IMPORTANT DETAILS AND NOTICES

Kaiser Permanente for Individuals and Families

HIPAA INFORMATION

Kaiser Permanente may have a health coverage plan for you even if you don't qualify for a plan that requires medical review. **If you live in Virginia or Washington, DC,** you may be eligible for Health Insurance Portability and Accountability Act (HIPAA) coverage. HIPAA is a federally mandated program that may apply to you if you have been turned down for medical coverage. **If you live in Maryland,** you may be eligible for health care coverage under the Maryland Health Insurance Plan (MHIP). MHIP is a program for Maryland residents who otherwise do not have access to health coverage. (See below.)

For residents of Virginia and Washington, DC

If you believe that you are HIPAA eligible and have indicated that on your application, and if you or your family members do not pass the Kaiser Permanente for Individuals and Families medical review, your application(s) will be forwarded to our HIPAA Membership Administration department to determine if you or your family members qualify for HIPAA coverage. To learn more about HIPAA eligibility and coverage, please call Member Services at **301-468-6000** or toll free at **1-800-777-7902**.

For residents of Maryland

If you reside in Maryland, you may be eligible for health care coverage under the Maryland Health Insurance Plan (MHIP). MHIP is a high-risk pool for Maryland residents who do not have access to health insurance. To obtain information regarding MHIP, contact:

Maryland Health Insurance Plan
10455 Mill Run Circle, RR291
Owings Mill, MD 21117-9685
Telephone: **1-888-444-9016** (toll free)

Website: **www.marylandhealthinsuranceplan.state.md.us**

Who is not eligible for MHIP?

You are not eligible for MHIP if you do not reside in Maryland or if you are eligible for any of the following programs or plans:

- Medicare
- Maryland Medical Assistance
- Maryland Children's Health Program
- Any employer-sponsored health plan

NOTICE OF INSURANCE INFORMATION PRACTICES

Abbreviated version

Virginia

Please be advised that Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (hereinafter Kaiser Permanente), has not received any personal information regarding your application from any person other than the applicant. Personal information necessary to determine eligibility for coverage and to make underwriting decisions may be collected from the application, medical questionnaire, and any pre-existing file with Kaiser Permanente. With written authorization by the applicant, any physician, nurse, hospital, clinic, or other provider having treated or attended to the applicant or the applicant's dependents listed on the application, and having possession of any records or information with respect thereto, is authorized to provide such information or records to Kaiser Permanente upon request for the purpose of evaluation of this application. Further, the applicant or individual designated to act on behalf of the applicant is entitled to receive a copy (or photocopy) of this authorization upon request.

Please also be assured that it is Kaiser Permanente's policy to protect the confidentiality of your private medical information to the full extent of the law.

Kaiser Permanente will not disclose any personal or privileged information about an individual that is collected or received unless the disclosure is:

- authorized in writing by the individual; or
- made to a medical care institution or medical professional for the purpose of
  - verifying insurance coverage or benefits, or
  - informing an individual of a medical problem of which the individual may not be aware, or
  - conducting an operations or services audit, provided that information is disclosed only as is reasonably necessary to accomplish the foregoing purposes; or
- made to an insurance regulatory authority; or
- made to a law enforcement or other government authority to protect Kaiser Permanente interests in preventing or prosecuting the perpetration of fraud upon it.

You have the right to see and obtain copies of the recorded personal information pertaining to you by submitting a written request. If you ask us to correct, amend, or delete any information about you in our files and if we refuse to do so, you have the right to give us a concise statement of what you believe is the correct information and we will put your statement in our file so that anyone reviewing it will see it.

Information obtained from a report prepared by an insurance-support organization may be retained by an insurance-support organization and disclosed to other persons.

This is an abbreviated version of the notice of information collection and disclosure practices. Kaiser Permanente's complete *Notice of Insurance Information Practices* form is available to you upon request.

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

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KAISER PERMANENTE®

KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES EXCLUSIONS AND LIMITATIONS

The following list contains exclusions and limitations associated with the benefits described in the *Plans & Benefits*, *Copayment Plans*, and *Deductible and HSA-Qualified Deductible Plans* brochures.

Preventive care

Limitations:

While the following services may be provided during the course of a preventive care visit, these are not considered preventive care: monitoring of chronic disease; diagnosis, follow-up and services provided to treat a specific disease; and nonroutine gynecological visits.

Emergency services

Limitations:

The member or someone on the member's behalf must notify us as soon as possible, but no later than 48 hours or the next business day, whichever is later, of the hospital admission. Follow-up care at a non-Plan hospital must be authorized by the Health Plan.

