# Summary of Services and Cost Shares

The Cost Shares listed here apply to Services provided to Members enrolled in this Platinum Metal plan. 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 Dependents are covered from birth to age 26, as defined by your Group and approved by Health Plan.

**MEMBER COST-SHARE**
Your Cost Share is the amount of the Allowable Charge (AC*) for a covered Service that you must pay through Copayments and Coinsurance.

In addition to the monthly Premium, you may be required to pay a Cost Share for some Services. The Cost Share is the Copayment, Deductible and Coinsurance, if any listed in the "Summary of Services and Cost Share" for each Service. You are responsible for payment of all Cost Shares. Copayments are due at the time you receive a Service. You will be billed for any 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).

## Copayments and Coinsurance

| Covered Service | You Pay |
|---|---|
| **Outpatient Care** | |
| Primary care office visits<br>(Internal medicine, family practice, or pediatrics) | $20 per visit |
| Specialty care office visits<br>(All Services provided by health care practitioners that are not Primary care Services) | $30 per visit |
| **Outpatient Surgery** | |
| Outpatient surgery facility fee (freestanding ambulatory surgical center or outpatient hospital) | $100 per visit |
| Outpatient surgery physician Services | No charge |
| **Hospital Inpatient Care** | |
| All charges incurred during a covered stay as an inpatient in a hospital | $150 per admission |
| Physician and surgical services | No charge |
| **Accidental Dental Injury Services** | The applicable Cost Share will apply based on type and place of Service |
| **Allergy Services** | |
| Evaluation and treatment | The applicable Cost Share will apply based on type and place of Service. |
| Injection visit and serum | The applicable Cost Share will apply based on type and place of Service, not to exceed the cost of the serum plus administration |
| **Ambulance Services** | |
| By a licensed ambulance Service, per encounter | No charge |

## Copayments and Coinsurance

| Covered Service | You Pay |
|---|---|
| Non-emergent transportation Services (ordered by a Plan Provider) | No charge |
| **Anesthesia for Dental Services** | The applicable Cost Share will apply based on type and place of Service |
| **Blood, Blood Products and Their Administration** | No charge |
| **Chemical Dependency and Mental Health Services**<br>Inpatient psychiatric and substance abuse Services, including detoxification | $150 per admission |
| Residential crisis Services | $150 per admission |
| Partial hospitalization | $20 per visit |
| Outpatient psychiatric and substance abuse Services<br>• Individual therapy | $20 per visit |
| • Group therapy | $10 per visit |
| Medication management visits | $20 per visit |
| **Cleft Lip, Cleft Palate, or Both** | The applicable Cost Share will apply based on type and place of Service |
| **Clinical Trials** | The applicable Cost Share will apply based on type and place of Service |
| **Diabetic Equipment, Supplies and Self-Management Training**<br>Diabetic equipment including insulin pumps | No charge |
| Self-management training | The applicable Cost Share will apply based on type and place of Service |
| **Dialysis**<br>Outpatient Care | $30 per visit |
| **Drugs, Supplies, and Supplements**<br>Administered by or under the supervision of a Plan Provider | No charge |
| **Durable Medical Equipment** | No charge |

## Copayments and Coinsurance

| Covered Service | You Pay |
|---|---|
| **Emergency Services**<br>Waived if admitted to the hospital<br><br>**Note:** 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.<br><br>Emergency Services HIV Screening Test | $100 per visit<br><br>No charge |
| **[Family Planning Services**<br>Office visits<br><br>All other Family Planning Services | No charge<br><br>The applicable Cost Share will apply based on type and place of Service] |
| **Habilitative Services**<br>(Refer to Section 3 for benefit limitations) | $30 per visit |
| **Hearing Services**<br>Hearing tests (newborn hearing screening tests are covered under preventive health care Services) | The applicable Cost Share will apply based on type and place of Service |
| **Home Health Care Services**<br>See Section 3 for benefit limitations | No charge |
| **Hospice Care** | No charge |
| **Maternity Services**<br>Routine global maternity care<br><br>Non-routine outpatient obstetrical care<br><br>Routine prenatal diagnostic testing<br><br>Non-routine prenatal diagnostic testing<br><br>Postpartum home health visits<br><br>Outpatient delivery<br>(All Services provided by Midwife) | <br>No charge<br><br>The applicable Cost Share will apply based on type and place of Service<br><br>No charge<br><br>$30 per visit<br><br>No charge<br><br>The applicable Cost Share will apply based on type and place of Service |
| **Medical Foods** | No charge |
| **Morbid Obesity Services** | The applicable Cost Share will apply based on type and place of Service |
| **Preventive Health Care Services**<br>(See Section 3 for benefit limitations) | No charge |

## Copayments and Coinsurance

| Covered Service | You Pay |
|---|---|
| **Prosthetic Devices** | |
| Internally implanted devices | No charge |
| Breast prosthetics | No charge |
| Artificial limbs | No charge |
| Ostomy and urological supplies | No charge |
| **Reconstructive Surgery** | The applicable Cost Share will apply based on type and place of Service |
| **Skilled Nursing Facility Care**<br>Limited to a maximum benefit of 60 days per contract year | $150 per admission |
| **Telemedicine Services** | No charge |
| **Therapy and Rehabilitation Services**<br>(Refer to Section 3 for benefit limitations) | $30 per visit |
| **Transplant Services** | The applicable Cost Share will apply based on type and place of Service |
| **Urgent Care** | |
| Office visit during regular office hours | The applicable Cost Share will apply based on type and place of Service |
| After-Hours Urgent Care or Urgent Care Center | $30 per visit |
| **Vision Services (for adults)** | |
| Eye exams | |
| • by an Optometrist | $20 per visit |
| • by an Ophthalmologist | $30 per visit |
| Eyeglass lenses and frames | You receive a 25% discount off retail** price for eyeglass lenses and for eyeglass frames |
| Contact lenses | You receive 15% discount off retail** price on initial pair of contact lenses |

