KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Certificate of Coverage

Public Employees Benefits Program (PEBB)

2016 Medical Benefits

Non-Medicare Actives - Consumer-Directed Health Plan

Published under the direction of the Washington State Health Care Authority (HCA)

Washington State Health Care Authority

This *COC* is effective January 1, 2016 through December 31, 2016

Member Services

Monday through Friday (except holidays)
8 a.m. to 6 p.m.
Portland area 503-813-2000
All other areas.....1-800-813-2000

TTY

All areas.....1-800-735-2900

Language interpretation services

All areas.....1-800-324-8010

kp.org

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INTRODUCTION

This *Certificate of Coverage* (*COC*), including the "Benefit Summary," describes the health care benefits of this Plan provided under the *Agreement* between Kaiser Foundation Health Plan of the Northwest, sometimes referred to as "Kaiser," "we," "our," or "us," and the Washington State Health Care Authority (HCA) for the Public Employees Benefits Program (PEBB). For benefits provided under any other plan, refer to that plan's certificate of coverage. Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *COC*. See the "Definitions" section for terms you should know.

This health benefit Plan is a high deductible health Plan that meets the requirements of Section 223 (c)(2) of the Internal Revenue Code. The health care coverage described in this *COC* is designed to be compatible for use with a Health Savings Account (HSA) under federal tax law.

The tax references contained in this *COC* relate to federal income tax only. The tax treatment of HSA contributions and distributions under your state income tax laws may differ from the federal tax treatment and differ from state to state. Kaiser Foundation Health Plan of the Northwest does not provide tax advice. You should consult with your financial or tax advisor for tax advice or more information, including information about your eligibility for an HSA.

Please be aware that enrollment in a high deductible health Plan that is HSA-compatible is only one of the eligibility requirements for establishing and contributing to an HSA. Some examples of other requirements include that you must not be:

- Covered by another health coverage Plan that is not also an HSA-compatible Plan, with certain exceptions.
- Enrolled in Medicare Part A or Part B.
- Able to be claimed as a dependent on another person's tax return.

Because the Washington State Health Care Authority offers this high deductible health plan to PEBB's Members as a "self-only" plan or as a "family" plan where dependents are covered, it is important to familiarize yourself with your coverage by reading this *COC* and the "Benefit Summary" completely. In some cases, certain provisions in this *COC* apply only to the family plan when dependents are mentioned. Otherwise, the content of this *COC* is applicable to both. Also, if you have special health care needs, carefully read the sections applicable to you.

If there is a conflict between the Plan *Agreement* and this *COC*, this *COC* will govern.

DEFINITIONS

Allowed Amount. The lower of the following amounts:

- The actual fee the provider, facility, or vendor charged for the Service.
- 160 percent of the Medicare fee for the Service, as indicated by the applicable Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS) code shown on the current Medicare fee schedule. The Medicare fee schedule is developed by the Centers for Medicare and Medicaid Services (CMS) and adjusted by Medicare geographical practice indexes. When there is no established CPT or HCPCS code indicating the Medicare fee for a particular Service, the Allowed Amount is 70 percent of the actual fee the provider, facility, or vendor charged for the Service.

Alternative Care. Services provided by an East Asian medicine practitioner or naturopath.

Benefit Summary. A section of this *COC* which provides a brief description of your medical Plan benefits and what you pay for covered Services.

Calendar Year. The 12-consecutive month time period of January 1 through December 31 of the same year.

Certificate of Coverage (COC). This *Certificate of Coverage* document provided to the Subscriber that specifies and describes benefits and conditions of coverage. After you enroll, you will receive a postcard that explains how you may either download an electronic copy of this *COC* or request that this *COC* be mailed to you.

Chemical Dependency. An illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

Coinsurance. The percentage of the Allowable Charge that Members are responsible to pay when the Plan provides benefits at less than 100% coverage.

Copayment. The defined dollar amount that Members pay when receiving covered Services.

Creditable Coverage. Prior health care coverage as defined in 42 U.S.C. 300gg as amended. Creditable Coverage includes most types of group and non-group coverage.

Custodial/Convalescent Care. Care that is designed primarily to assist the Member in activities of daily living, including institutional care that serves primarily to support self-care and provide room and board. Custodial/Convalescent Care includes, but is not limited to, help walking, getting into and out of bed, bathing, dressing, feeding, preparing special diets, and supervision of medications that are ordinarily self-administered. Kaiser reserves the right to determine which services constitute Custodial or Convalescent Care.

Deductible. The amount you must pay for certain Services you receive in a Calendar Year before we will cover those Services, subject to any applicable Copayment or Coinsurance, in that Calendar Year.

Dependent. A Member who meets the eligibility requirements as a Dependent.

Durable Medical Equipment (DME). Non-disposable supply or item of equipment that is able to withstand repeated use, primarily and customarily used to serve a medical purpose and generally not useful to the Member if the Member is not ill or injured.

Emergency Medical Condition. A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Services. All of the following with respect to an Emergency Medical Condition:

- A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, including ancillary services and patient observation, routinely available to the emergency department to evaluate the Emergency Medical Condition.
- Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act requires to stabilize the patient.

Essential Health Benefits. Essential Health Benefits means benefits that the U.S. Department of Health and Human Services (HHS) Secretary defines as essential health benefits. Essential Health Benefits must be equal to the scope of benefits provided under a typical employer plan, except that they must include at least the following: ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

External Prosthetic Devices. External prosthetic devices are rigid or semi-rigid external devices required to replace all or any part of a body organ or extremity.

Family. A Subscriber and all of his or her enrolled Dependents.

Family Planning Services. Those medical care Services related to planning the birth of children through the use of birth control methods, including elective sterilization.

Formulary. A list of outpatient prescription drugs, selected by Kaiser and revised periodically, which are covered when prescribed by a Participating Provider and filled at a Participating Pharmacy.

Group. Washington Public Employees Benefits Program (PEBB).

Health Savings Account (HSA). A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified high deductible health Plan and meet other tax law requirements.

Kaiser does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for a Health Savings Account.

Home Health Agency. A "home health agency" is an agency that: (i) meets any legal licensing required by the state or other locality in which it is located; (ii) qualifies as a participating home health agency under Medicare; and (iii) specializes in giving skilled nursing facility care Services and other therapeutic Services, such as physical therapy, in the patient's home (or to a place of temporary or permanent residence used as your home).

Homemaker Services. Assistance in personal care, maintenance of a safe and healthy environment, and Services to enable the individual to carry out the plan of care.

Kaiser. Kaiser Foundation Health Plan of the Northwest, an Oregon nonprofit corporation, who provides Services and benefits for Members enrolled in this Plan - Public Employees Benefits (PEBB) Program. This *COC* sometimes refers to Kaiser as "we," "our," or "us."

Kaiser Permanente. Kaiser, Kaiser Foundation Hospitals (a California nonprofit corporation), and the Medical Group, which is Northwest Permanente, P.C., Physicians and Surgeons, a professional corporation of physicians organized under the laws of the state of Oregon. Medical Group contracts with the Kaiser to provide professional medical Services to Members and others primarily on a capitated, prepaid basis in Participating Facilities.

Medical Directory. The *Medical Directory* lists primary care and specialty care Participating Providers; includes addresses, maps, and telephone numbers for Participating Medical Offices and other Participating Facilities; and provides general information about getting care at Kaiser Permanente. After you enroll, you will receive a flyer that explains how you may either download an electronic copy of the *Medical Directory* or request that the *Medical Directory* be mailed to you.

Medical Group. Northwest Permanente, P.C., Physicians and Surgeons, which is a professional corporation of physicians organized under the laws of the state of Oregon. Medical Group contracts with Kaiser to provide professional medical Services to Members and others primarily on a capitated, prepaid basis in Participating Facilities.

Medically Necessary. A Service that in the judgment of a Primary Care Provider (PCP) or Participating Provider is required to prevent, diagnose, or treat a medical condition. A Service is Medically Necessary only if a PCP or Participating Provider determines that its omission would adversely affect your health and its provision constitutes a medically appropriate course of treatment for you in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community and in accordance with applicable law.

A Service is "Medically Necessary" if it is recommended by the Member's PCP or Participating Provider and Medical Group's Medical Director or provider designee and if all of the following conditions are met:

1. The purpose of the Service or intervention is to treat a medical condition;
2. It is the appropriate level of Service or intervention considering the potential benefits and harm to the patient;
3. The level of Service or intervention is known to be effective in improving health outcomes;
4. The level of Service or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention; and
5. For new interventions, effectiveness is determined by scientific evidence. Existing interventions are determined effective first by scientific evidence, then by professional standards, then by expert opinion.

Applicable terms:

A health "intervention" is a service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a medical condition (i.e., disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of "Medical Necessity," a health "intervention" means not only the intervention itself, but also the medical condition and patient indications for which it is being applied.

"Effective" is an intervention, supply or level of service that can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

An intervention or service may be medically indicated yet not be a covered benefit or meet the standards of this definition of "Medical Necessity." Medical Group may choose to cover interventions, or Services that do not meet this definition of "Medical Necessity," however, is not required to do so.

"Treating provider" is a health care provider who has personally evaluated the patient.

"Health outcomes" are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

An intervention is considered to be new if it is not yet in widespread use for the medical condition and patient indications being considered.

"New interventions" for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion (see "existing interventions" below).

"Scientific evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not

available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

For "existing interventions," the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of "medical necessity." If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet Kaiser Permanente's definition of "medical necessity" in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

A level of service, supply or intervention is considered "cost effective" if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative. Cost-effective does not necessarily mean lowest price.

Medicare. A federal health insurance program for people aged 65 and older, certain people with disabilities, and those with end-stage renal disease (ESRD).

Member. An employee, retiree, dependent (including surviving dependent), or state-registered domestic partner who is eligible and enrolled under this *COC*, and for whom Kaiser has received applicable premium. This *COC* sometimes refers to a Member as "you" or "enrollee." The term Member may include the Subscriber, his or her dependent, or other individual who is eligible for and enrolled under this *COC*.

Non-Participating Facility. Any of the following licensed institutions that provide Services, but which are not Participating Facilities: hospitals and other inpatient centers, ambulatory surgical or treatment centers, birthing centers, medical offices and clinics, skilled nursing facilities, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation settings. This includes any of these facilities that are owned and operated by a political subdivision or instrumentality of the state and other facilities as required by federal law and implementing regulations.

Non-Participating Physician. Any licensed physician who is not a Participating Physician.

Non-Preferred Brand-Name Drug. A Brand-Name drug or supply that is not approved by Company's Regional Formulary and Therapeutics Committee and requires prior authorization for coverage.

Non-Participating Provider. Any Non-Participating Physician or any other person who is not a Participating Provider and who is regulated under state law, to practice health or health-related Services or otherwise practicing health care Services consistent with state law.

Orthotic Devices. Orthotic devices are rigid or semi-rigid external devices (other than casts) required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

Out-of-Pocket Maximum. The total amount of Deductibles, Copayment and Coinsurance you will be responsible to pay in a Calendar Year, as described in the "Out-of-Pocket Maximum" section of this *COC*.

Participating Facility. Any facility listed as a Participating Facility in the *Medical Directory* for our Service Area. Participating Facilities are subject to change.

Participating Hospital. Any hospital listed as a Participating Hospital in the *Medical Directory* for our Service Area. Participating Hospitals are subject to change.

Participating Medical Office. Any outpatient treatment facility listed as a Participating Medical Office in the *Medical Directory* for our Service Area. Participating Medical Offices are subject to change.

Participating Pharmacy. Any pharmacy owned and operated by Kaiser Permanente and listed as a Participating Pharmacy in the *Medical Directory* for our Service Area. Participating Pharmacies are subject to change.

Participating Physician. Any licensed physician who is an employee of the Medical Group, or any licensed physician who, under a contract directly or indirectly with Kaiser, has agreed to provide covered Services to Members with an expectation of receiving payment, other than Deductible, Copayments, or Coinsurance, from Kaiser rather than from the Member.

Participating Provider. (a) A person regulated under state law, to practice health or health-related Services or otherwise practicing health care Services consistent with state law; or (b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment either of whom, under a contract directly or indirectly with Kaiser, has agreed to provide covered Services to Members with an expectation of receiving payment, other than Deductible, Copayments, or Coinsurance, from Kaiser rather than from the Member. Participating Providers must agree to standards related to:

- Provision, Utilization Review, and cost containment of health Services;
- Management and administrative procedures; and
- Provision of cost-effective and clinically efficacious health Services.

Participating Skilled Nursing Facility. A facility that provides inpatient skilled nursing Services, rehabilitation Services, or other related health Services and is licensed by the state of Oregon or Washington and approved by Kaiser. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Participating Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily custodial care, including training in routines of daily living. A "Participating Skilled Nursing Facility" may also be a unit or section within another facility (for example, a Participating Hospital) as long as it continues to meet the definition above.

Patient Protection and Affordable Care Act of 2010. Means the Patient Protection and Affordable Care Act of 2010 (Public Law 11 - 148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111 - 152).

Plan. The Public Employee Benefits Program (PEBB) health benefit plan of coverage agreed to between PEBB and Kaiser Foundation Health Plan of the Northwest (Kaiser).

Post-Stabilization Care. The Services you receive for the acute episode of your Emergency Medical Condition after your treating physician determines that your Emergency Medical Condition is clinically stable. ("Clinically stable" means that no material deterioration of the Emergency Medical Condition is likely, within reasonable medical probability, to result from or occur during your discharge or transfer from the hospital.)

Preferred Brand-Name Drug. The first approved version of a drug or supply that Company's Regional Formulary and Therapeutics Committee has approved. Marketed and sold under a proprietary, trademark-protected name by the pharmaceutical company that holds the original patent.

Premium. Monthly membership charges paid by Group.

Primary Care Provider (PCP). A Participating Provider who provides, prescribes, or directs all phases of a Member's care, including appropriate referrals to Non-Participating Providers. The PCP has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist

care, and maintaining the continuity of Member care. PCPs, as designated by Medical Group, may include, but are not limited to, Pediatricians, Family Practitioners, General Practitioners, Internists, Physicians Assistant (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP).

Proof of Continuous Coverage. The Certificate of Creditable Coverage provided to the member by the member's prior health plan; or a letter from the member's employer, on the employer's letterhead, providing the time period the member and/or dependent(s) of the member were covered by health insurance.

Service Area. Our Service Area consists of Clark and Cowlitz counties in the state of Washington.

In Oregon:

Benton: 97330, 97331, 97333, 97339, 97370.

Clackamas: 97004, 97009, 97011, 97013, 97015, 97017, 97022, 97023, 97027, 97034, 97035, 97036, 97038, 97042, 97045, 97049, 97055, 97067, 97068, 97070, 97086, 97089, 97222, 97267, 97268, 97269.

Columbia: All ZIP codes.

Hood River: 97014.

Linn: 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97389.

Marion: 97002, 97020, 97026, 97032, 97071, 97137, 97301, 97302, 97303, 97304, 97305, 97306, 97307, 97308, 97309, 97310, 97311, 97312, 97313, 97314, 97317, 97325, 97342, 97346, 97352, , 97362, 97373, 97375, 97381, 97383, 97384, 97385, 97392.

Multnomah: All ZIP codes.

Polk: All ZIP codes.

Washington: All ZIP codes.

Yamhill: All ZIP codes.

Services. Health care services, supplies, or items.

Specialist. Any licensed Participating Physician who practices in a specialty care area of medicine (not family medicine, pediatrics, gynecology, obstetrics, general practice, or internal medicine). In most cases, you will need a referral in order to receive covered Services from a Specialist.

Spinal and Extremity Manipulation (Diversified or Full Spine Specific (FSS)). The Diversified manipulation/adjustment entails a high-velocity, low amplitude thrust that usually results in a cavitation of a joint (quick, shallow thrusts that cause the popping noise often associated with a chiropractic manipulation/adjustment).

Spouse. Lawful Spouse or state-registered domestic partner.

Stabilize. To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver the infant (including the placenta).

Subscriber. The employee, surviving dependent, or retiree who provides the basis for eligibility for enrollment under this Plan as defined in this *COC*.

The CHP Group. A network of alternative care and chiropractic providers who provide Participating Provider Services and which provides utilization management and prior authorization services for Kaiser

Permanente. You can contact The CHP Group by calling 1-800-449-9479, 8 a.m. to 5 p.m. (PT), Monday through Friday. You can also obtain a list of Participating Providers by visiting www.chpgroup.com.

Urgent Care. Treatment for an unforeseen condition that requires prompt medical attention to keep it from becoming more serious, but that is not an Emergency Medical Condition.

Utilization Review. The formal application of criteria and techniques designed to ensure that each Member is receiving Services at the appropriate level; used as a technique to monitor the use of or evaluate the medical necessity, appropriateness, effectiveness, or efficiency of a specific Service, procedure, or setting.

BENEFIT SUMMARY

Deductible	$1,400 for a family of one Member (self-only)/$2,800 for an entire Family of two or more Members per Calendar Year. All Services except preventive care, vision hardware, and health education classes are subject to the Deductible. (Note: All Deductible, Copayment, and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise noted. The Deductible and Out-of-Pocket Maximum amounts are subject to increase if the U.S. Department of Treasury changes the minimum Deductible and Out-of-Pocket Maximum amounts required for High Deductible Health Plans.)
Out-of-Pocket Maximum	Copayments and Coinsurance paid by a Member for covered Services throughout the Calendar Year shall not be more than $5,100 for one Member (self-only) or $10,200 for an entire Family of two or more Members. The following charges will not accumulate toward the Out-of-Pocket Maximum: • Vision hardware such as eyeglasses and contact lenses for adult (members 19 and older); • Health education classes; • Any Services excluded from coverage under this *COC*; • Any amount not covered under this Plan on the basis Kaiser covered the benefit maximum amount or paid the maximum number of visits for a Service.

