you are experiencing an Emergency Medical Condition you should call 911 immediately. If you are not sure whether you are experiencing an Emergency Medical Condition, please contact us at the number listed on the reverse side of your ID card for immediate medical advice. You or your representative must notify the Health Plan as soon as possible, [and](#) not to exceed forty-eight (48) hours or the ~~next-1<sup>st</sup>~~ business day, whichever is later, if you receive care at a hospital emergency room (ER) to ensure coverage. If the emergency room visit was not due to an “Emergency Medical Condition,” as defined in the [“Definitions”<sup>2</sup>](#) Appendix ~~of this EOC~~, and was not authorized by [the](#) Health Plan, you will be responsible for all charges.

We cover Emergency Services as follows:

#### **Inside our Service Area**

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

#### **Outside [of](#) our Service Area**

We cover reasonable charges for Emergency Services if you are injured or become ill while temporarily outside [of](#) our Service Area.

We do not cover Services for conditions that, before leaving the Service Area, you should have known might require Services while you are away, such as: dialysis for ~~end-stage renal disease~~ [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.

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## **Continuing Treatment Following Emergency Services**

### **Inside our Service Area**

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

### **Inside another Kaiser Permanente Region**

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

### **Outside our Service Area**

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

### **Transport to a Service Area**

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

## **Continued Care in Non-Plan Facility Limitation**

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

## **Filing Claims for Non-Plan Emergency Services**

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

## **Emergency Services HIV Screening Test**

We cover the cost of a voluntary HIV screening test performed on a Member while the Member is receiving emergency medical Services, other than HIV screening, at a hospital emergency room. The test is covered whether or not the HIV screening test is necessary for the treatment of the medical emergency which caused the member to seek Emergency Services.

Covered Services include:

1. The costs of administering such a test;
2. All lab costs to analyze the test; and
3. The costs of telling the Member the results of the test; and any applicable follow-up instructions for obtaining health care and supportive Services.

Other than the Cost Share shown in the Summary of Services and Cost Shares for Emergency Services, no additional Cost Share will be imposed for these Services.

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### *Emergency Services Limitations:*

- **Notification:** If you receive care at a hospital emergency room or are admitted to a non-Plan Hospital, you, or someone on your behalf, must notify us as soon as possible, but not later than 48 hours or the next business day, whichever is later, of the emergency room visit or hospital admission, unless it was not reasonably possible to notify us. If you are admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us as provided herein, we will not cover the emergency room visit, or hospital care you receive after transfer would have been possible.
- **Continuing or Follow-up Treatment:** Except as provided for under “Continuing Treatment Following Emergency Surgery,” we do not cover continuing or follow-up treatment after Emergency Services unless authorized by Health Plan. We cover only the out-of-Plan emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Foundation Health Plan or allied plan service area.
- **Hospital Observation:** Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit copayment will not be waived.

### **Q. [FAMILY PLANNING SERVICES**

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We cover the following:

1. [Women’s Preventive Services (WPS), including:
  - a. Patient education and contraceptive method counseling for all women of reproductive capacity;
  - b. Coverage for: FDA-approved contraceptive devices; hormonal contraceptive methods; and the insertion or removal of contraceptive devices. This includes any Medically Necessary exams associated with the use of contraceptive drugs and devices; and
  - c. Female sterilization.
    - i. (Note: WPS are preventive care and are covered at no charge.)]
2. [Additional family planning counseling[, including pre-abortion and post-abortion counseling][.][;][; and]
3. [Vasectomies][.][;][; and]
4. [[Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (i) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (ii) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.]

### *Voluntary termination of pregnancy limitations:*

- We cover up to a maximum of two voluntary terminations of pregnancy during a contract year.]]
- 1. [[Family planning counseling [, including pre-abortion and post-abortion counseling] and information on birth control.]
- 2. [Insertion and removal, and any Medically Necessary exams associated with the use of contraceptive drugs and devices. Contraceptive devices (other than diaphragms) and implantable contraceptive drugs are supplied by the provider, and are covered under this benefit. Contraceptive drugs and diaphragms are covered only under an “Outpatient Prescription Drug Rider”, if applicable.]

