KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Large Group
Deductible Plan
Evidence of Coverage

Group Name: School Employees Benefit Board (SEBB)

Group Number: 22560

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Member Services
Monday through Friday (except holidays)
8 a.m. to 6 p.m.

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All other areas.....1-800-813-2000

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All areas.....711

Language interpretation services
All areas.....1-800-324-8010

kp.org

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

A Nonprofit Corporation

Know your rights under the Balance Billing Protection Act

Beginning January 1, 2020, Washington state law protects you from "surprise billing" or "balance billing" if you receive emergency care or are treated at an in-network hospital or outpatient surgical facility

What is "surprise billing" or "balance billing" and when does it happen?

Under your health plan, you're responsible for certain cost-sharing amounts. This includes copayments, coinsurance and deductibles. You may have additional costs or be responsible for the entire bill if you see a provider or go to a facility that is not in your plan's provider network.

Some providers and facilities have not signed a contract with your insurer. They are called "out-of-network" providers or facilities. They can bill you the difference between what your insurer pays and the amount the provider or facility bills. This is called "surprise billing" or "balance billing."

Insurers are required to tell you, via their websites or on request, which providers, hospitals and facilities are in their networks. And hospitals, surgical facilities and providers must tell you which provider networks they participate in on their website or on request.

When you CANNOT be balance billed:

Emergency Services

The most you can be billed for emergency services is your plan's in-network cost-sharing amount even if you receive services at an out-of-network hospital in Washington, Oregon or Idaho or from an out-of-network provider that works at the hospital. The provider and facility cannot balance bill you for emergency services.

Certain services at an In-Network Hospital or Outpatient Surgical Facility

When you receive surgery, anesthesia, pathology, radiology, laboratory, or hospitalist services from an out-of-network provider while you are at an in-network hospital or outpatient surgical facility, the most you can be billed is your in-network cost-sharing amount. These providers cannot balance bill you.

In situations when balance billing is not allowed, the following protections also apply:

- Your insurer will pay out-of-network providers and facilities directly. You are only responsible for paying your in-network cost-sharing.
- Your insurer must:
  - Base your cost-sharing responsibility on what it would pay an in-network provider or facility in your area and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or certain out-of-network services (described above) toward your deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 30 business days.
- A provider, hospital, or outpatient surgical facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital or facility in any OTHER situation, you may still be balance billed, or you may be responsible for the entire bill.

This law does not apply to all health plans. If you get your health insurance from your employer, the law might not protect you. Be sure to check your plan documents or contact your insurer for more information.

If you believe you've been wrongly billed, file a complaint with the Washington state Office of the Insurance Commissioner at **www.insurance.wa.gov** or call 1-800-562-6900.

DEDUCTIBLE PLAN BENEFIT SUMMARY

This "Benefit Summary," which is part of the *Evidence of Coverage (EOC)*, is a summary of answers to the most frequently asked questions about benefits. This summary does not fully describe benefits, limitations, or exclusions. To see complete explanations of what is covered for each benefit, including exclusions and limitations, and for additional benefits that are not included in this summary, please refer to the "Benefits," "Exclusions and Limitations," and "Reductions" sections of this *EOC*. Exclusions, limitations and reductions that apply to all benefits are described in the "Exclusions and Limitations" and "Reductions" sections of this *EOC*. For a list of defined terms, refer to the "Definitions" section of this *EOC*.

Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.

Deductible	
Self-only Deductible per Year (for a Family of one Member)	$125
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$125
Family Deductible per Year (for an entire Family)	$250
Out-of-Pocket Maximum	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$2,000
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$2,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	$4,000
Note: All Deductible, Copayments, and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise indicated in this *EOC*.	
Service	**You Pay**
Preventive Care Services	
Routine preventive physical exam (includes adult, well baby, and well child)	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	
Primary care visit (includes routine OB/GYN visits and medical office visits, health education Services, and diabetic outpatient self-management training and education, including medical nutrition therapy)	$20 ($0 for Members age 17 years and younger)
Specialty care visit (includes routine hearing exams, health education Services and diabetic outpatient self-management training and education, including medical nutrition therapy)	$30
TMJ therapy visit	$30 after Deductible
Nurse treatment room visits to receive injections	$10
Administered medications, including injections (all outpatient settings)	20% Coinsurance after Deductible
Urgent Care visit	$40
Emergency department visit	20% Coinsurance after Deductible
Outpatient surgery visit	20% Coinsurance after Deductible
Vasectomy	$0
Chemotherapy/radiation therapy visit	$30 after Deductible
Respiratory therapy visit	$30 after Deductible

Cardiac rehabilitative therapy visit	$30 after Deductible
Inpatient Hospital Services	
Room and board, surgery, anesthesia, X-ray, imaging, laboratory, and drugs	20% Coinsurance after Deductible
Vasectomy	$0
Acupuncture Services	
Physician-referred acupuncture	$30 per visit
Ambulance Services	
Per transport	20% Coinsurance after Deductible
Bariatric Surgery Services	
Inpatient hospital Services	20% Coinsurance after Deductible
Chemical Dependency Services	
Outpatient Services	$20 ($0 for Members age 17 years and younger)
Inpatient hospital Services	20% Coinsurance after Deductible
Residential Services	20% Coinsurance after Deductible
Day treatment Services	$20 ($0 for Members age 17 years and younger)
Dialysis Services	
Outpatient dialysis visit	$30 after Deductible
Home dialysis	$0
External Prosthetic Devices and Orthotic Devices	
External Prosthetic Devices	20% Coinsurance after Deductible
Orthotic Devices	20% Coinsurance after Deductible
Habilitative Services (Visit maximums do not apply to habilitative Services for treatment of mental health conditions.)	
Outpatient Services (up to 60 visits combined for physical, occupational, speech and neurodevelopmental therapy)	$30
Inpatient Services	20% Coinsurance after Deductible
Home Health Services	
Home health (up to 130 visits per Year)	20% Coinsurance after Deductible
Hospice Services	
Hospice Services (respite care is limited to no more than five consecutive days per three months of hospice care)	$0
Infertility Services	
Diagnosis office visit	50% Coinsurance after Deductible
Diagnosis laboratory procedures	50% Coinsurance after Deductible

Limited Outpatient Prescription Drugs and Supplies	
Certain preventive medications (including, but not limited to, aspirin, fluoride, liquid iron for infants, and tobacco use cessation drugs)	$0
Certain self-administered IV drugs, fluids, additives, and nutrients including the supplies and equipment required for their administration	$0
Blood glucose test strips	Refer to your Outpatient Prescription Drug Rider
FDA-approved prescription and over-the-counter contraceptive drugs or devices	$0
Insulin	Subject to the applicable drug tier Copayment or Coinsurance shown in your Outpatient Prescription Drug Rider, not subject to Deductible, up to $100 for each 30-day supply
Self-administered chemotherapy medications used for the treatment of cancer	Refer to your Outpatient Prescription Drug Rider
Maternity and Newborn Care	
Scheduled prenatal care visits and postpartum visits	$0
Inpatient hospital Services	20% Coinsurance after Deductible
Home birth obstetrical care and delivery	$30
Medical Foods and Formula	
Medical foods and formula	20% Coinsurance after Deductible
Mental Health Services	
Outpatient Services	$20 ($0 for Members age 17 years and younger)
Intensive outpatient Services	$20 ($0 for Members age 17 years and younger)
Partial hospitalization	$20 ($0 for Members age 17 years and younger)
Assertive Community Treatment (ACT) Services	$0
Inpatient hospital Services	20% Coinsurance after Deductible
Residential Services	20% Coinsurance after Deductible
Naturopathic Medicine	
Physician-referred evaluation and treatment	$30 per visit
Out-of-Area Coverage for Dependents	
Limited office visits, laboratory, diagnostic X-rays, and prescription drug fills as described in the *EOC* under "Out-of-Area Coverage for Dependents" in the "How to Obtain Services" section.	20% of the actual fee the provider, facility, or vendor charged for the Service
Outpatient Durable Medical Equipment (DME)	
Outpatient Durable Medical Equipment (DME)	20% Coinsurance after Deductible
Peak flow meters, blood glucose monitors, and lancets	20% Coinsurance
Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures	
Laboratory	$20 per department visit
Genetic testing	$20 per department visit

X-ray, imaging, and special diagnostic procedures	$20 per department visit
CT, MRI, PET scans	$50 per department visit
Reconstructive Surgery Services	
Inpatient hospital Services	20% Coinsurance after Deductible
Outpatient surgery visit	20% Coinsurance after Deductible
Rehabilitative Therapy Services (Visit maximums do not apply to rehabilitative therapy Services for treatment of mental health conditions.)	
Outpatient Services (up to 60 visits combined for physical, occupational, speech and neurodevelopmental therapy)	$30
Inpatient Services	20% Coinsurance after Deductible
Skilled Nursing Facility Services	
Inpatient skilled nursing Services (up to 100 days per Year)	20% Coinsurance after Deductible
Spinal and Extremity Manipulation Therapy Services	
Self-referred Spinal and Extremity Manipulation therapy	$30 per visit
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INTRODUCTION

This *Evidence of Coverage* (*EOC*), including the "Benefit Summary" and any benefit riders attached to this *EOC*, describes the health care benefits of this Large Group Deductible Plan issued through the School Employees Benefit Board (SEBB) Program under the *Professional Services Contract (Contract)* between Kaiser Foundation Health Plan of the Northwest and the Washington State Health Care Authority (HCA). For benefits provided under any other Plan, refer to that Plan's evidence of coverage.

The provider network for this Deductible Plan is the Classic network. In this EOC, Kaiser Foundation Health Plan of the Northwest is sometimes referred to as "Company," "we," "our," or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this EOC. See the "Definitions" section for terms you should know. The benefits under this Plan are not subject to a pre-existing condition waiting period.

It is important to familiarize yourself with your coverage by reading this *EOC* and the "Benefit Summary" completely, so that you can take full advantage of your Plan benefits. Also, if you have special health care needs, carefully read the sections applicable to you.

Term of this *EOC*

This *EOC* is effective for the period stated on the cover page, unless amended. Your Group's benefits administrator can tell you whether this *EOC* is still in effect.

About Kaiser Permanente

Kaiser Permanente provides or arranges for Services directly to you and your Dependents through an integrated medical care system. We, Participating Providers, and Participating Facilities work together to provide you with quality medical care Services. Our medical care program gives you access to all of the covered Services you may need, such as routine Services with your own primary care Participating Provider, inpatient hospital Services, laboratory and pharmacy Services, and other benefits described under the "Benefits" section. Plus, our preventive care programs and health education classes offer you and your Family ways to help protect and improve your health.

We provide covered Services to you using Participating Providers and Participating Facilities except as described under the following sections:

- "Referrals to Non-Participating Providers and Non-Participating Facilities" in the "How to Obtain Services" section.
- "Emergency, Post-Stabilization, and Urgent Care" section.
- Limited coverage for Members as described under "Receiving Care in Another Kaiser Foundation Health Plan Service Area" and "Out-of-Area Coverage for Dependents" in the "How to Obtain Services" section.
- "Ambulance Services" in the "Benefits" section.

To obtain information about Participating Providers and Participating Facilities go to **kp.org/directory/nw** or call Member Services.

For more information, see the "How to Obtain Services" section or contact Member Services. If you would like additional information about your benefits, important health plan disclosures, other products or Services, please call Member Services or e-mail us by registering at **kp.org**.

DEFINITIONS

The following terms, when capitalized and used in any part of this *EOC,* mean:

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 *EOC* which provides a brief description of your medical Plan benefits and what you pay for covered Services.

Charges. Charges means the following:

- For Services provided by Medical Group and Kaiser Foundation Hospitals, the charges in Company's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members.
- For Services for which a provider or facility (other than Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Company negotiates with the capitated provider.
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if the Member's benefit Plan did not cover the pharmacy item. (This amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Company.)
- For all other Services, the payments that Company makes for Services (or, if Company subtracts Deductible, Copayment, or Coinsurance from its payment, the amount Company would have paid if it did not subtract the Deductible, Copayment, or Coinsurance).

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 Charges that you must pay when you receive a covered Service.

Company. Kaiser Foundation Health Plan of the Northwest, an Oregon nonprofit corporation. This *EOC* sometimes refers to our Company as "we," "our," or "us."

Copayment. The defined dollar amount that you must pay when you receive a covered Service.

Cost Share. The Deductible, Copayment, or Coinsurance you must pay for 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 health coverage.

Deductible. The amount you must pay for certain Services you receive in a Year before we will cover those Services, subject to any applicable Copayment or Coinsurance, in that Year. Deductible amounts include the Deductible take-over amounts as described in the "Deductible" section of this *EOC*.

Dependent. A Member who meets the eligibility requirements for a Dependent as described in the "Eligibility" section.

Dependent Limiting Age. The general and student maximum ages established for Dependents (other than Spouse) by your Group for Dependent eligibility that are approved by Company and shown in the "Benefit Summary."

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 you if you are not ill or injured.

Emergency Medical Condition. A medical, mental health, or substance use disorder condition that manifests itself by acute symptoms of sufficient severity (including, but not limited to, severe pain or emotional distress) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment 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.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

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).

***Evidence of Coverage* (*EOC*).** This *Evidence of Coverage* document provided to the Subscriber that specifies and describes benefits and conditions of coverage. This document, on its own, is not designed to meet the requirements of a summary plan description (SPD) under ERISA. After you enroll, you will receive a postcard that explains how you may either download an electronic copy of this *EOC* or request that this *EOC* be mailed to you. *Evidence of Coverage* (*EOC*) has the same meaning as Certificate of Coverage (*COC*) defined in the *Contract* between Company and HCA.

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 Dependents.

Gender Affirming Treatment. Medical treatment or surgical procedures, including hormone replacement therapy, necessary to change the physical attributes of one's outward appearance to accord with the person's actual gender identity.

Group. The employer, union trust, or association with which we have an *Contract* that includes this *EOC*.

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 Permanente. Kaiser Foundation Hospitals (a California nonprofit corporation), Medical Group, and Kaiser Foundation Health Plan of the Northwest (Company).

Medical Facility Directory. The *Medical Facility Directory* 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 an e-mail or flyer that explains how you may either download an electronic copy of the *Medical Facility Directory* or request that the *Medical Facility Directory* be mailed to you.

Medical Group. 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 Company to provide professional medical Services to Members and others primarily on a capitated, prepaid basis in Participating Facilities.

Medically Necessary. Our determination that the Service is all of the following: (i) medically required to prevent, diagnose or treat your condition or clinical symptoms; (ii) in accordance with generally accepted standards of medical practice; (iii) not solely for the convenience of you, your family and/or your provider; and, (iv) the most appropriate level of Service which can safely be provided to you. For purposes of this definition, "generally accepted standards of medical practice" means (a) standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; (b) physician specialty society recommendations; (c) the view of physicians practicing in the relevant clinical area or areas within Kaiser Permanente locally or nationally; and/or (d) any other relevant factors reasonably determined by us. Unless otherwise required by law, we decide if a Service is Medically Necessary. You may appeal our decision as set forth in the "Grievances, Claims, Appeals, and External Review" section. The fact that a Participating Provider has prescribed, recommended, or approved a Service does not, in itself, make such Service Medically Necessary and, therefore, a covered Service.

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. A person who is eligible and enrolled under this *EOC,* and for whom we have received applicable Premium. This *EOC* sometimes refers to a Member as "you." The term Member may include the Subscriber, his or her Dependent, or other individual who is eligible for and has enrolled under this *EOC*.

New Episode of Care. Treatment for a new condition or diagnosis for which you have not been treated by a Participating Provider of the same licensed profession within the previous 90 days, and are not currently undergoing any active treatment.

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-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.

Non-Participating Vendor. Any business, or any provider or facility regulated under state law to practice health or health-related services or otherwise practicing health care services consistent with state law, that sells or leases Durable Medical Equipment (DME), vision hardware (glasses and contact lenses), hearing aids, and other medical supplies and equipment, and that is not a Participating Vendor.

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 Deductible, Copayments, and Coinsurance you will be responsible to pay in a Year, as described in the "Out-of-Pocket Maximum" section of this *EOC*.

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

Participating Hospital. Any hospital listed as a Participating Hospital in the *Medical Facility Directory*. Participating Hospitals are subject to change.

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

Participating Pharmacy. A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate, that is listed as a Participating Pharmacy in the *Medical Facility Directory*. 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 Company, has agreed to provide covered Services to Members with an expectation of receiving payment, other than Deductible, Copayment, or Coinsurance, from Company 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 Company, has agreed to provide covered Services to Members with an expectation of receiving payment, other than Deductible, Copayment, or Coinsurance, from Company rather than from the Member.

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 Company. 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.

Participating Vendor. Kaiser Permanente, or any business (or any provider or facility regulated under state law to practice health or health-related services or otherwise practicing health care services consistent with state law) that sells or leases Durable Medical Equipment (DME), vision hardware (glasses and contact

lenses), hearing aids, and other medical supplies and equipment and that is owned or operated by Kaiser Permanente or that contracts directly with Kaiser Permanente.

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. Any hospital expense, medical expense, or hospital and/or medical expense policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Post-Stabilization Care. The Services you receive after your treating physician determines that your Emergency Medical Condition is clinically stable.

Premium. Monthly membership charges paid by Group.

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

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. The person to whom you are legally married under applicable law. For the purposes of this *EOC*, the term "Spouse" includes a person who is legally recognized as your domestic partner in a valid Certificate of State Registered Domestic Partnership issued by the state of Washington, validly registered as your domestic partner under the laws of another state, or otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your Group.

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. A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber.

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 Company. 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 https://**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.

Year. A period of time that is a calendar year beginning on January 1 of any year and ending at midnight December 31 of the same year.

PREMIUM, ELIGIBILITY, AND ENROLLMENT

In these sections, "health plan" is used to refer to a plan offering medical, vision, or dental coverage, or a combination developed by the School Employees Benefits Board (SEBB) and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

Premium

Your Group is responsible for paying the Premium. If you are responsible for any contribution to the Premium, your Group will tell you the amount and how to pay your Group.

Eligibility

The school employee's SEBB Organization will inform the school employee whether or not they are eligible for benefits upon employment and whenever their eligibility status changes. The communication will include information about the school employee's right to appeal eligibility and enrollment decisions. Information about a school employee's right to an appeal can be found in the "Appeal Rights" section of this *EOC*. For information on how to enroll, see the "Enrollment" section.