Benefits will be provided at the payment levels specified below and in the "Benefits Details" section of this *COC* up to the benefit maximum limits. The numbered Services below correspond with the benefit descriptions in the following section, "Benefit Details." Please read the "Benefit Details" and the "Benefit Exclusions and Limitations" sections for specific benefit limitations, maximums, and exclusions.

COVERED SERVICE	BENEFIT
1. Accidental injury to teeth	100% subject to $20 Copayment per visit after Deductible
2. Ambulance Services	
Air ambulance	100% subject to 15% Coinsurance after Deductible per trip
Ground ambulance	100% subject to 15% Coinsurance after Deductible per trip
3. Ambulatory surgical center	100% subject to 15% Coinsurance after Deductible
4. Blood and blood derivatives	100% after Deductible
5. Chemical Dependency Services	
Inpatient and residential	100% subject to 15% Coinsurance after Deductible
Outpatient	100% subject to $20 Copayment after Deductible per visit
Day treatment Services	100% subject to $20 Copayment after Deductible per day
6. Clinical Trials	
Services in connection with clinical trials (See criteria details under the Clinical trials section)	Payment levels are determined by the setting in which the Service is provided.

COVERED SERVICE	BENEFIT
7. Diabetic education	100% subject to $20 office visit Copayment after Deductible per visit or the $30 specialty office visit Copayment after Deductible per visit
8. Diagnostic testing, laboratory, mammograms, and X-ray	100% subject to 15% Coinsurance after Deductible, 100% for preventive tests
9. Dialysis	
Outpatient	100% subject to $30 Copayment after Deductible per visit
Home	100% after Deductible
10. Durable Medical Equipment, supplies, and prostheses	100% subject to 20% Coinsurance after Deductible
11. Emergency room Services *(Copayment waived if admitted directly as inpatient from emergency room)*	100% subject to 15% Coinsurance after Deductible
12. Hearing Examinations and Hearing Aids	
Hearing exams	100% subject to $30 Copayment after Deductible per exam
Hearing aids	100% after Deductible; benefit maximum of $800 every 36 months
13. Home health – up to 130 visits per Calendar Year	100% subject to 15% Coinsurance after Deductible
14. Hospice care (including respite care)	100% after Deductible
15. Inpatient Hospital Services	
Inpatient hospital Services	100% subject to 15% Coinsurance after Deductible
Inpatient professional Services	100% subject to 15% Coinsurance after Deductible
Outpatient hospital Services	100% subject to 15% Coinsurance after Deductible
Outpatient surgery professional Services	100% subject to 15% Coinsurance after Deductible
16. Mental health Services	
Inpatient and residential	100% subject to 15% Coinsurance after Deductible
Outpatient and intensive outpatient Services	100% subject to $20 Copayment after Deductible per office visit or per day
17. Neurodevelopmental therapy	
Inpatient—up to 60 days per Calendar Year	100% subject to 15% Coinsurance after Deductible
Outpatient—up to 60 visits per Calendar Year	100% subject to $30 Copayment after Deductible per visit

COVERED SERVICE	BENEFIT
18. Obstetrical care, maternity and newborn care	
Inpatient hospital Services	100% subject to 15% Coinsurance after Deductible
Professional inpatient and outpatient Services	100% subject to 15% Coinsurance after Deductible
19. Office Visits	100% subject to $20 Copayment after Deductible per visit
Specialty visits	100% subject to $30 Copayment after Deductible per visit
Urgent Care visits	100% subject to $40 Copayment after Deductible per visit
Injections provided in the Nurse Treatment Area	100% subject to $10 Copayment after Deductible per visit
20. Organ transplants	
Inpatient facility Services	100% subject to 15% Coinsurance after Deductible
Inpatient professional Services	100% subject to 15% Coinsurance after Deductible
21. Phenylketonuria (PKU) supplements	100% after Deductible when provided for the disorder
22. Physical, occupational, speech, and massage therapies	
Inpatient—up to 60 days per Calendar Year	100% subject to 15% Coinsurance after Deductible
Outpatient—up to 60 visits per Calendar Year for all therapies combined	100% subject to $30 Copayment after Deductible per visit
23. Prescription drugs, insulin, and diabetic supplies	
Retail—up to a 30-day supply	
All disposable diabetic supplies, all insulin, and Formulary generic drugs	100% subject to $15 Copayment after Deductible per prescription or refill
Preferred brand-name drugs or supplies	100% subject to $40 Copayment after Deductible per prescription or refill
Non-Preferred brand-name drugs and supplies	100% subject to $75 Copayment after Deductible per prescription or refill
Specialty Drugs	100% subject 50% Coinsurance up to $150 maximum
Mail-order—up to a 90-day supply	
All disposable diabetic supplies, all insulin, and Formulary generic drugs	100% subject to $30 Copayment after Deductible per prescription or refill
Preferred brand-name drugs or supplies	100% subject to $80 Copayment after Deductible per prescription or refill
Non-preferred brand-name drugs and supplies	100% subject to $150 Copayment after Deductible per prescription or refill
Specialty drugs and supplies	(Not all specialty drugs are available for mailing order)
Contraceptive drugs or devices	100%
24. Preventive care	100%
25. Radiation-chemotherapy Services	100% after Deductible

COVERED SERVICE	BENEFIT
26. Reconstructive surgery	Payment levels are determined by the setting in which the Service is provided
27. Skilled nursing facility—up to 150 days per Calendar Year	100% subject to 15% Coinsurance after Deductible
28. Spinal and Extremity Manipulation Therapy Services	
Self-referred Spinal and Extremity Manipulative therapy of the spine and extremities up to 12 visits per Member per Calendar Year.	100% subject to $30 Copayment after Deductible per visit
Additional visits may be covered if prior approval is received.	
29. Temporomandibular joint dysfunction (TMJ)	
Non-surgical Services	100% subject to $30 Copayment after Deductible per visit
Inpatient and outpatient surgical Services	100% subject to 50% Coinsurance after Deductible for one Medically Necessary TMJ related surgery per year.
30. Tobacco cessation	$0
31. Transgender Surgical Services	Payment levels are determined by the setting in which the Service is provided.
32. Vision care for adults (routine) (For members 19 and over)	
Routine eye exams: one exam annually	100% subject to $20 Copayment after Deductible per exam
Hardware once every 24 months: either lenses and frames, or contact lenses	100% up to $150 benefit maximum
33. Vision Care for children (routine comprehensive) (covered until the end of the month in which the Member turns 19 years of age)	
Routine eye exams: one exam annually	100% subject to $20 Copayment per exam
Hardware once every 24 months: either lenses and frames, or contact lenses	100%
34. Weight Control and Obesity Treatment Bariatric surgery for clinically severe obesity only when all of the following requirements have been met: • A Participating Provider determines that the surgery meets Utilization Review criteria developed by Medical Group and approved by Kaiser. • The Member fully complies with the Kaiser Permanente Severe Obesity Evaluation and Management Program's contract for participation approved by Kaiser.	100% subject to 15% Coinsurance after Deductible

Deductible

For each Calendar Year, all covered Services are subject to the Deductible and count toward the Deductible, except for certain preventive care Services and other items that are shown as not subject to the Deductible in the "Benefit Summary."

For Services that are subject to the Deductible, you must pay Charges for the Services when you receive them, until you meet your Deductible. If you are the only Member in your Family, then you must meet the Member Deductible. If there is at least one other Member in your Family, then you must each meet the Member Deductible, or your Family must meet the Family Deductible, whichever is less. Each Member Deductible amount counts toward the Family Deductible amount. Once the Family Deductible is satisfied, no further Member Deductible will be due for the remainder of the Calendar Year. The Member and Family Deductible amounts are shown in the "Benefit Summary."

Increasing the Deductible

If the U.S. Department of Treasury increases the minimum Deductible required in high deductible health Plans, we will increase the Deductible if necessary to meet the new minimum Deductible requirement, and we will notify your Group.

Changes to your Family. When your Family changes during a Calendar Year from self-only enrollment to two or more Members (or vice versa), the only Deductible payments that will count in the new Family are those for Services that Members in the new Family received in that Calendar Year under this *COC*. For example:

- If you add Dependents to your Family, the only Deductible payments that will count in the new Family are those for Services that Members in the new Family received in that Calendar Year under this *COC*.
- If all of your Dependents cease to be Members in your Family so that your Family becomes a Family of one Member (self-only), only the amounts that had been applied toward the Deductible for Services that you received during the Calendar Year will be applied toward the Deductible required for self-only enrollment. You must pay Charges for covered Services you receive on or after the date you become a Family of one Member until you meet the Deductible required for self-only enrollment, even if the Family had previously met the Deductible for a Family of two or more Members.

Out-of-Pocket Maximum

There is a maximum to the total dollar amount of Deductible, Copayments, and Coinsurance that you must pay for covered Services that you receive within the same Calendar Year. The Member and Family Out-of-Pocket Maximum amounts are shown in the "Benefit Summary" and they accumulate as follows:

- If you are the only Member in your Family (self-only), then you must meet the Member Out-of-Pocket Maximum.
- If there is at least one other Member in your Family, each Member Out-of-Pocket Maximum amount counts toward the Family Out-of-Pocket Maximum amount, then you must each meet the Member Out-of-Pocket Maximum, or your Family must meet the Family Out-of-Pocket Maximum, whichever is less. All Deductibles, Copayment, and Coinsurance count toward the Out-of-Pocket Maximum unless otherwise indicated. After you reach the Out-of-Pocket Maximum, you are not required to pay Copayments and Coinsurance for these Services for the remainder of the Calendar Year. Member Services can provide you with the amount you have paid toward your Out-of-Pocket Maximum.

BENEFIT DETAILS

All benefits are subject to the exclusions, limitations, and eligibility provisions contained in this *COC* and in the "Benefits Exclusions and Limitations" section. Kaiser Permanente provides Services through all types of

health care providers licensed under state law. Benefits are payable for preventive care and Medically Necessary Services that are provided by Participating Providers or obtained in accordance with referral or authorization requirements, except for Emergency Services or as provided under coordination of benefits provisions. Authorization and referral requirements are described in the "Prior and Concurrent Authorization" section of this *COC*. Services received after termination of this Plan's coverage will not be covered, except when required by law. Services that are provided by mental health Participating Providers to Members diagnosed as having a mental disorder will be covered as mental health care, regardless of the cause of the disorder.

1. Accidental injury to teeth

The Services of a licensed dentist will be covered subject to a $20 office visit Copayment after Deductible for repair of accidental injury to natural teeth. Evaluation of the injury and development of a written treatment plan must be completed within 30 days from the date of injury. Treatment must be completed within the period established in the treatment plan unless delay is medically indicated and the written treatment plan is modified. Services for the following are not covered: Injuries caused by biting or chewing; malocclusion resulting from an accidental injury, except for emergency stabilization; orthodontic treatment; dental implants; conditions not directly resulting from the accident; and treatment not completed within the time period established in the written treatment plan.

2. Ambulance Services

Emergency ground ambulance Services are subject to 15% Coinsurance after Deductible per trip to a Participating Facility, or the nearest facility where care is available. If ground ambulance Services are not appropriate for transporting the Member to the nearest facility, the Plan covers emergency air ambulance subject to 15% Coinsurance after Deductible per trip. The Service must meet the definition of an Emergency Medical Condition and be considered the only appropriate method of transportation, based solely on medical necessity. If a Participating Provider orders a Member's transfer from one facility to another, the ambulance transportation Copayment will not apply.

3. Ambulatory surgical center

Services at an ambulatory surgical center (discharged within 24 hours of admission) are covered subject to 15% Coinsurance after Deductible per surgery or procedure. Services must be provided at a Participating Facility.

General anesthesia Services and related facility charges in conjunction with any non-covered dental procedure performed in an ambulatory surgical center are covered subject to 15% Coinsurance after Deductible if such anesthesia Services and related facility charges are Medically Necessary because the Member:

- Is under the age of seven, or is physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
- Has a medical condition that the Member's PCP determines would place the Member at undue risk if the dental procedure were performed in a dental office. Services are subject to Utilization Review by Kaiser using criteria developed by Medical Group and approved by Kaiser.

For the purpose of this section, "general anesthesia Services" means Services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command. Nitrous oxide analgesia is not reimbursable as general anesthesia.

4. Blood and blood derivatives

Blood and blood derivatives, including but not limited to, synthetic factors, plasma expanders, and their administration, are covered in full after Deductible when Medically Necessary.

5. Chemical Dependency Services

Medically Necessary inpatient and outpatient Chemical Dependency treatment and supporting Services are covered on the same basis as other chronic illness or disease, subject to the inpatient hospital Coinsurance after Deductible or office visit Copayment after Deductible. The Member's PCP or Participating Provider must authorize all Chemical Dependency treatment in advance, and a Participating Facility for an approved treatment program must provide the Services. Court-ordered treatment will be covered only if it is determined by the PCP or Participating Provider to be Medically Necessary.

Chemical Dependency is an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

Inpatient prescription drugs prescribed in connection with Chemical Dependency treatment are covered. All other prescription drugs are paid according to the provisions under "Prescription Drugs, Insulin and Diabetic Supplies."

When the Member is not yet enrolled in a dependency treatment program, Medically Necessary detoxification is covered as a medical Emergency Service.

6. Services Provided in Connection with Clinical Trials

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

- We would have covered the Services if they were not related to a clinical trial.
- You are 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:
  - A Participating Provider makes this determination.
  - You provide us with medical and scientific information establishing this determination.
  - If any Participating Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Participating Provider unless the clinical trial is outside the state where you live.
- 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:
  - The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
  - The study or investigation is a drug trial that is exempt from having an investigational new drug application.
  - 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 cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
  - It is comparable to the National Institutes of Health system of peer review of studies and investigations.
  - It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

- For covered Services related to a clinical trial, you will pay the Deductible, Copayment, or Coinsurance you would pay if the Services were not related to a clinical trial. For example, see "Inpatient Hospital Services" in the "Benefit Summary" for the Deductible, Copayment, or Coinsurance that applies to hospital inpatient care.

7. Diabetic education

Medically Necessary diabetic education is covered subject to the $20 office visit Copayment after Deductible or $30 specialty visit Copayment after Deductible for each visit. The Member's PCP or Participating Provider must prescribe the Services.

8. Diagnostic testing, Laboratory, mammograms and X-ray

Laboratory or special diagnostic procedures (CT scans, mammograms, MRI), imaging, including X-ray, ultrasound imaging, cardiovascular testing, nuclear medicine, and allergy testing, prescribed by the Member's PCP or Participating Provider, and provided at a Participating Facility are covered in full subject to a 15% Coinsurance after Deductible per visit. Screening and special diagnostic procedures during pregnancy and related genetic counseling when Medically Necessary for prenatal diagnosis of congenital disorders are included. Some Services, such as preventive screenings and routine mammograms, are not covered under this "Diagnostic Testing" benefit but may be covered under the "Preventive Care Services" section. We cover preventive care Services without charge.

9. Dialysis—outpatient

Outpatient professional and facility Services necessary for dialysis when referred by the Member's PCP or Participating Provider are covered in full subject to the $30 specialty office visit Copayment after Deductible for each dialysis treatment. Home dialysis is 100% covered after Deductible. Dialysis is covered while you are temporarily absent from our Service Area. A temporary absence is an absence lasting less than twenty-one (21) days. Services must be preauthorized prior to departure from our Service Area.

10. Durable Medical Equipment, supplies, and prostheses

This Plan covers the rental or purchase of Durable Medical Equipment, medical supplies, and prostheses at 80% of allowed charges after Deductible, subject to preauthorization by the Member's PCP or

Participating Provider and if obtained through a Participating Facility. Disposable supplies used for treatment of diabetes are covered under the "Prescription Drugs, Insulin, and Diabetic Supplies" benefit.

Durable Medical Equipment (DME) is equipment that:

- Is prescribed by the Member's PCP or Participating Provider;
- Is Medically Necessary;
- Is primarily and customarily used only for a medical purpose;
- Is designed for prolonged use; and
- Serves a specific therapeutic purpose in the treatment of the Member's illness or injury.

Covered Services include:

- The rental or purchase (at the option of Kaiser) of Durable Medical Equipment such as wheelchairs, hospital beds, and respiratory equipment (combined rental fees shall not exceed full purchase price);
- Diabetic equipment and supplies, including external insulin pumps, infusion devices, glucose monitors, diabetic foot care appliances, injection aids, and lancets not covered in the pharmacy benefit;
- Casts, splints, crutches, trusses, or braces;
- Oxygen and rental equipment for its administration;
- Ostomy supplies;
- Artificial limbs or eyes (including implant lenses prescribed by a Participating Provider and required as a result of cataract surgery or to replace a missing portion of the eye);
- The initial external prosthesis and brassiere necessitated by surgery of the breast, and replacement of these items when necessitated by normal wear, a change in medical condition or when additional surgery is performed that warrants a new prosthesis and/or brassiere; prosthetic brassieres are limited to up to four every twelve months when required to hold a prosthesis;
- Penile prosthesis when impotence is caused by a covered medical condition (not psychological), is a complication which is a direct result of a covered surgery, or is a result of an injury to the genitalia or spinal cord and other accepted treatment has been unsuccessful; and
- A wig or hairpiece to replace lost hair due to radiation therapy or chemotherapy for a covered condition, up to a lifetime benefit maximum payment of $100 per person; and
- Electric breast pumps.

11. Emergency Services

Emergency visits at an emergency room facility are covered subject to a 15% Coinsurance after Deductible per visit. Use of a hospital emergency room for a non-medical emergency is not covered.

12. Hearing Examinations and Hearing Aids

Hearing examinations to determine hearing loss are covered, subject to a $30 Copayment after Deductible for each visit, when authorized by the Member's PCP and obtained through a Participating Provider.