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3. [Tubal ligations.]
4. [Vasectomies.]
5. [[Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (i) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (ii) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.]

### ***Voluntary termination of pregnancy limitations:***

- We cover up to a maximum of two (2) voluntary terminations of pregnancy during a contract year.]]

**Note:** Diagnostic procedures are covered, but not under this section (see “X-ray, Laboratory and Special Procedures”).]

## **R. HABILITATIVE SERVICES**

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### **[Children under age 21]**

We cover Medically Necessary Services, including speech therapy, occupational therapy and physical therapy, for children under the age of 21 years with a congenital or genetic birth defect, to enhance the child’s ability to function. Medically Necessary Habilitative Services are those Services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, and shall include Services that enhance functional ability without effecting a cure. Congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. The term congenital or genetic birth defect includes: (1) autism or an autism spectrum disorder and (2) cerebral palsy.

[Medical ~~Necessity~~-Necessary Services to treat autism and autism spectrum disorders shall include Applied Behavioral Analysis (ABA).]

### **[Adults age 21 or older]**

We cover Medically Necessary Habilitative Services that are designed to enhance a Member's functional ability, without effecting a cure, for the treatment of autism or an autism spectrum disorder, "Medically Necessary Habilitative Services" include occupational therapy, physical therapy, speech therapy, and (ABA).]

### ***Habilitative Services Exclusions:***

- Assistive technology Services and devices.
- Services provided through federal, state or local early intervention programs, including school programs.
- Services not preauthorized by Health Plan.
- Services for a Member that has plateaued and is able to demonstrate stability of skills and functioning even when Services are reduced.
- Services not provided by a licensed or certified therapist.

## **S. HEARING SERVICES**

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### **[Hearing Exams]**

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

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### **Hearing Aids**

We cover the following:

1. Medically Necessary hearing aids for both children and adults. Hearing aid means an electronic device worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing including an ear mold, if necessary.
2. Hearing aid evaluations and diagnostic procedures to determine the hearing aid model which will best compensate for loss of hearing.
3. Visits to verify that the hearing aid conforms to the prescription.
4. Visits for fitting, counseling, adjustment, cleaning, and inspection.

### ***Hearing Aid Limitations:***

- [Your hearing aid Benefit Allowance is [\$500 – \$5,000].
- [Coverage is provided for one Hearing Aid for each hearing impaired ear every [~~twelve (12)~~ – ~~sixty (60)~~] months. Two Hearing Aids are covered every [~~twelve (12)~~ – ~~sixty (60)~~] months only if both are required to provide significant improvement that is not obtainable with only one Hearing Aid, as determined by your Plan Provider.]
- [You are not required to obtain Hearing Aids for both ears at the same time. The [~~twelve (12)~~ – ~~sixty (60)~~] month benefit period extends separately for each ear, and commences at the initial point of sale for each ear.]
- [The hearing aid Benefit Allowance must be used at the initial point of sale for each hearing aid. Any part of the hearing aid Benefit Allowance that is not exhausted at the initial point of sale may not be used at a later time.]
- [The type of Hearing Aid is limited to the models provided by Kaiser Permanente or the Kaiser Permanente-designated Hearing Aid vendor.]

[You may apply the hearing aid Benefit Allowance toward a hearing aid upgrade. However, you must pay the difference in the hearing aid Benefit Allowance and the cost of the hearing aid upgrade.]]

### ***Hearing Services Exclusions:***

- [Tests to determine an appropriate hearing aid; ~~and~~
- Hearing aids or tests to determine their efficacy.]
- [Replacement of parts and batteries.]
- Replacement of lost or broken hearing aid.]
- Repair of hearing aid beyond one year.]
- Comfort, convenience, or luxury equipment or features.]
- Hearing aids prescribed and ordered prior to coverage or after termination of coverage]

## **T. HOME HEALTH CARE**

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

1. Skilled nursing care
2. Home health aide Services: and
3. Medical social Services.]

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

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

### **Home Health Visits Following Mastectomy or Removal of Testicle**

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

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

### ***Home Health Care Limitations:***

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

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

Additional limitations may be stated in the "Summary of Services and Cost Share."

