KAISER PERMANENTE®

2010 Summary of Benefits

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

HDHP (HSA-Qualified) Mandated Plan ($30/$40/$1,000 IP/0%/$2,700/$5,250) Small Group (Maryland)

The following is a limited description of benefits offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP-MAS). Not all services and procedures are covered by your benefits contract. This Summary of Benefits is for informational and comparison purposes only and does not create rights not given through the benefit plan.

A Primary Care Physician must be selected. If not, one will be assigned to you by the Health Plan. With the exception of Emergency Services and Out-of-Area Urgent Care Services, all covered Services must be provided by or arranged for by your Plan Primary Care Physician and authorized by the Health Plan. Services such as medically necessary routine gynecological exams, mental health and substance abuse services, and optometry services may be obtained without a referral from you Plan Primary Care Physician; however, they must be provided by a Plan Physician or other Plan Provider.

PLAN DETAILS		
Copayments	$30 (PCP) / $40 (Specialty)	
Coinsurance (Plan pays / Member pays)	100% / 0%, except as otherwise indicated	
Deductible (including Prescription Drug coverage)	Individual: $2,700	Other than Individual: $5,450
Maximum Out-of-Pocket Expense	Individual: $5,250	Other than Individual: $10,500
Lifetime Maximum	No lifetime maximum	

BENEFITS	MEMBER PAYS
OUTPATIENT SERVICES	
Well Child Office Visit	
Birth to age 2	$10 per visit (Deductible waived)
Age 2 through age 13	$10 per visit (Deductible waived)
All other well child office visits	$10 per visit (Deductible waived)
Adult Preventive Health Office Visit	$30 per visit (Deductible waived)
Office Visit for Illness	
Primary Care Office Visit	$30 per visit after Deductible met
Specialty Care Office Visit	$40 per visit after Deductible met
OBGYN visits (non-routine)	$30 per visit after Deductible met
Routine pre-natal visit (after confirmation of pregnancy) and first post-natal visit	$30 per visit after Deductible met
Diagnostic Tests and Procedures, X-rays & Laboratory Services	$40 per visit or 50% of the cost of the service, whichever is less (after Deductible met)
Outpatient surgery or other outpatient procedures	$40 per visit or the cost of the service, whichever is less after Deductible met
HOSPITAL SERVICES	
Inpatient hospital care, including inpatient maternity care	$1,000 per admission after Deductible met
Inpatient physician services	$30 per visit after Deductible met
CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES	
Inpatient hospital care	$1,000 per admission after Deductible met
Inpatient physician services	$30 per visit after Deductible met
Outpatient services	30% of allowable charge after Deductible met
Medication management visit	$40 per visit after Deductible met
THERAPY & REHABILITATION SERVICES	
Inpatient hospital care	$1,000 per admission after Deductible met
Inpatient physician services	$30 per visit after Deductible met
Outpatient services (limited to 30 visits per condition per contract year)	$40 per visit after Deductible met
Chiropractic services (limited to 20 visits per condition per contract year)	$40 per visit after Deductible met
INFERTILITY SERVICES	
Covered Services obtained after diagnosis of infertility has been confirmed	50% of allowable charge after Deductible met
EMERGENCY SERVICES	
Hospital Emergency Room (waived if admitted as inpatient)	$100 per visit after Deductible met
Ambulance	No charge after Deductible met
HOSPITAL ALTERNATIVES	
Skilled Nursing Facility (limited to 100 days per contract year)	$40 per day after Deductible met
Home Health Care	No charge after Deductible met
Hospice Care	No charge after Deductible met
OTHER SERVICES	
Durable Medical Equipment (DME)	
Basic DME	No charge after Deductible met
Oxygen equipment	No charge after Deductible met
Prosthetics	
Internal prosthetics	No charge after Deductible met
External prosthetics	No charge after Deductible met

BENEFITS	MEMBER PAYS
Vision	
Office visit for medical conditions of the eye	$30 per visit (PCP) / $40 per visit (Specialty) after Deductible met
Routine eye refractions to determine need for vision correction	Not covered except for aphakic patients
Eyeglass frames and lenses (limited to one pair of glasses per contract year)	Not covered except for aphakic patients
Contact lenses	Not covered except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for the use in the treatment of a disease or injury
Prescription Drugs	
Prescription drugs described in the "Covered Services" section All covered drugs must be purchased at a Kaiser Permanente Medical Center Pharmacy, an affiliated network pharmacy or through Kaiser Permanente's mail order delivery service. Except for maintenance medications, you will receive up to a 30 day supply of the prescribed drug Up to a 90 day supply of maintenance drugs will be dispensed in a single dispensing	75% of allowable charge after Deductible met

NOTE: This Summary of Benefits is for comparison purposes only and does not create rights not given through the benefit plan.