Hearing aids and rental/repair, including fitting and follow-up care, are covered after the Deductible has been reached, to a benefit maximum payment of $800 every 36 months.

13. Home Health

When provided by a Participating Provider (Home Health Agency) and approved by the Member's PCP, the following home health Services are covered subject to 15% Coinsurance after Deductible: Part-time or intermittent skilled nursing care, physical therapy, respiratory therapy, and speech therapy; home infusion therapy; ancillary Services, including occupational therapy, clinical social Services, Durable Medical Equipment, and intermittent home health aide Services, when provided in conjunction with the above skilled Services. Home health visits are covered up to 130 visits per Calendar Year.

14. Hospice Services (including respite care)

Medically Necessary or palliative hospice Services and Durable Medical Equipment, for terminally ill Members are covered in full after the Deductible has been reached, for up to six months. Coverage may be provided beyond the initial six-month period when preauthorized by Medical Group. Services must be part of a written program of care by a state-licensed or Medicare-approved hospice program as provided by Participating Providers. Respite care is covered after Deductible in the most appropriate setting for a maximum of five consecutive days per month of hospice care. Counseling and bereavement Services associated with hospice are covered after Deductible for up to one year.

15. Inpatient Hospital Services

Inpatient hospital Services. This Plan covers Medically Necessary hospital accommodation and inpatient Services, Durable Medical Equipment, and drugs prescribed by a Participating Provider for treatment of covered conditions (including, but not limited to, general nursing care, surgery, diagnostic tests and exams, radiation and X-ray therapy, blood and blood derivatives, bone and eye bank Services, and take-home medications dispensed by the hospital at the time of discharge). Inpatient hospital Services are 100% covered, subject to 15% Coinsurance after Deductible. Convalescent, custodial, or domiciliary care is not covered.

Covered Services under this benefit include those provided by the PCP and Participating Providers (Specialist, surgeon, assistant surgeon, and anesthesiologist) when deemed Medically Necessary.

Kaiser must be notified of emergency admissions on the first working day following admission or as soon as reasonably possible, by calling 503-735-2596 or, toll free, 1-877-813-5993. Kaiser reserves the right to require the Member's admission or transfer to a Participating Facility of Kaiser's choice, upon consultation with the Member's physician. If the Member refuses to transfer to the specified facility, all costs incurred after the date the transfer could have occurred will be the Member's responsibility to pay.

Outpatient hospital Services. Services for outpatient surgery, day surgery, or short-stay obstetrical Services (discharged within 24 hours of admission) are covered subject to 15% Coinsurance after Deductible per surgery or procedure. Services must be provided at a Participating Facility.

Dental anesthesia—inpatient/outpatient. General anesthesia Services and related facility charges in conjunction with any dental procedure performed in a hospital are covered subject to the applicable inpatient/outpatient facility Coinsurance if such anesthesia Services and related facility charges are Medically Necessary because the Member:

- Is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
- Has a medical condition that the Member's PCP or Participating Provider determines would place the Member at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the Member's PCP or Participating Provider.

For the purpose of this section, "general anesthesia Services" means Services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway

independently and respond purposefully to physical stimulation or verbal command. Nitrous oxide analgesia is not reimbursable as general anesthesia.

16. Mental health Services

We cover mental health Services as found in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by the American Psychiatric Association when Services are necessary for:

- Crisis intervention.
- Evaluation.
- Treatment of mental disorders or chronic conditions that a mental health Participating Provider determines to be Medically Necessary and expects to result in objective, measurable improvement.

Mental health Services are subject to Utilization Review by Kaiser using criteria developed by Medical Group and approved by Kaiser. You may request these criteria by calling Member Services.

We cover Participating Provider Services under this "Mental health Services" section only if they are provided by a licensed psychiatrist, licensed psychologist, licensed clinical social worker, licensed mental health counselor, licensed professional counselor, licensed marriage and family therapist, or advanced practice psychiatric nurse.

Services are subject to exclusions and limitations listed in this "Mental health Services" section.

Benefit Period. The benefit period for coverage described in this "Mental health Services" section is per Calendar Year.

Inpatient Hospital Services. Professional and facility Services for diagnosis and treatment of mental illness are covered at 15% Coinsurance after Deductible, subject to Utilization Review criteria prior authorization requirements as described in the "Prior and Concurrent Authorization" section of this COC, and use of the Participating Providers and Participating Facilities. This includes Medically Necessary diagnosis and treatment of eating disorders (bulimia and anorexia nervosa).

Outpatient Services. Services for diagnosis and treatment of mental illness are covered at a $20 Copayment after Deductible per office visit or $20 Copayment after Deductible per day for intensive outpatient visit, subject to the requirements to obtain prior authorization as described in the "Prior and Concurrent Authorization" section of this *COC* and the use of Participating Providers and Participating Facilities. This includes Medically Necessary diagnosis and treatment of eating disorders (bulimia and anorexia nervosa).

We cover mental health Services in a skilled nursing facility, when all of the following are true:

- You are substantially confined to a skilled nursing facility in lieu of Medically Necessary hospitalization.
- Your Participating Physician determines that it is feasible to maintain effective supervision and control of your care in a skilled nursing facility and that the Services can be safely and effectively provided in a skilled nursing facility.
- You receive prior authorization from Kaiser in accordance with Utilization Review criteria developed by Medical Group and approved by Kaiser.

We cover in home mental health Services, when all of the following are true:

- You are substantially confined to your home (or a friend's or relative's home), or the care is provided in lieu of Medically Necessary hospitalization.

- Your Participating Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home.
- You receive prior authorization from Kaiser in accordance with Utilization Review criteria developed by Medical Group and approved by Kaiser.

Preauthorization is not required for Emergency Services admissions, including involuntary commitment to a state hospital. This Plan will cover court-ordered treatment only if determined to be Medically Necessary by a Participating Provider. All costs for mental health Services in excess of the coverage provided under this *COC*, including the cost of any care for which the Member failed to obtain prior authorization or any Services received from someone other than a Participating Provider will be the Member's sole responsibility to pay.

17. Neurodevelopmental therapy

Subject to the inpatient hospital Coinsurance after Deductible, Kaiser will pay up to 60 days of inpatient hospital Services per Calendar Year for Medically Necessary neurodevelopmental therapies. Outpatient Services for neurodevelopmental therapies are provided in full subject to the $30 specialty office visit Copayment after Deductible for each visit, up to 60 visits per Calendar Year for all therapies combined. Benefits include only the Services of Participating Providers authorized to deliver occupational therapy, speech therapy, and physical therapy and must be prescribed by the Member's PCP or Participating Provider. Benefits are payable only for Medically Necessary Services where significant deterioration condition would result without such Services, or to restore and improve function.

The Member will not be eligible for both the "Physical, Occupational, Speech, and Massage Therapy" benefit and this benefit for the same Services for the same condition.

18. Obstetric, maternity and newborn care

This Plan covers Services, including supplies for pregnancy and pregnancy complications. There is no pre-existing condition waiting period. Services must be determined by the Member's PCP or women's health care Participating Provider, in conjunction with the mother, to be Medically Necessary and appropriate based on accepted medical practice. Professional Services covered in full not subject to Deductible include prenatal and postpartum care, and prenatal testing (in accordance with the standards set forth by the Board of Health). After Deductible, Professional Services covered in full include normal or cesarean delivery, home births for low risk pregnancies, and complications resulting from pregnancy.

We will not limit the length of a maternity inpatient hospital stay for a mother and baby to less than 48 hours for vaginal delivery and 96 hours for a cesarean section delivery. The length of inpatient hospital stay is determined by the Member's PCP or Participating Provider, in consultation with the mother.

Medically Necessary maternity inpatient hospital Services for mother and baby are covered, including complication of pregnancy for obstetrical care, subject to the inpatient hospital Coinsurance after Deductible. Routine newborn medical Services following birth and initial physical exam, newborn PKU test, and newborn nursery care will be covered during hospitalization of the mother receiving maternity benefits under this Plan, and will not be subject to a Coinsurance or Copayment. Certain maternity Services, such as screening for gestational diabetes and breastfeeding counseling and support, are covered under the "Preventive Care Services" section.

Use of birthing centers for delivery must be preauthorized as described in the "Prior and Concurrent Authorization" section of this *COC*. Medically Necessary Services furnished in connection with childbirth at your home are covered when provided by a Participating Provider, subject to the specialty care office visit Copayment.

Hospitalization for newborn children for other than routine newborn care will be covered subject to the inpatient hospital Coinsurance after Deductible for the first 21 days from the date of birth, provided the mother is covered by this Plan after Deductible. Benefits for professional and other Services for necessary follow-up care for newborns are provided subject to any applicable Deductible, Copayment or Coinsurance amounts for the first 21 days from the date of birth provided the mother is covered by this Plan. Benefits for Services received by the newborn beyond the initial 21 days are subject to the eligibility requirements of this Plan, including submission of any PEBB Program application for coverage, and payment of any required premium. If premium is not due, the application requirement is waived; however, please notify the PEBB Program or your employing agency of the birth so that your records may be updated.

Services related to voluntary and involuntary termination of pregnancy on an outpatient basis are covered, subject to the $30 specialty visit Copayment after Deductible. Inpatient hospital Services related to voluntary and involuntary termination of pregnancy are covered, subject to the inpatient hospital Coinsurance after Deductible.

19. Office visits

Services provided by the Member's PCP are covered in full subject to a $20 Copayment after Deductible for each office visit or a Specialist when referred by the Member's PCP, are covered in full subject to a $30 Copayment after Deductible for each office visit. A $40 Urgent Care visit Copayment applies after Deductible to qualifying Urgent Care received during certain hours at designated Urgent Care facilities and Participating Medical Offices within the Service Area and from Non-Participating Providers outside the Service Area. Injections, including allergy injections, are covered in full subject to a $10 Copayment after Deductible when received in a nurse treatment room. Family Planning Services are covered when provided by the Member's PCP or women's health care Participating Provider.

20. Organ transplants

Transplant Services for bone marrow, cornea, heart, heart-lung, kidney, liver, lung, pancreas, pancreas after kidney, simultaneous kidney-pancreas, small bowel, small bowel/liver, and stem cell, including professional and Participating Facility fees for inpatient accommodation, diagnostic tests and exams, surgery and follow-up care, are covered subject to inpatient hospital Coinsurance after Deductible or office visit Copayments after Deductible and preauthorization requirements as described in the "Prior and Concurrent Authorization" section of this *COC*. This benefit includes covered donor expenses if the donor recipient is a Member of this Plan. See other benefits of this Plan for related Services, such as prescription drugs and outpatient laboratory and X-ray.

Organ transplants are covered when preauthorized as described in the "Prior and Concurrent Authorization" section of this *COC*, performed in a Participating Facility, and meet all the following criteria:

- The Service is required because of a disease, illness, or injury and is performed for the primary purpose of preventing, improving, or stabilizing the disease, illness, or injury.
- There is sufficient evidence to indicate that the Service will directly improve the length or quality of the Member's life. Evidence is considered sufficient to draw conclusions if it is peer-reviewed (as defined by the National Association of Insurance Commissioners), is well-controlled, directly or indirectly relates the Service to the length or quality of life, and is reproducible both within and outside of research settings.
- The Service's expected beneficial effects on the length or quality of life outweigh its expected harmful effects.

- The Service is a cost-effective method available to address the disease, illness or injury. "Cost-effective" means there is no other equally effective intervention available and suitable for the Member which is more conservative or substantially less costly.

Organ transplant recipient. If a Member is accepted into a Participating Facility's transplant program and continues to follow that program's prescribed protocol, all organ transplant Services for the Member receiving the organ are covered according to the transplant benefit protocol. This includes transportation to and from a Participating Facility (beyond that distance the Member would normally be required to travel for most hospital Services).

Organ transplant donor. The costs related to organ removal, as well as the cost of treating complications directly resulting from the surgery, are covered, provided the organ recipient is a Member of this Plan, and provided the donor is not eligible for coverage under any other health care plan or government-funded program.

Benefit limitations. Transplants that are not preauthorized or are not performed in a Participating Facility are not covered. Benefits for costs relating to donor searches are provided only for allogenic bone marrow transplants. Direct medical costs for up to 15 searches are covered. No other benefits are provided for Services relating to locating a donor for organ transplants.

21. Phenylketonuria (PKU) supplements

Phenylketonuria supplements are covered in full for treatment of this disorder.

Equipment and supplies for the administration of enteral and parenteral therapy are covered under "Durable Medical Equipment, Supplies and Prostheses."

Dietary formulas, oral nutritional supplements, special diets and prepared foods/meals, except treatment of phenylketonuria (PKU) and total parenteral and enteral nutritional therapy as set forth above are excluded.

22. Physical, occupational, speech, and massage therapies

Treatment of acute conditions or acute exacerbations of chronic conditions, which in the judgment of a Participating Physician will show sustainable, objective, measurable improvement, that is prescribed by the Member's PCP and provided by a Participating Provider is covered for inpatient and outpatient physical, occupational, speech, and massage therapy Services to restore or improve functional abilities when physical and/or sensory-perceptual impairment exists due to a covered injury, illness, stroke, or surgery.

Inpatient Services are covered in full up to 60 days per Calendar Year, subject to the inpatient hospital Coinsurance after Deductible when provided as part of an acute medical inpatient hospitalization or skilled nursing facility (SNF) stay.

Outpatient therapy Services are covered in full up to 60 visits for all therapies combined per Calendar Year, subject to the $30 specialty office visit Copayment after Deductible. The Member will not be eligible for both the "Neurodevelopmental Therapy" benefit and this benefit for the same Services for the same condition.

23. Prescription drugs, insulin, and diabetic supplies

Retail. Up to a 30-day supply or refill of outpatient prescription drugs, insulin, and disposable diabetic supplies necessary for the treatment of diabetes, is covered, after Deductible, subject to the Copayments explained below, or the actual cost of the prescription if less than the Copayment. The Member may obtain up to a 90-day supply for an individual prescription at one filling, with the payment of two single-month Copayments after Deductible. In order to receive a quantity sufficient for a 90-day supply, the prescription should specify that each fill is for 90 days. Prescriptions written for a quantity sufficient

for only a 30-day supply with the ability to refill for an additional 30 days or longer may be limited to a 30-day supply per fill. Single-dose, long-acting drugs, and drugs packaged or dispensed in a single unit (such as inhalers) are subject to a single Copayment after Deductible.

Generic drugs will be dispensed unless a suitable generic is not available. Generic drugs are prescription drugs that are sufficiently similar to brand-name products to have achieved an AB-rating from the U.S. Food and Drug Administration (FDA). Approved drugs include federal legend drugs and insulin when prescribed by the Member's PCP, Participating Provider, or any licensed dentist according to our drug Formulary guidelines. Any exclusion of drugs and medicines will also exclude their administration.

Under the Formulary process, Members pay the Copayments listed below for drugs listed on the Formulary. The Formulary is a listing of preferred pharmaceutical substances and formulas. A group of Participating Providers who are physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. These preferred drugs are included on the Formulary after consideration regarding safety, efficacy, cost, and compliance. Participating Providers can request the review of any drug at any time. Drugs may be added or removed from the Formulary as information warrants. For more information about the Formulary process or to find out if a particular drug is on the Formulary, call our Formulary Applications Services Team (FAST) at 503-261-7900 or toll free 888-572-7231.

Prescription, FDA approved contraceptive drugs, supplies and devices, such as, but not limited to, injectable contraceptive drugs, internally implanted time-release contraceptive drugs and contraceptive devices such as intrauterine devices (IUDs), diaphragms, cervical caps, emergency contraception, and long-acting progestational agents determined most appropriate by the PCP or women's health care Participating Provider for use by the Member are covered without charge and are not subject to the Deductible.

Certain preventive medications (including but not limited to, aspirin, fluoride, and liquid iron for children ages 6 to 12 months at risk for anemia) according to and as recommended by, the USPSTF, when obtained with a prescription order.

Prior Authorization and Step Therapy Prescribing Criteria

Prior authorization is required when you are prescribed certain drugs or supplies before they can be covered. A Participating Provider may request prior authorization if he or she determines that the drug or supply is Medically Necessary. Prescribing Participating Providers must supply to Company the medical information necessary for Company to make the prior authorization determination. Coverage for a prescribed drug or supply that is approved for prior authorization begins on the date Company approves the request.

A list of those drugs and supplies that require prior authorization is available online at kp.org or you may contact Member Services at 1-800-813-2000.

We apply step therapy prescribing criteria, developed by Medical Group and approved by Company, to certain drugs and supplies. The step therapy prescribing criteria require that you try a therapeutically similar drug (step 1) for a specified length of time before we will cover another drug (step 2) prescribed for the same condition. A list of drugs and supplies subject to step therapy prescribing criteria, and the requirements for moving to the next step drug, is available online at **kp.org** or you may contact Member Services at 1-800-813-2000.

Retail Copayments for up to a 30-day supply:

- $15 Copayment after Deductible per prescription or refill for all disposable diabetic supplies, all insulin, and Formulary generic drugs.
- $40 Copayment after Deductible per Preferred brand-name drugs.

- $75 Copayment after Deductible per Non-Preferred brand drugs.
- 50% Coinsurance up to $150 for Specialty drug.

The applicable generic or brand-name Copayment applies for non-Formulary drugs deemed Medically Necessary through the exception process.

Kaiser Permanente reserves the right to limit the quantity fill on an initial prescription to assure that the patient can tolerate the medication. Kaiser Permanente also reserves the right to limit the prescription quantity of any drug where a restricted dosage would constitute medically prudent and efficacious treatment.