To enroll an eligible Dependent the Subscriber must follow the procedural requirements described in the "Enrollment" section. The SEBB Program or SEBB Organization verifies the eligibility of all Dependents and requires the Subscriber to provide documents that prove a Dependent's eligibility.

The following are eligible as Dependents:

- Legal Spouse.
- State-registered domestic partner as defined in the state statute and substantially equivalent legal unions from other jurisdictions as defined in the Washington state statute.
- Children. Children are eligible through the last day of the month in which their 26th birthday occurs except as described in this section. Children are defined as the Subscriber's:
    - Children as defined in state statutes that establish a parent-child relationship, except when parental rights have been terminated;
    - Children of the Subscriber's Spouse, based on the Spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to a Subscriber (and eligibility as a Dependent) ends on the same date the marriage with the Spouse ends through divorce, annulment, dissolution, termination, or death;
    - Children for whom the Subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
    - Children of the Subscriber's state-registered domestic partner, based on the state-registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the Subscriber (and eligibility as a Dependent) ends on the same date the Subscriber's legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death;
    - Children specified in a court order or divorce decree for whom the Subscriber has a legal obligation to provide support or health care coverage;
    - Extended Dependent in the legal custody or legal guardianship of the Subscriber, the Subscriber's Spouse, or Subscriber's state-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended

Dependent child does not include a foster child unless the Subscriber, the Subscriber's Spouse, or the Subscriber's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and

- Children of any age with a developmental or physical disability 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. The following requirements apply to Dependents with a disability:
  - The Subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26;
  - The Subscriber must notify the SEBB Program in writing when the child is no longer eligible under this subsection;
  - A child with a developmental or physical disability who becomes self-supporting is not eligible as of the last day of the month in which they become capable of self-support;
  - A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility under this subsection if they later become incapable of self-support; and
  - The SEBB Program with input from the medical plan will periodically verify the eligibility of a Dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday. Verification will require renewed proof of disability and dependency from the Subscriber.

Enrollment

A Subscriber or Dependent is eligible to enroll in only one SEBB medical plan even if eligibility criteria is met under two or more Subscribers. For example, a Dependent child who is eligible for enrollment under two parents working for the same, or two different SEBB Organizations may be enrolled as a Dependent under both parents but is limited to a single enrollment in SEBB medical.

A school employee may waive enrollment in SEBB medical if they are enrolled in other employer-based group medical, a TRICARE plan, or Medicare. If a school employee waives enrollment in SEBB medical, the school employee cannot enroll eligible Dependents.

Subscribers and their Dependents must reside or work in the Service Area except for temporary residency outside the Service Area for purposes of attending school, court-ordered coverage for Dependents or other unique family arrangements, when approved in advance by KFHPNW. KFHPNW has the right to verify eligibility.

How to Enroll

A school employee must use the SEBB My Account online enrollment system or submit a *School Employee Enrollment* form to their SEBB Organization when they become newly eligible for SEBB benefits. The online enrollment or form must be received no later than 31 days after the date the school employee becomes eligible. If the school employee does not enroll online or return the *School Employee Enrollment* form by the deadline, the school employee will be enrolled in Uniform Medical Plan Achieve 1, a tobacco use premium surcharge will be incurred, and any eligible Dependents cannot be enrolled until the SEBB Program's next annual open enrollment or when a qualifying event occurs that creates a special open enrollment.

To enroll an eligible Dependent, the school employee must include the Dependent's enrollment information in SEBB My Account or on the form and provide the required document(s) as proof of the Dependent's eligibility. The Dependent will not be enrolled in SEBB health plan coverage if the SEBB Program or the SEBB Organization is unable to verify their eligibility within the SEBB Program enrollment timelines.

All other Subscribers may enroll by submitting the required forms to the SEBB Program. The SEBB Program must receive the school employee's elections no later than 60 days from the date the school employee's SEBB health plan coverage ended or from the postmark date on the election notice sent by the SEBB Program, whichever is later. The school employee's first premium payment and applicable premium surcharges are due no later than 45 days after the election ends as described above. Premiums and applicable premium surcharges associated with continuing SEBB medical, must be made to the HCA as well as premiums associated with continuing SEBB medical, dental and vision insurance coverage. For more information see "Options for Continuing SEBB Medical Coverage" section.

A Subscriber or their Dependents may also enroll during the SEBB Program's annual open enrollment (see "Annual Open Enrollment" section) or during a special open enrollment (see "Special Open Enrollment" section). The Subscriber must provide proof of the event that created the special open enrollment.

A school employee must notify their SEBB Organization to remove Dependents within 60 days of the last day of the month when the Dependent no longer meets the eligibility criteria described under the "When Can a Subscriber Enroll or Remove Eligible Dependents?" All other Subscribers must notify the SEBB Program to remove a Dependent within 60 days of the last day of the month when the Dependent no longer meets the eligibility criteria described under "When Can a Subscriber Enroll or Remove Eligible Dependents?" section. Consequences for not submitting notice within 60 days may include, but are not limited to:

- The Dependent losing eligibility to continue SEBB medical coverage under one of the continuation coverage options described under "Options for Continuing SEBB Medical Coverage" section of this *EOC*;
- The Subscriber being billed for claims paid by the health plan for Services that were rendered after the Dependent lost eligibility;
- The Subscriber being unable to recover Subscriber-paid insurance premiums for a Dependent that lost their eligibility; and
- The Subscriber being responsible for premiums paid by the state for the Dependent's health plan coverage after the Dependent lost eligibility.

When Medical Coverage Begins

For a school employee and their eligible Dependents **enrolling when the school employee is newly eligible,** SEBB medical coverage begins the first day of the month following the date the school employee becomes eligible.

Exceptions:

- The school employee's benefits will begin on the first day of work when their first day of work is on or after September 1, but not later than the first day of school for the current school year as established by the SEBB Organization.
- When a school employee establishes eligibility toward SEBB benefits at any time in the month of August, the SEBB benefits begin on September 1 only if the school employee is also determined to be eligible for the school year that begins on September 1.

For a Subscriber or their eligible Dependents **enrolling during a special open enrollment**, SEBB medical coverage begins the first day of the month following the later of the event date or the date the online enrollment or required form is received.

Exceptions:

If the special open enrollment is due to the birth or adoption of a child, or when the Subscriber has assumeda legal obligation for total or partial support in anticipation of adoption of a child, SEBB medical coverage begins as follows:

- For an employee, medical coverage will begin the first day of the month in which the event occurs;
- For the newly born child, medical coverage begins the date of birth;
- For a newly adopted child, medical coverage begins on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier; or
- For a Spouse or state-registered domestic partner of a Subscriber, medical coverage will begin the first day of the month in which the event occurs.
- Enrollment of an extended Dependent or a Dependent with a disability will begin the first day of the month following the later of the event date or eligibility certification.

Annual Open Enrollment

School employees may make the following changes to their enrollment during the SEBB Program's annual open enrollment:

- Enroll in or change their medical plan
- Waive their medical plan enrollment
- Enroll after waiving medical plan enrollment
- Enroll or remove eligible Dependents

Other Subscribers may make the following changes to their enrollment during the SEBB Program's annual open enrollment:

- Enroll in or terminate enrollment in a medical plan
- Enroll or remove eligible Dependents
- Change their medical plan

The school employee must submit the change online in SEBB My Account or return the required enrollment/change form to their SEBB Organization. All other Subscribers must submit the form to the SEBB Program. The form must be received no later than the last day of the annual open enrollment. The enrollment change will become effective January 1st of the following year.

Special Open Enrollment

A Subscriber 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 (IRC) and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the Subscriber, their Dependent, or both. A special open enrollment event must be an event other than a school employee gaining initial eligibility or regaining eligibility for SEBB benefits. The special open enrollment may allow a Subscriber to:

- Enroll in or change their medical plan
- Waive their medical plan enrollment
- Enroll after waiving medical plan enrollment
- Enroll or remove eligible Dependents

To make an enrollment change, the school employee must make the change online in SEBB My Account or submit the required forms to their SEBB Organization. All other Subscribers must submit the form to the SEBB Program. The forms must be received no later than 60 days after the event that created the special open enrollment. In addition to the required forms, the SEBB Program or SEBB Organization will require the Subscriber to provide proof of the Dependent's eligibility, evidence of the event that created the special open enrollment, or both.

Exception:

If a school employee wants to enroll a newborn or child whom the school employee has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption in SEBB health plan coverage, the school employee should notify their SEBB Organization 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 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. School employees should contact their payroll or benefits office for the required forms.

See "When Can a Subscriber Enroll or Remove Eligible Dependents?" section.

When Can a Subscriber Change Their Health Plan?

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

- Subscriber gains a new Dependent due to:
  - Marriage or registering a state-registered domestic partnership;
  - Birth, adoption or when the Subscriber assumes a legal obligation for total or partial support in anticipation of adoption; or
  - A child becomes eligible as an extended Dependent through legal custody or legal guardianship.
- Subscriber or their 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);
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan;
- Subscriber has a change in employment from a SEBB Organization to a public school district that straddles county lines or is in a county that borders Idaho or Oregon, which results in the Subscriber having different medical plans available. The Subscriber may change their election if the change in employment causes:
  - The Subscriber's current medical plan to no longer be available, in this case the Subscriber may select from any available medical plan; or
  - The Subscriber has one or more new medical plans available, in this case the Subscriber may select to enroll in a newly available plan.
  - As used in this subsection the term "public school district" shall be interpreted to not include charter schools and educational service districts.
- Subscriber's Dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
- Subscriber or their Dependent has a change in residence that affects health plan availability. If the Subscriber moves and their current health plan is not available in the new location, the Subscriber must select a new health plan otherwise there will be limited accessibility to network providers and covered Services;

- A court order requires the Subscriber or any other individual to provide insurance coverage for an eligible Dependent of the Subscriber (a former Spouse or former state-registered domestic partner is not an eligible Dependent);
- Subscriber or their Dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the Subscriber or the Subscriber's Dependent loses eligibility for coverage under Medicaid or CHIP;
- Subscriber or their Dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP;
- Subscriber or their Dependent enrolls in coverage under Medicare, or the Subscriber or a Subscriber's Dependent loses eligibility for coverage under Medicare. If the Subscriber's current medical plan becomes unavailable due to the Subscriber's or a Subscriber's Dependent's enrollment in Medicare, the Subscriber must select a new medical plan ;
- Subscriber or their Dependent's current medical plan becomes unavailable because the Subscriber or enrolled Dependent is no longer eligible for a health savings account (HSA);
- Subscriber or their Dependent experiences a disruption of care that could function as a reduction in benefits for the Subscriber or their Dependent for a specific condition or ongoing course of treatment. The Subscriber may not change their health plan election if the Subscriber or a Subscriber's Dependent physician stops participation with the Subscriber's health plan unless the SEBB Program determines that a continuity of care issue exists. The SEBB Program will consider but is not limited to considering the following:
  - Active cancer treatment such as chemotherapy or radiation therapy;
  - Treatment following a recent organ transplant;
  - A scheduled surgery;
  - Recent major surgery still within the postoperative period; or
  - Treatment of a high-risk pregnancy.

Note: If an enrollee's provider or health care facility discontinues participation with this Plan, the enrollee may not change medical plans until the SEBB Program's next annual open enrollment or when another qualifying event occurs that creates a special open enrollment, unless the SEBB Program determines that a continuity of care issue exists. The Plan cannot guarantee that any physician, hospital, or other provider will be available or remain under contract with us.

When Can a School Employee Waive Their Medical Plan Coverage, or Enroll after Waiving Coverage?

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

- School employee gains a new Dependent due to:
  - Marriage or registering for a state-registered domestic partnership;
  - Birth, adoption, or when the school employee has assumed a legal obligation for total or partial support in anticipation of adoption; or
  - A child becoming eligible as an extended Dependent through legal custody or legal guardianship.
- School employee or a school employee's Dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the HIPAA;
- School employee has a change in employment status that affects the school employee's eligibility for their employer contribution toward their employer-based group medical;

- The school employee's Dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group medical;

  Note: "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation.

- School employee or a school employee's Dependent has a change in enrollment under an employer-based group medical plan during its annual open enrollment that does not align with the SEBB Program's annual open enrollment;
- School 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 and that change in residence results in the Dependent losing their health insurance;
- A court order requires the school employee or any other individual to provide a health plan for an eligible Dependent of the school employee (a former Spouse or former state-registered domestic partner is not an eligible Dependent);
- School employee or a school employee's Dependent enrolls in coverage under Medicaid or a state children's health insurance program (CHIP), or the school employee or a school employee's Dependent loses eligibility for coverage under Medicaid or CHIP;

  Note: A school employee may only return from having waived SEBB medical for the events described immediately above. A school employee may not waive their SEBB medical for the events described immediately above.

- School employee or a school employee's Dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP;
- School employee or a school employee's Dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan;
- School employee becomes eligible and enrolls in Medicare, or loses eligibility for Medicare.

When Can a Subscriber Enroll or Remove Eligible Dependents?

To enroll a Dependent, the Subscriber must include the Dependent's enrollment information and provide any required documents as proof of the Dependent's eligibility. The Dependent will not be enrolled if their eligibility is not verified. Any one of the following events may create a special open enrollment:

- Subscriber gains a new Dependent due to:
  - Marriage or registering a state-registered domestic partnership;
  - Birth, adoption or when a school employee has assumed a legal obligation for total or partial support in anticipation of adoption; or
  - A child becoming eligible as an extended Dependent through legal custody or legal guardianship.
- Subscriber or their Dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the HIPAA;
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan;
- Subscriber's Dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

  Note: "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation.

- Subscriber or their Dependent has a change in enrollment under an employer-based group medical insurance plan during its annual open enrollment that does not align with the SEBB Program's annual open enrollment;
- Subscriber'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 and that change in residence results in the Dependent losing their health insurance;
- A court order requires the school employee or any other individual to provide insurance coverage for an eligible Dependent of the Subscriber (a former Spouse or former state-registered domestic partner is not an eligible Dependent);
- Subscriber or their Dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the school employee or a school employee's Dependent loses eligibility for coverage under Medicaid or CHIP; or
- Subscriber or their Dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from Medicaid or a CHIP.

National Medical Support Notice (NMSN)

When a NMSN requires a Subscriber to provide health plan coverage for a Dependent child the following provisions apply:

- The Subscriber may enroll their Dependent child and request changes to their health plan coverage as described under subsection (3) of this section. School employees use SEBB My Account or submit the required forms to their SEBB Organization. All other Subscribers submit the required forms to the SEBB Program.
- If the Subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN, the SEBB Organization or the SEBB Program may make enrollment or health plan coverage changes according to subsection (3) of this section upon request of:
  - The child's other parent; or
  - Child support enforcement program.
- Changes to health plan coverage or enrollment are allowed as directed by the NMSN:
  - The Dependent will be enrolled under the Subscriber's health plan coverage as directed by the NMSN;
  - A Subscriber who has waived SEBB medical will be enrolled in medical as directed by the NMSN, in order to enroll the Dependent;
  - The Subscriber's selected health plan will be changed if directed by the NMSN;
  - If the Dependent is already enrolled under another SEBB Subscriber, the Dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN; or
  - If the Subscriber is eligible for and elects Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or other continuation coverage, the NMSN will be enforced and the Dependent must be covered in accordance with the NMSN.
- Changes to health plan coverage or enrollment as described in 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 Subscriber's health plan coverage as described in 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.

When Medical Coverage Ends

Medical plan enrollment ends on the following dates:

- The SEBB Organization terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the employer-initiated termination notice is effective;
- The school employee terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the school employee's resignation is effective; or
- The school employee's work pattern is revised such that the school employee is no longer anticipated to work six hundred thirty (630) hours during the school year. In this case, eligibility for the employer contribution ends as of the last day of the month in which the change is effective.

Premium payments and applicable premium surcharges become due the first of the month in which medical coverage is effective. Premium payments and applicable premium surcharges are not prorated during any month, even if an enrollee dies or asks to terminate their medical plan before the end of the month.

A Member who is receiving Covered Services in a hospital on the date of termination shall continue to be eligible for Covered Services while an inpatient for the condition which the Member was hospitalized, until one of the following events occurs:

- According to KFHPNW clinical criteria, it is no longer Medically Necessary for the Member to be an inpatient at the facility.
- The remaining benefits available for the hospitalization are exhausted, regardless of whether a new calendar year begins.
- The Member becomes covered under another agreement with a group health plan that provides benefits for the hospitalization.
- The Member becomes enrolled under an agreement with another carrier that provides benefits for the hospitalization.

This provision will not apply if the Member is covered under another agreement that provides benefits for the hospitalization at the time coverage would terminate, except as set forth in this section, or if the Member is eligible for COBRA continuation coverage as set forth on page [insert page number].

When medical plan enrollment ends, the enrollee may be eligible for continuation coverage or conversion to other health plan coverage if they apply within the timelines explained in the "Options for Continuing SEBB Medical Coverage" section or "Conversion of Coverage" section.

If a Subscriber enrolls in continuation coverage, the Subscriber is responsible for timely payment of premiums and applicable premium surcharges. If the monthly premium or applicable premium surcharge remains unpaid for 30 days, it will be considered delinquent. A Subscriber is allowed a grace period of 30 days from the date the monthly premium or applicable premium surcharge becomes delinquent to pay the unpaid premium balance or applicable premium surcharge. If the Subscriber is not eligible for the employer contribution and has premium balance or applicable premium surcharge remains unpaid for 60 days from the original due date, the Subscriber's medical coverage (including enrolled Dependents) will be terminated retroactive to the last day of the month for which the monthly premium and any applicable premium surcharge was paid.

A school employee who needs the required forms for an enrollment or benefit change may contact their SEBB Organization. All other Subscribers may contact the SEBB Program.

Medicare Eligibility and Enrollment

If a school employee or their Dependent becomes eligible for Medicare, they should contact the nearest Social Security Administration office to ask about the advantages of immediate or deferred Medicare enrollment.

An individual shall be deemed eligible for Medicare when they have the option to receive Part A Medicare benefits. Medicare secondary payer regulations and guidelines will determine primary/secondary payer status for individuals covered by Medicare.