### ***Home Health Care Exclusions:***

- Custodial care (see definition in ~~the Section 4: "Exclusions, Limitations, and Reductions"~~ section of this EOC).
- Routine administration of oral medications, eye drops, and/or ointments.
- General maintenance care of colostomy, ileostomy, and ureterostomy.
- Medical supplies or dressings applied by a Member or family caregiver.
- Corrective appliances, artificial aids, and orthopedic devices.
- Homemaker Services.
- Care that a Plan Provider determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, and we provide or offer to provide that care in one of these facilities.
- Services not preauthorized by the Health Plan.
- Transportation and delivery service costs of Durable Medical Equipment, medications, drugs, medical supplies and supplements to the home.

## **U. HOSPICE CARE**

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

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the home if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

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

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

### **Definitions:**

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

### **V. [INFERTILITY SERVICES]**

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We cover the following:

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

### **Note[s]:**

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

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3. [ [In vitro fertilization, if:
  - a. [The Member's oocytes are fertilized with the Member's spouse's sperm; and]
  - b. The [Member has][Member's and the Member's spouse have] a history of infertility of at least two (2) years duration; or the infertility is associated with any of the following:
    - i. Endometriosis;
    - ii. Exposure in utero to diethylstilbestrol, commonly known as DES;
    - iii. Blockage of, or surgical removal of, one (1) or both fallopian tubes (lateral or bilateral salpingectomy); or
    - iv. Abnormal male factors, including oligospermia, contributing to the infertility;
  - c. The Member has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this EOC; and
  - d. The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or the American Fertility Society minimal standards for programs of in vitro fertilization.]
4. Intracytoplasmic Sperm Injection (ICSI) if the Member meets medical guidelines;
5. Preimplantation Genetic Diagnosis (PGD) if the Member meets medical guidelines[.];]
6. [Gamete intrafallopian transfers (GIFT); and
7. Zygote intrafallopian transfers (ZIFT).]

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

### ***[Infertility Limitations:***

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

### ***Infertility Services Exclusions:***

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

## **W. INFUSION THERAPY SERVICES**

We cover Services for infusion therapy, which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion Services also include enteral nutrition, which

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is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parentally. Infusion services may be received at multiple sites of service, including facilities, professional provider offices, and ambulatory infusion centers and from home infusion providers. The Cost Share amount will apply based on the place and type of Service provided.

### **W.X. MATERNITY SERVICES**

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We cover obstetrical Services for pre-and post-natal services, which includes routine and non-routine office visits, x-ray, lab and specialty tests. The Health Plan covers birthing classes and breastfeeding support, supplies, and counseling from trained providers during pregnancy and/or in the postpartum period.~~routine global maternity care; care for conditions that existed prior to pregnancy; care for high risk conditions that develop during pregnancy; and non-routine obstetrical care.~~

~~“Routine global maternity” means care provided after the first visit where pregnancy is confirmed, and includes all of the following Services, subject to a Cost Share: (a) the normal series of regularly scheduled preventive prenatal care exams; (b) physician charges for labor and delivery, including cesarean section; and (c) routine postpartum follow up consultations and exams.~~

Services for pre-existing conditions care related to the development of a high risk condition(s) during pregnancy, and non-routine obstetrical care are covered subject to applicable Cost Share for specialty, diagnostic, and/or treatment Services.

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

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

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

Comprehensive lactation (breastfeeding) education and counseling, by trained clinicians during pregnancy and/or postpartum period in conjunction with each birth, Breastfeeding equipment is issued, per pregnancy. The breast feeding pump (including any equipment that is required for pump functionality) is covered for six (6) months at no cost sharing to the member.

#### **Maternity Services Exclusions**

- Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.