Exceptions are part of the Formulary process. For most patients, Formulary drugs are the best treatment alternative. However, this is not always the case. Members pay in full for non-Formulary drugs unless the non-Formulary drug meets certain criteria. When a Participating Provider believes that a non-Formulary drug is the most appropriate therapy to meet a patient's individual medical needs, the PCP or Participating Provider may make an exception based on one of the following:

- The patient is intolerant of Formulary alternatives.
- The patient has experienced treatment failure with Formulary alternatives.
- The patient is allergic to Formulary alternatives.
- The patient is a new Member currently using a non-Formulary drug. (A transition period is available while new Members change to the Formulary alternative.)

The non-Formulary drug is for a dosage form or strength used in titrating a dose. Titration is a process of gradually changing a patient from one dosage level to another. When an exception is granted, the drug is covered subject to the applicable Copayment after Deductible.

If the Member disagrees with the exception review decision, they may submit a written appeal within 185 days. The Member's case will be reviewed by a Participating Provider on the Kaiser Permanente Regional Formulary and Therapeutics Committee who was not involved in the original review.

Drugs must be prescribed by a PCP, Participating Provider, or any licensed dentist according to our drug Formulary guidelines and purchased at a Participating Pharmacy. A limited supply of prescription drugs purchased from a Non-Participating Facility or non-Participating Pharmacy is covered subject to the applicable pharmacy Copayment after Deductible when dispensed or prescribed in connection with covered Emergency Services treatment.

Mail-order benefit. Kaiser operates a centralized automated refill system that provides a Mail-Delivery Pharmacy Service for Members. Covered drugs prescribed by a PCP, Participating Provider, or any licensed dentist according to our drug Formulary guidelines, based upon sound clinical guidelines are available through the Mail-Delivery Pharmacy for up to a 90-day supply subject to the Copayments after Deductible set forth below. A prescription processed through the Mail-Delivery Pharmacy may be automatically provided for up to a 90-day supply at the Copayments after Deductible specified below when the drug is appropriate for use as prescribed. In all cases, Kaiser reserves the right to limit the quantity fill on an initial prescription to assure the patient can tolerate the medication, based upon sound clinical guidelines, or in any case where a restricted dosage constitutes medically prudent and efficacious treatment.

Mail-order up to a 90-day supply:

- $30 Copayment after Deductible per prescription or refill for all disposable diabetic supplies, all insulin, and Formulary generic drugs.
- $80 Copayment after Deductible per Preferred brand-name drugs.

- $ 150 Copayment after Deductible per Non-Preferred brand drugs.

The applicable generic or brand-name Copayment applies for non-Formulary drugs deemed Medically Necessary through the exception process.

Some over-the-counter diabetic and home care products not covered by the prescription benefit are also available through the Mail-Delivery Pharmacy. Certain drugs that require special handling are not provided through the Mail-Delivery Pharmacy. This may include drugs that are time or temperature sensitive, drugs that cannot legally be sent by U.S. mail, certain high cost drugs, and drugs that require professional administration or observation.

Members can order prescriptions by telephone, online, or by mail. To order by telephone or online, Members will need to provide their health record number, the prescription number, the name of the drug, and credit card information. Call 503-778-2678 from the Portland area or 1-800-548-9809 from other areas. Visit Kaiser Permanente online at **kp.org**.

To order by mail, complete a prescription refill order form and mail it with a bank card number. Allow about 7-10 business days for an order to arrive; however, most orders arrive sooner. Delivery is by U.S. mail.

Off-label drugs. FDA-approved drugs used for off-label indications will be provided only if recognized as effective for treatment: 1) in one of the standard reference compendia; 2) in the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or 3) by the Federal Secretary of Health and Human Services. No benefits will be provided for any drug when the FDA has determined its use to be contra-indicated.

a. "Off-label" means the prescribed use of a drug which is other than that stated in its FDA-approved labeling.

b. "Standard reference compendia" means:

1. The American Hospital Formulary Service-Drug Information;
2. The American Medical Association Drug Evaluation;
3. The United States Pharmacopoeia-Drug Information; or
4. Other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services or the insurance commissioner.

c. "Peer-reviewed medical literature" means scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

Your rights to safe and effective pharmacy Services. State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this Plan and what coverage limitations are in your *COC*. If you would like more information about the drug coverage policies under this Plan, or if you have a question or a concern about their pharmacy benefit, please contact Member Services at 1-800-813-2000.

If you would like to know more about your rights under the law, or if you think anything you received from this Plan may not conform to the terms of your *COC*, you may contact the Washington State Office of the Insurance Commissioner at 1-800-562-6900. For concerns about the pharmacists or pharmacies serving you, please call the Washington State Department of Health at 1-800-896-0522.

24. Preventive Care Services

We cover a variety of preventive care Services, which are Services to keep you healthy or to prevent illness, and are not intended to treat an existing illness, injury, or condition. These preventive care Services are subject to all coverage requirements described in this "Benefit Details" section and all provisions in the "Benefit Exclusions and Limitations" section.

Preventive care Services include:

- Services recommended by, and rated A or B by, the U.S. Preventive Services Task Force (USPSTF). You can access the list of preventive care Services at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC.
- Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
- Preventive care and screenings for women supported by HRSA. You can access the list of women's preventive care Services at http://www.hrsa.gov/womensguidelines.

We cover these preventive care Services without charge. Should you receive Services for an existing illness, injury, or condition during a preventive care examination, you may be charged an office visit Copayment.

Covered preventive care Services include, but are not limited to:

- Bone mass measurement (bone densitometry) is covered for those at risk.
- Cholesterol tests (all types) are covered in full.
- Colorectal screening tests (one fecal occult blood test per year plus one flexible sigmoidoscopy every five years, one colonoscopy every 10 years) are covered for Members 50 years of age or older or for younger Members who are at high risk. These tests are covered more frequently if your Participating Provide recommends them because you are at high risk for colorectal cancer or disease.
- Contraceptive services and supplies, including, but not limited to, tubal ligation, and insertion/removal of IUD, or implanted birth control drugs and devices.
- Fasting glucose tests are covered in full.
- Healthy diet counseling and counseling for obesity and weight management.
- Immunizations are covered in full.
- Age 18 and older, routine physical examinations are covered every five years and every two years after age 50.
- Mammograms are covered every year for women 40 years of age or over and more frequently for women who are at high risk for breast cancer or disease; breast exams are covered every year; pelvic exams; chlamydia and cervical cancer screening are covered every year or as recommended by your PCP or women's health care Services Participating Provider.
- Prostate cancer screening examinations are covered once every two years for men 50 years of age or older or for younger Members who are at high risk, and more frequently if your Participating Provider recommends it because you are at high risk for prostate cancer or disease.
- Digital rectal exam and Prostate Specific Antigen (PSA) tests (not including monitoring or ultrasensitive tests) are covered once each year for men 50 years of age or older or for younger Members who are at high risk for prostate cancer or disease, and more frequently if your Participating Provider recommends them because you are at high risk for prostate cancer or disease.

- Services provided by the Member's PCP or women's health care Participating Provider are covered in full.
- Well-baby and well-child Services are covered from birth to age 18.

25. Radiation and chemotherapy Services

Prescribed radiation and chemotherapy Services are covered in full after Deductible when provided by a Participating Provider.

26. Reconstructive surgery Services

We cover inpatient and outpatient reconstructive surgery Services as indicated below:

- To correct significant disfigurement resulting from an injury or from Medically Necessary surgery.
- To correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function.
- To treat congenital hemangioma known as port wine stains on the face.

Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery, and reconstruction of an unaffected breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.

Payment levels will be determined by the Service provided (e.g., external prostheses will be provided at no charge, reconstruction of the breast will be paid at the surgery payment level as described under "Hospital Services," and post-mastectomy brassieres are covered at the Durable Medical Equipment level).

27. Skilled nursing facility Services

Medically Necessary care in a Participating Skilled Nursing Facility is covered in full up to 150 days per Calendar Year, subject to inpatient hospital Coinsurance after Deductible. Additional coverage may be approved by Medical Group if the stay is in lieu of hospitalization. Participating Provider visits while in a Participating Skilled Nursing Facility are covered in full. These Services are subject to Utilization Review by Kaiser using criteria developed by Medical Group and approved by Kaiser. Skilled nursing facility confinement for mental health conditions, mental retardation, or for care which is primarily domiciliary, convalescent, or custodial in nature is not covered.

28. Spinal and Extremity Manipulation Therapy Services

Self-referrals for manipulative therapy of the spine and extremities are covered up to a total of twelve (12) visits per Member per Calendar Year subject to a $30 Copayment after Deductible per visit. You must get prior authorization from The CHP Group at least 72 hours in advance for any other visits during that Calendar Year. To request prior authorization, call The CHP Group at 1-800-449-9479, 8 a.m. to 5 p.m. (PT), Monday through Friday. Additional visits will be covered only if determined by The CHP Group to be Medically Necessary in accordance with Utilization Review standards adopted by The CHP Group and approved by Kaiser.

- Except in the case of misrepresentation, prior authorization review decisions will not be retrospectively denied. Kaiser may revoke or amend an authorization for Services you have not yet received if your membership terminates, your coverage changes, you lose eligibility, or we receive information that is materially different from that which was reasonably available at the time of the original determination.

29. Temporomandibular joint dysfunction (TMJ)

Medical Services for Medically Necessary treatment of temporomandibular joint dysfunction (TMJ), except for upper and lower jaw augmentation or reduction Services and/or orthognathic surgery, are covered subject to the $30 specialty visit Copayment after Deductible for each visit and at

50% Coinsurance after Deductible for one Medically Necessary TMJ related surgery per year.. This coverage exception does not apply to children with congenital anomalies.

30. Tobacco cessation

Kaiser supports various options for quitting all forms of tobacco use. Our "Freedom from Tobacco" classes include:

- Relaxation techniques.
- Understanding tobacco addiction.
- Practicing effective ways to remain tobacco free.

These health education classes are offered through Kaiser. Members do not pay a fee to participate. For more information or to register, call 503-286-6816 in the Portland area or 360-604-2070 from Washington.

31. Transgender Surgical Services

We cover surgery Services subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request these criteria by calling Member Services. You pay any applicable Deductible, Copayment, or Coinsurance that you would pay if the Services were not related to transgender surgery.

Coverage includes Services directly related to the covered transgender surgery, such as pre-surgery consultations and post-surgery follow-up exams; outpatient surgery procedures; and inpatient hospital Services (including room and board). There are other related Services that are not covered under this section, but they may be covered under other sections in this *COC*. Examples of these Services are: Psychological counseling is covered under the "Mental Health Services" section, outpatient prescription drugs under the "Prescription Drugs, Insulin and Diabetes Supplies" and outpatient laboratory and imaging Services are covered under the "Diagnostic Testing" section.

32. Vision Services for adults (routine)

Routine eye examinations, including refractions, when provided by an ophthalmologist or optometrist Participating Provider, are covered annually subject to a $20 office visit Copayment after Deductible. An allowance of $150 toward prescription eyeglass lenses and frames, or contact lenses, including expenses associated with their fitting, is provided once every 24 months when obtained through a Participating Facility. Vision Services covered under this "Vision Services for adults (routine)" section are only for Members age 19 and older.

33. Vision Services for children (routine)

Routine eye examinations, including refractions, when provided by an ophthalmologist or optometrist Participating Provider, are covered annually subject to a $20 office visit Copayment. Prescription eyeglass lenses and frames, or contact lenses, including expenses associated with their fitting, is provided once every 24 months when obtained through a Participating Facility. Vision Services covered under this "Vision Services for children (routine)" section are only for Members up to the end of the month in which they turn 19 years of age.

34. Weight Control and Obesity Treatment

Bariatric surgery for clinically severe obesity is covered only when all of the following requirements have been met:

- A Participating Provider determines that the surgery meets Utilization Review criteria developed by Medical Group and approved by Kaiser.

- The Member fully complies with the Kaiser Permanente Severe Obesity Evaluation and Management Program's contract for participation approved by Kaiser.

BENEFIT EXCLUSIONS AND LIMITATIONS

In addition to any exclusion listed in the previous pages, this Plan does not cover the following:

1. Services not provided by a Participating Provider or obtained in accordance with Kaiser's standard referral and authorization requirements, except for Emergency Services and Urgent Care or as covered under coordination of benefits provisions.

2. Services provided by Non-Participating Providers are not covered inside or outside of the Service Area except for: Emergency Services and Urgent Care; as specifically provided in the Outside of the Service Area section; or when otherwise specifically provided.

3. Experimental or investigational services, supplies, and drugs. For Members enrolled in and participating in qualifying clinical trials, this exclusion does not apply to Medically Necessary conventional Services that we would cover if typically provided absent a clinical trial.

4. That additional portion of a physical exam beyond a routine physical that is specifically required for the purpose of employment, travel, immigration, licensing or insurance and related reports.

5. Services for which no charge is made, or for which a charge would not have been made if the Member had no health care coverage or for which the Member is not liable; services provided by a family member.

6. Drugs and medicines not prescribed by a PCP, Participating Provider, or any licensed dentist, except for Emergency Services and Urgent Care.

7. Cosmetic services, which means those services that are intended primarily to change or maintain your appearance and will not result in significant improvement in physical function. This exclusion does not apply to Services that are covered under "25. Reconstructive surgery Services" and "30. Transgender Surgical Services" in the "Benefit Details" section.

8. Skilled nursing facility confinement for treatment of mental health conditions or mental retardation, when primary use of the facility is as a place of residence or convalescence, or when treatment is primarily custodial in nature.

9. Conditions caused by or arising from acts of war.

10. Dental care including:

- Orthognathic surgery (except for children with congenital anomalies);
- Myofascial pain dysfunction (MPD); and
- Dental implants.

11. Surrogacy. Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. A "Surrogacy Arrangement" is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. See "Surrogacy Arrangements" in the "Reductions" section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

12. Reversal of voluntary sterilization.

13. Testing and treatment of infertility and sterility, including but not limited to artificial insemination, and in-vitro fertilization.

14. Services provided solely for the comfort of the Member, except palliative care provided under the "Hospice Services" benefit.

15. Coverage for an organ donor, unless the recipient is a Member of this Plan.

16. Weight Control and Obesity Treatment.

Non-surgical: Any weight loss or weight control programs, treatments, services, or supplies, even when prescribed by a physician, including, but not limited to, prescription and over-the-counter drugs, exercise programs (formal or informal) and exercise equipment. Travel expenses associated with non-surgical or surgical weight control or obesity services are not covered.

Surgical: Surgery for dietary or weight control, and any direct or non-direct complications arising from such non-covered surgeries, whether prescribed or recommended by a physician, including surgeries such as:

1. Gastric banding (including adjustable gastric/lap banding and vertical banded gastroplasty).

2. Mini-gastric banding (gastric bypass using a Billroth II type of anastomosis).

3. Distall gastric bypass (long limb gastric bypass).

4. Billopancreatic bypass and billopancreatic with duodenal switch.

5. Jejunoileal bypass.

6. Gastric stapling or liposuction.

7. Removal of excess skin.

8. Bariatric surgery if you had bariatric surgery within the past 10 years.

The surgical exclusion for weight control and obesity treatment will not apply to pre-authorized, Medically Necessary bariatric surgery of adult morbid obesity as specifically set forth in this COC and the Kaiser Permanente Bariatric Management criteria. More than one bariatric surgery for you or your enrolled Dependents will not be covered under the PEBB Program.

17. Evaluation and treatment of learning disabilities, including dyslexia, except as provided for neurodevelopmental therapies.

18. Orthoptic therapy (eye training); vision services, except as specified for "Vision Services." Surgery to improve the refractive character of the cornea, including any direct complications.

19. Orthotics, except foot care appliances for prevention of complications associated with diabetes which are covered.

20. Services for which a Member has contractual right to recover cost under homeowner's or other no-fault coverage, to the extent that it can be determined that the Member received double recovery for such services.

21. Any medical services not specifically listed as covered.

22. Direct complications arising from excluded services, except Emergency Services to stabilize the Member.

23. Pharmaceutical treatment or prevention of impotence or sexual dysfunction.

24. When Medicare coverage is primary, charges for services provided to Members through a "private contract" agreement with a physician or practitioner who does not provide services through the Medicare program.

25. Replacement of lost or stolen medications.

26. Recreation therapy.

27. Mental health services, including evaluations and psychological testing, on court order or as a condition of parole or probation, unless Medically Necessary.

Psychological testing for ability, aptitude, intelligence, or interest.

Mental health Services for intellectual disability after diagnosis.

Mental health Services for substance related disorders, except as covered under "Chemical Dependency Services" in the "Benefit Details" section.

Mental health Services for diagnostic codes 302 through 302.9, as found in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association.

Custodial care.

Residential mental health treatment programs that are not solely for Medically Necessary mental health conditions requiring inpatient treatment (examples include, but are not limited to schools, wilderness programs, or behavioral health programs for adolescents).

28. All travel-related Services, including travel-only immunizations (such as yellow fever, typhoid, and Japanese encephalitis).

29. Travel and Lodging, transportation or living expenses for any person, including the patient, are limited to travel and lodging expenses needed for Member to receive cover Services outside our Service Area, subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

30. Services that are not health care services, supplies, or items. These include, but are not limited to:

- Teaching manners and etiquette.
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning.
- Items and services that increase academic knowledge or skills.
- Teaching and support services to increase intelligence.
- Academic coaching or tutoring for skills such as grammar, math, and time management.
- Teaching you how to read, whether or not you have dyslexia.
- Educational testing.
- Teaching art, dance, horse riding, music, play or swimming.
- Teaching skills for employment or vocational purposes.
- Vocational training or teaching vocational skills.
- Professional growth courses.
- Training for a specific job or employment counseling.
- Aquatic therapy and other water therapy.