A Member who is enrolled in Medicare has the option of continuing coverage under this *EOC* while on Medicare coverage. Coverage between this *EOC* and Medicare will be coordinated as outlined in "Coordination of Benefits" section.

Appeal Rights

Any current or former school employee of a SEBB Organization or their Dependent may appeal a decision made by the SEBB Organization regarding SEBB eligibility, enrollment, or premium surcharges to the SEBB Organization.

Any enrollee may appeal a decision made by the SEBB Program regarding SEBB eligibility, enrollment, premium payments, or premium surcharges to the SEBB Appeals Unit.

Any enrollee may appeal a decision regarding the administration of SEBB medical by following the appeal provisions of the plan, with the exception of eligibility, enrollment, and premium payment decisions.

HOW TO OBTAIN SERVICES

As a Member, you must receive all covered Services from Participating Providers and Participating Facilities, except as otherwise specifically permitted in this *EOC*.

We will not directly or indirectly prohibit you from freely contracting at any time to obtain health care Services from Non-Participating Providers and Non-Participating Facilities outside the Plan. However, if you choose to receive Services from Non-Participating Providers and Non-Participating Facilities except as otherwise specifically provided in this *EOC*, those Services will not be covered under this *EOC* and you will be responsible for the full price of the Services. Any amounts you pay for non-covered Services will not count toward your Deductible (if any) or Out-of-Pocket Maximum.

Using Your Identification Card

We provide each Member with a Company identification (ID) card that contains the Member health record number. Have your health record number available when you call for advice, make an appointment, or seek Services. We use your health record number to identify your medical records, for billing purposes and for membership information. You should always have the same health record number. If we ever inadvertently issue you more than one health record number, please let us know by calling Member Services. If you need to replace your ID card, please call Member Services.

Your ID card is for identification only, and it does not entitle you to Services. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-member for any Services he or she receives. If you allow someone else to use your ID card, we may keep your card and terminate your membership (see the "Termination for Cause" section). We may request photo identification in conjunction with your ID card to verify your identity.

Advice Nurses

If you are unsure whether you need to be seen by a physician or where to go for Services, or if you would like to discuss a medical concern, call Member Services during normal business hours, evenings, weekends, and holidays to be directed to one of our advice nurses.

You may also use the Member section of our website, **kp.org**, to send *nonurgent* questions to an advice nurse or pharmacist.

Your Primary Care Participating Provider

Your primary care Participating Provider plays an important role in coordinating your health care needs, including Participating Hospital stays and referrals to Specialists. We encourage you and your Dependents to each choose a primary care Participating Provider. For information about choosing your primary care Participating Provider, please call Member Services or visit **kp.org**.

You may select a primary care Participating Provider from a primary care area of medicine including, but not limited to, family medicine, internal medicine, or pediatrics. Female Members also have the option of choosing a women's health care Participating Provider as their primary care Participating Provider, as long as the women's health care Participating Provider accepts designation as primary care Participating Provider. A women's health care Participating Provider must be an obstetrician or gynecologist, a physician assistant specializing in women's health, an advanced registered nurse practitioner of women's health, or a certified nurse midwife, practicing within his or her applicable scope of practice.

You may change your primary care Participating Provider at any time by calling Member Services. The change will take effect immediately.

Women's Health Care Services

We cover women's health care Services provided by a participating family medicine physician, physician's assistant, gynecologist, certified nurse midwife, doctor of osteopathy, obstetrician, and advanced registered nurse practitioner, practicing within his or her applicable scope of practice.

Medically appropriate maternity care, including Services for complications of pregnancy, covered reproductive health Services, preventive Services, general examinations, gynecological Services, and follow-up visits are provided to female Members directly from a Participating Provider, without a referral from their primary care Participating Provider. Annual mammograms for women 40 years of age or older are covered with or without a referral from a Participating Physician. Mammograms are provided more frequently to women who are at high risk for breast cancer or disease with a Participating Provider referral. We also cover breast examinations, pelvic examinations, and cervical cancer screenings annually for women 18 years of age or older, and at any time with a referral from your women's health care Services Participating Provider. Women's health care Services also include any appropriate Service for other health problems discovered and treated during the course of a visit to a women's health care Participating Provider for a women's Service.

Appointments for Routine Services

Routine appointments are for medical needs that are not urgent such as checkups and follow-up visits that can wait more than a few days.

If you need to make a routine care appointment, go to **kp.org** to schedule an appointment online or call Member Services. Try to make your routine care appointments as far in advance as possible. For information about getting other types of care, refer to the "Emergency, Post-Stabilization, and Urgent Care" section.

Getting Assistance

We want you to be satisfied with your health care Services. If you have any questions or concerns about Services you received from Participating Providers or Participating Facilities, please discuss them with your primary care Participating Provider or with other Participating Providers who are treating you.

Most Participating Medical Offices owned and operated by Kaiser Permanente have an administrative office staffed with representatives who can provide assistance if you need help obtaining Services. Member Services representatives are also available to assist you Monday through Friday (except holidays), from 8 a.m. to 6 p.m.

Portland area.....503-813-2000

All other areas..... 1-800-813-2000

TTY for the hearing and speech impaired 711

Language interpretation services..... 1-800-324-8010

You may also e-mail us by registering on our website at **kp.org**.

Member Services representatives can answer questions you have about your benefits, available Services, and the facilities where you can receive Services. For example, they can explain your benefits, how to make your first medical appointment, what to do if you move, what to do if you need Services while you are traveling, and how to replace your ID card. These representatives can also help you if you need to file a claim, complaint, grievance, or appeal, as described in the "Grievances, Claims, Appeals, and External Review" section. Upon request Member Services can also provide you with written materials about your coverage.

Referrals

Referrals to Participating Providers and Participating Facilities

Primary care Participating Providers 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. Your primary care Participating Provider will refer you to a Specialist when appropriate. In most cases, you will need a referral to see a Specialist the first time. If the Specialist is not an employee of Medical Group, your referral will need prior authorization approval in order for the Services to be covered, except as described in the "Acupuncture Services," "Rehabilitative Therapy Services," and "Spinal and Extremity Manipulation Therapy Services" sections of the *EOC*. Please call Member Services for information about specialty Services that require a referral or discuss your concerns with your primary care Participating Provider. 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 Participating Provider and Company.

Some outpatient specialty care is available in Participating Medical Offices without a referral. You do not need a referral for outpatient Services provided in the following departments at Participating Medical Offices owned and operated by Kaiser Permanente. Please call Member Services to schedule routine appointments in these departments:

- Audiology (routine hearing exams).
- Cancer Counseling.
- Chemical Dependency Services.
- Mental Health Services.
- Obstetrics/Gynecology.
- Occupational Health.
- Social Services.

Referrals to Non-Participating Providers and Non-Participating Facilities

If your Participating Physician decides that you require Services not available from Participating Providers or Participating Facilities, he or she will recommend to Medical Group and Company that you be referred to a Non-Participating Provider or Non-Participating Facility. 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 Company determines that the Services are covered Services, Company will authorize your referral to a Non-Participating Provider or Non-Participating Facility for the covered Services. You pay the same Cost Share for authorized referral Services that you would pay if you received the Services from a Participating Provider or at a Participating Facility. You will need written authorization in advance in order for the Services to be covered. If Company 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 Company. 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 authorization when necessary. The following are examples of Services **that** require prior, concurrent, or post-service authorization**:**

- Acupuncture Services (physician referred). The initial evaluation and management visit and up to six treatment visits in a New Episode of Care do not require authorization.
- Bariatric surgery Services.
- Breast reduction surgery.
- Dental and orthodontic Services for the treatment of craniofacial anomalies.
- Drug formulary exceptions.
- Durable Medical Equipment.
- External Prosthetic Devices and Orthotic Devices.
- Gender Affirming Treatment.
- General anesthesia and associated hospital or ambulatory surgical facility Services provided in conjunction with non-covered dental Services.
- Habilitative Services.
- Hospice and home health Services.

- Inpatient hospital Services.
- Inpatient and residential Chemical Dependency Services.
- Inpatient, residential, and Assertive Community Treatment (ACT) mental health Services.
- Naturopathic medicine.
- 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. The initial evaluation and management visit and up to six treatment visits in a New Episode of Care for physical, massage, occupational, and speech therapies do not require authorization.
- Routine foot Services.
- Skilled nursing facility Services.
- Transplant Services.
- Travel and lodging expenses.

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 Company 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 review decisions will not be retrospectively denied. Prior authorization determinations shall expire no sooner than forty-five days from the date of approval. 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, or if we receive information that is materially different from that which was reasonably available at the time of the original determination.

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. Company 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 you are not liable for any amounts we owe. You will be liable for the cost of non-covered Services that you receive from any providers or facilities, including Participating Providers and/or Participating Facilities.

Provider Whose Contract Terminates

You may be eligible to continue receiving covered Services from a Participating Provider for a limited period of time after our contract with the Participating Provider terminates.

This continuity of care provision applies when our contract with a Participating Provider terminates or when a physician's employment with Medical Group terminates, except when the termination is for cause (including quality of care issues) or because the Participating Provider:

- Has retired.
- Has died.
- No longer holds an active license.
- Has moved outside our Service Area.
- Has gone on sabbatical.
- Is prevented from continuing to care for patients because of other circumstances.

If we directly or indirectly terminate the contract with Medical Group and/or any other primary care Participating Provider while your Plan is in effect and while you are under the care of the provider, we will notify you. We will retain financial responsibility for covered Services by that provider, in excess of any applicable Cost Share, for 90 days following the notice of termination to you.

Additionally, if we directly or indirectly terminate the contract with Medical Group and/or any Participating Provider who is a Specialist, while your Plan is in effect and while you are under the care of the provider, we will notify you. We will retain financial responsibility for covered Services by that provider until we can make arrangements for the Services to be provided by another Participating Provider.

Receiving Care in Another Kaiser Foundation Health Plan Service Area

You may receive covered Services from another Kaiser Foundation Health Plan, if the Services are provided, prescribed, or directed by that other plan, and if the Services would have been covered under this *EOC*. Covered Services are subject to the terms and conditions of this *EOC*, including prior authorization requirements, the applicable Cost Share shown in the "Benefit Summary," and the exclusions, limitations and reductions described in this *EOC*.

For more information about receiving care in other Kaiser Foundation Health Plan service areas, including availability of Services, and provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at **kp.org/travel**.

Out-of-Area Coverage for Dependents

This limited out-of-area benefit is available to Dependent children who are under the Dependent Limiting Age as shown in the "Benefit Summary" and who are outside any Kaiser Foundation Health Plan service area.

We cover certain Medically Necessary Services that a Dependent child receives from Non-Participating Providers 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 *EOC*. Any other Services not specifically listed as covered are excluded under this out-of-area benefit.

- 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 Year.
- Laboratory and diagnostic X-rays – limited to ten visits per Year. This benefit does not include special diagnostic procedures such as CT, MRI, or PET scans.

- Prescription drug fills – limited to ten fills per Year.

You pay the Cost Share as shown in the "Benefit Summary" under the "Out-of-Area Coverage for Dependents" section.

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

- "Receiving Care in Another Kaiser Foundation Health Plan Service Area."
- Services covered in the "Emergency, Post-Stabilization, and Urgent Care" section and under "Your Primary Care Participating Provider" in the "How to Obtain Services" section.
- "Transplant 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:

Kaiser Permanente
National Claims Administration – Northwest
PO Box 370050
Denver, CO 80237-9998

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 12 months after receiving that Service. If it is not reasonably possible to submit a claim within 12 months, 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 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, POST-STABILIZATION, AND URGENT CARE

Coverage, Cost Share, and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Urgent Care from a Participating Provider or Participating Facility, we cover those Services only if they are covered under the "Benefits" section (subject to the "Exclusions and Limitations" section).

If you receive Emergency Services, Post-Stabilization Care, or Urgent Care from a Non-Participating Provider or Non-Participating Facility, we cover those Services only if they meet both of the following requirements:

- This "Emergency, Post-Stabilization, and Urgent Care" section says that we cover the Services if you receive them from a Non-Participating Provider or Non-Participating Facility.
- The Services would be covered under the "Benefits" section (subject to the "Exclusions and Limitations" section) if you received them from a Participating Provider or Participating Facility.

If you receive covered inpatient hospital Services, you pay the Cost Share shown in the "Benefit Summary" under "Inpatient Hospital Services," regardless of whether the Services also constitute Emergency Services or Post-Stabilization Care. If you visit an emergency department and are not admitted directly as an inpatient, you pay the emergency department visit Cost Share shown in the "Benefit Summary" under "Outpatient Services" for all Services received in the emergency department.

You do not need to file a claim for Services that you receive from a Participating Provider or Participating Facility. If you receive covered Emergency Services, Post-Stabilization Care, or Urgent Care from a Non-Participating Provider or Non-Participating Facility, the Non-Participating Provider or Non-Participating Facility may agree to bill you for the Services or may require that you pay for the Services when you receive them. In either case, to request payment or reimbursement from us, you must file a claim as described in the "Post-service Claims – Services Already Received" section.

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive 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 "Benefits" section (subject to the "Exclusions and Limitations" section) if you had received them from Participating Providers or Participating Facilities. You pay the emergency department visit Cost Share shown in the "Benefit Summary" under "Outpatient Services" for all Services received in the emergency department.

If you have an Emergency Medical Condition, we cover licensed ambulance Services that are not ordered by a Participating Provider only if all of the following are true:

- Your condition requires use of medical Services that only a licensed ambulance can provide.
- Use of all other means of transportation, whether or not available, would endanger your health.
- The ambulance transports you to a hospital where you receive covered Emergency Services.

Emergency Services are available from Participating Hospital emergency departments 24 hours a day, seven days a week. Contact Member Services or see our *Medical Facility Directory* for locations of these emergency departments.

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, Participating Facility, or Participating Vendor provides the Services.
- We authorize the Services from the Non-Participating Provider, Non-Participating Facility, or Non-Participating Vendor 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 from a Non-Participating Provider, Non-Participating Facility, or Non-Participating Vendor is limited to the Allowed Amount. In addition to the applicable Cost Share, you are responsible for paying any amount over the Allowed Amount, and any such payments do not count toward the Deductible or the Out-of-Pocket Maximum. You are not responsible for paying any amount over the Allowed Amount for Post-Stabilization Care from a Non-Participating Provider at a Participating Facility.

To request prior authorization for your receiving Post-Stabilization Care from a Non-Participating Provider, Non-Participating Facility, or Non-Participating Vendor, 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, Non-Participating Facility, or Non-Participating Vendor.

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, Participating Facility, or Participating Vendor, we will either authorize the Services from the Non-Participating Provider, Non-Participating Facility, or Non-Participating Vendor, or arrange to have a Participating Provider, Participating Facility, or Participating Vendor (or other designated provider, facility, or vendor) 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.

Urgent Care

Inside our Service Area

We cover Urgent Care inside our Service Area during certain hours at designated Urgent Care facilities and Participating Medical Offices. Please contact Member Services or see our *Medical Facility Directory* for Urgent Care locations and the hours when you may visit them for covered Urgent Care.

Outside our Service Area

If you are temporarily outside our Service Area, we cover Urgent Care you receive from a Non-Participating Provider or Non-Participating Facility if we determine that the Services were necessary to prevent serious deterioration of your health and that the Services could not be delayed until you returned to our Service Area.

WHAT YOU PAY

Deductible

For each Year, most covered Services are subject to the Deductible amounts shown in the "Benefit

Summary." The "Benefit Summary" indicates which Services are subject to the Deductible.

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 self-only Deductible. If there is at least one other Member in your Family, then you must each meet the individual Family Member Deductible, or your Family must meet the Family Deductible, whichever occurs first. Each individual Family Member Deductible amount counts toward the Family Deductible amount. Once the Family Deductible is satisfied, no further individual Family Member Deductible will be due for the remainder of the Year. The Deductible amounts are shown in the "Benefit Summary."

After you meet the Deductible, you pay the applicable Copayments and Coinsurance for covered Services for the remainder of the Year until you meet your Out-of-Pocket Maximum (see "Out-of-Pocket Maximum" in this "What You Pay" section).

For each Year, the following amounts count toward your Deductible:

- Charges you pay for covered Services you receive in that Year and that are subject to the Deductible.
- **Deductible take-over.** Payments that were counted toward your deductible under your prior group health coverage if all of the following requirements are met:
  - This group health coverage with Company replaces the Group's prior group health coverage.
  - Your prior group health coverage was not with Company or with any Kaiser Foundation Health Plan.
  - You were covered under Group's prior group health coverage on the day before the effective date of this *EOC*.
  - The payments were for Services you received during the period of 12 months or less that occurred between the plan year effective date under Group's prior group health coverage and your effective date of coverage under this *EOC*.
  - The payments were for Services that we would have covered under this *EOC* if you had received them as a Member during the term of this *EOC*.
  - We would have counted the payments toward your Deductible under this *EOC* if you had received the Services as a Member during the term of this *EOC*.

Note: If your Group has purchased benefits with a specific benefit Deductible, such as a prescription drug benefit, payments made for these benefits will be counted only to that specific benefit Deductible and will accumulate separately from the Deductible for covered Services shown in the "Benefit Summary."

Copayments and Coinsurance

The Copayment or Coinsurance for each covered Service is shown in the "Benefit Summary." Copayments or Coinsurance are due when you receive the Service. You are not responsible for paying any amount over the Allowed Amount for Services received from a Non-Participating Provider at a Participating Facility.

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 Year.

If you are the only Member in your Family, then you must meet the self-only Out-of-Pocket Maximum. If there is at least one other Member in your Family, then you must each meet the individual Family Member Out-of-Pocket Maximum, or your Family must meet the Family Out-of-Pocket Maximum, whichever occurs first. Each individual Family Member Out-of-Pocket Maximum amount counts toward the Family Out-of-Pocket Maximum amount. The Out-of-Pocket Maximum amounts are shown in the "Benefit Summary."

All Deductible, Copayments, 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 Year. Member Services can provide you with the amount you have paid toward your Out-of-Pocket Maximum.

The following amounts do not count toward the Out-of-Pocket Maximum and you will continue to be responsible for these amounts even after the Out-of-Pocket Maximum is satisfied:

- Payments for Services that are not covered under this *EOC*.
- Payments that you make because we already covered the benefit maximum amount or the maximum number of days or visits for a Service.
- Payments for Services under the "Adult Vision Hardware and Optical Services Rider," if purchased by your Group.
- Payments for Services under the "Hearing Aid Rider," if purchased by your Group.
- Amounts recovered from a liability claim against another party subject to reimbursement under the "Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-fault Insurance" section.