### **X.Y. MEDICAL FOODS**

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We cover medical foods and low protein modified food products for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry including a disease for which the State screens newborn babies. Coverage is provided if the medical foods and low protein food products are prescribed as

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Medically Necessary for the therapeutic treatment of inherited metabolic diseases, and are administered under the direction of a Plan Provider.

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

Low protein modified foods are food products that are (1) specially formulated to have less than one (1) gram of protein per serving, and (2) intended to be used under the direction of a Plan Provider for the dietary treatment of an inherited metabolic disease.

### **Medical Foods Exclusions:**

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

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

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

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

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

### **Amino Acid Based Elemental Formula Exclusions:**

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

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

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

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

### ~~**Medical Foods Exclusions:**~~

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

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### Y.Z. MORBID OBESITY

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We cover diagnosis and treatment of morbid obesity including gastric bypass surgery or other surgical method that is recognized by the National Institutes of Health ([NIH](#)) as effective for long-term reversal of morbid obesity, and is consistent with criteria approved by the ~~National Institutes of Health~~[NIH](#).

Morbid obesity is defined as:

1. A weight that is at least [one-hundred \(100\)](#) pounds over or twice the ideal weight for a patients frame, age, height, and gender, as specified in the 1983 Metropolitan Life Insurance tables; or
2. A body mass index (BMI) that is equal to or greater than [thirty-five \(35\)](#) kilograms per meter squared with a comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary condition, sleep apnea, or diabetes; or
3. A BMI of [forty \(40\)](#) kilograms per meter squared without such comorbidity.

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

#### ***Morbid Obesity Services Exclusions***

- Services not preauthorized by [the Health Plan](#)

### Z.AA. ORAL SURGERY

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

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

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

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

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

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

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

[The Health Plan](#) provides coverage for cleft lip, ~~and~~ cleft palate [or both](#) under a separate benefit. Please see ~~the "Cleft Lip, Cleft Palate, or Both" section of this EOC for coverage~~ [in this section](#).

#### ***Oral Surgery Exclusions:***

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

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- Medical and dental Services for treatment ~~of the condition commonly referred to as~~ TMJ ~~(temporomandibular joint syndrome)~~.
- Orthodontic Services.
- Dental appliances.

### AA.BB. PREVENTIVE HEALTH CARE SERVICES

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

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

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

[We cover medically appropriate preventive health care Services based on your age, sex, or other factors, as determined by your primary care Plan Physician pursuant to national preventive health care standards.

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

1. Preventive care exams, including:
  - a. Routine physical examinations and health screening tests appropriate to your age and sex;
  - b. Well-woman examinations; and
  - c. Well child care examinations;
2. Routine and necessary immunizations [(travel immunizations are not preventive and are covered under Outpatient Services in this section)] for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;

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3. An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
4. Low dose screening mammograms to determine the presence of breast disease is covered as follows:
  - a. One mammogram for persons age 35 through 39;
  - b. One mammogram biennially for persons age 40 through 49; and
  - c. One mammogram annually for person 50 and over;
5. Bone mass measurement to determine risk for osteoporosis;
6. Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to men who are age 40 or older;
7. Colorectal cancer screening in accordance with screening guidelines issued by the American Cancer Society including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy;
8. Cholesterol test (lipid profile);
9. Diabetes screening (fasting blood glucose test);
10. Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis and HPS), subject to the following:
  - a. Annual chlamydia screening is covered for ~~(1a)~~ women under ~~the~~ age of 20, if they are sexually active; and ~~(2b)~~ women age 20 years of age or older, and men of any age, who have multiple risk factors, which include: ~~(i)~~ a prior history of sexually transmitted diseases; (ii) new or multiple sex partners; (iii) inconsistent use of barrier contraceptives; or (iv) cervical ectopy;
  - b. Human Papillomavirus Screening (HPS) as recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;
11. HIV tests;
12. TB tests;
13. Newborn hearing screenings that include follow up audiological examinations, as recommended by a physician or audiologist, and performed by a licensed audiologist to confirm the existence or absence of hearing loss when ordered by a Plan Provider; [and]
14. Associated preventive care radiological and lab tests not listed above[.]; and]
15. [BRCA counseling and genetic testing is covered a no Cost Share. Any follow up Medically Necessary treatment is covered at the applicable Cost Share based upon type and place of Service-][.]; and]
16. CT scan of the Thorax when ordered as a preventive for smokers age 55 to 80 years of age.]