## Copayments and Coinsurance

| Covered Service | You Pay |
|---|---|
| **Vision Services (for children under age 19)** | |
| Eye exams | |
| • by an Optometrist | $20 per visit |
| • by an Ophthalmologist | $30 per visit |
| Eyeglass lenses and frames<br>(Limited to one pair of frames per Contract Year from a selected group of frames; limited to one pair of polycarbonate or plastic single vision or bifocal lenses (ST28) per Contract Year) | No charge |
| Contact lenses<br>(Limited to 3-month supply of contact lenses from a selected list of contacts once per Contract Year) | No charge |
| Contact lenses<br>Medically necessary contacts limited to two pair, per eye, per Contract Year from a selected list of contacts | No charge |
| Low vision aids<br>(Unlimited low vision aids from available supply) | No charge |
| **X-ray, Laboratory and Special Procedures** | |
| Diagnostic imaging | $30 per visit |
| Laboratory tests | $30 per visit |
| Specialty Imaging (including CT, MRI, PET Scans, Nuclear Medicine, and Interventional Radiology) | $150 per test |
| Sleep lab | $150 per visit |
| Sleep studies | $30 per visit |

"The applicable Cost Share will apply based on type and place of Service" means that the Cost Share to be paid for the covered Service may vary depending on where and how a Member receives the respective Service. For example, the Cost Share for outpatient care will apply if the Member receives the Service in an outpatient care setting or the Cost Share for inpatient care will apply if the Member receives the Service in a hospital

** "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 maximum amount of Copayments and Coinsurance that an individual or Family is obligated to pay for covered Services, except as excluded below, per Contract Year. Once you or your Family have met your Out-of-Pocket Maximum, you will not be required to pay any additional Cost Shares for covered Services that apply toward the Out-of-Pocket Maximum for the rest of the Contract Year.

**Individual Out-of-Pocket Maximum.** If you are covered as a Subscriber, and you do not have any Dependents covered under the plan, your medical expenses for covered Services apply toward the Individual Out-of-Pocket Maximum indicated below.

**Family Out-of-Pocket Maximum.** If you have one or more Dependents covered under this plan, all Family member medical expenses for covered Services together apply toward the Family Out-of-Pocket Maximum indicated below. 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, this Member will not be required to pay any additional Cost Shares for covered Services for the rest of the Contract Year. Other Family members will continue to pay Cost Shares until the Family Out-of-Pocket Maximum is met. After two or more Members of your Family combined have met the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be met for all Members of the Family for the rest of the Contract Year.

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

- Eyeglass lenses and frames, contact lenses (for Adults)
- Dental Services ( for Adults)
- Morbid Obesity Services

| **Out-of-Pocket Maximum** | |
|---|---|
| | **Individual Out-of-Pocket Maximum**<br>$1,500 per individual per Contract year<br><br>**Family Out-of-Pocket Maximum**<br>$3,000 per Family Unit per Contract year |

# SECTION 3 – Benefits

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

- You are a Member on the date the Services are rendered;
- You have met any Deductible requirement described in the "Deductible" section of the Summary of Cost Shares in the Appendix.
- You have not met the maximum benefit for the Service, if any. A maximum benefit applies per Member per calendar year.
- The Services are provided by a Plan Provider (unless the Service is to be provided by a non-Plan Provider subject to an approved referral as described in Section 2) in accordance with the terms and conditions of this EOC including but not limited to the requirements, if any, for prior approval (authorization);
- The Services are Medically Necessary; and
- You receive the Services from a Plan Provider except as specifically described in this EOC.

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

- Emergency Services
- Urgent Care outside our Service Area
- Authorized referrals to non-Plan Providers (as described in Section 2)
- Visiting Member Services as described in Section 2

**Exclusions and Limitations:**
Exclusions and limitations that apply only to a particular benefit are described in this section. Other exclusions, limitations, and reductions that generally affect benefits are described in the "Exclusions, Limitations, and Reductions" section of this EOC.

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

## A. Outpatient Care

We cover the following outpatient care:

- Primary care visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics/gynecology Services (refer to "Preventive Health Care Services" for coverage of preventive care Services);
- Specialty care visits (refer to "Referrals to Plan Providers" in the "How to Obtain Services" section for information about referrals to Plan specialists);
- Consultations and immunizations for foreign travel (refer to "Outpatient Prescription Drugs Benefit Appendix," attached to this EOC, for coverage of self-administered travel vaccines);
- Diagnostic testing for care or treatment of an illness, or to screen for a disease for which you have been determined to be at high risk for contracting, including, but not limited to:
  - Diagnostic examinations, including digital rectal exams and prostate antigen (PSA) tests provided:
    - to persons age 40 and over who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society;
  - 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, in accordance with the most recently published guidelines of the American College of Gastroenterology, in consultation with the American Cancer Society;
  - Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A "qualified individual" means
    - an estrogen deficient individual at clinical risk for osteoporosis;
    - an individual with a specific sign suggestive of spinal osteoporosis, including roentgeno-graphic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
    - an individual receiving long-term gluco-corticoid (steroid) therapy;
    - an individual with primary hyper-parathyroidsm; or
    - an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