BENEFITS

The Services described in this "Benefits" section are covered only if all the following conditions are satisfied, and will not be retrospectively denied:

- You are a current Member at the time Services are provided.
- A Participating Provider determines that the Services are Medically Necessary.
- The Services are provided, prescribed, authorized, or directed by a Participating Physician except where specifically noted to the contrary in this *EOC*.
- You receive the Services from a Participating Provider, Participating Facility, or from a Participating Skilled Nursing Facility, except where specifically noted to the contrary in this *EOC*.
- You receive prior authorization for the Services, if required under "Prior and Concurrent Authorization and Utilization Review" in the "How to Obtain Services" section.

All Services are subject to exclusions, limitations and reductions. This "Benefits" section lists exclusions and limitations that apply only to a particular benefit.

All covered Services are subject to any applicable Cost Share as described in the "What You Pay" section and in the "Benefit Summary."

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 diagnose or treat a current or ongoing illness, injury, sign or symptom of a disease, or condition. These preventive care Services are subject to all coverage requirements described in this "Benefits" section and all provisions in the "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 **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 **www.hrsa.gov/womensguidelines/**.

Services received for a current or ongoing illness, injury, sign or symptom of a disease, or condition during a preventive care examination or procedure may be subject to the applicable Cost Share.

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

- Bone densitometry.
- Cervical cancer screening.
- Chlamydia test.
- Cholesterol tests (all types).
- Colorectal cancer screening, including exam, bowel preparation medications, colonoscopy, sigmoidoscopy, and fecal occult test.
- Contraceptive drugs that you receive at a Participating Provider's office, if available.
- Contraceptive Services and supplies, including, but not limited to, transabdominal and transcervical sterilization procedures, and insertion/removal of IUD or implanted birth control drugs and devices.
- Depression screening for Members 12 years of age and older, including pregnant and postpartum women.
- Diabetic retinopathy screening.
- Fasting glucose test.
- Healthy diet counseling and counseling for obesity and weight management.
- Immunizations.
- Mammography.
- Pre-exposure prophylaxis (PrEP) therapies for Members who are at high risk for HIV infection.
- Routine preventive physical exam (adult, well-child, and well-baby).
- Screening for physical, mental, sexual, and reproductive health care needs that arise from a sexual assault.
- Screening prostate-specific antigen (PSA) test (not including monitoring or ultrasensitive tests).

When a Participating Provider determines that a recommended Service is medically appropriate for an individual and the individual satisfies the criteria for the Service or treatment, we will provide coverage for the recommended Service regardless of sex assigned at birth, gender identity, or gender of the individual otherwise recorded by us.

If you would like additional information about covered preventive care Services, call Member Services. Information is also available online at **kp.org**.

Benefits for Outpatient Services

We cover the following outpatient Services for diagnosis, treatment, and preventive medicine upon payment of any applicable Cost Share shown in the "Benefit Summary" in the "Outpatient Services" section:

- Allergy testing and treatment materials.
- Cardiac rehabilitative therapy visits.
- Chemotherapy and radiation therapy Services.
- Diagnostic Services and scope insertion procedures, such as colonoscopy, endoscopy, and laparoscopy.

- Drugs, injectables, and radioactive materials used for therapeutic or diagnostic purposes, if they are administered to you in a Participating Medical Office or during home visits, subject to the drug formulary and exclusions described under the "Limited Outpatient Prescription Drugs and Supplies" section.
- Emergency department visits.
- Gender Affirming Treatment.
- Internally implanted devices, including cochlear implants, except for internally implanted insulin pumps.
- Nurse treatment room visits to receive injections, including allergy injections.
- Outpatient surgery and other outpatient procedures, including interrupted pregnancy surgery performed in an outpatient setting.
- Primary care visits for internal medicine, gynecology, family medicine, and pediatrics.
- Rehabilitative therapy Services such as physical, occupational, and speech therapy Services, subject to the benefit limitations shown in the "Rehabilitative Therapy Services" section of the "Benefit Summary."
- Respiratory therapy.
- Routine hearing exams.
- Specialty care visits (includes home birth).
- Treatment for temporomandibular joint (TMJ) disorder.
- Urgent Care visits.
- Vasectomy.

Outpatient Services of the following types are covered only as described under the following sections in this "Benefits" section:

- "Acupuncture Services."
- "Ambulance Services."
- "Chemical Dependency Services."
- "Dialysis Services."
- "External Prosthetic Devices and Orthotic Devices."
- "Habilitative Services."
- "Health Education Services."
- "Home Health Services."
- "Hospice Services."
- "Infertility Services."
- "Limited Dental Services."
- "Limited Outpatient Prescription Drugs and Supplies."
- "Mental Health Services."
- "Naturopathic Medicine."
- "Outpatient Durable Medical Equipment (DME)."
- "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures."
- "Preventive Care Services."

- "Reconstructive Surgery Services."
- "Rehabilitative Therapy Services."
- "Services Provided in Connection with Clinical Trials."
- "Spinal and Extremity Manipulation Therapy Services."
- "Telehealth Services."
- "Transplant Services."

Benefits for Inpatient Hospital Services

We cover the following Services when you are admitted as an inpatient in a Participating Hospital:

- Anesthesia.
- Blood, blood products, blood storage, and their administration, including the Services and supplies of a blood bank.
- Chemotherapy and radiation therapy Services.
- Dialysis Services (this benefit is subject to the benefit limitations described under "Dialysis Services" in this "Benefits" section).
- Drugs and radioactive materials used for therapeutic purposes, except for the types of drugs excluded under the "Limited Outpatient Prescription Drugs and Supplies" section.
- Durable Medical Equipment and medical supplies.
- Emergency detoxification.
- Gender Affirming Treatment.
- General and special nursing care Services.
- Internally implanted devices, including cochlear implants, except for internally implanted insulin pumps.
- Interrupted pregnancy surgery when performed in an inpatient setting.
- Laboratory, X-rays and other imaging, and special diagnostic procedures.
- Medical foods and formulas if Medically Necessary.
- Medical social Services and discharge planning.
- Operating and recovery rooms.
- Orthognathic surgery and supplies for treatment of temporomandibular joint (TMJ) disorder or injury, sleep apnea or congenital anomaly.
- Palliative care.
- Participating Physician's Services, including consultation and treatment by Specialists.
- Prescription drugs, including injections.
- Rehabilitative therapy Services such as massage, physical, occupational, and speech therapy Services.
- Respiratory therapy.
- Room and board, including a private room if Medically Necessary.
- Specialized care and critical care units.
- Temporomandibular joint (TMJ) surgery for the treatment of TMJ disorders subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

- Vasectomy.

Inpatient Services of the following types are covered only as described under the following headings in this "Benefits" section:

- "Bariatric Surgery Services."
- "Chemical Dependency Services."
- "Dialysis Services."
- "Health Education Services."
- "Hospice Services."
- "Infertility Services."
- "Limited Dental Services."
- "Maternity and Newborn Care."
- "Mental Health Services."
- "Reconstructive Surgery Services."
- "Rehabilitative Therapy Services."
- "Skilled Nursing Facility Services."
- "Telehealth Services."
- "Transplant Services."

Acupuncture Services

We cover acupuncture Services as described in this "Acupuncture Services" section. East Asian medicine practitioners use acupuncture to influence the health of the body by the insertion of very fine needles. Acupuncture treatment is primarily used to relieve pain, reduce inflammation, and promote healing. Covered Services include:

- Evaluation and treatment.
- Acupuncture.
- Electro-acupuncture.

We cover acupuncture Services when provided by a Participating Provider when you receive a referral from a Participating Physician, and only when the Services are provided as outpatient Services in the Participating Provider's office. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. However, you do not need authorization for an initial evaluation and management visit and up to six treatment visits with a Participating Provider for a New Episode of Care. A list of Participating Providers may be obtained from Member Services or by visiting **https://www.chpgroup.com**.

Acupuncture Services Exclusions

- Acupressure.
- Behavioral training and modification, including but not limited to biofeedback, hypnotherapy, play therapy, and sleep therapy.
- Breathing, relaxation, and East Asian exercise techniques.
- Chemical Dependency Services.

- Cosmetics, dietary supplements, recreation, health or beauty classes, aids, or equipment.
- Costs or charges incurred for which the Member is not legally required to pay, or for professional Services rendered by a person who resides in the Member's home, or who is related to the Member by marriage or blood (including parents, children, sisters, brothers, or foster children).
- Cupping.
- Dermal friction technique.
- Dietary advice and health education based on East Asian medical theory.
- Disorders connected to military service, any treatment or service to which the Member is legally entitled through the United States Government or for which facilities are available.
- East Asian massage and tui na.
- Environmental enhancements, modifications to dwellings, property or motor vehicles, adaptive equipment, personal lodgings, travel expenses, meals.
- Expenses incurred for any Services provided before coverage begins or after coverage ends.
- Health or exercise classes, aids, or equipment.
- Infra-red therapy.
- The following laboratory Services:
  - Comprehensive digestive stool analysis.
  - Cytotoxic food allergy test.
  - Darkfield examination for toxicity or parasites.
  - EAV and electronic tests for diagnosis or allergy.
  - Fecal transient and retention time.
  - Henshaw test.
  - Intestinal permeability.
  - Loomis 24-hour urine nutrient/enzyme analysis.
  - Melatonin biorhythm challenge.
  - Salivary caffeine clearance.
  - Sulfate/creatine ratio.
  - Thermography, hair analysis, heavy metal screening, and mineral studies.
  - Tryptophan load test.
  - Urinary sodium benzoate.
  - Urine saliva pH.
  - Zinc tolerance test.
- Laserpuncture.
- Moxibustion.
- Nambudripad allergy eliminated technique (NAET).
- Obesity or weight control.

- Personal or comfort items, environmental enhancements, modifications to dwellings, property or motor vehicles, adaptive equipment, and training in the use of the equipment, personal lodging, travel expenses, or meals.
- Point injection therapy.
- Qi gong.
- Services designed to maintain optimal health in the absence of symptoms.
- Sonopuncture.

Ambulance Services

We cover licensed ambulance Services only when all of the following are true:

- A Participating Physician determines that your condition requires the use of medical Services that only a licensed ambulance can provide.
- A Participating Physician determines that the use of all other means of transportation, whether or not available, would endanger your health.
- The ambulance transports you to or from a location where you receive covered Services.

Ambulance Services Exclusions

- Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Participating Facility or other location.

Bariatric Surgery Services

We cover bariatric surgery Services for clinically severe obesity only when all of the following requirements have been met:

- A Medical Group physician determines that the surgery meets Utilization Review criteria developed by Medical Group and approved by Company.
- You fully comply with the Kaiser Permanente Severe Obesity Evaluation and Management Program's contract for participation approved by Company.

Chemical Dependency Services

We cover Chemical Dependency 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. Coverage includes medical treatment for withdrawal symptoms (including methadone maintenance).

You do not need to obtain prior authorization for the following Chemical Dependency Services:

- Emergency detoxification for medical conditions associated with acute alcohol, drug, or other substance abuse.
- Chemical Dependency treatment Services provided in a behavioral health agency licensed or certified in the state of Washington, limited to:
    - The first two business days of inpatient or residential Services.
    - The first three business days of withdrawal management Services.

Additional Services require prior authorization as described under "Prior and Concurrent Authorization and Utilization Review" in the "How to Obtain Services" section.

Outpatient Services for Chemical Dependency

We cover individual office visits and group therapy visits for Chemical Dependency.

We cover in-home chemical dependency 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 Company in accordance with Utilization Review criteria developed by Medical Group and approved by Company.

Inpatient Hospital Services for Chemical Dependency

We cover inpatient hospital Services for Chemical Dependency, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the inpatient facility.

Residential Services

We cover residential Services in a residential program, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the residential facility.

Day Treatment Services

We cover day treatment Services in a day treatment program.

Dialysis Services

We cover two types of dialysis: hemodialysis and peritoneal dialysis. You pay the Cost Share shown in the "Benefit Summary" under "Dialysis Services." We cover dialysis Services for acute renal failure and end-stage renal disease subject to Utilization Review criteria developed by Medical Group and approved by Company.

We cover treatment at outpatient dialysis facilities.

We also cover home dialysis. Coverage includes necessary equipment, training, and medical supplies.

If you receive dialysis Services as part of an inpatient hospital stay or at a Participating Skilled Nursing Facility, the Services will be covered according to your inpatient hospital or skilled nursing facility benefit.

External Prosthetic Devices and Orthotic Devices

We cover External Prosthetic Devices and Orthotic Devices, subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company, when the following are true:

- The device is Medically Necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience.
- The device is required to replace all or part of an organ or extremity designated by CMS in the "L codes" of the Healthcare Common Procedure Coding System.

This coverage includes all Services and supplies that are Medically Necessary for the effective use of an External Prosthetic Device or Orthotic Device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device.

Internally implanted prosthetic and Orthotic Devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, artificial hearts, artificial larynx, and hip joints, are not covered under this "External Prosthetic Devices and Orthotic Devices" benefit, but may be covered if they are implanted during a surgery that we are covering under another section of this "Benefits" section.

Covered External Prosthetic Devices and Orthotic Devices include but are not limited to:

- Compression garments for burns.
- Diabetic foot care appliances and therapeutic shoes and inserts to prevent and treat diabetes-related complications.
- External prostheses after a Medically Necessary mastectomy, including prostheses when Medically Necessary, and up to four brassieres required to hold a prosthesis every 12 months.
- Fitting and adjustments.
- Halo vests.
- Lymphedema wraps and garments.
- Maxillofacial prosthetic devices: coverage is limited to the least costly clinically appropriate treatment as determined by a Participating Physician. We cover maxillofacial prosthetic devices if they are necessary for restoration and management of head and facial structures that cannot be replaced with living tissue and are defective because of disease, trauma, or birth and developmental deformities when this restoration and management are performed for the purpose of:
  - Controlling or eliminating infection;
  - Controlling or eliminating pain; or
  - Restoring facial configuration or functions such as speech, swallowing, or chewing, but not including cosmetic procedures rendered to improve the normal range of conditions.
- Ocular prosthesis.
- Prosthetic devices for treatment of temporomandibular joint (TMJ) conditions.
- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity. This includes but is not limited to ostomy and urological supplies.
- Repair or replacement (unless due to loss or misuse).
- Rigid and semi-rigid Orthotic Devices required to support or correct a defective body part.
- Tracheotomy equipment.

We periodically update the list of approved External Prosthetic Devices and Orthotic Devices to keep pace with changes in medical technology and clinical practice. To find out if a particular prosthetic or orthotic device is on our approved list for your condition, please call Member Services.

Coverage is limited to the standard External Prosthetic Device or Orthotic Device that adequately meets your medical needs. Our guidelines allow you to obtain non-standard devices (those not on our approved list for your condition) if we determine that the device meets all other coverage requirements, and Medical Group or a designated physician determines that the device is Medically Necessary and that there is no standard alternative that will meet your medical needs.

External Prosthetic Devices and Orthotic Devices Exclusions

- Comfort, convenience, or luxury equipment or features.
- Corrective Orthotic Devices such as items for podiatric use (such as shoes and arch supports, even if custom-made, except footwear described above for diabetes-related complications).
- Dental appliances and dentures.
- Internally implanted insulin pumps.
- Repair or replacement of External Prosthetic Devices and Orthotic Devices due to loss or misuse.

Habilitative Services

We cover inpatient and outpatient habilitative Services subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. Coverage includes the range of Medically Necessary Services or health care devices designed to help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical, occupational, speech, and aural therapy, and other Services for people with disabilities and that:

- Takes into account the unique needs of the individual.
- Targets measurable, specific treatment goals appropriate for the person's age, and physical and mental condition.

We cover these habilitative Services at the Cost Share shown in the "Benefit Summary." The "Benefit Summary" also shows a visit maximum for habilitative Services. That visit maximum will be exhausted (used up) for a Year when the number of visits that we covered during the Year under this *EOC*, plus any visits we covered during the Year under any other evidence of coverage with the same group number printed on this *EOC*, add up to the visit maximum. After you reach the visit maximum, we will not cover any more visits for the remainder of the Year. Visit maximums do not apply to habilitative Services to treat mental health conditions covered under this *EOC*.

The following habilitative Services are covered as described under the "External Prosthetic Devices and Orthotic Devices" and "Outpatient Durable Medical Equipment (DME)" sections:

- Braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts.
- Durable Medical Equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax.

Habilitative Services Exclusions

- Activities that provide diversion or general motivation.
- Custodial care or services for individualized education program development.
- Daycare.
- Exercise programs for healthy individuals.
- Housing.
- Recreational activities.
- Respite care.
- Services and devices delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEA) requirements.
- Services solely for palliative purposes.
- Social services.
- Specialized job testing.

Health Education Services

We cover a variety of health education Services to help you take an active role in improving and maintaining your health, such as individual and group visits, free phone-based "Talk with a Health Consultant" program, and health education classes. These Services include:

- Diabetic counseling.

- Diabetic and other outpatient self-management training and education.
- Medical nutritional therapy for diabetes.
- Post coronary counseling and nutritional counseling.
- Tobacco use cessation.

If you receive health education Services during a primary care visit, you pay the primary care Cost Share shown in the "Benefit Summary." If you receive health education Services during a specialty care visit, you pay the specialty care Cost Share shown in the "Benefit Summary." There are fees for some health education classes. For more information about our health education programs, see our *Healthy Living* catalog, call Member Services, or go to **kp.org**. To use the free phone-based program, "Talk with a Health Consultant," call 503-286-6816 or 1-866-301-3866 (toll free) and select option 2.

Health Education Services Exclusions

- Educational and clinical programs for weight control.

Home Health Services

Home health Services are Services provided in the home by nurses, medical social workers, mental health and chemical dependency professionals, home health aides, and physical, occupational, speech, and respiratory therapists. We cover home health Services only if all of the following are true:

- You are substantially confined to your home (or to a place of temporary or permanent residence used as your home) or the care is provided in lieu of Medically Necessary hospitalization.
- A Medical Group 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 Company in accordance with Utilization Review criteria developed by Medical Group and approved by Company.
- Services are provided through a licensed Home Health Agency.

