



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

**Summary of Benefits
MONTGOMERY COLLEGE
HMO SIG – Mid-Large Groups (\$15/\$30)
(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	\$15 (PCP) / \$30 (Specialty)
Coinsurance (Plan pays / Member pays)	100% / 0% except as otherwise indicated
Deductible	None
Maximum Annual Copayment	Individual: \$3,500 Family: \$9,400
Lifetime Maximum	No lifetime maximum
BENEFITS	
MEMBER PAYS	
OUTPATIENT SERVICES	
Preventive Health Office Visit	No charge
Preventive Health Screening Tests	No charge
Office Visit for Illness	
Primary Care Office Visit	\$15 per visit (Copayment waived for children under age 5)
Specialty Care Office Visit	\$30 per visit
Routine pre-natal visit (after confirmation of pregnancy) and first post-natal visit	No charge
Diagnostic Tests and Procedures, X-rays & Laboratory Services	No charge
Specialty Imaging (e.g., CT, MRI, PET scan & Nuclear Medicine)	No charge
Outpatient Surgery (other than in a provider's office)	\$30 per procedure
HOSPITAL SERVICES	
Inpatient hospital care, including inpatient maternity care	\$100 per admission
Inpatient physician services	No charge
CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES	
Inpatient hospital care	\$100 per admission
Outpatient services	\$20 per visit for individual therapy; \$10 per visit for group therapy
THERAPY & REHABILITATION SERVICES	
Inpatient hospital care	\$100 per admission
Outpatient services (Limited to up to 30 visits of physical therapy or 90 consecutive days of occupational or speech therapy per contract year per injury, incident or condition)	\$30 per visit
INFERTILITY SERVICES	
Office visits	50% of allowable charge
All other covered services for treatment of infertility (In vitro fertilization benefit limited to 3 attempts per live birth and a lifetime maximum Health Plan benefit of \$100,000)	50% of allowable charge
URGENT CARE & EMERGENCY SERVICES	
Urgent Care Office Visit	\$15 per visit (PCP) / \$30 per visit (Specialty)
After hours Urgent Care or Urgent Care Center	\$30 per visit
Hospital Emergency Room (waived if admitted as inpatient)	\$75 per visit
Ambulance	No charge
HOSPITAL ALTERNATIVES	
Skilled Nursing Facility (limited to 100 days per contract year)	\$100 per admission
Home Health Care (limited to 2 hours per visit; Intermittent care shall not exceed 3 visits in one day)	No charge
Hospice Care	No charge

BENEFITS		MEMBER PAYS
OTHER SERVICES		
Durable Medical Equipment (DME)		
Basic DME		No charge
Oxygen equipment		No charge for 1 st 3 months then 50% of allowable charge thereafter
Prosthetics		
Internal prosthetics		No charge
External prosthetics		No charge
Vision		
Office visit for medical conditions of the eye		\$15 per visit (PCP) / \$30 per visit (Specialty)
Routine eye refractions to determine need for vision correction		\$15 per visit with Optometrist \$30 per visit with Ophthalmologist (referral required)
Eyeglass frames and lenses (limited to one pair of glasses per contract year)		Member receives 25% discount off retail price when purchased from Plan Providers
Contact lenses		Member receives 15% discount off retail price on initial pair of contact lenses only, when purchased from Plan Providers
Prescription Drugs		
Covered prescription drugs (up to a 60-day supply) (Up to a 90-day supply for 1.5 copays)		Plan Pharmacy & Mail Order – \$15 Generic / \$30 Brand Participating Network Pharmacy – \$16 Generic / \$37 Brand
RIDERED BENEFITS		MEMBER PAYS
Dental		
Covered dental services		Plan C - \$30 for preventive dental care services

This Benefit and Service Summary contains only a partial, general description of the plan benefits and services and does not fully describe the exclusions and limitations associated to this benefit plan. To request a full list of Exclusions and Limitations for Mid-Large Groups, please call Member Services at 301-468-6000 or 1-800-777-7902 (TTY 301-879-6380), Monday through Friday, 7:30 a.m. – 5:30 p.m.

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.

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.

Form Numbers: MDLG-ALL-SEC1(4/09); MDLG-ALL-SEC2(1/09); MDLG-ALL-SEC3 (1/09); MDLG-ALL-SEC4 (4/09); MDLG-ALL-SEC5(1/08); MDLG-ALL-SEC6(1/09); MDLG-ALL-SEC7(1/09); MDLG-ALL-APPX-DEF(1/09); MDLG-HMO-COST(1/09); and any amendments or riders attached thereto.

BENEFIT SPECIFIC LIMITATIONS:

The Services listed below contain limitations specific to the benefits outlined in this Benefit and Service Summary.

Preventive Health Services

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

- Monitoring 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,
- Services provided when you show signs or symptoms of a specific disease or disease process,
- Non-routine gynecological visits,
- Treatment of a medical condition or problem identified during the course of the preventive screening exam, such as removal of a polyp during a sigmoidoscopy.