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

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

Additional outpatient Services are covered, but only as specifically 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:

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

Additional inpatient Services are covered, but only as specifically 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, 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 satisfied:

- The accident has been reported to your primary care Plan Physician within 72 hours of the accident.
- A Plan Provider provides the restorative dental Services.
- The injury occurred as the result of an external force that is defined as violent contact with an external object, not force incurred while chewing.
- The injury was sustained to Sound Natural Teeth.
- The covered Services must be requested within 60 days of the injury.
- The covered Services are provided during the 12 consecutive month period commencing from the date that the injury occurred.

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

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

**Accidental Dental Injury Services Exclusions:**

- Services provided by non-Plan Providers.
- Services provided after 12 months from the date 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
- Injections and serum

## E. Ambulance Services

We cover licensed ambulance Services only if your medical condition requires either: (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, provided during an encounter with an ambulance Service, as a result of a 911 call.

We cover medically appropriate non-emergent transportation Services when ordered by a Plan Provider.

We will not cover ambulance or non-emergent transportation Services in any other circumstances, even if no other transportation is available. We cover ambulance and medically appropriate non-emergent transportation Services only inside our Service Area, except as related to out of area Services covered under the "Emergency Services" provision in this section of

the EOC. Your cost share will apply to each encounter whether or not transport was required.

**Ambulance Services Exclusions:**

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

## F. Anesthesia for Dental Services

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

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

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

- A fully accredited specialist in pediatric dentistry; or
- A fully accredited specialist in oral and maxillofacial surgery; and
- For whom hospital privileges has 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

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

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

**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 hospitalized, we cover all medical Services of physicians and other health professionals as performed, prescribed or directed by a Plan Provider including:

- Individual therapy
- Group therapy
- Shock therapy
- Drug therapy
- Education
- Psychiatric nursing care
- 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 12 days annually.

We cover treatment in a structured multidisciplinary program as an alternative to inpatient psychiatric hospitalization.

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 24 hours but more than 4 hours in a day in a licensed or certified facility or program.

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

- Evaluations
- Crisis intervention
- Individual therapy
- Group therapy
- Electroshock therapy (ECT)
- Psychological testing
- Medical treatment for withdrawal symptoms
- 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.
- 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 necessary and appropriate.
- Evaluations that are primarily for legal or administrative purposes, and are not Medically Necessary.

## I. 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.

## J. Clinical Trials

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

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

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

a. The Services would be covered if they were not related to a clinical trial.

b. The Covered Person is eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   (1) A Plan Provider makes this determination.
   (2) The Subscriber or Covered Person provides us with medical and scientific information establishing this determination.

c. If any Plan Providers participate in the clinical trial and will accept the Covered Person as a participant in the clinical trial, the Covered Person must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where the Covered Person lives.

d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
   (1) The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
   (2) The study or investigation is a drug trial that is exempt from having an investigational new drug application.

(3) The study or investigation is approved or funded by at least one of the following:
- The National Institutes of Health.
- The Centers for Disease Control and Prevention.
- The Agency for Health Care Research and Quality.
- The Centers for Medicare & Medicaid Services.
- A bona fide clinical trial cooperative group or center of any of the above entities, 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
- The Department of Defense, the Department of Veterans Affairs, the Department of Energy; or .a qualified non-governmental research entity to which the National Cancer Institute has awarded a support grant;
- A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA; or
- 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.

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

***Clinical trials exclusions:***

a. The investigational Service.

b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

**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.

## K. Diabetic Equipment, Supplies, and Self-Management

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

- insulin-using diabetes;
- insulin-dependent diabetes;
- non-insulin using diabetes; or
- elevated blood glucose levels induced by pregnancy, including gestational diabetes.

**Note:** Insulin is not covered under this benefit. Refer to the "Outpatient Prescription Drug Benefit Appendix,"for coverage.

**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.

## L. Dialysis

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

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

We cover the following renal dialysis Services:

- Outpatient maintenance dialysis treatments in a Plan dialysis facility. Coverage includes the cost of laboratory tests, equipment, supplies and other Services associated with your treatment.

- Inpatient maintenance dialysis if you are admitted to a Plan Hospital because your medical condition requires specialized hospital Services on an inpatient basis.
- Plan Provider Services related to inpatient and outpatient dialysis.

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

We cover home dialysis, which includes:
- Hemodialysis;
- Home intermittent peritoneal dialysis (IPD);
- Home continuous cycling peritoneal dialysis (CCPD); and
- Home continuous ambulatory peritoneal dialysis (CAPD).

## M. Drugs, Supplies, and Supplements

***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:
- Oral infused or injected drugs, and radioactive materials used for therapeutic purposes, including chemotherapy;
- Injectable devices;
- The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
- Dressing and casts;
- 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 Benefit Appendix" for coverage of self-administered outpatient prescription drugs; ,including self-administered travel vaccines; "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. "Family Planning Services" for the insertion and removal of contraceptive drugs and devices.