The "Benefit Summary" shows a visit maximum for home health Services. That visit maximum will be exhausted (used up) for a Year when the number of visits that we covered during the Year under this *EOC*, plus any visits we covered during the Year under any other evidence of coverage with the same group number printed on this *EOC*, add up to the visit maximum. After you reach the visit maximum, we will not cover any more visits for the remainder of the Year.

The following types of Services are covered in the home only as described under these headings in this "Benefits" section:

- "Chemical Dependency Services."
- "Dialysis Services."
- "Mental Health Services."
- "Outpatient Durable Medical Equipment (DME)."
- "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures."

Home Health Services Exclusions

- "Meals on Wheels" or similar food services.
- Nonmedical, custodial, homemaker or housekeeping type services except by home health aides as ordered in the approved plan of treatment.
- Private duty or continuous nursing Services.

- Services designed to maintain optimal health in the absence of symptoms.
- Services not included in an approved plan of treatment.
- Services of a person who normally lives in the home or who is a member of the family.
- Services that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. These Services are excluded even if we would cover the Services if they were provided by a qualified medical professional in a hospital or skilled nursing facility.
- Supportive environmental materials such as handrails, ramps, telephones, air conditioners, and similar appliances and devices.

Hospice Services

Hospice is a specialized form of interdisciplinary care designed to provide palliative care to help alleviate your physical, emotional, and spiritual discomfort through the last phases of life due to a terminal illness. It also provides support to your primary caregiver and your family. When you choose hospice, you are choosing to receive palliative (comfort) care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice Services at any time. You pay the Cost Share shown in the "Benefit Summary" under "Hospice Services."

We cover hospice Services if all of the following requirements are met:

- A Medical Group physician has diagnosed you with a terminal illness and determines that your life expectancy is six months or less.
- The Services are provided in your home (or a place of temporary or permanent residence used as your home).
- The Services are provided by a licensed hospice agency approved by Kaiser Foundation Hospitals.
- The Services are necessary for the palliation and management of your terminal illness and related conditions.
- The Services meet Utilization Review by Company using criteria developed by Medical Group and approved by Company.

We cover the following hospice Services:

- Counseling and bereavement Services for up to one year.
- Durable Medical Equipment (DME).
- Home health aide Services.
- Medical social Services.
- Medication and medical supplies and appliances.
- Participating Physician Services.
- Rehabilitative therapy Services for purposes of symptom control or to enable you to maintain activities of daily living.
- Services of volunteers.
- Short-term inpatient Services including respite care and care for pain control and acute and chronic symptom management.
- Skilled nursing Services, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers.

Infertility Services

We cover the diagnosis of involuntary infertility. Infertility Services include diagnostic imaging and laboratory tests, limited to tests to rule out sexually transmitted diseases, hormone level tests, semen analysis, and diagnostic laparoscopy or hysteroscopy. This benefit includes diagnosis of both male and female infertility; however, Services are covered only for the person who is the Member. You may have additional coverage if your Group has purchased an "Infertility Treatment Services Rider."

Infertility Services Exclusions

- Inpatient and outpatient Services for the treatment of infertility.
- Donor semen (including the Member's own semen), donor eggs (including the Member's own eggs), and Services related to their procurement and storage.
- Oral and injectable drugs used in the treatment of infertility.
- Services related to conception by artificial means, such as in vitro fertilization (IVF), ovum transplants, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and artificial insemination.
- Services to reverse voluntary, surgically induced infertility.

Limited Dental Services

We do not cover dental Services except as described below. Services are 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.

Covered Dental Services

We cover dental Services only as described below:

- Dental and orthodontic Services for the treatment of craniofacial anomalies if the Services are Medically Necessary to improve or restore function.
- Dental Services necessary for or resulting from medical treatment such as surgery on the jawbone and radiation treatment, limited to (a) emergency dental Services, or (b) extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.
- General anesthesia and associated hospital or ambulatory surgical facility Services in conjunction with non-covered dental Services when Medically Necessary for Members who:
    - have a medical condition that your Participating Physician determines would place you at undue risk if the dental procedure were performed in a dental office; or
    - are children under age seven, or are physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office.

You pay the Cost Share you would pay if the Services were not related to a covered dental Service.

Limited Dental Services Exclusions

The following dental Services are not covered, except where specifically noted to the contrary in this *EOC*:

- Dental appliances and dentures.
- Dental implants.
- Extraction of teeth, except as described above in the "Covered Dental Services" section.
- Hospital Services for dental care, except as described above in the "Covered Dental Services" section.
- Orthodontics, except as described above in the "Covered Dental Services" section.

- Routine or preventive dental Services.
- Services to correct malocclusion.

Limited Outpatient Prescription Drugs and Supplies

We do not cover outpatient prescription drugs or supplies except as described below. You may have additional coverage if your Group has purchased separate prescription drug coverage.

Covered Drugs and Supplies

We cover limited outpatient drugs and supplies as described in this "Limited Outpatient Prescription Drugs and Supplies" section and only if all of the following conditions are met:

- The drug or supply is prescribed by a Participating Provider or any licensed dentist in accordance with our drug formulary guidelines. Over-the-counter contraceptive drugs, devices, and products, approved by the U.S. Food and Drug Administration (FDA), do not require a prescription in order to be covered.
- The law requires the drug or supply to bear the legend "Rx only," or the drug or supply is a non-prescription item that our drug formulary lists for your condition.
- You obtain the drug or supply at a Participating Pharmacy (including our Mail-Order Pharmacy) or in a prepackaged take-home supply from a Participating Facility or Participating Medical Office. You may obtain a first fill of the drug or supply at any Participating Pharmacy. All refills must be obtained through a pharmacy owned and operated by Kaiser Permanente (including our Mail-Order Pharmacy), or at another Participating Pharmacy that we designate for covered refills. See your *Medical Facility Directory*, visit **kp.org/directory/nw**, or contact Member Services.

Items covered under this "Limited Outpatient Prescription Drugs and Supplies" benefit include:

- Certain preventive medications (including, but not limited to, aspirin, fluoride, liquid iron for children ages 6 to 12 months at risk for anemia, and tobacco cessation drugs) according to, and as recommended by, the USPSTF, when obtained with a prescription order.
- Certain self-administered IV drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as IV or intraspinal-infusion) for up to a 30-day supply, including the supplies and equipment required for their administration.
- Drugs, injectables, and radioactive materials used for therapeutic or diagnostic purposes, if they are administered to you in a Participating Medical Office or during home visits. We cover these items upon payment of the administered medications Cost Share shown under "Outpatient Services" in the "Benefit Summary."
- Drugs prescribed for an indication if the FDA has not approved the drug for that indication (off-label drugs) are covered only if our Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health and Human Services.
- FDA approved prescription and over-the-counter contraceptive drugs and devices including injectable contraceptives and internally implanted time-release contraceptive drugs, emergency contraceptives, spermicide, and contraceptive devices such as condoms, intrauterine devices, diaphragms, and cervical caps. You may receive a 12-month supply of a contraceptive drug at one time, unless you request a smaller supply or the prescribing provider determines that you must receive a smaller supply. We may limit the covered refill amount in the last quarter of the Year if we have previously covered a 12-month supply of the contraceptive drug within the same Year.

- Glucagon emergency kits, insulin, ketone test strips for urine-testing, blood glucose test strips, and disposable needles and syringes when prescribed for the treatment of diabetes. We cover additional diabetic equipment and supplies, including lancets and injection aids, under the "Outpatient Durable Medical Equipment (DME)" section and the "External Prosthetic Devices and Orthotic Devices" section.
- Self-administered chemotherapy medications used for the treatment of cancer.
- Prescription medications purchased in a foreign country when associated with an Emergency Medical Condition.

These limited drugs and supplies are available to you even if your Group has not purchased additional drug coverage. If your Group has purchased additional drug coverage, the limited drugs and supplies listed in this "Limited Outpatient Prescription Drugs and Supplies" section are not covered under it.

Day Supply Limit

The prescribing provider determines how much of a drug or supply to prescribe. For purposes of day supply coverage limits, the prescribing provider determines the amount of a drug or supply that constitutes a Medically Necessary 30-day (or any other number of days) supply for you. When you pay the applicable Cost Share shown in the "Benefit Summary," you will receive the prescribed supply up to the day supply limit. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantity that exceeds the day supply limit, unless due to medication synchronization, in which case we will adjust the applicable Copayment for the quantity that exceeds the day supply limit.

You may receive a 12-month supply of a contraceptive drug at one time, unless you request a smaller supply or the prescribing provider determines that you must receive a smaller supply. We may limit the covered refill amount in the last quarter of the Year if we have previously covered a 12-month supply of the contraceptive drug within the same Year.

How to Get Covered Drugs or Supplies

Participating Pharmacies are located in many Participating Facilities. To find a Participating Pharmacy please see your *Medical Facility Directory*, visit **kp.org/directory/nw**, or contact Member Services.

Participating Pharmacies include our Mail-Order Pharmacy. This pharmacy offers postage-paid delivery to addresses in Oregon and Washington. Some drugs and supplies are not available through our Mail-Order Pharmacy, for example drugs that require special handling or refrigeration, or are high cost. Drugs and supplies available through our Mail-Order Pharmacy are subject to change at any time without notice.

If you would like to use our Mail-Order Pharmacy, call 1-800-548-9809 or order online at **kp.org/refill**.

About Our Drug Formulary

Our drug formulary is a list of drugs that our Regional Formulary and Therapeutics Committee has reviewed and approved for our Members and includes drugs covered under this *EOC*. Drugs on the formulary have been approved by the FDA.

Our Regional Formulary and Therapeutics Committee is made up of Participating Physicians, other Participating Providers, pharmacists, and administrative staff. The committee chooses drugs for the formulary based on several factors, including safety and effectiveness as determined from a review of the scientific literature. They may not approve a drug if there is not enough scientific evidence that it is clinically effective. They may also exclude a drug if it does not have a clinical or cost advantage over comparable formulary drugs.

The Regional Formulary and Therapeutics Committee meets to review new drugs and reconsider drugs currently on the market. After this review, they may add drugs to the formulary or remove drugs from it. If a drug is removed from the formulary, you will need to switch to another comparable drug that is on the drug

formulary, unless your old drug meets exception criteria. Refer to the "Drug Formulary Exception Process" in this "Limited Outpatient Prescription Drugs and Supplies" section for more information.

When a drug is removed from the formulary, we will notify Members who filled a prescription for the drug at a Participating Pharmacy within the prior three months. If a formulary change affects a prescription drug you are taking, we encourage you to discuss any questions or concerns with your Participating Provider or another member of your health care team.

To see if a drug or supply is on our drug formulary, go online to **kp.org/formulary**. You may also call our Formulary Application Services Team (FAST) at 503-261-7900 or toll free at 1-888-572-7231. If you would like a copy of our drug formulary or additional information about the formulary process, please call Member Services. The presence of a drug on our drug formulary does not necessarily mean that your Participating Provider will prescribe it for a particular medical condition.

Drug Formulary Exception Process

Our drug formulary guidelines include an exception process that is available when a Participating Provider or any licensed dentist prescribes a drug or supply that our drug formulary does not list for your condition, if the law requires the item to bear the legend "Rx only." The exception process is not available for drugs or supplies that the law does not require to bear this legend, or for any drug or supply prescribed by someone other than a Participating Provider or any licensed dentist.

A Participating Provider or any licensed dentist may request an exception if he or she determines that the non-formulary drug or supply is Medically Necessary. We will make a coverage determination within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests. A request may be expedited if you are experiencing a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a nonformulary drug.

If the information provided is not sufficient to approve or deny the request, we will notify your prescribing Participating Provider that additional information is required in order to make a determination. This additional information will be due within five calendar days for standard requests or two business days for expedited requests.

After we receive the first piece of information (including documents) we requested, we will make a decision and send notification within four calendar days (for standard requests) or two days (for expedited requests), or by the deadline for receiving the information, whichever is sooner.

We will approve the exception if all of the following requirements are met:

- We determine that the drug or supply meets all other coverage requirements except for the fact that our drug formulary does not list it for your condition.
- Medical Group or a designated physician makes the following determinations:
  - The drug or supply is Medically Necessary because you are allergic to, or intolerant of, or have experienced treatment failure with, any alternative drugs or supplies that our drug formulary lists for your condition.
  - Your condition meets any additional requirements that the Regional Formulary and Therapeutics Committee has approved for the drug or supply. For this drug or supply, the Participating Pharmacy can provide a copy of the additional criteria upon request. In some cases, there may be a short delay in filling your prescription while your information is being reviewed.

If we approve an exception through this exception process, then we will cover the drug or supply at the applicable Cost Share shown in the "Benefit Summary."

If we do not approve the formulary exception request, we will send you a letter informing you of that decision. You may request a review by an independent review organization. The process is explained in our denial letter and under "External Review" in the "Grievances, Claims, Appeals, and External Review" section.

Your Prescription Drug Rights

You have the right to safe and effective pharmacy Services. You also have the right to know what drugs are covered under this Plan and the limits that apply. If you have a question or a concern about your prescription drug benefits, please contact Member Services or visit us online at **kp.org**.

If you would like to know more about your rights, or if you have concerns about your Plan you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900 or **www.insurance.wa.gov**. If you have a concern about the pharmacists or pharmacies serving you, please contact the Washington State Department of Health at 360-236-4700, **www.doh.wa.gov**, or **HSQACSC@doh.wa.gov**.

Limited Outpatient Prescription Drugs and Supplies Exclusions

- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.
- Drugs prescribed for an indication if the FDA has determined that use of the drug for that indication is contraindicated.
- Drugs and supplies that are available without a prescription, even if the non-prescription item is in a different form or different strength (or both), except that this exclusion does not apply to drugs or supplies that our drug formulary lists for your condition.
- Drugs and supplies ordered from the Mail-Order Pharmacy to addresses outside of Oregon or Washington.
- Drugs that the FDA has not approved.
- Drugs used in weight management.
- Drugs used to enhance athletic performance.
- Extemporaneously compounded drugs unless the formulation is approved by our Regional Formulary and Therapeutics Committee.
- Injectable drugs that are self-administered (except insulin).
- Nutritional supplements.
- Replacement of drugs and supplies due to loss, damage, or carelessness.
- The following are excluded, but you may have coverage for them if your Group purchased an "Outpatient Prescription Drug Rider":
    - Prescription drugs and supplies that are dispensed on an outpatient basis, except those listed under "Covered Drugs and Supplies" of this "Limited Outpatient Prescription Drugs and Supplies" section.
    - Drugs for treatment of infertility.
    - Drugs used for the treatment or prevention of sexual dysfunction disorders.

Maternity and Newborn Care

We cover the following maternity and newborn care Services:

- Prenatal care visits and postpartum visits.
- Maternity hospital care for mother and baby, including Services for complications of pregnancy.
- Vaginal or cesarean childbirth delivery in a hospital or in a birth center, including facility fees.

- Home childbirth Services when provided by a Participating Provider, including Medically Necessary supplies of a home birth, for low risk pregnancies.
- Newborn medical Services following birth and initial physical exam.
- Newborn PKU test.

We will not limit the length of a maternity 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 stay is determined by an attending Participating Provider, in consultation with the mother. Our policy complies with the federal Newborns' and Mothers' Health Protection Act of 1996 (NMHPA).

Newborns are covered from the moment of birth for the first 21 days of life and are subject to their own Cost Share. In order for coverage to continue beyond this 21-day period, you must follow the rules for adding Dependents as described under the "Enrollment" section.

Certain maternity Services, such as screening for gestational diabetes and breastfeeding counseling and support, are covered under the "Preventive Care Services" section. Outpatient Services for laboratory, X-ray, imaging, and special diagnostic procedures are covered under the "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" section.

Maternity and Newborn Care Exclusions

- Home birth Services provided by family or Non-Participating Providers.

Medical Foods and Formula

We cover the following Medically Necessary medical foods and formula subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company:

- Elemental formula for the treatment of eosinophilic gastrointestinal associated disorder.
- Enteral formula for home treatment of severe intestinal malabsorption when the formula comprises the sole or essential source of nutrition.
- Medical foods and formula necessary for the treatment of phenylketonuria (PKU), specified inborn errors of metabolism, or other metabolic disorders.

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, including Services for treatment of eating disorders when associated with a diagnosis of a DSM categorized mental health condition, 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.

We cover mental health Services subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request the 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, advanced practice psychiatric nurse, licensed behavioral analyst, licensed assistant behavioral analyst or registered behavioral analyst interventionist. The benefits described in this "Mental Health Services" section comply with the Mental Health Parity and Addiction Equity Act.

Outpatient Services

We cover individual office visits, group therapy visits, intensive outpatient visits, partial hospitalization, and Assertive Community Treatment (ACT) Services for mental health. ACT Services are designed to provide comprehensive outpatient treatment and support to Members who are diagnosed with a severe mental illness and whose symptoms of mental illness lead to serious dysfunction in daily living.

We cover mental health Services provided 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 Company in accordance with Utilization Review criteria developed by Medical Group and approved by Company.

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 Company in accordance with Utilization Review criteria developed by Medical Group and approved by Company.

Inpatient Hospital Services

We cover inpatient hospital Services for mental health, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the inpatient facility. Prior authorization is not required for Members who are involuntarily committed and subsequently treated in a state hospital.

Residential Services

We cover residential Services in a residential facility, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the residential facility.

Psychological Testing

If, in the professional judgment of a Participating Provider you require psychological testing as part of diagnostic evaluation, prescribed tests are covered in accord with this "Mental Health Services" section. We do not cover court-ordered testing or testing for ability, aptitude, intelligence, or interest unless Medically Necessary.

Naturopathic Medicine

Naturopathic medicine is a form of health care that uses a wide range of natural approaches. Naturopathic physicians diagnose and treat patients by using natural modalities such as clinical nutrition, herbal medicine, and homeopathy. Covered Services include evaluation and treatment.

We cover Services when provided by a Participating Provider when you receive a referral from a Participating Physician, and only when the Services are provided as outpatient Services in the Participating Provider's office. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. A list of Participating Providers may be obtained from Member Services or by visiting https://**www.chpgroup.com**.