### ***Preventive Health Services Limitation:***

While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services. Applicable Cost Shares will apply.

- Monitoring a chronic disease;
- Follow-up Services after you have been diagnosed with a disease;
- Testing and diagnosis for specific diseases for which you have been determined to be at high risk for contracting based on factors determined by national standards;
- Services provided when you show signs or symptoms of a specific disease or disease process;
- Non-routine gynecological visits; and
- Treatment of a medical condition or problem identified during the course of a preventive screening exam.

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

### **BB.CC. PROSTHETIC DEVICES**

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We cover the devices listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is ill or injured. Coverage includes fitting and adjustment of these devices, repair or replacement (unless due to loss or misuse), and Services to determine whether you need the prosthetic. If we do not cover the prosthetic, we will try to help you find facilities where you may obtain what you need at a reasonable price. Coverage is limited to the standard device that adequately meets your medical needs.

#### **Internally Implanted Devices**

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

#### **Ostomy and Urological Supplies**

We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets [the](#) Health Plan’s criteria for Medical Necessity.

#### **Breast Prosthetics**

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

#### ***Breast Prosthetics Limitation:***

- Coverage for mastectomy bras is limited to a maximum of two (2) per [calendar][contract] [policy] year.

#### ***Prosthetic Devices Exclusions:***

- Services not preauthorized by Health Plan.
- Internally implanted breast prosthetics for cosmetic purposes.
- External prosthetics, except as provided in this ~~S~~ection under “Cleft-Lip, Cleft Palate, or Both”, “Hearing Services”, or as provided under a “Prosthetic and Orthotic Devices Rider”, if applicable.
- Repair or replacement of prosthetics devices due to loss or misuse.
- [\[Hair Prostheses.\]](#)
- Microprocessor and robotic controlled external prosthetics and orthotics that does not meet [the](#) Health Plan criteria ~~as for Medical Necessity~~[Necessary](#).
- Multifocal intraocular lens implants.

### **CC.DD. RECONSTRUCTIVE SURGERY**

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We cover reconstructive surgery. This shall include plastic, cosmetic and related procedures required to: ~~-(a1)~~ to correct significant disfigurement resulting from an injury or Medically Necessary surgery, ~~(b2)~~ to correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function, and

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(e3) to treat congenital hemangioma known as port wine stains on the face for Members age 18 or younger, (d4) breast augmentation is covered only if determined to be ~~a medical necessity~~ Medical Necessary.

Following mastectomy, we ~~also~~ cover reconstructive breast surgery and all stages of reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. Mastectomy is the surgical removal of all or part of a breast as a result of breast cancer. Reconstructive breast surgery is surgery performed as a result of a mastectomy to reestablish symmetry between the two (2) breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

### ***Reconstructive Surgery Exclusions:***

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

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

### **DD.EE. SKILLED NURSING FACILITY CARE**

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

We cover the following Services:

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

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

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

### ***Skilled Nursing Facility Care Exclusions:***

- Custodial care (see definition under “Exclusions” in ~~the Section 4: “Exclusions, Limitations, and Reductions”~~ section of this EOC).
- Domiciliary care.

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### **EE.FF. – TELEMEDICINE SERVICES**

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

Telemedicine Services means the delivery of healthcare Services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Not all medical services are conducive to telemedicine, as such the provider will make a determination whether the member should instead be seen in a face-to-face medical office setting.