**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.

## N. Durable Medical Equipment

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

Durable Medical Equipment does not include coverage for prosthetic devices, such as 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.

### *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 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.

**1. Oxygen and Equipment**

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

**2. 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 Health Plan's criteria for medical necessity. A Plan Provider must certify the continued medical need every 30 days.

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

**4. Asthma Equipment**
We cover the following asthma equipment for pediatric and adult asthmatics when purchased from a Plan Provider:

- Spacers
- Peak-flow meters
- Nebulizers

**5. Bilirubin Lights**
We cover bilirubin lights for infants, who are under age 3, for a period not to exceed 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 Health Plan.

## O. Emergency Services

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

If you experience an Emergency Medical Condition you should contact 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, not to exceed forty-eight (48) hours or the next 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 of this EOC, and was not authorized by 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 our Service Area:**
We cover reasonable charges for Emergency Services if you are injured or become ill while temporarily outside 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, 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 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 48 hours of any hospital admission, or on the first working day following the admission, unless it was not reasonably possible to notify us within that time. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us, of if you choose not to be transferred, we will not cover any Services you receive after transfer would have been possible.

**Filing Claims for Non-Plan Emergency Services**
Keep all your receipts for Emergency Services provided by non-Plan Providers and verify that the non-Plan Provider has submitted the claims. All claims must be filed with us within six 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, 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:

- The costs of administering such a test;
- All laboratory expenses to analyze the test; and
- The costs of communicating to the patient 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, or 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.

## P. Family Planning Services

We cover the following:

- Family planning counseling, including pre-abortion and post-abortion counseling] and information on birth control.
- 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 drugs and diaphragms are covered only under an "Outpatient Prescription Drug Benefit Appendix.
- Tubal ligations.
- Vasectomies.
- 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 calendar year.

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

## Q. Habilitative Services

We cover Medically Necessary habilitative Services, which are health care Services that help a person keep, learn, or improve skills and functioning for daily living,

including, but not limited to applied behavioral analysis for the treatment of autism spectrum disorder. Services also include speech therapy, occupational therapy and physical therapy.

**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.

## R. Hearing Services

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

**Hearing Services Exclusions:**

- Tests to determine an appropriate hearing aid; and
- Hearing aids or tests to determine their efficacy.

## S. Home Health Care

Except as provided for Visiting Member Services, 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:

- Skilled nursing care
- Home health aide Services
- Medical social Services

Home Health Care is 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 48 hours of inpatient hospitalization following the surgery, are entitled to the following:

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

**Home Health Care Limitations:**

- Home Health Care visits shall be limited to 90 visits per, and up to four (4) hours per visit per episode of care.

**Note**: If a visit lasts longer than four hours, then each four-hour increment counts as a separate visit. For example, if a nurse comes to your home for five hours and then leaves, that counts as two 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 four hours, that counts as two visits.

**Home Health Care Exclusions:**

- Custodial care (see definition under "Exclusions" in the "Exclusions, Limitations, and Reductions" section of this EOC).
- Routine administration of oral medications, eye drops, ointments.
- General maintenance care of colostomy, ileostomy, and ureterostomy.
- Medical supplies or dressings applied by a Member or family caregiver.
- Corrective appliances, artificial aids, and orthopedic devices.
- Homemaker Services.
- 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 Health Plan.
- Transportation and delivery service costs of Durable Medical Equipment, medications, drugs, medical supplies and supplements to the home.

## T. Hospice Care

Hospice Care is for terminally ill Members. If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is 6 months or less, you can choose Hospice 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:

- Nursing care;

- Physical, occupational, speech, and respiratory therapy;
- Medical social Services;
- Home health aide Services;
- Homemaker Services;
- Medical supplies and appliances;
- Palliative drugs in accord with our drug formulary guidelines;
- Physician care;
- General hospice inpatient Services for acute symptom management including pain management;
- Respite Care that may be limited to 5 consecutive days for any one inpatient stay up to 4 times in any calendar year;
- 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
- Services of hospice volunteers.

**Definitions:**

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

***Hospice Care*** means a coordinated, inter-disciplinary program of hospice care 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.

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

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

***Hospice Care Limitation:***
Hospice Care Services are limited to a maximum of 180 days per eligibility period.

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## U. Maternity Services

We cover obstetrical Services for routine global maternity care and non-routine outpatient maternity care.

"Routine global maternity" means care provided after the first visit where pregnancy is confirmed, and includes all of the following as a single Service: (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. If a pregnancy terminates prior to delivery, the routine global maternity period will end when the pregnancy terminates.

"Non-routine outpatient maternity care" includes (a) care provided for a condition not usually associated with pregnancy; (b) care provided for conditions existing prior to pregnancy; (c) care provided for high risk condition(s) that develop during pregnancy. Services for non-routine outpatient maternity care are covered subject to applicable Cost Share for specialty, diagnostic, and/or treatment Services.

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

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

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

## V. Medical Foods

We cover medical foods and low protein modified food products for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry 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.

## W. Morbid Obesity

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 as effective for long-term reversal of morbid obesity, and is consistent with criteria approved by the National Institutes of Health.

Morbid obesity is defined as:

- A weight that is at least 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
- A body mass index (BMI) that is equal to or greater than 35 kilograms per meter squared with a comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary condition, sleep apnea, or diabetes; or
- A BMI of 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 Health Plan.