Naturopathic Medicine Exclusions

- Acupressure.
- Behavioral training and modification, including but not limited to biofeedback, hypnotherapy, play therapy, and sleep therapy.
- Breathing, relaxation, and East Asian exercise techniques.
- Chemical Dependency Services.
- Cosmetics, dietary supplements, recreation, health or beauty classes, aids, or equipment.
- Costs or charges incurred for which the Member is not legally required to pay, or for professional Services rendered by a person who resides in the Member's home, or who is related to the Member by marriage or blood (including parents, children, sisters, brothers, or foster children).
- Cupping.
- Dermal friction technique.
- Dietary advice and health education based on East Asian medical theory.
- Disorders connected to military service, any treatment or service to which the Member is legally entitled through the United States Government or for which facilities are available.
- East Asian massage and tui na.
- Environmental enhancements, modifications to dwellings, property or motor vehicles, adaptive equipment, personal lodgings, travel expenses, meals.
- Expenses incurred for any Services provided before coverage begins or after coverage ends.
- Health or exercise classes, aids, or equipment.
- Infra-red therapy.
- The following laboratory Services:
    - Comprehensive digestive stool analysis.
    - Cytotoxic food allergy test.
    - Darkfield examination for toxicity or parasites.
    - EAV and electronic tests for diagnosis or allergy.
    - Fecal transient and retention time.
    - Henshaw test.
    - Intestinal permeability.
    - Loomis 24-hour urine nutrient/enzyme analysis.
    - Melatonin biorhythm challenge.
    - Salivary caffeine clearance.
    - Sulfate/creatine ratio.
    - Thermography, hair analysis, heavy metal screening, and mineral studies.
    - Tryptophan load test.
    - Urinary sodium benzoate.
    - Urine saliva pH.

  - Zinc tolerance test.
- Laserpuncture.
- Moxibustion.
- Nambudripad allergy eliminated technique (NAET).
- Obesity or weight control.
- Personal or comfort items, environmental enhancements, modifications to dwellings, property or motor vehicles, adaptive equipment, and training in the use of the equipment, personal lodging, travel expenses, or meals.
- Point injection therapy.
- Qi gong.
- Services designed to maintain optimal health in the absence of symptoms.
- Sonopuncture.

Outpatient Durable Medical Equipment (DME)

We cover outpatient Durable Medical Equipment (DME) subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. DME must be for use in your home (or a place of temporary or permanent residence used as your home).

When you receive DME in a home health setting in lieu of hospitalization, DME is covered at the same level as if it were received in an inpatient hospital care setting.

We decide whether to rent or purchase the DME, and we select the vendor. We also decide whether to repair, adjust, or replace the DME item when necessary.

Covered DME includes but is not limited to the following:

- Bilirubin lights.
- CADD (continuous ambulatory drug delivery) pumps.
- Diabetic equipment and supplies including external insulin pumps, infusion devices, blood glucose monitors, continuous glucose monitors, lancets, and injection aids.
- Enteral pumps and supplies.
- Home ultraviolet light therapy equipment for treatment of certain skin conditions.
- Osteogenic bone stimulators.
- Osteogenic spine stimulators.
- Oxygen and oxygen supplies.
- Peak flow meters.
- Ventilators.
- Wheelchairs.

We periodically update the list of approved DME items to keep pace with changes in medical technology and clinical practice. To find out if a particular DME item is on our approved list for your condition, please call Member Services.

Coverage is limited to the standard DME item that adequately meets your medical needs. Our guidelines allow you to obtain non-standard DME items (those not on our approved list for your condition) if we determine that the item meets all other coverage requirements, and Medical Group or a designated physician

determines that the item is Medically Necessary and that there is no standard alternative that will meet your medical needs.

Outpatient Durable Medical Equipment (DME) Exclusions

- Comfort, convenience, or luxury equipment or features.
- Devices for testing blood or other body substances unless specifically listed as covered in this "Outpatient Durable Medical Equipment (DME)" section.
- Exercise or hygiene equipment.
- Modifications to your home or car.
- More than one corrective appliance or artificial aid or item of Durable Medical Equipment, serving the same function or the same part of the body, except for necessary repairs, adjustments, and replacements as specified in this "Outpatient Durable Medical Equipment (DME)" section.
- Non-medical items, such as sauna baths or elevators.
- Repair or replacement of DME items due to loss or misuse.
- Spare or duplicate use DME.

Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures

We cover outpatient Services for laboratory, X-ray, imaging, and special diagnostic procedures. Some Services, such as preventive screenings and routine mammograms, are not covered under this "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" benefit but may be covered under the "Preventive Care Services" section.

Women 40 years of age or older, who are seeking annual routine mammograms, may contact the Radiology Department directly to set up appointments.

For Members age 50 or older or for younger Members who are at high risk, covered preventive colorectal screening tests include one fecal occult blood test per year plus one flexible sigmoidoscopy every five years, one colonoscopy every 10 years, or one double contrast barium enema every five years. These tests are covered more frequently if your Participating Provider recommends them because you are at high risk for colorectal cancer or disease.

We cover prostate screening examinations 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.

We cover genetic testing and related Services for genetic counseling and medically appropriate genetic testing for the purpose of diagnostic testing to determine disease and/or predisposition of disease, and to develop treatment plans. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. Covered Services are limited to preconception and prenatal testing for detection of congenital and heritable disorders, and testing for the prediction of high-risk occurrence or reoccurrence of disease when Medically Necessary.

Laboratory, X-ray, and Imaging

We cover outpatient laboratory, X-ray, and imaging Services. Covered outpatient laboratory, X-ray, and imaging Services include, but are not limited to:

- Bone densitometry.
- Cardiovascular testing.
- Cultures.

- Glucose tolerance.
- X-ray.
- Ultrasound imaging.
- Urinalysis.

Special Diagnostic Procedures

Special diagnostic procedures may or may not involve radiology or imaging technology. Some special diagnostic Services may be subject to a higher Cost Share, as shown in the "Benefit Summary." Covered special diagnostic procedures include, but are not limited to:

- CT scans.
- Mammograms.
- MRI.
- Nerve conduction studies.
- PET scans.
- Pulmonary function studies.
- Sleep studies.

Procedures such as scope insertion for colonoscopy, endoscopy, and laparoscopy are not covered under this "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" benefit but may be covered if they are performed during a Service we are covering under another section of this "Benefits" section.

Reconstructive Surgery Services

We cover inpatient and outpatient reconstructive surgery Services as indicated below, when prescribed by a Participating Physician. Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

- 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.

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

Mastectomy-related prosthetics and Orthotic Devices are covered under and subject to the "External Prosthetic Devices and Orthotic Devices" section.

Rehabilitative Therapy Services

We cover inpatient and outpatient physical, massage, occupational, and speech therapy Services, when prescribed by a Participating Provider, subject to the benefit descriptions and limitations contained in this "Rehabilitative Therapy Services" section. Covered Services include treatment of neurodevelopmental conditions to restore and/or improve function, or to provide maintenance for conditions which, in the judgment of your Participating Provider, would result in significant deterioration without the treatment.

These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. However, you do not need authorization for an initial evaluation and management visit and up to six treatment visits with a Participating Provider for physical, massage, occupational, and speech therapy Services for a New Episode of Care.

Outpatient Rehabilitative Therapy Services

We cover outpatient rehabilitative therapy Services for the treatment of conditions which, in the judgment of the Participating Provider, will show sustainable, objective, measurable improvement as a result of the prescribed therapy. Prescribed outpatient therapy Services must receive prior authorization as described under "Prior and Concurrent Authorization and Utilization Review" in the "How to Obtain Services" section.

The "Benefit Summary" shows a visit maximum for each rehabilitative therapy Service. That visit maximum will be exhausted (used up) for the Year when the number of visits that we covered during the Year under this *EOC* plus any visits we covered during the Year under any other evidence of coverage with the same group number printed on this *EOC* add up to the visit maximum. After you reach the visit maximum, we will not cover any more visits for the remainder of the Year. This limitation does not apply to inpatient hospital Services, or to outpatient rehabilitative therapy Services to treat mental health conditions covered under this *EOC*.

Outpatient Rehabilitative Therapy Services Limitations

- Physical therapy, massage therapy, and occupational therapy Services are covered as Medically Necessary to restore or improve functional abilities when physical and/or sensory perceptual impairment exists due to injury, illness, stroke, or surgery.
- We cover only the following massage therapy Services:
  - Gua sha—A method in traditional Chinese medicine in which the skin on the back, limbs, and other parts of the body are lubricated and then pressured and scraped with a rounded object.
  - Tui na—Pushing and gathering soft tissue.
  - Shiatsu—A Japanese method of massage that uses acupressure.
- Speech therapy Services are covered as Medically Necessary for speech impairments of specific organic origin such as cleft palate, or when speech, language, or the swallowing function is lost due to injury, illness, stroke, or surgery.
- Therapy Services do not include maintenance therapy for chronic conditions except for neurodevelopmental conditions.

Inpatient Rehabilitative Therapy Services

We cover inpatient rehabilitative therapy Services in an inpatient setting.

Inpatient rehabilitative therapy Services are covered for the treatment of conditions which, in the judgment of a Participating Provider will show sustainable, objective, measurable improvement as a result of the prescribed therapy and must receive prior authorization as described under the "Prior and Concurrent Authorization and Utilization Review" in the "How to Obtain Services" section.

Rehabilitative Therapy Services Exclusions

- Services designed to maintain optimal health in the absence of symptoms.

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 (FDA).
  - 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 Cost Share 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 Cost Share that applies to hospital inpatient care.

Services Provided in Connection With Clinical Trials Exclusions

- The investigational Service.
- Services provided solely for data collection and analysis and that are not used in your direct clinical management.

Skilled Nursing Facility Services

We cover skilled inpatient Services in a licensed Participating Skilled Nursing Facility, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the facility. The skilled inpatient Services must be those customarily provided by Participating Skilled Nursing Facilities. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

The "Benefit Summary" shows a day maximum for skilled nursing facility Services under "Skilled Nursing Facility Services." That day maximum will be exhausted (used up) for a Year when the number of days that we covered during the Year under this *EOC,* plus any days we covered during the Year under any other evidence of coverage with the same group number printed on this *EOC*, add up to the day maximum. After you reach the day maximum, we will not cover any more days for the remainder of the Year.

We cover the following:

- Blood, blood products, blood storage, and their administration, including the Services and supplies of a blood bank.
- Dialysis Services.
- Medical and biological supplies.
- Medical social Services.
- Nursing Services.
- Rehabilitative therapy Services.
- Room and board.

Spinal and Extremity Manipulation Therapy Services

We cover Spinal and Extremity Manipulation therapy Services as described in this "Spinal and Extremity Manipulation Therapy Services" section, including evaluation and management, diagnostic radiology, musculoskeletal treatments, hot and cold packs, treatment for the onset of an illness or injury, aggravation of an illness or injury, and treatment for the exacerbation of an illness or injury.

Self-referred Spinal and Extremity Manipulation Therapy Services

We cover visits for self-referred Spinal and Extremity Manipulation therapy Services when provided by a Participating Provider and only when the Services are provided as outpatient Services in the Participating Provider's office. You do not need a referral or prior authorization to seek these Services from a Participating Provider. A list of Participating Providers may be obtained from Member Services or by visiting **https://www.chpgroup.com**.

Physician-referred Spinal and Extremity Manipulation Therapy Services

We cover physician-referred Spinal and Extremity Manipulation therapy Services when provided by a Participating Provider when you receive a referral from a Participating Physician, and only when the Services are provided as outpatient Services in the Participating Provider's office. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. However, you do not need authorization for an initial evaluation and management visit and up to six treatment visits with a Participating Provider for a New Episode of Care. A list of Participating Providers may be obtained from Member Services or by visiting **https://www.chpgroup.com**.

Spinal and Extremity Manipulation Therapy Services Exclusions

- Services designed to maintain optimal health in the absence of symptoms.

Telehealth Services

Telehealth allows a Member, or person acting on the Member's behalf, to interact with a Participating Provider who is not physically at the same location.

We cover telehealth Services at no Charge when all of the following are true:

- The Service is otherwise covered under this *EOC*.
- The Service is determined by a Participating Provider to be Medically Necessary.
- Medical Group determines the Service may be safely and effectively provided using telehealth, according to generally accepted health care practices and standards.

Telemedical Services

Telemedical Services are Services provided via synchronous two-way interactive video conferencing by a Participating Provider. Telephone calls and communication by facsimile machine, electronic mail, or other electronic messaging systems that do not include remote visual contact between the provider and Member, are not considered telemedical Services.

Telephone Services

We cover scheduled telephone visits with a Participating Provider.

Transplant Services

We cover inpatient and outpatient Services for the listed transplants under this "Transplant Services" section at National Transplant Network facilities if you meet Utilization Review criteria developed by Medical Group and approved by Company. You pay the Cost Share you would pay if the Services were not related to a transplant. For Services we provide (or pay for) for actual or potential donors, there is no Charge.

A National Transplant Network facility is a transplant facility that meets all of the following requirements:

- It is licensed in the state where it operates.
- It is certified by Medicare as a transplant facility for the specific transplant.
- It is designated by Company as a transplant facility for the specific transplant.
- It is able to meet reasonable access standards for organ transplants based on Regional Organ Procurement Agency statistics for the facility location (a Regional Organ Procurement Agency is the geographic area designated by a state-licensed organ procurement organization for transplants in the state of Washington).

We cover only the following transplants at National Transplant Network facilities. Covered transplants include human and artificial transplants subject to Utilization Review criteria developed by Medical Group and approved by Company, and manufacturer's recommendation.

- Bone marrow.
- Cornea.
- Heart.
- Heart-lung.
- Kidney.
- Liver.
- Lung.
- Pancreas.

- Pancreas after kidney.
- Simultaneous kidney-pancreas.
- Small bowel.
- Small bowel/liver.
- Stem cell.

After the referral to a transplant facility, the following apply:

- If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made.
- Company, Participating Hospitals, Medical Group, Participating Providers, and Participating Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor.
- In accord with our guidelines for Services for living transplant donors, we provide or pay for certain donation-related Services for a donor, or an individual identified by Medical Group as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. Our criteria for donor Services are available by calling Member Services.
- We may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. Your transplant coordinator can provide information about covered expenses.

Transplant Services Exclusions

- Non-human organs and their implantation.

EXCLUSIONS AND LIMITATIONS

The Services listed in this "Exclusions and Limitations" section are either completely excluded from coverage or partially limited under this *EOC*. These exclusions and limitations apply to all Services that would otherwise be covered under this *EOC* and are in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in this *EOC*.

Certain Exams and Services. Physical examinations and other Services are excluded when: (a) required for obtaining or maintaining employment or participation in employee programs, (b) required for insurance or governmental licensing, (c) court ordered or required for parole or probation, or (d) received while incarcerated.

Cosmetic Services. 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 "Reconstructive Surgery Services" in the "Benefits" section.

Custodial Care. Assistance with activities of daily living (such as walking, getting in and out of a bed or chair, bathing, dressing, eating, using the toilet, and taking medicine) or personal care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure, certification, or the presence of a supervising licensed nurse.

Dental Services. This exclusion does not apply to Services that are covered under "Limited Dental Services" in the "Benefits" section.

Designated Blood Donations. Collection, processing, and storage of blood donated by donors whom you designate, and procurement and storage of cord blood is covered only when Medically Necessary for the imminent use at the time of collection for a designated recipient.

Detained or Confined Members. Services provided or arranged by criminal justice officials or institutions for detained or confined Members are limited to Services which meet the requirements of Emergency Services under this *EOC*.

Employer Responsibility. We do not reimburse the employer for any Services that the law requires an employer to provide. When we cover any of these Services we may recover the Charges for the Services from the employer.

Experimental or Investigational Services. Services are excluded if any of the following is true about the Service:

- They cannot be legally marketed in the United States without the approval of the U.S. Food and Drug Administration (FDA), and the FDA has not granted this approval.
- They are the subject of a current new drug or new device application on file with the FDA.
- They are provided as part of a Phase I, Phase II, or Phase IV clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Services.
- They are provided pursuant to a written protocol or other document that lists an evaluation of the Services' safety, toxicity, or efficacy as among its objectives.
- They are subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity, or efficacy of Services.
- They are provided pursuant to informed consent documents that describe the Services as experimental or investigational, or in other terms that indicate that the Services are being evaluated for their safety, toxicity, or efficacy.
- The prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that:
  - Use of the Services should be substantially confined to research settings, or
  - Further research is necessary to determine the safety, toxicity, or efficacy of the Services.

In making determinations whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:

- Your medical records.
- The written protocols and other documents pursuant to which the Service has been or will be provided.
- Any consent documents you or your representative has executed or will be asked to execute, to receive the Service.
- The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body.
- The published authoritative medical or scientific literature about the Service, as applied to your illness or injury.
- Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

We consult Medical Group and then use the criteria described above to decide if a particular Service is experimental or investigational.

This exclusion does not apply to Services that we cover under "Services Provided in Connection with Clinical Trials" in the "Benefits" section of this *EOC*.

Eye Surgery. Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures.

Family Services. Services provided by a member of your immediate family.

Genetic Testing. Genetic testing and related Services are excluded except as described under "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" in the "Benefits" section.

Government Agency Responsibility. We do not reimburse the government agency for any Services that the law requires be provided only by or received only from a government agency. When we cover any of these Services, we may recover the Charges for the Services from the government agency. However, this exclusion does not apply to Medicaid.

Hearing Aids. Hearing aids, tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid, unless your Group has purchased the "Hearing Aid Rider."

Hypnotherapy. All Services related to hypnotherapy.

Low-Vision Aids. Low-vision aids are excluded, unless your employer Group has purchased the "Pediatric Vision Hardware and Optical Services Rider."

Non-Medically Necessary Services. Services that are not Medically Necessary.

Nonreusable Medical Supplies. Nonreusable medical supplies, such as splints, slings, and wound dressing, including bandages and ace wrap bandages, are limited to those supplied and applied by a licensed health care provider, while providing a covered Service. Nonreusable medical supplies that a Member purchases or obtains from another source are excluded.

Optometric Vision Therapy and Orthoptics (Eye Exercises). Services related to optometric vision therapy and orthoptics (eye exercises) are excluded.

Professional Services for Evaluation, Fitting, and Follow-Up Care for Contact Lenses.