KFHP-MAS: MDSG-HSA-SEC1(7/06); MDSG-SEC2(7/06); MDSG-SEC3 (7/06); MDSG-HSA-SEC4 (7/06); MDLG-ALL-SEC5(05/04); MDSG- SEC6(7/06); MDSG-ALL-SEC7(1/05); MDSG-APP DEF HSA (7/06); MDSG HMO-HSA COST (11/07) and any attached riders or amendments.

EXCLUSIONS AND LIMITATIONS:

This plan does not cover all health care expenses and includes limitation and exclusions. The Services listed below contain exclusions and limitations that apply to the benefits outlined in this Benefit and Service Summary. When a Service is excluded, all Services related to that excluded Service are also excluded, even if they would otherwise be covered under this benefit plan.

This Benefit and Service Summary contains only a partial, general description of the plan benefits and services, but does describe fully the exclusions and limitations associated with your Kaiser Permanente coverage. Once enrolled for coverage, you will receive your KFHP-MAS Evidence of Coverage (EOC) which contains a complete listing of services, limitations, general and benefit specific exclusions and a description of all the terms and conditions of coverage. Your EOC provides you with information on what services and supplies will not be covered, regardless of whether the service is medically necessary.

1. Services that are not medically necessary.
2. Services performed or prescribed under the direction of a person who is not a Health Care Practitioner.
3. Services that are beyond the scope of practice of the Health Care Practitioner performing the Service.
4. Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for Services received for which the recipient is liable.
5. Services for which a Covered Person is not legally, or as a customary practice, required to pay in the absence of a Health Benefit Plan.
6. The purchase, examination, or fitting of eye glasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for the use in the treatment of a disease or injury.
7. Personal Care Services and Domiciliary Care Services.
8. Services rendered by a Health Care Practitioner who is a Covered Person's spouse, mother, father, daughter, son, brother or sister.
9. Experimental Services.
10. Practitioner, Hospital, or clinical Services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.
11. In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
12. Services to reverse a voluntary sterilization procedure.
13. Services for sterilization or reverse sterilization for a Dependent minor.
14. Medical or surgical treatment for reducing or controlling weight.
15. Services incurred before the effective date of coverage for a Covered Person.
16. Services incurred after a Covered Person's termination of coverage.
17. Surgery or related Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.
18. Services for injuries or diseases related to a Covered Person's job to the extent the Covered Person is required to be covered by a workers' compensation law.
19. Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor, union, trust, or similar persons or groups.
20. Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.
21. Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form.
22. Inpatient admissions primarily for diagnostic studies, unless authorized by the Health Plan.
23. The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers.
24. Except for covered ambulance Services, travel, whether or not recommended by a Health Care Practitioner.
25. Except for Emergency Services, Services received while the Covered Person is outside the United States.
26. Immunizations related to foreign travel.
27. Dental work or treatment which includes Hospital or professional care in connection with:
    a. The operation or treatment for the fitting or wearing of dentures;
    b. Orthodontic care or malocclusion;
    c. Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within six months of the accident; and
    d. Dental implants;
28. Accidents occurring while and as a result of chewing.
29. Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these Services are determined to be medically necessary.
30. Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these Services are deemed to be medically necessary.
31. Inpatient admissions primarily for physical therapy, unless authorized by the Health Plan.
32. Treatment leading to or in connection with transsexualism, or sex changes or modifications, including but not limited to surgery.
33. Treatment of sexual dysfunction not related to organic disease.
34. Services that duplicate benefits provided under federal, state, or local laws, regulations or programs.
35. Organ transplants except those specified in the "Covered Services" section of the Evidence of Coverage.
36. Non-human organs and their implantation.
37. Non-replacement fees for blood and blood products.
38. Lifestyle improvements, including nutrition counseling, or physical fitness programs.
39. Wigs or cranial prosthesis.
40. Weekend admission charges, except for emergencies and maternity, unless authorized by the Health Plan.

41. Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.
42. Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical Services for TMJ and CPS, if medically necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury.
43. Services resulting from accidental bodily injuries arising out of a motor vehicle accident, to the extent the Services are payable under a medical expense payment provision of an automobile insurance policy.
44. Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.
45. Services for, or related to, the removal of an organ from a Covered Person for the purposes of transplantation into another person unless the:
    a. transplant recipient is covered under Health Plan and is undergoing a covered transplant; and,
    b. Services are not payable by another carrier.
46. Physical examinations required for obtaining or continuing employment, insurance, or government licensing.
47. Non-medical ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy;
48. Private Hospital room unless authorized by the Health Plan.
49. Private duty nursing, unless authorized by the Health Plan.
50. Treatment for mental health or substance abuse not authorized by Health Plan through its Managed Care System, or a mental health or substance abuse condition determined by the Health Plan through its Managed Care System to be untreatable.
51. Services related to smoking cessation.
52. The following vision Services are not covered:
    - Sunglasses without corrective lenses unless medically necessary;
    - Any eye surgery solely for the purpose of corrective refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), and astigmatism;
    - Eye exercises;
    - Cosmetic contact lenses;
    - All Services related to contact lenses including examinations, fitting and dispensing, and follow-up visits; and
    - Replacement of lost or broken lenses or frames.
53. Dental - If a Dental HMO or POS Rider is purchased by the employer group, the following limitations and exclusions will apply:

    Limitations (Preventive and Point-of-Service Dental Plans):

    - Replacement of a bridge, crown or denture within 5 years after the date it was originally installed.
    - Replacement of a filling within 2 years after original date of placement.
    - Coverage for periodic oral exams, prophylaxes (cleanings) and fluoride applications is limited to once every 6 months.
    - Crown and bridge fees apply to treatment involving 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%.
    - Full mouth x-rays or panoramic film is limited to one set every 3 years.
    - Retreatment of root canal within 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 for any type, including any associated material is covered once every 36 months per quadrant or surgical site.
    - Coverage for root planning or scaling is limited to once every 24 months per quadrant.
    - Full mouth debridement is limited to once every 3 months.
    - Periodontal maintenance after active therapy is limited to twice per 12 months within 24 months after definitive periodontal therapy.

    Exclusions (Preventive and Point-of-Service Dental Plans):

    - Services for injuries or conditions, which are covered under worker's compensation and/or employer's liability laws.
    - Services which are provided without cost to members by any federal, state, municipal, county, or other subdivision's program (with the exception of Medicaid).
    - Services which, 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 under your medical plan.
    - Hospitalization for any dental procedures.
    - 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 Schedule of Dental Fees provided by the Dental Administrator.
    - Services related to the treatment of TMD (Temporomandibular Disorder).
    - Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
    - Dental expenses incurred in connection with any dental procedure that was started prior to the Member's effective date of coverage under the Dental Rider.
    - Lab fees for excisions and biopsies, except as may be otherwise covered under the Member's medical plan
    - Treatment of malignancies, neoplasm, or congenital malformations, except as may otherwise be covered under the Member's medical plan.
    - Experimental procedures, implantations, or pharmacological regimens.
    - Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.

- Charges for second opinions, unless pre-authorized.
- Procedures requiring fixed prosthodontic restoration which are necessary for complete oral rehabilitation or reconstruction.
- Occlusal guards, except for the purpose of controlling habitual grinding.

Exclusions (Preventive Dental Plans only):

- Services provided by dentists or other practitioners of healing arts not associated with Health Plan and/or Dental Administrator, except upon referral arranged by a Participating Dental Provider and authorized or when required in a covered emergency.
- Services provided by non-Participating Dental Providers or not pre-authorized by Dental Administrator (with the exception of out-of-area emergency dental services).

Exclusions (Point-of-Service Dental Plans only):

- Orthodontic treatment for adults.
- Orthodontic treatment related to TMD (Temporomandibular Disorder).

Kaiser Permanente shall not be bound by the exclusions and limitations listed herein, but rather, the benefits, services, exclusions and limitations listed in your EOC. Consult the plan documents (i.e., Evidence of Coverage) to determine governing contractual provisions, including detailed benefits, exclusions and limitations relating to the benefit plan.