Prosthetic Devices

- Coverage for mastectomy bras is limited to a maximum of two per contract year.
- Coverage for hair prosthesis is limited to one prosthesis per course of chemotherapy and/or radiation therapy, not to exceed a maximum benefit of \$350 per prosthesis.
- Coverage is limited to standard devices that adequately meet your needs (if Rider purchased for External Prosthetic and Orthotic Devices).

Physical, Speech and Occupational Therapy

- 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.
- Physical therapy is limited to the restoration of an existing physical function, except as provided in the "Habilitative Services" section of this benefit.

Urgent Care

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 extreme personal emergency.

Prescription Drugs

- For drugs prescribed by a dentist, coverage is limited to antibiotics and pain relief drugs that are included on our Formulary and purchased at a Plan Pharmacy or a Participating Network Pharmacy.
- 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.

Dental (if Rider purchased by employer group)

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.

BENEFIT SPECIFIC EXCLUSIONS:

The Services listed below contain exclusions that apply to the benefits outlined in this Benefit and Service Summary.

Ambulance Services

- Transportation by car, taxi, bus, gurney van, wheelchair van, 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.

Chemical Dependency and Mental Health Services

- Services for Members who, in the opinion of the Plan Provider, are seeking services and supplies for other than therapeutic purposes.
- Psychological and neuropsychological 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 indicated.

Psychiatric Residential Crisis Services

- Long-term residential treatment Services

Complementary Alternative Medicine (if Rider purchased)

- Services deemed not medically necessary.
- Services requested when the Member's medical condition does not satisfy Health Plan's clinical guidelines established for alternative care.

Dental (if Rider purchased by employer group)

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.

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).

Point-of-Service Dental Plans only:

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

Durable Medical Equipment

- 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.

Hearing Services (if Rider purchased)

- Replacement of parts and batteries.
- Replacement of lost or broken Hearing Aid.
- Repair of Hearing Aid beyond one year.
- Comfort, convenience, or luxury equipment or features.
- Hearing Aids prescribed and ordered prior to coverage or after termination of coverage.

Home Health Care

- Custodial care.
- 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.
- Services not preauthorized by Health Plan.
- Care that a Plan Provider determines may be provided in a Plan Facility and we provide or offer to provide that care in one of these facilities.
- Transportation and delivery service costs of Durable Medical Equipment, medications and drugs, medical supplies, and supplements to the home.

Hospice Care

- Services not preauthorized by Health Plan.

Infertility

- Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member's eggs and/or male Member's sperm for future attempts.
- Assisted reproductive procedures and any related testing or service that includes the use of donor sperm, donor eggs or donor embryos.
- Any charges associated with donor eggs, donor sperm or donor embryos.
- Infertility Services, except for covered Services for in vitro fertilization, when the member does not meet medical guidelines established by the American College of Obstetricians and Gynecologists.
- Services to reverse voluntary, surgically induced infertility.
- Infertility Services when the infertility is the result of an elective male or female surgical procedure.
- Assisted reproductive technologies and procedures, including, but not limited to: gamete intrafallopian transfers (GIFT); zygote intrafallopian transfers (ZIFT); intracytoplasmic sperm injection (ICSI); assisted hatching; preimplantation genetic diagnosis (PGD); and prescription drugs related to such procedures.

Prescription Drugs

- Drugs for which a prescription is not required by law, except if the drug is approved by Formulary 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 the Evidence of Coverage.
- Drugs to shorten the duration of the common cold.
- Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from the Health Plan's standard packaging for prescription medications.
- 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.
- Diabetic equipment and supplies which are covered under your medical benefit.
- Drugs for the treatment of sexual dysfunction disorders.

Prosthetic Devices

- Internally implanted breast prosthetics for cosmetic purposes.
- External prosthetics or orthotics, except as provided in this Section under "Cleft-Lip, Cleft Palate, or Both," "Hearing Services," or as provided under a "Prosthetic and Orthotic Devices Rider," if applicable.
- Repair or replacement of prosthetics due to loss or misuse.

External Prosthetic & Orthotic Devices (if Rider purchased)

Except as specifically covered under your Evidence of Coverage, the following Services are excluded:

- More than one piece of equipment or device for the same part of the body, except for replacements; spare devices or alternate use devices.
- Dental prostheses, devices and appliances.
- Hearing aids.
- Corrective lenses and eyeglasses.
- Repair or replacement due to misuse or loss.
- Orthopedic shoes or other supportive devices, unless the shoe is an integral part of a leg brace.
- Non-rigid appliances and supplies, including but not limited to: jobst stockings, elastic garments and stockings, and garter belts.
- Comfort, convenience, or luxury equipment or features.

Skilled Nursing Facility Care

- Custodial care.
- Domiciliary care.

Therapy and Rehabilitation Services

- Except as provided for cardiac rehabilitation Services, no coverage is provided for any therapy that the Plan Physician determines cannot achieve measurable improvement in function within a two-month period.

Urgent Care

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

Vision

- Sunglasses without corrective lenses unless medically necessary.
- 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.
- Non-corrective contact lenses.
- Contact lens Services other than the initial fitting and purchase of contact lenses.
- Replacement of lost or broken lenses or frames.
- Orthoptic (eye training) therapy.