HOW TO OBTAIN CARE

Primary Care Providers

Members may select a Primary Care Provider (PCP) at any Participating Medical Office when enrolling in this Plan. One PCP may be selected for the entire Family or a different PCP may be selected for each Family Member. Except for qualifying Emergency Services or authorized referrals, Members must use Participating Facilities. The Member may change from one PCP to another by contacting Member Services. The change

will be made immediately if the selected PCP's caseload permits. If the selected PCP's caseload is full, the Member will be given a list of PCPs available in the Participating Medical Office of their choice.

Once the Member changes PCPs, any referrals that were made by the previous PCP are valid as long as the referral was authorized by Medical Group. The Member should notify the new PCP that he or she has been receiving specialty Services from a Participating Provider so the PCP can make arrangements for the Member to continue to receive specialty Services.

Referrals to Participating Providers and Participating Facilities

PCPs provide primary medical care, including pediatric care and obstetrics/gynecology care. Specialists provide specialty medical care in areas such as surgery, orthopedics, cardiology, oncology, urology, dermatology, and allergy/immunology. A PCP or Participating Provider will refer you to a Specialist when appropriate. Please call Member Services for information about specialty Services that require a referral or discuss it with your PCP.

Generally, Members need a referral to see a Specialist the first time. Any PCP can make a referral to a Specialist when needed. Once a Member has been referred to a Specialist, he or she will not need a referral for return visits for the same condition. In some cases, a standing referral may be allowed to a Specialist for a time period that is in accord with your individual medical needs, as determined by the PCP and Kaiser.

Some outpatient specialty Services are available in Participating Medical Offices without a referral. Please call Member Services to schedule routine appointments in the following departments that do not require a referral for outpatient Services:

- Cancer Counseling.
- Chemical Dependency Services.
- Mental health Services.
- Obstetrics/Gynecology.
- Occupational Health.
- Ophthalmology.
- Optometry (routine eye exams).
- Social Services.
- Spinal and Extremity Manipulation therapy self-referred Services.

Referrals to Non-Participating Providers and Non-Participating Facilities

If your PCP decides that you require Services not available from Participating Providers or Participating Facilities, he or she will recommend to Medical Group and Kaiser that you be referred to a Non-Participating Provider or Non-Participating Facility inside or outside our Service Area. If the Medical Group's assigned Participating Provider determines that the Services are Medically Necessary and are not available from a Participating Provider or Participating Facility and determines that the Services are covered Services, Kaiser will authorize your referral to a Non-Participating Provider or Non-Participating Facility for the covered Services. The Deductible, Copayments, and Coinsurance for these approved referral Services are the same as those required for Services provided by a Participating Provider or Participating Facility. You will need written authorization in advance in order for the Services to be covered. If Kaiser authorizes the Services, you will receive a written "Authorization for Outside Medical Care" approved referral to the Non-Participating Provider or Non-Participating Facility, and only the Services and number of visits that are listed on the written referral will be covered, subject to any benefit limitations and exclusions applicable to these Services.

Prior and Concurrent Authorization and Utilization Review

When you need Services, you should talk with your Participating Provider about your medical needs or your request for Services. Your Participating Provider provides covered Services that are Medically Necessary. Participating Providers will use their judgment to determine if Services are Medically Necessary. Some Services are subject to approval through Utilization Review, based on Utilization Review criteria developed by Medical Group or another organization utilized by the Medical Group and approved by Kaiser. If you seek a specific Service, you should talk with your Participating Provider. Your Participating Provider will discuss your needs and recommend an appropriate course of treatment.

If you request Services that must be approved through Utilization Review and the Participating Provider believes they are Medically Necessary, the Participating Provider may submit the request for Utilization Review on your behalf. If the request is denied, we will send a letter to you within five calendar days of the Participating Provider's request. If you choose to submit a request for services directly to Member Relations, we will notify you within five calendar days of the decision. The decision letter will explain the reason for the determination along with instructions for filing an appeal. You may request a copy of the complete Utilization Review criteria used to make the determination. Please contact Member Relations at 503 813 4480.

Your PCP or Participating Provider will request prior or concurrent authorization when necessary. The following are examples of Services that require prior or concurrent authorization:

- Alternative Care referred Services.
- Bariatric surgery Services.
- Breast reduction surgery.
- Chemical Dependency Services (inpatient and residential).
- Drug Formulary exceptions.
- Durable Medical Equipment.
- General anesthesia and associated hospital or ambulatory surgical facility Services provided in conjunction with non-covered dental Services.
- Hospice and home health Services.
- Inpatient hospital Services, including birthing centers.
- Mental health Services (inpatient and residential).
- Non-emergency medical transportation.
- Open MRI.
- Plastic surgery.
- Referrals for any Non-Participating Facility Services or Non-Participating Provider Services.
- Referrals to Specialists who are not employees of Medical Group.
- Rehabilitative therapy Services.
- Routine foot care.
- Skilled nursing facility Services.
- Organ transplant Services.

If you ask for Services that the Participating Provider believes are not Medically Necessary and does not submit a request on your behalf, you may ask for a second opinion from another Participating Provider. You

should contact the manager in the area where the Participating Provider is located. Member Services can connect you with the correct manager, who will listen to your issues and discuss your options.

For more information about Utilization Review, a copy of the complete Utilization Review criteria developed by Medical Group and approved by Kaiser for a specific condition, or to talk to a Utilization Review staff person, please contact Member Services.

Except in the case of misrepresentation, prior authorization determinations that relate to your Membership eligibility are binding on us if obtained no more than five business days before you receive the Service. Prior authorization determinations that relate to whether the Service is Medically Necessary or are covered under the Plan are binding on us if obtained no more than 30 days before you receive the Service. We may revoke or amend an authorization for Services you have not yet received if your membership terminates or your coverage changes or you lose your eligibility.

Participating Providers and Participating Facilities Contracts

Participating Providers and Participating Facilities may be paid in various ways, including salary, per diem rates, case rates, fee-for-service, incentive payments, and capitation payments. Capitation payments are based on a total number of Members (on a per-Member per-month basis), regardless of the amount of Services provided. Kaiser may directly or indirectly make capitation payments to Participating Providers and Participating Facilities only for the professional Services they deliver, and not for Services provided by other physicians, hospitals, or facilities. Call Member Services if you would like to learn more about the ways Participating Providers and Participating Facilities are paid to provide or arrange medical and hospital Services for Members.

Our contracts with Participating Providers and Participating Facilities provide that Members are not liable for any amounts owed by Kaiser. However, the Member will be liable for the cost of non-covered Services received from a Participating Provider or Participating Facility, as well as unauthorized Services obtained from Non-Participating Providers and Non-Participating Facilities.

Second opinions

Members have the right to a second opinion regarding a medical diagnosis or treatment plan from a qualified Participating Provider of the Member's choice. Members may obtain a list of Participating Provider by calling Member Services.

Individual case management

When Medically Necessary and cost-effective, Kaiser may provide Alternative Care Services to a Member on a case-by-case basis. In order for Kaiser to provide Alternative Care Services, a written agreement that specifies Services, benefits, and limitations must be signed by the Member and the PCP or Participating Provider. Kaiser reserves the right to terminate these extended benefits when the Services are no longer Medically Necessary, cost-effective, feasible, or at any time by sending written notice to the Member.

Home health care alternative to hospitalization

When provided at equal or lesser cost, the benefits of this Plan will be available for home health care instead of hospitalization or other institutional care when furnished by a home health, hospice, or home care agency Participating Provider. Substitution of less expensive or less intensive Services will be made only with the consent of the Member, and when the Member's PCP or Participating Provider advises that the Services will adequately meet the Member's needs. Kaiser will base the decision to substitute less expensive or less intensive Services on the Member's individual medical needs. Kaiser may require a written treatment plan which is approved by the Member's PCP or Participating Provider. Care will be covered on the same basis as for the institutional care substituted. Benefits will be applied to the maximum Plan benefit payable for

hospital or other institutional expenses, and will be subject to any applicable Deductible, Copayment, and Coinsurance amounts required by this Plan.

Self-referral for women's health Services

Women Members shall have direct and timely access to Participating Providers specializing in women's health care (WHC) Services. WHC Services are provided by a family medicine Participating Physician, physician's assistant, gynecologist, certified nurse midwife, doctor of osteopathy, obstetrician, and advanced register nurse practitioner, practicing within their applicable scope of practice.

Medically appropriate maternity Services, including Services for complications of pregnancy, prenatal, delivery, and postnatal care, covered reproductive Services, preventive Services, general examinations, gynecological Services, and follow-up visits are provided to women Members directly from a Participating Provider, without a referral from their PCP. WHC Services also include any appropriate Services for other health problems discovered and treated during the course of a visit to a WHC Participating Provider for women's Services.

POST-SERVICE CLAIMS – SERVICES ALREADY RECEIVED

In general, if you have a medical bill from a Non-Participating Provider or Non-Participating Facility, our Claims Administration Department will handle the claim. Member Services can assist you with questions about specific claims or about the claim procedures in general.

If you receive Services from a Non-Participating Provider following an authorized referral from a Participating Provider, the Non-Participating Provider will send the bill to Claims Administration directly. You are not required to file a claim.

However, if you receive Services from a Non-Participating Provider or Non-Participating Facility without an authorized referral and you believe Company should cover the Services, you need to send a completed medical claim form and the itemized bill to:

Claims Administration
Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099

You can request a claim form from Member Services or download it from **kp.org**. When you submit the claim, please include a copy of your medical records from the Non-Participating Provider or Non Participating Facility if you have them.

Company accepts CMS 1500 claim forms for professional Services and UB-04 forms for hospital claims. Even if the provider bills Company directly, you still need to submit the claim form.

You must submit a claim for a Service within 90 days after receiving that Service. If it is not reasonably possible to submit a claim within 90 days, then you must submit a claim as soon as reasonably possible, but in no case more than 15 months after receiving the Service, except in the absence of legal capacity.

We will reach a decision on the claim and pay those covered Charges within 30 calendar days from receipt unless additional information, not related to coordination of benefits, is required to make a decision. If the 30 day period must be extended, you will be notified in writing with an explanation about why. This written notice will explain how long the time period may be extended depending on the requirements of applicable state and federal laws, including the ERISA.

You will receive written notification about the claim determination. This notification will provide an explanation for any unpaid amounts. It will also tell you how to appeal the determination if you are not satisfied with the outcome, along with other important disclosures required by state and federal laws.

If you have questions or concerns about a bill from Company, you may contact Member Services for an explanation. If you believe the Charges are not appropriate, Member Services will advise you on how to proceed.

EMERGENCY SERVICES

If a Member has an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department. A Member does not need prior authorization for Emergency Services. When a Member has an Emergency Medical Condition, we cover Emergency Services he or she receives from Participating Providers, Participating Facilities, Non-Participating Providers, and Non-Participating Facilities anywhere in the world, as long as the Services would have been covered under the "Benefit Details" section (subject to the "Benefit Exclusions and Limitations" section) if the Member had received them from Participating Providers or Participating Facilities.

Post-Stabilization Care

Post-Stabilization Care is Services you receive for the acute episode of your Emergency Medical Condition after that condition is clinically stable. ("Clinically stable" means that no material deterioration of the Emergency Medical Condition is likely, within reasonable medical probability, to result from or occur during your discharge or transfer from the hospital.)

We cover Post-Stabilization Care only if one of the following is true:

- A Participating Provider or Participating Facility provides the Services.
- We authorize the Services from the Non-Participating Provider or Non-Participating Facility before you receive the Services (or later, if extraordinary circumstances delay your ability to call us but you call us as soon as reasonably possible).

Coverage for Post-Stabilization Care at a Non-Participating Provider or Non-Participating Facility is limited to the Allowed Amount. You are responsible for paying any amount over the Allowed Amount, in addition to applicable Copayments and Coinsurance, and any such payments do not count toward the Deductible or the Out-of-Pocket Maximum.

To request prior authorization for your receiving Post-Stabilization Care from a Non-Participating Provider or Non-Participating Facility, you or someone on your behalf must call us at 503-735-2596, or toll free at 1-877-813-5993, before you receive the Services if it is reasonably possible to do so, but no later than 24 hours after any admission.

We understand that extraordinary circumstances can delay your ability to call us, for example if you are unconscious or if there is no parent or guardian with a young child. In these cases, you or someone on your behalf must call us as soon as reasonably possible. If you (or someone on your behalf) do not call us by the applicable deadline, we will not cover Post-Stabilization Care that you receive from a Non-Participating Provider or Non-Participating Facility.

After we are notified, we will discuss your condition with the Non-Participating Provider. If we decide that the Post-Stabilization Care is Medically Necessary and would be covered if you received it from a Participating Provider or Participating Facility, we will either authorize the Services from the Non-Participating Provider or Non-Participating Facility, or arrange to have a Participating Provider or Participating Facility (or other designated provider or facility) provide the Services. If we decide to arrange to have a Participating Provider or Participating Facility (or other designated provider or facility), provide the Services to you, we may authorize special transportation Services that are medically required to get you to the provider or facility. This may include transportation that is otherwise not covered.

OUT-OF-AREA COVERAGE

This limited out-of-area benefit is available to Dependent children covered under this *COC*.

We cover certain Medically Necessary Services that a Dependent child receives from Non-Participating Providers outside our Service Area but inside the United States (which for the purpose of this benefit means the 50 states, the District of Columbia, and United States territories). These out-of-area benefits are limited to the following Services as otherwise covered under this *COC*:

- Office visits are limited to preventive care, primary care, specialty care, outpatient physical therapy visits, outpatient mental health and chemical dependency Services, and allergy injections – limited to ten visits combined per Calendar Year).
- Laboratory and diagnostic X-rays – limited to ten visits per Calendar Year. This benefit does not include special diagnostic procedures such as CT, MRI, or PET scans.
- Prescription drug fills – limited to ten fills per Calendar Year.

You pay the Deductible, Copayment, or Coinsurance as shown in the "Benefit Summary."

This out-of-area benefit cannot be combined with any other benefit, so we will not pay under this "Out-of-Area Coverage" for a Service we are covering under another section.

WHEN THE MEMBER HAS OTHER MEDICAL COVERAGE

This Coordination of Benefits (COB) provision applies when the Member has health care coverage under more than one Plan. To avoid delays in claim processing, you and your provider should file all claims with each Plan at the same time. If Medicare is your Primary Plan, Medicare may submit your claims to your Secondary Plan for you.

The order of benefit determination rules described under this "When the Member has other Medical Coverage" section determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its contract terms without regard to the possibility that another Plan may cover some expenses.

The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable Expense. If the Secondary Plan receives a claim without the Primary Plan's payment details, the Secondary Plan will notify the submitting provider and/or you as soon as possible and within 30 days of receipt of the claim that the claim is incomplete. After receiving the missing information, the Secondary Plan will promptly process the claim. If the Primary Plan has not processed the claim within 60 days and is not waiting for additional information, the provider and/or you may submit the claim to the Secondary Plan with a notice that the Primary Plan has failed to pay the claim. The Secondary Plan must pay the claim as the Primary Plan within calendar 30 days. After payment information is received from the Primary Plan, the Secondary Plan may recover any excess amount paid under the "Right of Recovery" provision.

Notice to Covered Persons

If you are covered by more than one health benefit Plan, and you do not know which is your primary Plan, you or your provider should contact any one of the health Plans to verify which Plan is primary. The health Plan you contact is responsible for working with the other Plan to determine which is primary and will let you know within thirty calendar days.

CAUTION: All health Plans have timely claim filing requirements. If you or your provider fail to submit your claim to a secondary health Plan within that Plan's claim filing time limit, the Plan can deny the claim. If you experience delays in the processing of your claim by the primary health Plan, you or your provider will need

to submit your claim to the secondary health Plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.

Definitions for this "When the Member has other Medical Coverage" section:

Plan. A Plan is any of the following that provides benefits or Services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate Plan.

- Plan includes: Group blanket disability insurance contracts and group insurance contracts issued by health care service contractor or health maintenance organizations (HMO), Closed Panel Plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental Plan, as permitted by law.
- Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental Plans, unless permitted by law.

Each contract for coverage is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan. This Plan means the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Primary Plan/Secondary Plan. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

When This Plan is primary, Kaiser determines payment for the benefits first before those of any other Plan without considering any other Plan's benefits. Kaiser will not reduce the Member's benefits under This Plan. When This Plan is secondary, Kaiser determines the benefits after those of another Plan and must make payment in an amount so that when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim equal 100 percent of the total Allowable Expense for that claim. This means that when This Plan is secondary, Kaiser must pay the amount which, when combined with what the Primary Plan paid, cannot be less than the same Allowable Expense the Secondary Plan would have paid if it had been the Primary Plan. In addition, if This Plan is secondary, Kaiser must calculate the savings (the amount paid subtracted from the amount Kaiser would have paid had Kaiser been the Primary Plan) and record these savings as a medical benefit reserve for the covered person. This reserve must be used to pay any medical expenses during that Calendar Year, whether or not they are an Allowable Expense under This Plan. If This Plan is Secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

Allowable Expense. Allowable Expense is a health care expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of Services, the Charges of each Service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
- If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit.
- If a person is covered by two or more Plans that provide benefits or Services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees.

Closed Panel Plan. Closed Panel Plan is a Plan that provides health care benefits to covered persons in the form of Services through a panel of providers who are primarily contracted by the Plan, and that excludes coverage for Services provided by other providers, except in cases of emergency or referral by a panel provider.

Custodial Parent. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the Calendar Year excluding any temporary visitation.

Order of Benefit Determination Rules

When a Member is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- A Plan that does not contain a COB provision that is consistent with state regulations is always primary unless the provisions of both Plans state that the complying Plan is primary.
- Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
- A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Subscriber or Dependent. The Plan that covers the person as a Subscriber is the Primary Plan and the Plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent, and primary to the Plan covering the person as a Subscriber (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as Subscriber is the Secondary Plan and the other Plan is the Primary Plan.

Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

- For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
  - The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan; or
  - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
- For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
  - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;
  - If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for health care expenses, the Plan of the parent assuming financial responsibility is primary;
  - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan or if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan;
  - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan or if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan; or
  - If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    1. The Plan covering the Custodial Parent.
    2. The Plan covering the spouse of the Custodial Parent.
    3. The Plan covering the non-Custodial Parent.
    4. The Plan covering the spouse of the non-Custodial Parent.
- For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the above provisions determine the order of benefits as if those individuals were the parents of the child.

Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Order of Benefit Determination Rules" section can determine the order of benefits.

COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an

employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Order of Benefit Determination Rules" section can determine the order of benefits.

Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than we would have paid had we been the Primary Plan.

Effect on the Benefits of This Plan. When This Plan is secondary, we may reduce the benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim equal 100 percent of the total Allowable Expense for that claim. Total Allowable Expense cannot be less than the same Allowable Expense the Secondary Plan would have paid if it had been the Primary Plan. In addition, the Secondary Plan must credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

Right to Receive and Release Needed Information. Certain facts about health care coverage and Services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. Kaiser may get the facts needed from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. Kaiser is not required to tell, or obtain the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable.

Facility of Payment. If payments that should have been made under This Plan are made by another Plan, Kaiser has the right, at our discretion, to remit to the other Plan the amount we determine appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered benefits paid under This Plan. To the extent of these payments, Kaiser is fully discharged from liability under This Plan.

Right of Recovery. Kaiser has the right to recover excess payment whenever we pay Allowable Expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. We may recover excess payment from any person to whom or for whom payment was made or any other issuers or Plans.

Questions about coordination of benefits?

Contact your state insurance department.

WHEN A THIRD PARTY IS RESPONSIBLE FOR INJURY OR ILLNESS (SUBROGATION)

Injuries or Illnesses Alleged to be Caused by Third Parties or Covered by No-fault Insurance

This "Injuries or Illnesses Alleged to be Caused by Third Parties or Covered by No-fault Insurance" section applies if you receive covered Services for an injury or illness alleged to be any of the following:

- Caused by a third party's act or omission.
- Received on the premises of a third party.

- Covered by a no-fault insurance provision.

If you obtain a settlement or judgment from or on behalf of a third party, or a payment under a no-fault insurance provision, you must pay us Charges for covered Services that you receive for the injury or illness, except that you do not have to pay us to the extent that the payment would leave you less than fully compensated for your injury or illness. This "Injuries or Illnesses Alleged to be Caused by Third Parties or Covered by No-fault Insurance" section does not affect your obligation to make any applicable Deductible, Copayment and Coinsurance payments for these covered Services, but we will credit any of these payments toward the amount you must pay us under this paragraph.

If you do not recover anything from or on behalf of the third party or no-fault insurance, then you are responsible only for any applicable Deductible, Copayment and Coinsurance payments.

To the extent permitted by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by any third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total Charges for the relevant covered Services.

To secure our rights, we will have a lien on the proceeds of any judgment or settlement you or we (when we subrogate) obtain against a third party or any other insurer, regardless of how those proceeds may be characterized or designated. The proceeds of any judgment or settlement that you or we obtain shall only be applied to satisfy our lien after you are reimbursed the total amount of the actual losses and damages you incurred.

Within 30 days after submitting or filing a claim or legal action against a third party or any insurer, you must send written notice of the claim or legal action to us at:

Patient Financial Services – TPL
Kaiser Foundation Health Plan of the Northwest
7201 N Interstate Avenue
Portland, OR 97217

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send to us all consents, releases, trust agreements, authorizations, assignments and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You must not take any action prejudicial to our rights.

You must provide us written notice before you settle a claim or obtain a judgment, or if it appears you will make a recovery of any kind. If you recover any amounts from any third party or any insurer based on your injury or illness, you must pay us after you are reimbursed the total amount of the actual losses and damages you incurred, or place the funds in a specifically identifiable account and retain control over the recovered amounts to which we may assert a right.

If your estate, parent, guardian, or conservator asserts a claim against a third party or any insurer based on your injury or illness, any settlement or judgment recovered shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Surrogacy Arrangements

If you enter into a Surrogacy Arrangement, you must pay us Charges for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the payments or other compensation you and any other payee are entitled to receive under the Surrogacy Arrangement. A "Surrogacy

Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Note: This "Surrogacy Arrangements" section does not affect your obligation to pay your Deductible, Copayment, Coinsurance, or other amounts you are required to pay for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph. After you surrender a baby to the legal parents, you are not obligated to pay Charges for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Surrogacy Third Party Liability Supervisor
Healthcare Recoveries, Inc.
P.O. Box 36380
Louisville, Kentucky 40233-6380
1-800-552-8314 fax 1-502-214-1137
Attn: Jessica Marquis- 800225-1409

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this "Surrogacy Arrangements" section without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Workers' Compensation or Employer's Liability

If you suffer from an injury or illness that is compensable under a workers' compensation or employer's liability law, we will provide Services subject to your obligation to reimburse us to the extent of a payment or any other benefit, including any amount received as a settlement that you receive under the law.

In addition, we or our Participating Providers will be permitted to seek reimbursement for these Services directly from the responsible employer or the government agency that administers the law.

GRIEVANCES, CLAIMS, APPEALS, AND EXTERNAL REVIEW

Company will review claims and appeals, and we may use medical experts to help us review them.

The following terms have the following meanings when used in this "Grievances, Claims, Appeals, and External Review" section:

A claim is a request for us to:

- Provide or pay for a Service that you have not received (pre-Service claim);
- Continue to provide or pay for a Service that you are currently receiving (concurrent care claim); or
- Pay for a Service that you have already received (post-Service claim).

An adverse benefit determination includes:

- Any decision by our Utilization Review organization that a request for a benefit under our Plan does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part for the benefit;
- The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by us or our designated Utilization Review organization regarding a covered person's eligibility to participate in our health benefit Plan; or
- Any prospective review or retrospective review determination that denied, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit.

An internal appeal is a request for us to review our initial adverse benefit determination.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur (urgent pre-Service appeal and urgent concurrent appeal), you must exhaust the internal claims and appeals procedure (as described below in this "Grievances, Claims, Appeals, and External Review" section).

Language and Translation Assistance

If we send you an adverse benefit determination at an address in a county where a federally mandated threshold language applies, then your notice of adverse benefit determination will include a notice of language assistance (oral translation) in that threshold language. A threshold language applies to a county if at least 10 percent of the population is literate only in the same federally mandated non-English language. You may request language assistance with your claim and/or appeal by calling 1-800-324-8010.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-324-8010

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-324-8010

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-324-8010

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-324-8010

Appointing a Representative

If you would like someone to act on your behalf regarding your claim, you may appoint an authorized representative, an individual who by law or by your consent may act on your behalf. You must make this appointment in writing. Please contact Member Services at 1-800-813-2000 for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal

While you are encouraged to use our appeal procedures, you have the right to seek assistance from the Office of the Insurance Commissioner. Contact them by mail, telephone, or online at:

Office of the Insurance Commissioner, Consumer Protection Division
P.O. Box 40256
Olympia, WA 98504
1-800-562-6900
http://www.insurance.wa.gov

Reviewing Information Regarding Your Claim

If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information (including complete medical necessity criteria, benefit provisions, guidelines, or protocols) used to make a denial determination. You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact Member Services at 1-800-813-2000.

Providing Additional Information Regarding Your Claim

When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please send or fax all additional information to:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 503-813-3985

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 503-813-3985

To arrange to give testimony by telephone, you should contact Member Relations at 503-813-4480.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect

If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures

There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this "Internal Claims and Appeals Procedures" section:

- Pre-Service claims (urgent and non-urgent)
- Concurrent care claims (urgent and non-urgent)
- Post-Service claims

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

Pre-Service Claims and Appeals

Pre-Service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive authorization before receiving a Service that must be authorized or precertified in order to be a covered benefit may be the basis for our denial of your pre-Service claim or a post-Service claim for payment. If you receive any of the Services you are requesting before we make our decision, your pre-Service claim or appeal will become a post-Service claim or appeal with respect to those Services. If you have any general questions about pre-Service claims or appeals, please call Member Services.

Here are the procedures for filing a pre-Service claim, a non-urgent pre-Service appeal, and an urgent pre-Service appeal.

Pre-Service Claim

- Tell us by mail, fax or orally that you want to make a claim for us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must mail, fax, or call your claim to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Phone: 1-800-813-2000
  Fax: 503-813-3985

- If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life or health (or the life or health of a fetus) or ability to regain maximum function; (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the

Services you are requesting; or (c) your attending provider requests that your claim be treated as urgent.

- We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than five calendar days after we receive your claim.

  We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial five calendar day period.

  If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you 45 days to send the information.

  We will make a decision within five calendar days after we receive the first piece of information (including documents) we requested.

  We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision.

  If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within five days following the end of the 45-day period.

- We will send written notice of our decision to you, and if applicable, to your provider.

  If your pre-service claim was considered on an urgent basis, we will notify you of our decision orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three days after that.

- If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Non-Urgent Pre-service Appeal

- Within 180 days after you receive our adverse benefit determination notice, you must tell us by mail, fax or orally that you want to appeal your denial of your pre-Service claim. Please include the following:

  (1) Your name and health record number;

  (2) Your medical condition or relevant symptoms;

  (3) The specific Service that you are requesting;

  (4) All of the reasons why you disagree with our adverse benefit determination; and

  (5) All supporting documents.

  Your request and the supporting documents constitute your appeal. You must mail, fax, or call us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Phone: 1-800-813-2000
  Fax: 503-813-3985

- We will acknowledge your appeal in writing within seventy-two hours after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision within 14 days after we receive your appeal, unless you are notified that additional time is needed to complete the review. The extension will not delay the decision beyond 30 days without your consent.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, which may be available to you.

Urgent Pre-service Appeal

- Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-Service claim. Please include the following:

  (1) Your name and health record number;

  (2) Your medical condition or relevant symptoms;

  (3) The specific Service that you are requesting;

  (4) All of the reasons why you disagree with our adverse benefit determination; and

  (5) All supporting documents.

  Your request and the supporting documents constitute your appeal. You must mail, fax or call us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Phone: 1-800-813-4480
  Fax: 503-813-3985

- When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-Service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Grievances, Claims, Appeals, and External Review" section), if our internal appeal decision is not in your favor.
- We will decide whether your appeal is urgent or non-urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life or health (or the life or health of a fetus) or ability to regain maximum function: or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting; or (c) your attending provider requests that your claim be treated as urgent.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.

- We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three days after that.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, which may be available to you.

Concurrent Care Claims and Appeals

Concurrent care claims are requests that Company continues to provide, or pay for, an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. If you have any general questions about concurrent care claims or appeals, please call Member Relations at 503-813-4480.

Unless you are appealing an urgent care claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you appeal our adverse benefit determination at least 24 hours before your ongoing course of covered treatment will end, then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then you will have to pay for the Services that we decide are not covered.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

Concurrent Care Claim

- Tell us that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either call, mail, or fax your claim to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Phone: 503-813-4480
  Fax: 503-813-3985

- If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your authorized care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life or health (or the life or health of a fetus) or ability to regain maximum function; (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting; or (c) your attending provider requests that your claim be treated as urgent.
- We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time.

  If you submitted your claim 24 hours or more before your authorized care is ending, we will make our decision before your authorized care actually ends.

If your authorized care ended before you submitted your claim, we will make our decision but no later than five calendar days after we receive your claim.

We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we send you notice before the initial five calendar day decision period ends.

If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information.

We will make our decision as soon as possible, if your care has not ended, or within five calendar days after we first receive any information (including documents) we requested.

We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision.

If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed five calendar days following the end of the timeframe we gave you for sending the additional information.

- We will send written notice of our decision to you and, if applicable to your provider.
- If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three days after receiving your claim.
- If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Non-Urgent Concurrent Care Appeal

- Within 180 days after you receive our adverse benefit determination notice, you must tell us by mail, fax or orally that you want to appeal our adverse benefit determination. Please include the following:

  (1) Your name and health record number;

  (2) Your medical condition or relevant symptoms;

  (3) The ongoing course of covered treatment that you want to continue or extend;

  (4) All of the reasons why you disagree with our adverse benefit determination; and

  (5) All supporting documents.

  Your request and all supporting documents constitute your appeal. You must either call, mail, or fax the appeal to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Phone: 1-800-813-2000
  Fax: 503-813-3985

- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision as soon as possible if your care has not ended but not later than 14 days after we receive your appeal. We may extend the time for making a decision on your appeal for up to an additional 16 days if there is good cause.
- If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, which may be available to you.

Urgent Concurrent Care Appeal

- Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following:

  (1) Your name and health record number;

  (2) Your medical condition or relevant symptoms;

  (3) The ongoing course of covered treatment that you want to continue or extend;

  (4) All of the reasons why you disagree with our adverse benefit determination; and

  (5) All supporting documents.

Your request and the supporting documents constitute your appeal. You must mail, fax or call your appeal to us at:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Phone: 503-813-4480
Fax: 503-813-3985

- When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Grievances, Claims, Appeals, and External Review" section).
- We will decide whether your appeal is urgent or non-urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life or health (or the life or health of a fetus) or ability to regain maximum function; (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting; or (c) your attending provider requests that your claim be treated as urgent.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three days after that.

- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, which may be available to you.

Post-service Claims and Appeals

Post-Service claims are requests that we pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-Service claims or appeals, please call Member Services.

Here are the procedures for filing a post-Service claim and a post-Service appeal:

Post-service Claim

- Within 180 days from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following:

  (1) The date you received the Services;

  (2) Where you received them;

  (3) Who provided them;

  (4) Why you think we should pay for the Services; and

  (5) Copy of the bill and any supporting documents.

  You must include a copy of the bill and any supporting documents. Your letter and the related documents constitute your claim. You may contact Member Services to obtain a claim form. You must mail your claim to the Claims Department at:

  Claims Administration
  Kaiser Foundation Health Plan of the Northwest
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099

- We will not accept or pay for claims received from you after 180 days from the date of Services, except in the absence of legal capacity.
- We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim.

  We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 30 days after we receive your claim.

  If we tell you we need more information, we will ask you for the information before the end of the initial 30-day decision period ends, and we will give you 45 days to send us the information.

  We will make a decision within 15 days after we receive the first piece of information (including documents) we requested.

  We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision.

  If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.
- If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Post-service Appeal

- Within 180 days after you receive our adverse benefit determination, tell us by mail, fax or orally that you want to appeal our denial of your post-Service claim. Please include the following:

  (1) Your name and health record number;

  (2) Your medical condition or relevant symptoms;

  (3) The specific Services that you want us to pay for;

  (4) All of the reasons why you disagree with our adverse benefit determination; and

  (5) All supporting documents.

  Your request and the supporting documents constitute your appeal. You must mail, fax or call us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Phone: 1-800-813-2000
  Fax: 503-813-3985

- We will acknowledge your appeal in writing within seventy-two hours after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision within 14 days after we receive your appeal. We may extend the time for making a decision on your appeal for up to an additional 16 days if there is good cause.
- If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

External Review

If you are dissatisfied with our final adverse benefit determination, you may have a right to request an external review. An external review is a request for an independent review organization (IRO) to determine whether our internal appeal decision is correct. For example, you have the right to request external review of an adverse benefit determination that is based on medical necessity, appropriateness, health care setting, level of care, or that the requested Service is not efficacious or otherwise unjustified under evidence-based medical criteria.

Within 180 days after the date of our appeal denial letter, you must mail, fax, or call your request for external review to Member Relations at:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Phone: 503-813-4480
Fax: 503-813-3985

Member Relations will forward your request to the IRO no later than the third business day after the date they receive your request for review. They will include written information received in support of the appeal

along with medical records and other documents relevant in making the determination. Within one day of selecting the IRO, we will notify the appellant of the name of the IRO and its contact information.

You must exhaust our internal claims and appeals procedure for your claim before you may request external review unless one of the following is true:

- External review is permitted to occur simultaneously with your urgent pre-Service appeal or urgent concurrent care appeal;
- Your request qualifies for expedited external review;
- We have failed to comply with federal requirements regarding our claims and appeals procedures; or
- We have failed to comply with the Washington requirement to make a decision regarding the appeal within 30 days for non-urgent appeals and 72 hours for urgent appeals.

Your request for external review will be expedited if the ordinary time period for external review would seriously jeopardize your life or health, the life or health of a fetus, or your ability to regain maximum function.

If we do not have an appropriate authorization to disclose your protected health information, including medical records that are pertinent to the external review, we must obtain a signed waiver from you. Without this information, we are unable to proceed with the external review process.

You are not responsible for the costs of the external review, and you may name someone else to file the request for external review for you if you give permission in writing and include that with your request for external review. Company will be bound by and act in accordance with the decision of the IRO notwithstanding the definition of Medically Necessary care. If we do not follow a decision of an IRO, you have the right to sue us.

Experimental or Investigational Determination and Appeal

Decisions on appeals about experimental or investigational services will be communicated in writing within 20 business days of receipt of a fully documented request, unless you consent in writing to an extension of time. Appeals that meet the criteria for an urgent appeal, as described in the "Urgent Pre-Service Appeal" section, will be expedited to meet the clinical urgency of the situation, not to exceed 72 hours.

If, on appeal, the decision to deny services is upheld, the final decision will specify (i) the name and professional qualifications of the individual(s) who made the final decision and (ii) the basis for the final decision.

Grievance Procedure

We want you to be satisfied with the Services you receive from Kaiser Permanente. We encourage you to discuss any questions or concerns about your care with your Participating Provider or another member of your health care team. If you are not satisfied with your Participating Provider, you may request another. Contact Member Services for assistance. You always have the right to a second opinion from a qualified Participating Provider at the applicable Deductible, Copayment, or Coinsurance.