## X. Oral Surgery

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

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

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

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

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

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

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

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

**Oral Surgery Exclusions:**

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

## Y. Preventive Health Care Services

In addition to any other preventive benefits described in the group contract or certificate, 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:

(a) 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);

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

(c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. This includes preventive Services for obesity. (Visit HRSA at: http://mchb.hrsa.gov); and

(d) With respect to women, such additional preventive care and screenings, not described in paragraph (a) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (Visit HRSA at: http://mchb.hrsa.gov).

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 also 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:

- Preventive care exams, including:
  - routine physical examinations and health screening tests appropriate to your age and sex;
  - well-woman examinations; and
  - well child care examinations; including age appropriate health screening for all children, as determined by the Mayor, from birth to 21 years of age;
- Routine and Medically Necessary immunizations (excluding travel immunizations) 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.
- An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
- High-risk human papillomavirus DNA testing every three years for women age 30 years and over whether or not they have normal Pap test results;
- Screening for gestational (pregnancy-related) diabetes in pregnant women between 24-28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes;
- Comprehensive lactation (breastfeeding) education and counseling, by trained clinicians during pregnancy and/or in the postpartum period in connection with each birth;
- Breastfeeding equipment issued, per pregnancy and in accordance with Health Plan coverage guidelines;
- Annual screening and counseling for sexually transmitted infections for all sexually active women;
- Annual screening and counseling for human immune-deficiency virus (HIV) infection for all sexually active women;
- Annual screening and counseling for interpersonal and domestic violence;
- Patient education and contraceptive counseling for all women with reproductive capacity;
- All prescribed FDA-approved contraceptive methods, including implanted contraceptive devices, hormonal contraceptive methods, barrier contraceptive methods, and female sterilization surgeries. Note that contraceptive methods that do not require clinician administration such as birth control pills will not be covered if you have outpatient drug coverage separate from your Health Plan coverage through another prescription drug provider;
- Low dose screening mammograms to determine the presence of breast disease is covered as follows: (i) one mammogram for persons age 35 through 39; (ii) one mammogram biennially for persons age 40 through 49; and (iii) one mammogram annually for person 50 and over;
- Bone mass measurement to determine risk for osteoporosis;
- Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to men who are age 40 or older;
- Colorectal cancer screening in accordance with screening guidelines issued by the American Cancer Society including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy;
- Cholesterol test (lipid profile);
- Diabetes screening (fasting blood glucose test);

- Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis and HPS), subject to the following:
  - Annual chlamydia screening is covered for (1) women under the age of 20, if they are sexually active; and (2) women 20 years of age or older, and men of any age, who have multiple risk factors, which include: (i) a prior history of sexually transmitted diseases; (ii) new or multiple sex partners; (iii) inconsistent use of barrier contraceptives; or (iv) cervical ectopy;
  - Human Papillomavirus Screening (HPS) as recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;
- HIV tests;
- TB tests;
- Smoking and tobacco cessation counseling;
- 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
- Associated preventive care radiological and lab tests not listed above.

**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;
- Lab, imaging, and other ancillary Services not included in routine prenatal care.
- Non-preventive Services performed in conjunction with a sterilization.
- Lab, imaging, and other ancillary Services associated with sterilizations.
- Complications that arise after a sterilization procedure.
- Treatment of a medical condition or problem identified during the course of a preventive screening exam;
- Over-the-counter contraceptive pills, supplies, and devices.
- Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.
- Replacement or upgrades for breastfeeding equipment that is not rented Durable Medical Equipment.
- Prescription contraceptives that do not require clinical administration for certain group health plans that provide outpatient prescription drug coverage that includes FDA-approved contraception that is separate from Health Plan coverage and furnished through another prescription drug provider.

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

## Z. Prosthetic Devices

We cover the devices listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is 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" benefits 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 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 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", or "Hearing Services",, if applicable.
- Repair or replacement of prosthetics due to loss or misuse.
- Hair Prostheses.
- Microprocessor and robotic controlled external prosthetics and orthotics not covered under the Medicare Coverage Database.
- Multifocal intraocular lens implants.

## AA. Reconstructive Surgery

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

Following mastectomy, we also cover reconstructive breast surgery and all stages of reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, 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 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
- Pierced earlobe repairs, except for the repair of an acute bleeding laceration

## BB. Skilled Nursing Facility Care

We cover up to 60 days of skilled inpatient Services in a licensed Skilled Nursing Facility per episode of care. The skilled inpatient Services must be those customarily provided by Skilled Nursing Facilities. A prior three-day stay in an acute care hospital is not required.

We cover the following Services:

- Room and board;
- Physician and nursing care;
- Medical social Services;
- Medical and biological supplies; and
- Respiratory therapy.

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

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

**Skilled Nursing Facility Care Exclusions:**

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

## CC. Telemedicine Services

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

## DD. Therapy and Rehabilitation Services

### Physical, Occupational, and Speech Therapy Services

We cover Medically Necessary inpatient and outpatient physical, occupational and speech therapy.**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 "Early Intervention 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.

**Spinal Manipulation Services**
For musculoskeletal illness or injury only, we cover spinal manipulation and other manual medical interventions for Members 12 years of age or older.

**Multidisciplinary Rehabilitation**
If, in the judgment of a Plan Provider, significant improvement is achievable within a two-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 therapy at a time in the rehabilitation treatment.