Services Related to a Non-Covered Service. When a Service is not covered, all Services related to the non-covered Service are also excluded. However, this exclusion does not apply to Services we would otherwise cover if they are to treat complications which arise from the non-covered Service and to Medically Necessary Services for a Member enrolled in and participating in a qualifying clinical trial if we would typically cover those Services absent a clinical trial.

Services That are Not Health Care Services, Supplies, or Items. This exclusion does not apply to Medically Necessary applied behavior analysis (ABA) Services. For example, we do not cover:

- 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.

Supportive Care and Other Services. Supportive care primarily to maintain the level of correction already achieved; care primarily for the convenience of the Member; and care on a non-acute, symptomatic basis are excluded.

Surrogacy. Services for anyone in connection with a Surrogacy Arrangement, whether traditional or gestational, 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.

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 covered Services at Non-Participating Facilities, subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

Travel Services. All travel-related Services including travel-only immunizations (such as yellow fever, typhoid, and Japanese encephalitis), unless your Group has purchased the "Travel Services Rider."

Vision Hardware and Optical Services. Corrective lenses, eyeglasses, and contact lenses are excluded unless your Group has purchased an "Adult Vision Hardware and Optical Services Rider" and/or "Pediatric Vision Hardware and Optical Services Rider.".

REDUCTIONS

Coordination of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan. To avoid delays in claim processing, you and your provider should file all your 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.

Plan, and other important terms that apply only to this provision, are defined below.

The order of benefit determination rules described under this "Coordination of Benefits" 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 30 calendar 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 "Coordination of Benefits" 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, individual, or blanket disability insurance contracts, and group or individual insurance contracts issued by health care service contractors 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 determines 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, we determine payment for the benefits first before those of any other Plan without considering any other Plan's benefits. We will not reduce your benefits under This Plan. When This Plan is secondary, we determine 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, we 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, we must calculate the savings (the amount paid subtracted from the amount we would have paid had we 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 deductible, 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. We may get the facts we need 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. We are 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, we have 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, we are fully discharged from liability under This Plan.

Right of Recovery. We have 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

Hospitalization on Your Effective Date

If you are an inpatient in a hospital on your membership effective date but had other Group coverage on the day before your membership effective date, coverage will commence on your effective date; however, you may be transferred to a Participating Hospital when a Participating Physician, in consultation with the attending physician, determines that you are medically stable. If you refuse to transfer to a Participating Hospital, all further costs incurred during the hospitalization are your responsibility.

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

This "Injuries or Illnesses Alleged to be Caused by Other 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 another party's act or omission.
- Received on the premises of another party.
- Covered by a no-fault insurance provision.

If you obtain a settlement, award, or judgment from or on behalf of another party or insurer, or a payment under a no-fault insurance provision, you must ensure we are reimbursed for covered Services that you receive for the injury or illness, except that we will not collect 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 Other Parties or Covered by No-fault Insurance" section does not affect your obligation to pay any applicable Cost Share for these covered Services. The amount of reimbursement due to the Plan is not limited by or subject to the Out-of-Pocket Maximum.

If you do not recover anything from or on behalf of the other party or no-fault insurance, then you are responsible only for any applicable Cost Share.

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 another 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 another 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, award, or settlement you or we (when we subrogate) obtain against another party or any other insurer, regardless of how those proceeds may be characterized or designated. The proceeds of any judgment, award, 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 another party or any insurer, you must send written notice of the claim or legal action to us at:

Equian, LLC
Attn: Subrogation Operations
P.O. Box 36380
Louisville, KY 40233
Fax: 502-214-1291

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 responsible party, and the responsible party's 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 award, or if it appears you will make a recovery of any kind. If you recover any amounts from another party or any other 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 another 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 other party. We may assign our rights to enforce our liens and other rights.

Surrogacy Arrangements

If you enter into a Surrogacy Arrangement, whether traditional or gestational, you must ensure we are reimbursed 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 we collect 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. This includes any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and includes both traditional surrogacy and gestational carriers. Note: This "Surrogacy Arrangements" section does not affect your obligation to pay any applicable Cost Share, or other amounts you are required to pay for these Services. 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 Other Party Liability Supervisor
Equian
P.O. Box 36380
Louisville, KY 40233-6380
Fax: 1-502-214-1137
Phone: 1-800-552-8314
Attn: Denise Aubrey: 1-800-947-9735

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 another party based on the surrogacy arrangement, your estate, parent, guardian, or conservator and any settlement, award, 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 that 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

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 denies, 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).

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 Cost Share.

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.
- Call Member Services at 1-800-813-2000; or
- Send 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: 1-855-347-7239

You may appoint an authorized representative to help you file your complaint. A written authorization must be received from you before any information will be communicated to your representative. Contact Member Services for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

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 complaint, we will respond within 30 calendar days, unless additional information is required.

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
www.insurance.wa.gov

Language and Translation Assistance

If we send you an adverse benefit determination, we will include a notice of language assistance (oral translation). You may request language assistance with your claim and/or appeal by calling 1-800-813-2000. The notice of language assistance "Help in Your Language" is also included in this *EOC*.

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. 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
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: 1-855-347-7239

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: 1-855-347-7239

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 another 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 final decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures

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

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 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 non-urgent pre-service claim, an urgent pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

Non-urgent Pre-service Claim

- You may request a pre-service benefit determination on your own behalf. Tell us in writing 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, call, 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: 1-800-813-2000
  Fax: 1-855-347-7239

- 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.

  If more information is needed to make a decision, we will ask you for the information before the initial decision period ends, and we will give you five calendar days to send the information.

  We will make a decision and send notification within four calendar days after we receive the first piece of information (including documents) we requested or by the deadline for receiving the information, whichever is sooner.

  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.

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

Urgent Pre-service Claim

- 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 two calendar days after we receive your claim.

  Within one calendar day after we receive your claim, we may ask you for more information.

- If more information is needed to make a decision, we will give you two calendar days to send the information.

  We will notify you of our decision within two calendar days of receiving the first piece of requested information or by the deadline for receiving the information, whichever is sooner.

  If we notify you of our decision orally, we will send you written confirmation within three days after the oral notification.

- 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 in writing or orally that you want to appeal our 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, call, or fax 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: 1-855-347-7239

- 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, call, or fax 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: 1-855-347-7239

- 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 receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three days after the oral notification.
- 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 Services at 1-800-813-2000.

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 non-urgent concurrent care claim, an urgent concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

Non-urgent 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 mail, call, 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: 1-855-347-7239

- 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. 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 no later than five calendar days after we receive your claim.

If more information is needed to make a decision, 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, five calendar days to send us the information.

We will make our decision and send notification as soon as possible if your care has not ended. If your care has ended, we will make our decision within four calendar days after we first receive any information (including documents) we requested or by the deadline for receiving the information, whichever is sooner.

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.

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

Urgent Concurrent Care Claim

- If we consider your concurrent care 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 receive your claim.
- If we notify you of our decision orally, we will send you written confirmation within three days after the oral notification.
- 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 in writing 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 mail, call, or fax 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: 1-855-347-7239

- 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 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, call, or fax 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: 1-855-347-7239

- 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 the oral notification.
- 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 at 1-800-813-2000.

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

Post-service Claim

- Within 12 months 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) 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:

  Kaiser Permanente
  National Claims Administration - Northwest
  PO Box 370050
  Denver, CO 80237-9998

- We will not accept or pay for claims received from you after 12 months from the date of Service, 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 more information is needed to make a decision, we will ask you for the information before the initial 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, call, or fax 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: 1-855-347-7239

- 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, call, or fax 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: 1-855-347-7239

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.

If an adverse benefit determination involves our decision to modify, reduce, or terminate an otherwise covered Service that you are receiving at the time the request for review is submitted and our decision is based upon a finding that the Service or level of care is no longer Medically Necessary, we will continue to provide the Service if requested by you until a determination is made by the IRO. If the IRO affirms our adverse benefit determination, you will be responsible for the cost of the continued Service.

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 title, specialty, and professional qualifications of the individual(s) who made the final decision and (ii) the basis for the final decision.

TERMINATION OF MEMBERSHIP

If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. In addition, Dependents' memberships end at the same time the Subscribers' membership ends.

You will be billed as a non-Member for any Services you receive after your membership terminates. Company and Participating Providers and Participating Facilities have no further liability or responsibility under this *EOC* after your membership terminates.

Termination Due to Loss of Eligibility

You and your Dependents must remain eligible to maintain your Group coverage. You must immediately report to your Group any changes in eligibility status, such as a Spouse's loss of eligibility due to divorce or a Dependent child who has reached the Dependent Limiting Age. If you no longer meet the eligibility requirements described in this *EOC*, please confirm with your Group's benefits administrator when your membership will end.

Termination for Cause

If you or any other Member in your Family is proven to have committed one of the following acts, we may terminate your membership under this *EOC* by sending written notice, including the specific reason for termination with supporting evidence, to the Subscriber at least 31 days before the membership termination date:

- Commission of a fraudulent act against us.
- Making an intentional misrepresentation of material fact in connection with this coverage.

  Examples. We would consider the following acts as fraudulent:

  - Intentionally presenting an invalid prescription or physician order for Services.
  - Intentionally letting someone else use your ID card to obtain Services pretending to be you.

We may report fraud and other illegal acts to the authorities for prosecution.

If we terminate your membership for cause, we will:

- Refund any amounts we owe your Group for Premium paid for the period after the termination date.
- Pay you any amounts we have determined that we owe you for claims during your membership.

We may deduct any amounts you owe Company, Participating Providers, or Participating Facilities from any payment we make to you.

If your coverage is terminated for any of the above reasons, you have the right to file an appeal. For more information, please contact Member Services.

Termination of Your Group's *Contract* With Us

If your Group's *Contract* with us terminates for any reason, your membership ends on the same date. We require the Group to notify Subscribers in writing if the *Contract* with us terminates.

Termination of Certain Types of Health Benefit Plans by Us

We may terminate a particular Plan or all Plans offered in the group market as permitted by law. If we discontinue offering a particular Plan in the group market, we will terminate the particular Plan upon 90 days prior written notice to you. If we discontinue offering all Plans in the group market, we may terminate the *Contract* upon 180 days prior written notice to you.

CONTINUATION OF MEMBERSHIP

Payment of Premium During a Labor Disputes

Any school employee or Dependent whose monthly premiums are paid in full or in part by the SEBB Organization may pay premiums directly to the Health Care Authority (HCA) if the school employee's compensation is suspended or terminated 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 school employee's compensation is suspended or terminated, HCA shall notify the school employee immediately by mail to the last address of record, that the school employee may pay premiums as they become due.

If coverage is no longer available to the school employee under this *EOC*, then the school employee may purchase an individual medical plan from this Plan at a premium rate consistent with premium rates filed with the Washington State Office of the Insurance Commissioner.

Conversion of Coverage

Enrollees (including Spouses and Dependents of a Subscriber terminated for cause) have the right to switch from SEBB group medical to an individual conversion plan offered by this Plan when they are no longer eligible to continue the SEBB group medical plan, and are not eligible for Medicare or covered under 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. 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 Member Services.

Options for Continuing SEBB Medical Coverage

A school employee and their Dependent covered by this medical Plan has options for continuing insurance coverage during temporary or permanent loss of eligibility. There are two continuation coverage options for SEBB medical plan enrollees:

- SEBB Continuation Coverage (COBRA)
- SEBB Continuation Coverage (Unpaid Leave)

These two options temporarily extend group insurance coverage when the enrollee's SEBB medical plan coverage ends due to a qualifying event. SEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal law and regulation and also includes coverage for some enrollees who are not qualified beneficiaries under federal COBRA continuation coverage. SEBB Continuation Coverage (Unpaid Leave) is an alternative created by the SEBB Program with wider eligibility criteria and qualifying event types. Enrollees who qualify for both types of SEBB Continuation Coverage (COBRA and Unpaid Leave) may choose to enroll in only one of the options.

You must notify the SEBB Program in writing within 30 days if, after electing COBRA, you or your Dependent become enrolled in Medicare (Part A, Part B, or both) or become covered under other group health plan coverage. If a Subscriber enrolls in COBRA and then becomes eligible for Medicare, their enrollment in COBRA coverage will be terminated when the Subscriber is eligible for Medicare. This may cause the COBRA coverage to be terminated early, before the Subscriber has used all the months they would otherwise be entitled to. Subscribers who are already enrolled in Medicare when they enroll in COBRA will not have their coverage terminated early.

The SEBB Program administers both continuation coverage options. Refer to the *SEBB Continuation Coverage Election Notice* for details.

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

Option for Coverage Under Public Employees Benefits Board (PEBB) Retiree Insurance

A retiring school employee is eligible to continue enrollment or defer enrollment in Public Employees Benefits Board (PEBB) insurance coverage as a retiree if they meet procedural and substantive eligibility requirements. See the *PEBB Retiree Enrollment Guide* for details.

Family and Medical Leave Act of 1993

A school employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward SEBB benefits in accordance with the FMLA. The SEBB Organization determines if the school employee is eligible for leave and the duration of the leave under FMLA. The school employee must continue to pay the school employee monthly premium contribution and applicable premium surcharge during this period to maintain eligibility.

If a school employee exhausts the period of leave approved under FMLA, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharge set by the Health Care Authority (HCA), with no contribution from the SEBB Organization while on approved leave. For additional information on continuation coverage, see the section titled "Options for Continuing SEBB Medical Coverage".

Paid Family Medical Leave Act

A school employee on approved leave under the Washington state Paid Family and Medical Leave Program may continue to receive the employer contribution toward SEBB benefits in accordance with the Paid Family and Medical Leave Program. The Employment Security Department determines if the school employee is eligible for the Paid Family and Medical Leave Program. The school employee must continue to pay the school employee monthly premium contribution and applicable premium surcharge during this period to maintain eligibility.

If a school employee exhausts the period of leave approved under the Paid Family and Medical Leave Program, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharge set by HCA, with no contribution from the SEBB Organization while on approved leave. For additional information on continuation coverage, see the section titled "Options for Continuing SEBB Medical Coverage".

Moving to Another Kaiser Foundation Health Plan Service Area

If you move to another Kaiser Foundation Health Plan service area, you should contact your Group's benefits administrator to learn about your Group health care options. You may be eligible to enroll in a plan in the other Kaiser Foundation Health Plan service area. Eligibility requirements, benefits, premium, deductible, and copayments and coinsurance may not be the same in the other service area.

MISCELLANEOUS PROVISIONS

Administration of *EOC*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this *EOC*.

EOC Binding on Members

By electing coverage or accepting benefits under this *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

Amendment of *EOC*

Your Group's *EOC* with us will change periodically. If these changes affect this *EOC*, your Group is required to make revised materials available to you.

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *EOC*.

Assignment

You may not assign this *EOC* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

Attorney Fees and Expenses

In any dispute between a Member and Company or Medical Group or Kaiser Foundation Hospitals, each party will bear its own attorneys' fees and other expenses, except as otherwise required by law.

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.

Governing Law

Except as preempted by federal law, this *EOC* will be governed in accord with Washington law and any provision that is required to be in this *EOC* by state or federal law shall bind Members and Company whether or not set forth in this *EOC*.

Any provision of this *EOC* 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.

Group and Members not Company Agents

Neither your Group nor any Member is the agent or representative of Company.

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.

Litigation Venue

Venue for all litigation between you and Company shall lie in Clark County, Washington.

No Waiver

Our failure to enforce any provision of this *EOC* will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Nondiscrimination

We do not discriminate in our employment practices or in the delivery of Services on the basis of race, ethnicity, nationality, actual or perceived gender, age, physical or mental disability, marital status, sexual orientation, genetic information, or religion.

Notices

We will send our notices to you to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call Member Services as soon as possible to give us their new address.

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives an overpayment, or from any person or organization obligated to pay for the Services.

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.

You have the right to request that Kaiser Permanente send your PHI directly to you, and not to the Subscriber of your Plan. You have the right to tell us where you want us to redirect communications containing your PHI, including a different mailing address, e-mail address or telephone number. To make a request for confidential communication, please call Member Services and ask for a "Non-Disclosure Directive" form or download the form from **kp.org/disclosures**. It may take up to three business days from the date of receipt of the form for us to process your request.

In addition to any PHI that you request to be sent directly to you, we are also committed to maintaining confidentiality for all sensitive health care Services, including Services related to reproductive health, sexually transmitted diseases, substance use disorder, gender dysphoria, gender affirming care, domestic violence, and mental health. For Dependents who have reached the age to consent for their own care, communications regarding sensitive health care Services will be directed only to the Member who receives the Services, and not to the Subscriber of the Plan.

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**.

Unusual Circumstances

We will do our best to provide or arrange for your health care needs in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Participating Facility, complete or partial destruction of facilities, and labor disputes. However, in these circumstances, neither we, nor any Participating Hospital, Medical Group, or any Participating Provider or Participating Facility shall have any liability or obligation because of a delay or failure to provide these Services. In the case of a labor dispute involving Company, we may postpone non-Emergency Services until after resolution of the labor dispute.

NONDISCRIMINATION STATEMENT AND NOTICE OF LANGUAGE ASSISTANCE

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 1-800-813-2000 (TTY: 711)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Phone: 1-800-813-2000

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: 1-800-368-1019
TDD: 1-800-537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Help in Your Language

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-813-2000** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-813-2000** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-813-2000** (TTY: **711**).

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電**1-800-813-2000**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-813-2000** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-813-2000** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-813-2000** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-813-2000**（TTY: **711**）まで、お電話にてご連絡ください。

ខ្មែរ (Khmer) ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-813-2000** (TTY: **711**)។

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-813-2000** (TTY: **711**) 번으로 전화해 주십시오.

ລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-813-2000** (TTY: **711**).

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yániłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-813-2000** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-813-2000** (TTY: **711**).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-800-813-2000** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

Română (Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-800-813-2000** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-813-2000** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-813-2000** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-813-2000** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-800-813-2000** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-813-2000** (TTY: **711**).

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST ALTERNATIVE CARE SERVICES RIDER

This rider is part of the *Evidence of Coverage (EOC)* to which it is attached. All provisions of this rider become part of the *EOC* "Benefits" section, except for the "Alternative Care Services Rider Benefit Summary," which becomes part of the *EOC* "Benefit Summary." This entire benefit rider is therefore subject to all the terms and provisions of the *EOC*.