#### ***Telemedicine Services Exclusion:***

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

### **FF.GG. THERAPY AND REHABILITATION SERVICES**

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#### **Physical, Occupational, and Speech Therapy Services**

If, in the judgment of a Plan Provider, significant improvement is achievable within a two (2)-month period, we cover physical, occupational and speech therapy[:

1. While you are confined in Plan Hospital; and
2. For up to [twenty (20)-ninety (90)] visits [or] ninety (90) consecutive days] of physical therapy [whichever is longer], and [twenty (20)-ninety (90)] visits [or] ninety (90) consecutive days] of occupational or speech therapy per [contract] [policy] [calendar] year per injury, incident or condition in a Plan Medical Center, a Plan Provider’s medical office, a Skilled Nursing Facility or as part of home health care. [These limits do not apply to necessary treatment of cleft lip or cleft palate.]
- ~~2. For up to [20-90 visits] [90 consecutive days of treatment] per injury, incident or condition for each therapy in a Plan Medical Center, a Plan Provider’s medical office, or a Skilled Nursing Facility, or as part of home health care. This limit does not apply to necessary treatment of cleft lip or cleft palate.]~~

#### ***Physical, Occupational, and Speech Therapy Services Limitations:***

- Physical therapy is limited to treatment to restore physical function that was lost due to injury or illness. It is not covered to develop physical function, except as provided for under “Habilitative Services” in this section.
- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Speech therapy is limited to treatment for speech impairments due to injury or illness.

#### **Multidisciplinary Rehabilitation Services**

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

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

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## ***Multidisciplinary Rehabilitation Services Limitations:***

- The limitations listed above for physical, occupation and speech therapy also applies to those Services when provided within a multidisciplinary program.

## **Cardiac Rehabilitation Services**

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

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

## **[Pulmonary Rehabilitation Services**

We cover pulmonary rehabilitation Services that are Medically Necessary; limited to one [\(1\)](#) program per lifetime.]

## ***Therapy and Rehabilitation Services Exclusions:***

- Long-term rehabilitative therapy.

## **GG.HH. TRANSPLANT SERVICES**

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

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

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

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

## ***Transplant Services Exclusions:***

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

## **HH.II. URGENT CARE**

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As described below you are covered for Urgent Care Services anywhere in the world. ~~“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.”~~ 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, ~~as shown in the Summary of Services and Cost Shares section~~).

[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.](#)

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### **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 Office please call:

[\[Inside the Washington, DC Metropolitan Area: \(301\) 468-6000\]](#)

[\[Outside of the Washington, DC Metropolitan Area: 1-800-777-7902\]](#)

[\[TTY: 711\]](#)

~~Inside the Washington, D.C. Metropolitan Area~~

~~[(703) 359-7878]~~

~~[TTY 711]~~

~~Outside the Washington, D.C. Metropolitan Area [1-800-777-7904]~~

~~[TTY 711]~~

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

### **Outside of our Service Area**

If you are injured or become ill while temporarily ~~outside~~ [outside of](#) the Service Area, we will cover reasonable charges for Urgent Care Services as defined in this section. 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 Plan Medical Office in the Service Area, or in the nearest Kaiser Foundation Health Plan Region for continuing or follow-up treatment.

### ***Urgent Care Limitations:***

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

### ***Urgent Care Exclusions:***

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

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## **H.J.J. VISION [EXAM] SERVICES**

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### **Medical Treatment**

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

### ***[Vision Services Exclusions:***

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

[**Note:** Discounts are available as a Value Added Service for lenses and frames.]

### **Eye Exams**

[We cover routine and necessary eye exams, including:

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

### ***Vision Exam Services Exclusions:***

- Eyeglass lenses and eyeglass frames.
- Eye exercises.
- All Services related to contact lenses including: exams, fitting, dispensing, and follow-up visits.
- Orthoptic (eye training) therapy.]]

### **Pediatric Eye Exams**

We cover the following for children [until the end of the month in which the child turns age 19](#)~~under age 19~~:

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

### **Pediatric Lenses and Frames**

We cover the following for children [until the end of the month in which the child turns age 19](#)~~under age 19~~ at no charge:

1. One [\(1\)](#) pair of lenses per year;
2. One [\(1\)](#) pair of frames per year from a select group of frames;
3. Regular contact lenses (in lieu of lenses and frames) for the first regular supply for that contact lens per year; or
4. Medically Necessary contact lenses up to two [\(2\)](#) pair per eye per year.]