**Multidisciplinary Rehabilitation 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 cardiac rehabilitation Services that are Medically Necessary following coronary surgery or a myocardial infarction, for up to 90 consecutive days.

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 program per lifetime.

**Therapy and Rehabilitation Services Exclusions:**
- Long-term rehabilitative therapy.
- Except as provided for cardiac and pulmonary rehabilitation Services, no coverage is provided for any therapy that the Plan Physician determines cannot achieve measurable improvement in function within a 90-day period.

## EE. Transplant Services

If the following criteria are met, we cover stem cell rescue and transplants of organs, tissue, or bone marrow:
- You satisfy all medical criteria developed by Medical Group and by the facility providing the transplant;
- The facility is certified by Medicare; and
- A Plan Provider provides a written referral for care at the facility.

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

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

## FF. Urgent Care

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.

### *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, D.C. Metropolitan Area
(703) 359-7878
TTY (703) 359-7616

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

TTY 1-800-700-4901

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

***Outside our Service Area***
If you are injured or become ill while temporarily outside the Service Area, 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 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 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, 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.

## GG. Vision Services

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

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

### Pediatric Lenses and Frames
We cover the following for children under age 21at no charge:
- One pair of lenses per year;
- One pair of frames per year from a select group of frames;
- Regular contact lenses (in lieu of lenses and frames) up to a 3 month supply per year; or
- Medically Necessary contact lenses up to two pair per eye per year.

**In addition,** we cover the following Services:

***Eye Exams***
Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses. Exams performed in an Optometry Department will be subject to the Primary Care Copayment. Exams performed in an Ophthalmology Department will be subject to the Specialty Care Copayment, if different.

***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.

***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.

***Contact Lenses***
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:
- Fitting of contact lenses;
- Initial pair of diagnostic lenses (to assure proper fit);
- Insertion and removal of contact lens training; and
- 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 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 jewelling.
- Low-vision devices.
- Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits.
- Orthoptic (eye training) therapy.

## HH. X-ray, Laboratory, and Special Procedures

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

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

# Outpatient Prescription Drug Benefit Appendix

Health Plan will provide coverage for Prescription Drugs as follows:

**DEFINITIONS**

**Allowable Charge:** Has the same meaning as defined in Definitions Appendix in your Small Group Evidence of Coverage.

**Brand Name Drug:** A prescription drug that has been patented and is produced by only one manufacturer.

**Coinsurance:** A percentage of the Allowable Charge that you must pay for each prescription or prescription refill.

**Contraceptive drug:** A drug or device that is approved by the FDA for use as a contraceptive and requires a prescription.

**Copayment:** The specific dollar amount that you must pay for each prescription or prescription refill.

**FDA:** The United States Food and Drug Administration.

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

**Limited Distribution Drug (LDD):** Prescription drug that is limited in distribution by the manufacturer or FDA.

**Mail Service Delivery Program:** A program operated by Health Plan that distributes prescription drugs to Members via mail. Certain drugs that require special handling are not provided through the mail-delivery service. This includes, but is not limited to, drugs that are time or temperature sensitive, drugs that cannot legally be sent by U.S. mail, and drugs that require professional administration or observation.

**Maintenance Medications:** A covered drug anticipated to be required for six months or more to treat a chronic condition.

**Medical Literature:** Scientific studies published in a peer-reviewed national professional medical journal.

**Nicotine Replacement Therapy:** A product that:

(a) is used to deliver nicotine to an individual attempting to cease the use of tobacco products;
(b) can be obtained only by a written prescription.

Nicotine Replacement Therapy does not include any over-the-counter products that may be obtained without a prescription.

**Non-Preferred Brand Drug:** A Brand Name Drug that is not on the Preferred Drug List.

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

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

**Preferred Brand Drug:** A Brand Name Drug that is on the Preferred Drug List.

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

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

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

## BENEFITS

Except as provided in the Limitations and Exclusions sections of this appendix, we cover drugs described below when prescribed by a Plan physician, a non-Plan Physician to whom you have an approved referral, or a dentist. Each prescription refill is subject to the same conditions as the original prescription. A Plan Provider prescribes drugs in accordance with Health Plan's Preferred Drug List. If the price of the drug is less than the Copayment, you will pay the price of the drug. You must obtain covered drugs from a Plan Pharmacy. You may also obtain prescription drugs using our Mail Service Delivery Program; ask for details at a Plan Pharmacy.

We cover the following prescription drugs:

- FDA-approved drugs for which a prescription is required by law.
- Compounded preparations that contain at least one ingredient requiring a prescription.
- Insulin.
- Oral chemotherapy drugs including oral anticancer medications.
- Drugs that are FDA-approved for use as contraceptives and diaphragms. For coverage of other types of contraception, including contraceptive injections, implants and devices, refer to "Family Planning Services" in Section 3 - Benefits of this Group Evidence of Coverage.
- Off label use of drugs when a drug is recognized in Standard Reference Compendia or certain Medical Literature as appropriate in the treatment of the diagnosed condition.
- Non-prescription drugs when they are prescribed by a Plan Provider and are listed on the Preferred Drug List.
- Growth hormone therapy (GHT) for treatment of children under age 18 with a growth hormone deficiency; or when prescribed by a Plan Physician, pursuant to clinical guidelines for adults.
- Hormone replacement therapy that is prescribed or ordered for treating symptoms and conditions of menopause.
- Limited Distribution Drugs (LDD) Regardless of where they are purchased, LDD's will be covered on the same basis as if they were purchased at a Plan Pharmacy