A grievance is a written complaint submitted by or on behalf of a covered person regarding Service delivery issues other than denial of payment for medical Services or nonprovision of Services, including dissatisfaction with medical care, waiting time for Services, provider or staff attitude or demeanor, or dissatisfaction with Service provided by the health carrier.

If you are not satisfied with the Services received at a particular medical office, or if you have a concern about the personnel or some other matter relating to Services and wish to file a grievance you may do so by following one of the procedures listed below.

- Contact the administrative office in the Participating Facility where you are having the problem.
- Calling Member Services at 1-800-813-2000; or
- Sending your written complaint to Member Relations at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 503-813-3985

All complaints are handled in a confidential manner.

After you notify us of a complaint, this is what happens:

- A representative reviews the complaint and conducts an investigation, verifying all the relevant facts.
- The representative or a Participating Provider evaluates the facts and makes a recommendation for corrective action, if any.
- When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
- When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

Grievance determinations are not adverse benefit determinations. There is not an internal or external appeal process for grievance determinations.

We want you to be satisfied with our facilities, Services, and Participating Providers. Using this grievance procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know.

While we encourage you to use our grievance procedure, you have the right to contact Washington's designated ombudsman's office, the Washington State Office of the Insurance Commissioner, for assistance with questions and complaints. Contact them by mail, telephone or online at:

Office of the Insurance Commissioner, Consumer Protection Division
P.O. Box 40256
Olympia, WA 98504
1-800-562-6900
http://www.insurance.wa.gov

ELIGIBILITY

Notice

This consumer-directed health plan (CDHP) is a qualified high-deductible health plan compatible with a Health Savings Account (HSA) under federal law. In addition to enrolling in a qualified high-deductible health plan, you must meet the eligibility requirements below to contribute to and use the funds from an HSA. Kaiser CDHP does not provide tax advice. If you are not eligible to have an HSA and enroll in Kaiser CDHP, you may be liable for tax penalties. If you have questions about whether you are eligible to have an HSA, call HealthEquity at 1-877-873-8823, or consult with a financial or tax advisor.

Who can enroll in Kaiser CDHP with an HSA?

NOTE: The following rules apply to the subscriber, who is the person directly enrolled in the plan (Kaiser CDHP) and is an employee or retiree of the sponsoring agency. Some rules are different for spouses and dependents.

IRS rules state that to enroll in an HSA, you must:

- Have a qualified, high-deductible health plan (also called a consumer-directed health plan).
- Have no other health coverage, with certain exceptions allowed by the IRS (for example, dental, vision, long-term care, and disability coverage are allowed).
- Not be enrolled in Medicare.*
- Not be enrolled in a flexible spending account (FSA). If you're currently enrolled in an FSA and want to enroll in Kaiser CDHP for 2012, you must spend all of your FSA dollars by December 31, 2011. This also would apply if your spouse has an FSA, even if you are not covering your spouse on your CDHP.
- Not be able to be claimed as a dependent on someone else's tax return.
- Not have received Veterans' Administration benefits (including prescription drugs) in the past three months, or have TRICARE coverage.
- Have a limited VEBA account (if you or your spouse has VEBA).

**The spouse or a dependent of an employee may be enrolled in Medicare as their secondary plan. PEBB rules require subscribers and dependents enrolled in PEBB retiree insurance coverage to enroll in Medicare if eligible. Also, if you or your dependent do not enroll in Medicare Part B when first eligible, you or your dependent may have to pay a premium penalty to enroll in Part B later.*

In addition, PEBB will not allow non-Medicare retiree or COBRA subscribers who have a family member enrolled in Medicare to select the CDHP/HSA. If you are a non-Medicare retiree or COBRA subscriber with a Medicare dependent enrolled on your account, you must disenroll your Medicare dependent from your PEBB coverage to enroll in a CDHP. Your disenrolled family member will not qualify for COBRA or other continuation coverage options through the PEBB Program.

Eligible Employees

In these sections we may refer to employees as "subscribers" or "enrollees." The employee's employing agency will inform the employee whether or not he or she is eligible for benefits upon employment and whenever the employee's eligibility status changes. The communication will include information about the employee's right to appeal eligibility and enrollment decisions. Information about an employee's right to an appeal can be found on page 66 of this Certificate of Coverage.

Eligible Dependents

To enroll in a health plan a dependent must be eligible and the employee must follow the procedural requirements for enrolling the dependent. The employing agency verifies the eligibility of all dependents and requires employees to provide documents that prove a dependent's eligibility.

The following are eligible as dependents:

1. Lawful spouse.
2. Registered domestic partner, defined to include the following:
    a. Effective January 1, 2010, a state-registered domestic partner; or
    b. A domestic partner who was qualified under PEBB eligibility criteria as a domestic partner before January 1, 2010, and was continuously enrolled under the employee in a PEBB health plan or life insurance.

1. Children. Children are eligible up to the last day of the month in which their 26 birthday occurred except as described in subsection (i) of this section. Children are defined as the subscriber's:
    a. Children as defined in state statutes that establish the parent-child relationship;
    b. Biological children, where parental rights have not been terminated;
    c. Stepchildren The stepchild's relationship to a subscriber (and eligibility as a PEBB dependent) ends on the same date the subscriber's legal relationship with the spouse or registered domestic partner ends through divorce, annulment, dissolution, termination, or death;
    d. Legally adopted children;
    e. Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
    f. Children of the subscriber's registered domestic partner;
    g. Children specified in a court order or divorce decree;
    h. Extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. "Children" does not include foster children for whom support payments are made to the subscriber through the state Department of Social and Health Services foster care program; and
    i. Children of any age with a developmental disability or physical handicap that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before age 26.
    j. The subscriber must provide evidence of the disability and evidence that the condition occurred before age 26.
        - The subscriber must notify the PEBB Program in writing when his or her dependent is not eligible under this section. The notification must be received by the PEBB Program no later than 60 days after the date that a child age 26 or older no longer qualifies under this subsection.
        - A child with a disability or physical handicap who becomes self-supporting is not eligible as of the last day of the month in which he or she becomes capable of self-support.
        - A child with a developmental disability or physical handicap age 26 and older who becomes capable of self-support does not regain eligibility under (i) of this subsection if he or she later becomes incapable of self-support.
        - The PEBB Program will verify the disability and dependency of children with disabilities periodically, but no more frequently than annually after the two-year period following the child's 26 birthday.
1. Parents of the subscriber.
    a. Parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as all of the following are met:
        - The parent maintains continuous enrollment in a PEBB medical plan;
        - The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;
        - The subscriber continues enrollment in PEBB insurance coverage; and
        - The parent is not covered by any other group medical plan.

b. Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the subscriber. Parents may not enroll additional dependents to their insurance coverage.

ENROLLMENT

An employee or dependent is eligible to enroll in only one PEBB medical plan even if eligibility criteria are met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two or more parents working for employers that participate in PEBB coverage may be enrolled as a dependent under only one parent.

An employee may waive enrollment in a PEBB medical plan if he or sheis enrolled in other employer-based group medical insurance, TRICARE, or Medicare. If an employee waives enrollment in a PEBB medical plan, the employee cannot enroll eligible dependents.

ALERT: When you retire, be sure to enroll in PEBB retiree coverage within 60 days of your retirement date or the date that your employer-paid coverage, COBRA coverage, or continuation coverage ends. Retirees may defer medical coverage if they have other employment that provides employer-based group medical insurance. If you do not enroll or formally defer PEBB coverage within 60 days of retirement or the date that your employer-paid coverage, COBRA coverage, or continuation coverage ends, you will not be able to return to PEBB coverage later.

How to Enroll

Employees must submit an *Employee Enrollment/Change* form to their employing agency. The form must be received by the employing agency no later than 31 days after the date the employee becomes eligible. To enroll an eligible dependent, the employee must include the dependent's enrollment information on the form and provide the required document(s) as evidence of the dependent's eligibility. The dependent will not be enrolled if his or her eligibility is not verified. If the employee does not return the *Employee Enrollment/Change* form in time to meet the procedural requirements, the employee will be enrolled in the Uniform Medical Plan Classic, and any eligible dependents cannot be enrolled until the next open enrollment.

An employee or his or her dependents may enroll during the annual open enrollment (see "Annual Open Enrollment" on page 60) or during a special open enrollment (see "Special Open Enrollment" on page 60). The employee must provide evidence of the event that created the special open enrollment.

Employees are required to notify their employing agency to remove dependents no later than 60 days from the last day of the month when dependents no longer meet the eligibility criteria described under Eligible Dependents. Consequences for not submitting notice within 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described on page 65;
- The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;
- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
- The subscriber may be responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

When Medical Enrollment Begins

For an employee and the employee's eligible dependent, enrolled when the employee is newly eligible, medical plan enrollment will begin the first day of the month following the day the employee became eligible. If the employee becomes eligible on the first working day of the month, coverage will begin on that date.

For an employee or an employee's eligible dependent enrolled during the PEBB Program's annual open enrollment, medical coverage will begin on January 1 of the following year.

For an employee or an employee's eligible dependent enrolled during a special open enrollment, medical coverage will begin the first day of the month following the later of the event date or the date the required form is received. If that date is the first of the month, the change in enrollment begins on that day.

Exceptions:

1. If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, medical plan coverage will begin the month in which the event occurs.
2. If adding a child who becomes eligible as an extended dependent through legal custody or legal guardianship, or a child who becomes eligible as a dependent with a developmental disability or physical handicap, medical coverage will begin on the first day of the month following eligibility certification.

Annual Open Enrollment

Employees may make a change to their enrollment during the PEBB Program's annual open enrollment as follows:

- Enroll in or waive their enrollment in a medical plan;
- Enroll or remove eligible dependents; or
- Change medical plan choice.

The employee must submit the required enrollment/change form to his or her employing agency. The form must be received no later than the last day of the annual open enrollment (usually November 30). The enrollment change will become effective January 1 of the following year.

Special Open Enrollment

Employees may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must be allowable under Internal Revenue Code and correspond to and be consistent with the event that creates the special open enrollment for the employee, the employee's dependent, or both. The special open enrollment may allow an employee to:

- Enroll in or change his or her health plan;
- Waive his or her health plan enrollment; or
- Enroll or remove eligible dependents.

To make an enrollment change, the employee must submit the required form(s) to his or her employing agency. The form(s) must be received no later than 60 days after the event that created the special open enrollment. In addition to the appropriate forms, the PEBB Program or employing agency will require the employee to prove eligibility or provide evidence of the event that created the special open enrollment.

Exception: If an employee wants to enroll a newborn or child whom the employee has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the employee should notify his or her employer by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required enrollment/change form must be received no later

than 12 months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. Employees should contact their personnel, payroll, or benefits office to get the required forms.

When can an employee change his or her health plan?

Any one of the following events may create a special open enrollment:

1. Employee acquires a new dependent due to:
    a. Marriage or registering a domestic partnership;
    b. Birth, adoption or when the employee assumes a legal obligation for total or partial support in anticipation of adoption;
    c. A child becomes eligible as an extended dependent through legal custody or legal guardianship; or
    d. A child becomes eligible as a dependent with a disability.
2. Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Employee or an employee's dependent has a change in employment status that affects the employee's or the employee's dependent's eligibility for the employer contribution toward employer-based group health insurance;
4. Employee or an employee's dependent has a change in residence that affects health plan availability. If the employee moves and the employee's current health plan is not available in the new location the employee must select a new health plan;
5. A court order or National Medical Support Notice requires the employee or any other individual to provide insurance coverage for an eligible dependent of the employee (a former spouse or former registered domestic partner is not an eligible dependent);
6. Employee or an employee's dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the employee or the employee's dependent loses eligibility for coverage under Medicaid or CHIP;
7. Employee or an employee's dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or a CHIP;
8. Employee or an employee's dependent becomes entitled to coverage under Medicare, or the employee or an employee's dependent loses eligibility for coverage under Medicare, or enrolls in or cancels enrollment in a Medicare Part D plan. If the employee's current health plan becomes unavailable due to the employee's or an employee's dependent's entitlement to Medicare, the employee must select a new health plan;
9. Employee or an employee's dependent's current health plan becomes unavailable because the employee or enrolled dependent is no longer eligible for a health savings account (HSA);
10. Employee or an employee's dependent experiences a disruption of care that could function as a reduction in benefits for the employee or the employee's dependent for a specific condition or ongoing course of treatment. The employee may not change his or her health plan election if the employee's or dependent's physician stops participation with the employee's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but is not limited to considering the following:

a. Active cancer treatment such as chemotherapy or radiation therapy for up to 90 days or until medically stable; or

b. Transplant within the last 12 months; or

c. Scheduled surgery within the next 60 days (elective procedures within the next 60 days do not qualify for this continuity of care); or

d. Recent major surgery still within the postoperative period of up to 8 weeks; or

e. Third trimester of pregnancy.

Note: If an enrollee's provider or health care facility discontinues participation with UMP Classic, the enrollee may not change medical plans until the next open enrollment period, unless the PEBB Program determines that a continuity of care issue exists. Kaiser cannot guarantee that any one physician, hospital, or other provider will be available or remain under contract with us.

When can an employee waive his or her medical plan coverage, or enroll after waiving coverage?

Any one of the following events may create a special open enrollment:

1. Employee acquires a new dependent due to:
    a. Marriage or registering a domestic partnership;
    b. Birth, adoption or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption;
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship; or
    d. A child becoming eligible as a dependent with a disability.
2. Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Employee or an employee's dependent has a change in employment status that affects the employee's or employee's dependent's eligibility for their employer contribution toward employer-based group medical insurance;
4. Employee or an employee's dependent has a change in enrollment under another employer-based group medical insurance plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;
5. Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States;
6. A court order or National Medical Support Notice requires the employee or any other individual to provide insurance coverage for an eligible dependent of the employee (a former spouse or former registered domestic partner is not an eligible dependent);
7. Employee or an employee's dependent becomes entitled to coverage under Medicaid or a state CHIP, or the employee or an employee's dependent loses eligibility for coverage under Medicaid or CHIP;
8. Employee or an employee's eligible dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP.

When can an employee enroll or remove eligible dependents?

To enroll a dependent, the employee must include the dependent's enrollment information and provide any required document(s) as evidence of the dependent's eligibility. The dependent will not be enrolled if his or her eligibility is not verified. Any one of the following events may create a special open enrollment:

1. Employee acquires a new dependent due to:
    a. Marriage or registering a domestic partnership;
    b. Birth, adoption or when an employee has assumed a legal obligation for total or partial support in anticipation of adoption;
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship; or
    d. A child becoming eligible as a dependent with a disability.
2. Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Employee or an employee's dependent has a change in employment status that affects the employee's or employee's dependent's eligibility for their employer contribution toward employer-based group health insurance;
4. Employee or an employee's dependent has a change in enrollment under another employer-based group health insurance plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment;
5. Employee 's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States;
6. A court order or National Medical Support Notice requires the employee or any other individual to provide insurance coverage for an eligible dependent of the employee (a former spouse or former registered domestic partner is not an eligible dependent);
7. Employee or an employee's dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under Medicaid or a CHIP; or
8. Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP.

National Medical Support Notice (NMSN)

When an NMSN requires an employee to provide health plan coverage for a dependent child the following provisions apply:

1. The employee may enroll his or her dependent child and request changes to his or her health plan coverage as described under subsection three of this section. Employees submit the required forms to their employing agency. All other subscribers submit the required forms to the PEBB Program.
2. If the employee fails to request enrollment or health plan coverage changes as directed by the NMSN, the employing agency or the PEBB Program may make enrollment or health plan coverage changes according to subsection three of this section upon request of:
    a. The child's other parent; or
    b. Child support enforcement program.
3. Changes to health plan coverage or enrollment are allowed as directed by the NMSN:
    a. The dependent will be enrolled under the employee's health plan coverage as directed by the NMSN;

b. An employee who has waived medical will be enrolled in medical as directed by the NMSN, in order to enroll the dependent;

c. The employee's selected health plan will be changed if directed by the NMSN;

d. If the dependent is already enrolled under another PEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN.

4. Changes to health plan coverage or enrollment as described in subsection (3)(a) through (c) of this section will begin the first day of the month following receipt of the NMSN. If the NMSN is received on the first day of the month, the change to health plan coverage or enrollment begins on that day. A dependent will be removed from the employee's health plan coverage as described in subsection (3)(d) of this section the last day of the month the NMSN is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.
5. The employee may be eligible to make changes to his or her health plan enrollment and salary reduction elections during a special open enrollment related to the NMSN.

MEDICARE ENTITLEMENT

Retirees and eligible dependents must enroll in Medicare Part A and Part B if entitled.

If an enrollee becomes entitled to Medicare, he or she should contact the nearest Social Security Administration office to ask about the advantages of immediate or deferred Medicare enrollment.

For employees and their enrolled spouses age 65 and older, the PEBB medical plan will provide primary insurance coverage, and Medicare coverage will be secondary. However, employees age 65 and older may choose to reject his or her PEBB medical plan and choose Medicare as their primary insurer. If an employee does so, the employee cannot enroll in a PEBB medical plan. The employee can again enroll in a PEBB medical plan during a special open enrollment or annual open enrollment. However, the employee must remain enrolled in PEBB dental, basic life and basic long-term disability insurance coverage.

In most situations, employees and their spouses can elect to defer Medicare Part B enrollment, without penalty, up to the date the employee terminates employment. If Medicare entitlement is due to disability, the enrollee must contact Medicare about deferral of premiums. Upon retirement, Medicare will become the primary insurance, and the PEBB medical plan becomes secondary.

Medicare guidelines direct that state-registered domestic partners who are age 65 or older must have Medicare as their primary insurer.