[In addition, we cover the following Services:

### **Eyeglass Lenses**

[We provide a discount on the purchase of regular eyeglass lenses, including add-ons, when purchased at a Kaiser Permanente Optical Shop. Regular eyeglass lenses are any lenses with a refractive value. If only one eye needs correction, we also provide a balance lens for the other eye. ] [\[We cover the purchase of eyeglass lenses at no charge when purchased at a Kaiser Permanente Optical Shop.\]](#)

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### **Frames**

[We provide a discount on the purchase of eyeglass frames, when purchased at a Kaiser Permanente Optical Shop. The discount includes the mounting of eyeglass lenses in the frame, original fitting of the frames, and subsequent adjustment.] [[We cover the purchase of eyeglass frames at no charge when purchased at a Kaiser Permanente Optical Shop.](#)]

### **Contact Lenses**

[We cover the [\[initial\] purchase of contact lenses at no charge when purchased at a Kaiser Permanente Optical Shop.](#)] [[We cover the initial fitting for contact lenses at no charge when purchased at a Kaiser Permanente Optical Shop.](#)] [We provide a discount on the initial fitting for contact lenses, when purchased at a Kaiser Permanente Optical Shop. Initial fitting means the first time you have ever been examined for contact lens wear at a Plan Facility. The discount includes the following Services:

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

[You will also receive a discount on your initial purchase of contact lenses, if you choose to purchase them at the same time.] [Note: Additional contact lens Services are available without the discount from any Kaiser Permanente Optical Shop.]

### **Vision Exclusions:**

- Industrial and athletic safety frames.
- Eyeglass lenses and contact lenses with no refractive value.
- Sunglasses without corrective lenses unless Medically Necessary.
- Any eye surgery solely for that the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), and astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
- Eye exercises.
- Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section.
- Replacement of lost, broken, or damaged lenses frames and contact lenses.
- Plano lenses.
- Lens adornment, such as engraving, faceting, or jewellery.
- Low-vision devices.
- Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits.
- Orthoptic (eye training) therapy.]

### **JJ.KK. [VISITING MEMBER SERVICES**

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We cover the same Medically Necessary Services that are covered under this plan in our Service Area, and your Cost Share may differ, when you are temporarily a visiting member in a different Kaiser Permanente Region or Group Health Cooperative service area. .

To receive more information about ~~V~~visiting Member Services, including facility locations across the United States, ~~you may call~~[contact](#) ~~our~~ Member Services ~~Department~~:

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[\[Inside the Washington, DC Metropolitan Area: \(301\) 468-6000\]](#)

[\[Outside of the Washington, DC Metropolitan Area: 1-800-777-7902\]](#)

[\[TTY: 711\]](#)

~~Inside the Washington, D.C. Metropolitan Area~~

~~[(301) 468 6000]~~

~~[TTY 711]~~

~~Outside the Washington, D.C. Metropolitan Area~~

~~[1 800 777 7902]~~

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

### ***Visiting Member Services Limitations:***

Access to Services in the visited service area will be subject to availability at the time you request the Service. Services may be unavailable due to temporary capacity constraints, inability to provide the Service generally, or other restrictions. If the Service is not available in the visited service area, you must call us for authorization to receive the Service.

### ***Visiting Member Service Exclusions:***

All the terms and conditions, exclusions and limitations that apply to covered Services in our Service Area, will apply to Services received as a visiting Member in a different Kaiser Permanente Region or Group Health Cooperative service area.]

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## **~~KK.LL.~~ – X-RAY, LABORATORY, AND SPECIAL PROCEDURES**

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

1. Diagnostic imaging;
2. Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
3. Special procedures, such as electrocardiograms and electroencephalograms;
4. Sleep lab and sleep studies; and
5. Specialty imaging: including CT, MRI, PET Scans, and Nuclear Medicine studies; and interventional radiology.