The Health Plan Pharmacy and Therapeutics Committee sets dispensing limitations in accordance with therapeutic guidelines based on the Medical Literature and research. The Committee also meets periodically to consider adding and removing prescribed drugs on the Preferred Drug List. If you would like information about whether a particular drug is included in our Preferred Drug List, please visit us on line at www.kaiserpermanente.org\formulary, or call the Member Services Call Center at the phone numbers listed below:

*Inside the Washington, D.C. Metropolitan Area*
[301-468-6000]
TTY [301-879-6380]

*Outside the Washington, D.C. Metropolitan Area*
[1-800-777-7902]

## WHERE TO PURCHASE COVERED DRUGS

We cover prescribed drugs only when purchased at a Plan Pharmacy, a Participating Network Pharmacy or through Health Plan's Mail Service Delivery Program. Most non-refrigerated prescription medications ordered through the Health Plan's Mail Service Delivery Program can be delivered anywhere in the United States.

## GENERIC AND PREFERRED DRUG REQUIREMENTS

### Generic vs. Brand Name Drugs

Plan Pharmacies and Participating Network Pharmacies will substitute a generic equivalent for a Brand Name Drug when a generic equivalent is on our Preferred Drug List unless one of the following conditions is met:

- The provider has prescribed a Brand Name Drug and has indicated "dispense as written" (DAW) on the prescription: or
- The Brand Name Drug is listed on our Preferred Drug List; or
- The Brand Name Drug is: (1) prescribed by a Plan physician, a non-Plan Physician to whom you have an approved referral, or a dentist; and (2) (a) there is no equivalent Generic Drug, or (b) an equivalent Generic Drug (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.

If you request a Brand Name Drug for which none of the above conditions has been met, you will be responsible for the Non-Preferred Brand Name Drug cost share.

### Preferred Brand vs. Non-Preferred Brand Drugs

Plan Pharmacies will dispense drugs from our Preferred Drug List unless the following criteria are met: (1) the Non-Preferred Brand Drug is prescribed by a Plan physician, a non-Plan Physician to whom you have a referral, or a dentist; and (2) (a) there is no equivalent drug in our Preferred Drug List, or (b) an equivalent Preferred Drug List drug (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.

If you request a Non-Preferred Brand Drug the applicable drug Cost Share will apply.

## DISPENSING LIMITATIONS

Except for Maintenance Medications as described below, Members may obtain up to a 30-day supply and will be charged the applicable Copayment or Coinsurance based on: (a) the prescribed dosage, (b) Standard Manufacturers Package Size, and (c) specified dispensing limits.

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

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

## MAINTENANCE MEDICATION DISPENSING LIMITATIONS

Members may obtain up to a 90-day supply of Maintenance Medications in a single prescription, when authorized by the prescribing Plan Provider or by a dentist or a referral physician. This does not apply to the first prescription or change in a prescription. Members will be charged two (2) times the amount of the applicable Copayment or Coinsurance for a 30-day supply. The day supply is based on: (a) the prescribed dosage; (b) Standard Manufacturer's Package Size; and (c) specified dispensing limits.

## PRESCRIPTIONS COVERED OUTSIDE THE SERVICE AREA; OBTAINING REIMBURSEMENT

The Health Plan covers drugs prescribed by non-Plan Providers and purchased at non-Plan Pharmacies when the drug was prescribed during the course of an emergency care visit or an urgent care visit (see "Emergency Services" and "Urgent Care Services" sections of the Group Evidence of Coverage), or associated with a covered, authorized referral outside Health Plan's Service Area. To obtain reimbursement, the Member must submit a copy of the itemized receipts for their prescriptions to Health Plan. We may require proof that urgent or emergency care Services were provided. Reimbursement will be made at the Allowable Charge less the applicable Copayment as shown below. Claims should be submitted to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
[Attention: Claims Department
P.O. Box 6233
Rockville, Maryland 20849-6233]

## LIMITATIONS AND EXCLUSIONS

***Limitations:***

Benefits are subject to the following limitations:

- For drugs prescribed by dentists, coverage is limited to antibiotics and pain relief drugs that are included on our Preferred Drug List and purchased at a Plan Pharmacy or a Participating Network Pharmacy, unless the criteria for coverage of Non-Preferred Brand Drugs has been met. The Non-Preferred Brand Drugs coverage criteria is detailed in this Outpatient Prescription Drug Appendix in the subsection titled, "Preferred Brand vs. Non-Preferred Brand Drugs"**.**
- In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with the Health Plan's emergency management department and/or our Pharmacy and Therapeutics Committee. If limited, the applicable Cost Share per prescription will apply. However, a Member may file a claim for the difference between the Cost Share for a full prescription and the pro-rata Cost Share for the actual amount received. Instructions for filing a claim can be found in Section 5 of your Group Evidence of Coverage. Claims should be submitted to:

  Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
  [Attention: Claims Department
  P.O. Box 6233
  Rockville, Maryland 20849-6233]

***Exclusions:***

The following are not covered under the Outpatient Prescription Drug Appendix. Please note that certain Services excluded below may be covered under other benefits in Section 3 of your Group Evidence of Coverage. Please refer to the applicable benefit to determine if drugs are covered:

- Drugs for which a prescription is not required by law, except for non-prescription drugs that are prescribed by a Plan Provider and are listed in our Preferred Drug List.
- Compounded preparations that do not contain at least one ingredient requiring a prescription and are not listed in our Preferred Drug List.