When Medical Enrollment Ends

Medical plan enrollment ends on the following dates:

1. On the last day of the month when any individual ceases to be eligible for PEBB insurance coverage.
2. On the date a plan terminates, if that should occur. Any person losing coverage will be given the opportunity to enroll in another PEBB medical plan.

Premium payments are not prorated if an enrollee dies or asks to cancel his or her medical plan before the end of the month.

If an enrollee or newborn eligible for benefits under "Obstetric and Newborn Care" is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB medical coverage ends and the enrollee is not immediately covered by other health plan coverage, benefits will be extended until whichever of the following occurs first:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization;
- The enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- The enrollee is covered by another health plan that will provide benefits for the services; or
- Benefits are exhausted.

When medical plan enrollment ends, the enrollee may be eligible for continuation of coverage or conversion to other health plan coverage if application is made within the timelines explained in the following sections.

The enrollee is responsible for timely payment of premiums. If the enrollee's insurance coverage is canceled due to lack of payment, the enrollee's eligibility to participate in PEBB medical coverage will end.

An enrollee who needs help getting the required forms for an enrollment or benefit change may contact the employing agency.

Options for Continuing PEBB Medical Coverage

Employees and their dependents covered by this health plan have options for continuing insurance coverage during temporary or permanent loss of eligibility. There are four possible continuation coverage options for PEBB health plan enrollees:

1. COBRA
2. PEBB Extension of Coverage
3. Leave Without Pay (LWOP) Coverage
4. PEBB retiree insurance coverage

The first three options temporarily extend group insurance coverage in some cases when the employee or dependent's PEBB medical plan coverage ends. COBRA coverage is governed by eligibility and administrative requirements in federal law and regulation. PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative in specific situations.

The fourth option above is only available to retiring employees and surviving dependents who meet eligibility and procedural requirements.

All four options are administered by the PEBB Program. Refer to the *PEBB Continuation of Coverage Election Notice* booklet or the *PEBB Retiree Enrollment Guide* for specific details or call PEBB Customer Service at **1-800-200-1004**.

Employees also have the right of conversion to individual medical insurance coverage when continuation of group medical insurance coverage is no longer possible. The employee's dependents also have options for continuing insurance coverage for themselves after losing eligibility.

Family and Medical Leave Act of 1993

Employees on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward insurance coverage in accordance with the federal FMLA. The employee's employing agency determines if the employee is eligible for leave and the duration of the leave under FMLA. The employee must continue to pay the employee premium contribution during this period to maintain eligibility. If the employee's contribution toward premiums is more than 60 days delinquent, insurance coverage will end as of the last day of the month for which a full premium was paid.

If an employee exhausts the period of leave approved under FMLA, insurance coverage may be continued by self-paying the full premium set by the HCA, with no contribution from the employer while on approved leave. For additional information on continuation of coverage, see the section titled "Options for Continuing PEBB Medical Coverage."

Payment of Premium During a Labor Dispute

Any employee or dependent whose monthly premiums are paid in full or in part by the employer may pay premiums directly to Kaiser or the HCA if the employee's compensation is suspended or canceled directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

While the employee's compensation is suspended or canceled, the employee shall be notified immediately by the HCA by mail addressed to the last address of record with the HCA, that the employee may pay premiums as they become due as provided in this section.

Conversion of Coverage

Enrollees have the right to switch from PEBB group medical coverage to an individual conversion plan offered through this plan when they are no longer able to continue the PEBB group medical plan, and are not eligible for Medicare or another group insurance coverage that provides benefits for hospital or medical care. Enrollees must apply for conversion coverage no later than 31 days after their group medical plan ends or within 31 days from the date the notice of termination of coverage is received, whichever is later.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. The rates, coverage and eligibility requirements of our conversion program differ from those of the enrollee's current group medical plan. To receive detailed information on conversion options under this medical plan, call Customer Service at Kaiser.

Appeals of Determinations of PEBB Eligibility

Any employee of a state agency and his or her dependent may appeal a decision by the employing state agency about PEBB eligibility or enrollment to the employing agency.

Any employee of an employer group or his or her dependent may appeal a decision made by an employer group regarding PEBB eligibility or enrollment to the employer group.

Any enrollee may appeal a decision made by the PEBB Program regarding eligibility, enrollment, or premium payments to the PEBB appeals committee.

Any enrollee may appeal a decision regarding administration of a PEBB medical plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment determinations.

Relationship to Law and Regulations

Any provision of this Certificate of Coverage that is in conflict with any governing law or regulation of the state of Washington is hereby amended to comply with the minimum requirements of such law or regulation.

MISCELLANEOUS PROVISIONS

Information about New Technology

When a new medical technology or procedure needs review, our Inter-regional New Technology Committee examines and evaluates data from government agencies, medical experts, medical journals, and medical specialty societies. Recommendations from this inter-regional committee then are passed onto the local committee. The committee reviews the national recommendations to see how they apply to local medical practices. Once this review takes place, the committee makes recommendations for the new technology or

procedure to become a covered benefit. In addition, the committee communicates practice guidelines to network providers and related health care providers. If the committee's recommendation is accepted, the new technology is added to the covered benefits, either immediately or when this contract renews.

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. Your PHI is individually identifiable information about your health, health care Services you receive, or payment for your health care. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, health research, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give PHI to others, such as government agencies or in judicial actions. In addition, Member-identifiable health information is shared with your Group only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices*. Giving us this authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices,* which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request. To request a copy, please call Member Services. You can also find the notice at your local Participating Facility or on our website at **kp.org.**

MEMBERS' RIGHTS AND RESPONSIBILITIES

Kaiser Foundation Health Plan of the Northwest believes that maintaining good health is a very important part of the Member's well-being. Providing the quality health care Services necessary to maintain good health requires a partnership between the Member and their health care professionals. Members need information to make appropriate decisions about their care and lifestyle choices. Health care professionals need the Member's involvement to ensure they receive appropriate and effective health care Services. Mutual respect and cooperation are essential to this partnership.

Exercise of Conscience

We recognize the right to exercise religious beliefs and conscience. If a Participating Provider or Participating Facility declines to provide a covered Service for reasons of conscience or religion, we will make arrangements to provide the covered Services.

At Kaiser Foundation Health Plan of the Northwest, Members have the right to:

- Be treated fairly, with respect and consideration, without regard to race, ethnicity, religion, gender, sexual orientation, nationality, cultural background, age, physical or mental disability, genetic information or financial status.
- Be supported in choosing and changing Participating Providers and seeking a second opinion within our Plan.
- Be involved in their health care decisions; be provided full information about their care, including unanticipated outcomes; the benefits and risks of and alternatives to recommended treatments or procedures regardless of cost or coverage; and realistic alternatives when hospital care is no longer appropriate. Get information about our policies, Services, facilities, and Member benefits and care in a way Members can understand.
- Be provided an interpreter if needed.
- Make recommendations about our policies (including Member rights and responsibilities) and Services.

- Consult with members of our ethics Services staff when faced with difficult medical ethics issues.
- Be supported if they change their mind about any procedure, refuse treatment, or decline to participate in medical training programs or research projects, and inform Members of the consequences of their decision.
- Make decisions about their future, and to specify their decisions in documents called advance directives.
- Be transferred only when medically appropriate and when the receiving facility is ready to accept them.
- Be provided with the names, professions, and educational backgrounds of the people treating them.
- Keep the Member's personal health information private and confidential. This includes all oral, written, and electronic records and communications about the Member's medical history, conditions, and care. All of our Participating Providers and staff—including contract providers—have agreed to this policy. We will use or disclose the Member's protected health information only when needed for treatment, payment, or health care operations such as measuring the quality of care. We will not use or disclose the Member's protected health information for any other purpose, except as described in our Notice of Privacy Practices. (See "Notice of Privacy Practices" for more information.)
- Expect an appropriate, confidential, and timely response, without sanction or reprisal, to any suggestions or complaints Members have about our policies or the care or Services we provide. Member Services will inform Members of complaint and appeal procedures and resources to help them.
- Receive information about charges and payment methods. Receive an itemized statement of non-covered Services upon request, for an additional service charge. (Medicare members are not required to pay this charge.)

At Kaiser Foundation Health Plan of the Northwest, Members have the responsibility to:

- Participate in the development of their treatment plan, to follow it, and to let their Participating Provider know if changes need to be made.
- Improve the quality and safety of their care by fully informing Participating Providers serving them about their medical history, medications, and any changes in their condition.
- Ask questions if the Member does not understand any aspect of their medical or dental condition or treatment.
- Be aware of the daily lifestyle decisions that affect their health and choices that can reduce the risks to their health and the health of their family.
- Tell their health care team if they are satisfied or dissatisfied with any aspect of their care.
- Provide their family, Participating Provider, and hospital with a copy of any advance directive they wish Kaiser Permanente to follow, should they be unable to make their own decisions.
- Treat their health care team with consideration and respect.
- Treat other patients with consideration and respect. When the Member is in the hospital, avoid having the volume on television sets too loud, having too many visitors, or holding loud conversations that may disturb other patients.
- Comply with the no-smoking, no-weapons, and visiting-hours policies.
- Be familiar with their health care benefits.
- Notify Kaiser if they have other health coverage. We will coordinate benefits if the other plan is the Member's primary plan.

- Have their membership identification (ID) card handy when they call for an appointment or advice, or when they come in for care.
- Notify Kaiser in advance if they will be late for, or have to cancel, an appointment.
- Pay their bills on time and pay their Deductibles, Copayments, and Coinsurance when coming in for care.

Q & A ABOUT KAISER PERMANENTE PHARMACY SERVICES

We hope the following common questions and answers will help you get the most from your pharmacy benefits.

Does this Plan limit or exclude certain medications my health care provider may prescribe? Does it encourage substitutions for some medications?

Yes, this Plan has some limitations and exclusions. We also encourage using generic medications when their brand-name equivalents do not provide better treatment.

A medication must be on our Formulary or meet exception criteria for you to pay your usual Copayment or Coinsurance. Medications on the Formulary have been approved by the U.S. Food and Drug Administration (FDA). They have also been reviewed and approved by our Formulary and Therapeutics Committee. This committee includes Participating Physicians and participating pharmacists. (Participating Physicians and pharmacists are those included in this Plan.)

The committee looks at safety, effectiveness, and cost. We may not approve a medication if there is not enough scientific evidence that it is clinically effective. We may also exclude a medication if it does not have a clinical or cost advantage over comparable Formulary medications. You can get a copy of the Formulary from one of our Participating Pharmacies. You can also view it online at **kp.org/formulary**.

Your Participating Provider can ask for an exception in special situations. He or she must feel that a non-Formulary medication is the most appropriate therapy for your medical needs. This might be because you have used Formulary medications and they were not effective. Or it might be because you are allergic to the Formulary medications or cannot tolerate them.

Dental prescriptions are limited to the FDA-approved prescription medications listed on the dental Formulary. No exceptions are allowed.

The following *types* of medications are excluded from the Formulary:

- Medications that treat infertility.
- Medications related to a service this Plan excludes.
- Over-the-counter medications, unless they are on the Formulary.
- Medications compounded in a pharmacy, unless they are on the Formulary.
- Medications used for weight management, sexual dysfunction, or to improve athletic performance.
- Medications that are replaced because of loss, damage, and/or carelessness.
- Mail-Delivery Pharmacy Service medications that need special handling, such as refrigeration; that have an unusually high cost; or that must be given by a professional, or in the presence of one.
- Medications not approved by the U.S. Food and Drug Administration.

We also do not cover special packaging, such as bubble wrap, even when the medication is covered.

When can my plan change the approved medication list (Formulary)? If a change occurs, will I have to pay more to use a medication I have been using?

Our Formulary and Therapeutics Committee meets every month to review new medications and reconsider old ones. Participating Providers can ask the committee to review a medication. After this review, we may add medications to the Formulary or remove medications from it.

Usually, if we remove a medication from the Formulary, you will need to switch to another comparable medication to keep paying just your Copayment. In some cases, your Participating Provider might find that the old medication meets the exception criteria.

When we remove a medication from the Formulary, we often send a letter to patients who use it, especially if the medication is very common. This gives them time to discuss the change with their Participating Provider.

What should I do if I want a change to limitations, exclusions, substitutions, or cost increases for any medication specified in my plan?

We have a process for reviewing what this Plan covers and how much you pay for medications. That process may include several steps. The first is an initial benefit determination. Upon review, if there is an adverse benefit determination, you will be provided with information regarding the appeal process. If, after appealing, the issue remains unresolved, a review by an independent review organization can be requested.

Once we receive all necessary information, initial benefit determinations are made within 15 days. Internal appeals are decided within 14 days of our receiving the appeal. Sometimes that is extended to 30 days. However, the process is faster if a delay would put your life or health at serious risk or cause you severe pain. In that case, we will respond within 72 hours or two business days, whichever is shorter.

How much do I have to pay to get a prescription filled?

See the "Benefit Summary" for Copayments and the "Prescription drugs, insulin, and diabetic supplies" section numbered 22.

Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?

To pay the Copayments or Coinsurance stated in this *COC,* you must fill prescriptions at a Participating Pharmacy listed in the *Medical Directory.*

You can also take advantage of our postage-paid Mail-Delivery Pharmacy Service. You can order by calling 1-800-548-9809. (For TTY call 711.) Or you can use the refill service on our website, **kp.org**.

How many days' supply of most medications can I get without paying another Copayment or other repeating charge?

Each Copayment covers up to a 30-day supply. If your Participating Provider prescribes a supply of less than 30 days, you will still pay the same Copayment, unless the actual cost of the medication is less. Your normal Copayment will also apply if you receive a smaller supply because of medication stability issues or therapy guidelines.

You can save money when you use our Mail-Delivery Pharmacy Service for refills. For example, you might be able to get a 90-day supply of a maintenance medication for just two Copayments.

What other pharmacy Services does my health plan cover?

We have a Medication Management Program. In this program, participating pharmacists and other staff work with our Participating Providers. Their goal is to ensure quality care and improve health outcomes for Members. At the same time, they try to lower the cost of medication therapy.

The program's primary focus is on reducing cardiovascular risk, especially by controlling lipid levels and high blood pressure. Staff educate patients, monitor and adjust medication doses, and link patients with their doctors. They also manage medication therapy for diabetes, asthma, and depression.

There is no extra charge for the Medication Management Program.

If you have questions about this process, call Membership Services 8 a.m. to 6 p.m., Monday through Friday. From Washington, call 1-800-813-2000. From Portland, call 503-813-2000. For TTY, call 1-800-735-2900. For language interpretation Services, call 1-800-324-8010. You can also sign on to **kp.org** and send us a secure electronic message.

Some terms

Brand-name medication—The first approved version of a medication. Marketed under a proprietary, trademark-protected name.

Food and Drug Administration (FDA)—The federal agency charged with reviewing and approving medications and medical technology for use in the United States.

Formulary—A listing of preferred pharmaceutical substances and formulas.

Formulary process—A system for maximizing the safety, efficacy, and cost-effectiveness of medications used by Members.

Generic medication—A medication that contains the same active ingredient as a brand-name medication and is equal in dosage, strength, quality, performance, and intended use. Must pass rigorous testing of equality from the FDA.

Maintenance medication—Maintenance medications or supplies are items that meet both of the following requirements:

- Our Regional Formulary and Therapeutics Committee determines that there is evidence that the medication is safe and effective to use for at least six months.
- The medication or supply is prescribed for regular or scheduled use rather than on an as-needed basis.

Non-Formulary—Non-Formulary medications are medications that are not on our Formulary list or are not used for the condition listed on the Formulary.

Therapeutic equivalent—Medication products within the same pharmacologic or therapeutic class that are expected to have similar effect and safety profiles when administered in equivalent doses.

COORDINATION OF BENEFITS
CONSUMER EXPLANATORY BOOKLET

Important Notice

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your *Certificate of Coverage (COC),* which determines your benefits.

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits issuers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Caution: All health plans have timely claim filing requirements. If you or your provider fail to submit your claim to a secondary plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim. To avoid delays in claims processing, if you are covered by more than one plan, you should promptly report to your providers and plans any changes in your coverage.

Coordination of benefits (COB) is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your *Certificate of Coverage* or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. To avoid delays in claim processing, if you are covered by more than one plan, you should promptly report to your providers and plans any changes in your coverage. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary. If you are covered by more than one health benefit plan, and you do not know which plan is your primary plan, you or your provider should contact any one of the health plans to find out. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within 30 calendar days.

When This Plan is Primary

If you or a family member is covered under another plan in addition to this one, we will be primary when:

- **Your Own Expenses.** The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.
- **Your Spouse's Expenses.** The claim is for your spouse, who is covered by Medicare, and you are not both retired.
- **Your Child's Expenses.** The claim is for the health care expenses of your child who is covered by this plan; and

- You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule"; or
- You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses; or
- There is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits according to the terms of your *Certificate of Coverage*, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

When we are knowingly the secondary plan, we will make payment promptly after receiving payment information from your primary plan. Your primary plan, and we as your secondary plan, may ask you and/or your provider for information in order to make payment. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the primary plan fails to pay within sixty calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim for us to make payment as if we were your primary plan. In such situations, we are required to pay claims within thirty calendar days of receiving your claim and the notice that your primary plan has not paid. This provision does not apply if Medicare is the primary plan. We may recover from the primary plan any excess amount paid under the "right of recovery" provision in the plan.

If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other plans.

We will determine our payment by subtracting the amount paid by the primary plan from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal to one hundred percent of the total allowable expense (the amount cannot be less than the same allowable expense the secondary plan would have paid if it had been the primary plan) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the plan(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a medical savings account to cover future medical claims which might not otherwise have been paid. For example, if the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.

Questions about coordination of benefits?

Contact your state insurance department.