Urgent care services

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, unless we determine that you were temporarily outside our service area because of extreme personal emergency.

Ambulance services

Exclusions:

Transportation by any type of transportation other than a licensed ambulance

Vision care

Exclusions:

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

HSA-qualified deductible (1250, 2500 deductible levels) and deductible (4500, 8000 deductible levels) plan exclusions:

- Exclusions noted above
- Eyeglass lenses and eyeglass frames
- All services related to contact lenses, including examinations, fitting and dispensing, and follow-up visits, except as otherwise noted

Prescription drugs

Exclusions:

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, except if the drug is approved under our preferred drug list guidelines
- Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes
- Replacement prescriptions necessitated by theft or loss
- Prescribed drugs and accessories that are necessary for services that are excluded under this agreement
- Drugs to shorten the duration of the common cold
- Special packaging (e.g., blister pack, unit dose, or unit-of-use packaging) that is different from Health Plan's standard packaging for prescription medications
- Alternative formulations or delivery methods that are (1) different from Health Plan's standard formulation or delivery method for prescription drugs and (2) deemed not medically necessary
- Diabetic equipment and supplies, which are covered under Section 3 of the *Membership Agreement*
- Drugs for treatment of sexual dysfunction disorder

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.
- In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with Health Plan's emergency management department.

Dental services

Exclusions:

The following services are not covered under your dental plan:

- Services provided by dentists or other practitioners of healing arts not associated with the Health Plan and/or dental administrator except upon referral arranged by a participating dental provider and authorized by Health Plan, or when required in a covered emergency
- Services for injuries or conditions that are covered under workers' compensation and/or employer's liability laws
- Services that are provided without cost to members by any federal, state, municipal, county, or other subdivision's program (with the exception of Medicaid)
- Services that, in the opinion of the attending dentist, are not necessary for the patient's dental health
- Cosmetic or aesthetic dentistry
- Oral surgery requiring the setting of fractures or dislocations, except as may be otherwise covered in your medical plan as described in Section 3 of the *Membership Agreement*
- Drugs obtainable with or without a prescription, except as may be otherwise covered in your medical plan as described in Section 3 of the *Membership Agreement*
- Hospitalization for any dental procedure
- Treatment required for conditions resulting from major disaster, epidemic, or war, including declared or undeclared war or acts of war
- Replacement due to loss or theft of prosthetic appliance
- Services that cannot be performed because of the general health of the patient
- Implantation and related restorative procedures
- Services not listed as covered dental services in the list of covered dental services provided by dental administrator
- Services provided by a nonparticipating dental provider or not preauthorized by dental administrator (with the exception of out-of-area emergency dental services)
- Services related to the treatment of TMD (temporomandibular disorder)
- Elective surgery including, but not limited to, extraction of nonpathologic, asymptomatic impacted teeth
- Dental expenses incurred in connection with any dental procedure that was started prior to your effective date of coverage under this dental plan and agreement. Examples include orthodontic work in progress, teeth prepared for crowns, and root canal therapy in progress.
- Lab fees for excisions and biopsies, except as may be otherwise covered in your medical plan described in the *Membership Agreement*
- Treatment of malignancies, neoplasm, or congenital malformations, except as may be otherwise covered in your medical plan as described in the *Membership Agreement*
- Experimental procedures, implantations, or pharmacological regimens

Limitations:

Covered dental services are subject to the following limitations:

- Replacement of a bridge, crown, or denture within five (5) years after the date it was originally installed
- Replacement of a filling within two (2) years after original date of placement
- Coverage for periodic oral exams, prophylaxes (cleanings), and fluoride applications is limited to once every six (6) months.
- Crown and bridge fees apply to treatment involving five (5) or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's usual, customary, and reasonable (UCR) fee, minus 25 percent.
- Full mouth X-rays or panoramic film is limited to one set every three (3) years.
- Retreatment of root canal within two (2) years of the original treatment
- Coverage for sealants is limited to the first and second permanent molars for children under the age of 16 once every 24 months.
- Coverage for periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site.
- Coverage for root planing or scaling is limited to once every 24 months per quadrant.
- Full mouth debridement is limited to once every 36 months.
- Periodontal maintenance after active therapy is limited to twice per 12 months within 24 months after definitive periodontal therapy.
- Coverage for relining of dentures is limited to once every 12 months.

To request a full list of exclusions and limitations, please call Member Services at **301-468-6000** or **1-800-777-7902** (TTY **301-879-6380**), from 7:30 a.m. to 5:30 p.m., Monday through Friday.

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