- Drugs obtained from a non-Plan Pharmacy, except when the drug is prescribed during an emergency or urgent care visit in which covered Services are rendered, or associated with a covered authorized referral outside the Service Area.
- Take home drugs received from a hospital, Skilled Nursing Facility, or other similar facility. Refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care" in Section 3 – Benefits of your Group Evidence of Coverage.
- Drugs that are not listed in our Preferred Drug List, except as described in this Appendix.
- Drugs that are considered to be experimental or investigational. Refer to "Clinical Trials" in Section 3 – Benefits of your Group Evidence of Coverage.
- Except as specifically covered under this Outpatient Prescription Drug Appendix, a drug (a) which can be obtained without a prescription, or (b) for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug.
- Drugs for which the Member is not legally obligated to pay, or for which no charge is made.
- Blood or blood products. Refer to "Blood, Blood Products and their Administration" in Section 3 – Benefits of your Group Evidence of Coverage.
- Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes including but not limited to drugs used to retard or reverse the effects of skin aging or to treat nail fungus or hair loss.
- Medical foods. Refer to "Medical Foods" in Section 3 – Benefits of your Group Evidence of Coverage.
- Drugs for the palliation and management of terminal illness if they are provided by a licensed hospice agency to a Member participating in our hospice care program. Refer to "Hospice Care" in Section 3 – Benefits of your Group Evidence of Coverage.
- Replacement prescriptions necessitated by theft or loss.
- Prescribed drugs and accessories that are necessary for Services that are excluded under this Group Evidence of Coverage.
- Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from the Health Plan's standard packaging for prescription drugs.
- Alternative formulations or delivery methods that are (1) different from the Health Plan's standard formulation or delivery method for prescription drugs and (2) deemed not Medically Necessary.
- Durable medical equipment, prosthetic or orthotic devices, and their supplies, including: peak flow meters, nebulizers, and spacers; and ostomy and urological supplies. Refer to "Durable Medical Equipment" and "Prosthetic Devices" in Section 3 – Benefits of your Group Evidence of Coverage.
- Drugs and devices that are provided during a covered stay in a hospital or Skilled Nursing Facility, or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits. This includes the equipment and supplies associated with the administration of a drug. Refer to "Drugs, Supplies, and Supplements" and "Home Health Services" in Section 3 – Benefits of your Group Evidence of Coverage.
- Bandages or dressings. Refer to "Drugs, Supplies, and Supplements" and "Home Health Services" in Section 3 – Benefits of your Group Evidence of Coverage.
- Diabetic equipment and supplies. Refer to "Diabetic Equipment Supplies, and Self-Management" in Section 3 – Benefits of this Group Evidence of Coverage.
- Growth hormone therapy (GHT) for treatment of adults age 18 or older, except when prescribed by a Plan Physician, pursuant to clinical guidelines for adults.
- Immunizations and vaccinations solely for the purpose of travel. Refer to "Outpatient Care" in Section 3 – Benefits of your Group Evidence of Coverage.
- Any prescription drug product that is therapeutically equivalent to an over-the-counter drug, upon a review and determination by the Pharmacy and Therapeutics Committee.
- Drugs for weight management.
- Drugs for treatment of sexual dysfunction disorder, such as erectile dysfunction.
- Drugs for the treatment of infertility.

**COPAYMENT/COINSURANCE:**

You pay the Copayment or Coinsurance amounts set forth below when purchasing covered outpatient prescription drugs from the Kaiser Permanente Plan Pharmacy, until you reach the Out-of-Pocket Limit. If the price of the drug is less than the Copayment, you will pay the price of the drug.

The following copayments and coinsurance apply to all covered Prescription Drugs purchased at a Kaiser Permanente Pharmacy, Participating Network Pharmacy, or through Kaiser Permanente Mail Service Delivery Program. These copayments and coinsurance amounts also apply to Covered Prescription drugs offered at Non-plan Pharmacies in connection with Emergency and Urgent Care Services.

- All covered drugs except oral chemotherapy drugs and oral anticancer medications:

| **30 Day Supply** | **Plan Pharmacy and Mail Delivery** | **Participating Network Pharmacy** |
|---|---|---|
| **Generic Drugs** | $5 | $15 |
| **Preferred Brand Drugs** | $15 | $25 |
| **Non-Preferred Brand Drugs** | $30 | $40 |

| | **Mail Delivery, Plan Pharmacy and Participating Network Pharmacy** |
|---|---|
| **90-day Supply of Maintenance Medication** | 2 Rx Copayments |

- Oral chemotherapy drugs and oral anticancer medications are covered at no charge.

*****Allowable Charge is defined in Definitions Appendix of the Group Evidence of Coverage to which this Appendix is attached.

**Out-of-Pocket Maximum:**

Cost Shares set forth in this Appendix apply toward the Out-of-Pocket Maximum set forth in the Summary of Services and Cost Shares in your EOC to which this Appendix is attached.

This Outpatient Prescription Benefit Appendix is subject to all the terms and conditions of the Group Evidence of Coverage and Small Group Evidence of Coverage to which this Appendix is attached. This Appendix does not change any of those terms and conditions, unless specifically stated in this Appendix.