General Benefit Requirements

We cover the Services described in this "Alternative Care Services Rider" only if all of the following requirements are met:

- Services are received from Participating Providers and provided as outpatient Services in the Participating Provider's office. You do not need a referral to seek care from a Participating Provider that is within his/her scope of license and determined to be Medically Necessary and not specifically limited or excluded in the *EOC*. A list of Participating Providers may be obtained from Member Services or by visiting **www.chpgroup.com**.
- You are required to pay the Copayment or Coinsurance amount to the Participating Provider at the time of service. You are not responsible for any fees in excess of Charges.
- You are responsible for paying the full amount for Services after you reach your benefit maximum.

Covered Services

Acupuncture Services

Under the "Acupuncture Services" section in the *EOC,* we cover certain outpatient acupuncture Services only if you receive a referral from a Participating Physician or prior authorization (or both).

Under this rider, we cover acupuncture Services without prior authorization, subject to visit limits and the applicable Cost Share shown in the "Alternative Care Services Rider Benefit Summary."

Massage Therapy

Under the "Rehabilitative Therapy Services" section in the *EOC,* we cover certain outpatient massage therapy Services only if you receive a referral from a Participating Physician or prior authorization (or both).

Under this rider, we cover massage therapy Services without prior authorization, subject to visit limits and the applicable Cost Share shown in the "Alternative Care Services Rider Benefit Summary."

Naturopathic Medicine

Under the "Naturopathic Medicine" section in the *EOC,* we cover certain outpatient naturopathic medicine Services only if you receive a referral from a Participating Physician or prior authorization (or both).

Under this rider, we cover naturopathic medicine Services without prior authorization, subject to visit limits and the applicable Cost Share shown in the "Alternative Care Services Rider Benefit Summary."

Benefit Maximum

Certain Services that we cover under this rider are subject to a benefit maximum as shown in the "Alternative Care Services Rider Benefit Summary." Your benefit maximum will be exhausted (used up) when the payments we have made for these Services that you received during a Year under this rider, plus any payments that we made for these Services that you received during the same Year under a similar rider in any other evidence of coverage with the same group number printed on this EOC, add up to the benefit maximum.

After you reach the benefit maximum for a Year, we will not cover any more of these Services under this rider for the rest of the Year. It is your responsibility to pay the full amount of any Charges incurred for these Services received that exceed the benefit maximum per Year.

Alternative Care Services Rider Benefit Summary

	Participating Providers
Benefit Maximum per Year massage therapy and naturopathic medicine Services combined	$1,000
	You Pay
Acupuncture (up to 20 visits per Year)	$30 per visit
Massage therapy (up to 20 visits per Year)	$25 per visit
Naturopathic medicine	$30 per visit

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST HEARING AID RIDER

This rider is part of the *Evidence of Coverage* (*EOC*) to which it is attached. All provisions of this rider become part of the *EOC* "Benefits" section, except for the "Hearing Aid Rider Benefit Summary," which becomes part of the *EOC* "Benefit Summary." This entire benefit rider is therefore subject to all the terms and provisions of the *EOC*. The hearing aid exclusion in the *EOC* "Exclusions and Limitations" section does not apply to Services we cover under this rider.

Hearing Aids

We cover hearing aids, visits to determine the appropriate hearing aid model, visits to verify that the hearing aid conforms to the prescription, and visits for fitting, counseling, adjustment, cleaning, and inspection. Hearing exams to determine the need for hearing correction and to provide a prescription for hearing aids are not covered under this "Hearing Aid Rider" (see the "Benefits" section of the *EOC*).

We provide an allowance for each ear toward the price of a hearing aid prescribed by a Participating Provider. The allowance is shown in the "Hearing Aid Rider Benefit Summary." You do not have to use the allowances for both ears at the same time, but we will not provide the allowance for an ear if we have previously covered a hearing aid for that ear within the same benefit period shown in the "Hearing Aid Rider Benefit Summary," under this or any other evidence of coverage (including riders) with the same group number printed on this *EOC*. The date we cover a hearing aid is the date on which you are fitted for the hearing aid. Therefore, if you are fitted for a hearing aid while you are covered under this *EOC*, and if we would otherwise cover the hearing aid, we will provide the allowance even if you do not receive the hearing aid until after you are no longer covered under this *EOC*.

We select the vendor that supplies the covered hearing aid. Covered hearing aids are electronic devices worn on the person for the purpose of amplifying sound and assisting in the process of hearing, including an ear mold, if necessary, and are limited to one of the following digital models: (i) in-the-ear; (ii) behind-the-ear; (iii) on-the-body (Body Aid Model); or (iv) canal/CIC aids.

Hearing Aid Exclusions

- Bone anchored hearing aids.
- Cleaners, moisture guards, and assistive listening devices (for example, FM systems, cell phone or telephone amplifiers, and personal amplifiers designed to improve your ability to hear in a specific listening situation).
- Hearing aids that were fitted before you were covered under this *EOC* (for example, a hearing aid that was fitted during the previous contract year will not be covered under this *EOC*, though it might be covered under your evidence of coverage for the previous contract year).
- Internally implanted hearing aids.
- Repair of hearing aids beyond the warranty period.
- Replacement of lost or broken hearing aids, if you have exhausted (used up) your allowance.
- Replacement parts and batteries.

Hearing Aid Rider Benefit Summary

Hearing Aid Services	You Pay
Visits for hearing aid Services	Refer to the specialty care visit Copayment or Coinsurance as shown in your *EOC* "Benefit Summary."
Hearing aids $1,400 allowance for each hearing aid per ear every 60 months	Any amount by which price exceeds allowance

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST OUTPATIENT PRESCRIPTION DRUG RIDER

This rider is part of the *Evidence of Coverage* (*EOC*) to which it is attached. This rider becomes part of the *EOC* "Benefits" section, except for the "Outpatient Prescription Drug Rider Benefit Summary," which becomes part of the *EOC* "Benefit Summary." The provisions of the *EOC* apply to this entire rider.

Note: We also cover some outpatient drugs and supplies in the "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC*.

Covered Drugs and Supplies

We cover outpatient prescription drugs and supplies as described in this "Outpatient Prescription Drug Rider," and only if all of the following conditions are met:

- The drug or supply is prescribed by a Participating Provider or any licensed dentist in accordance with our drug formulary guidelines.
- The law requires the drug or supply to bear the legend "Rx only," or the drug or supply is a non-prescription item that our drug formulary lists for your condition. These items include glucagon emergency kits, insulin, ketone test strips for urine-testing, blood glucose test strips, and disposable needles and syringes, when prescribed for the treatment of diabetes. We cover additional diabetic equipment and supplies under the "Limited Outpatient Prescription Drugs and Supplies" and "Outpatient Durable Medical Equipment (DME)" sections of the *EOC*.
- You obtain the drug or supply at a Participating Pharmacy (including our Mail-Order Pharmacy) or in a prepackaged take-home supply from a Participating Facility or Participating Medical Office. You may obtain a first fill of the drug or supply at any Participating Pharmacy. All refills must be obtained through a pharmacy owned and operated by Kaiser Permanente (including our Mail-Order Pharmacy), or at another Participating Pharmacy that we designate for covered refills. See your *Medical Facility Directory*, visit **kp.org**, or contact Member Services.

Cost Share for Covered Drugs and Supplies

When you get a prescription from a Participating Pharmacy, Participating Facility, or Participating Medical Office, or order a prescription from our Mail-Order Pharmacy, you pay the applicable Cost Share as shown in the "Outpatient Prescription Drug Rider Benefit Summary." This applies for each prescription consisting of up to the day supply shown in the "Outpatient Prescription Drug Rider Benefit Summary."

Outpatient prescription drugs and supplies are subject to the applicable Cost Share until the medical Out-of-Pocket Maximum is met.

If Charges for the drug or supply are less than your Copayment, you pay the lesser amount.

Day Supply Limit

The prescribing provider determines how much of a drug or supply to prescribe. For purposes of day supply coverage limits, the prescribing provider determines the amount of a drug or supply that constitutes a Medically Necessary 30-day (or any other number of days) supply for you. When you pay the applicable Cost Share shown in the "Outpatient Prescription Drug Rider Benefit Summary," you will receive the prescribed supply up to the day supply limit. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantity that exceeds the day supply limit, unless due to medication synchronization, in which case we will adjust the applicable Copayment for the quantity that exceeds the day supply limit.

Medication Synchronization

Medication synchronization is the coordination of medication refills, if you are taking two or more medications for a chronic condition, so that your medications are refilled on the same schedule. You may request medication synchronization for a new prescription from the prescribing provider or a Participating Pharmacy who will determine the appropriateness of medication synchronization for the drugs being dispensed and inform you of the decision.

If the prescription will be filled to more or less than the prescribed day supply limit for the purpose of medication synchronization, we will adjust the applicable Copayment accordingly.

How to Get Covered Drugs or Supplies

Participating Pharmacies are located in many Participating Facilities. To find a Participating Pharmacy, please see your *Medical Facility Directory*, visit **kp.org**, or contact Member Services.

Participating Pharmacies include our Mail-Order Pharmacy. This pharmacy offers postage-paid delivery to addresses in Oregon and Washington. Some drugs and supplies are not available through our Mail-Order Pharmacy, for example drugs that require special handling or refrigeration, or are high cost. Drugs and supplies available through our Mail-Order Pharmacy are subject to change at any time without notice.

If you would like to use our Mail-Order Pharmacy, call 1-800-548-9809 or order online at **kp.org/refill**.

Definitions

The following terms, when capitalized and used in this "Outpatient Prescription Drug Rider," mean:

- **Brand-Name Drug.** The first approved version of a drug. Marketed and sold under a proprietary, trademark-protected name by the pharmaceutical company that holds the original patent.
- **Generic Drug.** A drug that contains the same active ingredient as a Brand-Name Drug and is approved by the U.S. Food and Drug Administration (FDA) as being therapeutically equivalent and having the same active ingredients(s) as the Brand-Name Drug. Generally, Generic Drugs cost less than Brand-Name Drugs, and must be identical in strength, safety, purity, and effectiveness.
- **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.
- **Preferred Brand-Name Drug.** A Brand-Name 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.
- **Specialty Drug.** A drug or supply, including many self-injectables as well as other medications, often used to treat complex chronic health conditions, is generally high cost, and is approved by the U.S. Food and Drug Administration (FDA). Specialty drug treatments often require specialized delivery, handling, monitoring, and administration.

About Our Drug Formulary

Our drug formulary is a list of drugs that our Regional Formulary and Therapeutics Committee has reviewed and approved for our Members and includes drugs covered under this rider. Drugs on the formulary have been approved by the FDA.

Our Regional Formulary and Therapeutics Committee is made up of Participating Physicians, other Participating Providers, pharmacists, and administrative staff. The committee chooses drugs for the formulary based on several factors, including safety and effectiveness as determined from a review of the scientific literature. They may not approve a drug if there is not enough scientific evidence that it is clinically effective. They may also exclude a drug if it does not have a clinical or cost advantage over comparable formulary drugs.

The Regional Formulary and Therapeutics Committee meets to review new drugs and reconsider drugs currently on the market. After this review, they may add drugs to the formulary or remove drugs from it. If a drug is removed from the formulary, you will need to switch to another comparable drug that is on the drug formulary, unless your old drug meets exception criteria. Refer to the "Drug Formulary Exception Process" in this rider for more information.

When a drug is removed from the formulary, we will notify Members who filled a prescription for the drug at a Participating Pharmacy within the prior three months. If a formulary change affects a prescription drug you are taking, we encourage you to discuss any questions or concerns with your Participating Provider or another member of your health care team.

Drugs on our formulary may move to a different drug tier during the Year. For example, a drug could move from the Non-Preferred Brand-Name Drug list to the Preferred Brand-Name Drug list. If a drug you are taking is moved to a different drug tier, this could change the Cost Share you pay for that drug.

To see if a drug or supply is on our drug formulary, or to find out what drug tier the drug is in, go online to **kp.org/formulary**. You may also call our Formulary Application Services Team (FAST) at 503-261-7900 or toll free at 1-888-572-7231. If you would like a copy of our drug formulary or additional information about the formulary process, please call Member Services. The presence of a drug on our drug formulary does not necessarily mean that your Participating Provider will prescribe it for a particular medical condition.

Drug Formulary Exception Process

Our drug formulary guidelines include an exception process that is available when a Participating Provider or any licensed dentist prescribes a drug or supply that our drug formulary does not list for your condition, if the law requires the item to bear the legend "Rx only." The exception process is not available for drugs and supplies that the law does not require to bear this legend, or for any drug or supply prescribed by someone other than a Participating Provider or any licensed dentist.

A Participating Provider or any licensed dentist may request an exception if he or she determines that the non-formulary drug or supply is Medically Necessary. We will make a coverage determination within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests. A request may be expedited if you are experiencing a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a nonformulary drug.

If the information provided is not sufficient to approve or deny the request, we will notify your prescribing Participating Provider that additional information is required in order to make a determination. This additional information will be due within five calendar days for standard requests or two business days for expedited requests.

After we receive the first piece of information (including documents) we requested, we will make a decision and send notification within four calendar days (for standard requests) or two days (for expedited requests), or by the deadline for receiving the information, whichever is sooner.

We will approve the exception if all of the following requirements are met:

- We determine that the drug or supply meets all other coverage requirements except for the fact that our drug formulary does not list it for your condition.
- Medical Group or a designated physician makes the following determinations:
  - The drug or supply is Medically Necessary because you are allergic to, or intolerant of, or have experienced treatment failure with, any alternative drugs or supplies that our drug formulary lists for your condition.
  - Your condition meets any additional requirements that the Regional Formulary and Therapeutics Committee has approved for the drug or supply. For this drug or supply, the pharmacy can provide a

copy of the additional criteria upon request. In some cases, there may be a short delay in filling your prescription while your information is being reviewed.

If we approve an exception through this exception process, then we will cover the drug or supply at the applicable Copayment or Coinsurance shown in the "Outpatient Prescription Drug Rider Benefit Summary."

If we do not approve the formulary exception request, we will send you a letter informing you of that decision. You may request a review by an independent review organization. The process is explained in our denial letter and under "External Review" in the "Grievances, Claims, Appeals, and External Review" section.

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.

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.

Prior Authorization Exception Process

We have a process for you or your prescribing Participating Provider to request a review of a prior authorization determination that a drug or supply is not covered. This exception process is not available for drugs and supplies that the law does not require to bear the legend "Rx only."

Your prescribing Participating Provider may request an exception if he or she determines that the drug or supply is Medically Necessary. Prescribing Participating Providers must supply to the Participating Pharmacy the medical information necessary to review the request for exception. A coverage determination will be made within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests. A request may be expedited if you are experiencing a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a nonformulary drug.

If the information provided is not sufficient to approve or deny the request, we will notify your prescribing Participating Provider that additional information is required in order to make a determination. This additional information will be due within five calendar days for standard requests or two business days for expedited requests.

After we receive the first piece of information (including documents) we requested, we will make a decision and send notification within four calendar days (for standard requests) or two days (for expedited requests), or by the deadline for receiving the information, whichever is sooner.

If the exception request is approved through this exception process, then we will cover the drug or supply at the applicable Cost Share shown in the "Outpatient Prescription Drug Rider Benefit Summary."

If the exception request is not approved, we will send you a letter informing you of that decision. You may request a review by an independent review organization. The process is explained in our denial letter and under "External Review" in the "Grievances, Claims, Appeals, and External Review" section.

Emergency Fill

For purposes of this section, "emergency fill" means a limited dispensed amount of the prescribed drug that allows time for the processing of a prior authorization request. You may have the right to receive an emergency fill of a prescription drug that requires prior authorization under the following circumstances:

- the Participating Pharmacy is unable to reach the Company's prior authorization department by phone, as it is outside the department's business hours; or
- the Participating Pharmacy is unable to reach the prescribing Participating Provider for full consultation, and
- delay in treatment would result in imminent emergency care, hospital admission or might seriously jeopardize the life or health of the patient or others in contact with the patient.

An emergency fill must be received at a Participating Pharmacy and is subject to the applicable Cost Share shown in the "Outpatient Prescription Drug Rider Benefit Summary." An emergency fill is limited to no more than a seven-day supply or the minimum packaging size available.

Your Prescription Drug Rights

You have the right to safe and effective pharmacy Services. You also have the right to know what drugs are covered under this Plan and the limits that apply. If you have a question or a concern about your prescription drug benefits, please contact Member Services or visit us online at **kp.org**.

If you would like to know more about your rights, or if you have concerns about your Plan you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900 or **www.insurance.wa.gov**. If you have a concern about the pharmacists or pharmacies serving you, please contact the Washington State Department of Health at 360-236-4700, **www.doh.wa.gov**, or **HSQACSC@doh.wa.gov**.

Medication Management Program

The Medication Management Program is available at no extra cost to Members who use Participating Pharmacies. The program's primary focus is on reducing cardiovascular risk by controlling lipid levels and high blood pressure. Providers, including pharmacists, nurse care managers, and other staff, work with Members to educate, monitor, and adjust medication doses.

Outpatient Prescription Drug Rider Limitations

- If your prescription allows refills, there are limits to how early you can receive a refill. We will refill your prescription when you have used at least 70 percent of the quantity, unless the law or your prescribing provider prohibits an early refill. Please ask your pharmacy if you have questions about when you can get a covered refill.
- The Participating Pharmacy may reduce the day supply dispensed at the applicable Cost Share to a 30-day supply in any 30-day period if it determines that the drug or supply is in limited supply in the market or for certain other items. Your Participating Pharmacy can tell you if a drug or supply you use is one of these items.
- For certain drugs or supplies we may limit the amount of a drug or supply that is covered for a specified time frame. Quantity limits are in place to ensure safe and appropriate use of a drug or supply. Drugs and supplies subject to quantity limits are indicated on our drug formulary, available at **kp.org/formulary**. You may also contact Member Services for more information.

Outpatient Prescription Drug Rider Exclusions

- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.

- Brand-Name Drugs for which a Generic Drug is available, unless approved. Refer to the "Prior Authorization and Step Therapy Prescribing Criteria" section.
- Drugs prescribed for an indication if the FDA has determined that use of that drug for that indication is contraindicated.
- Drugs prescribed for an indication if the FDA has not approved the drug for that indication, except that this exclusion does not apply if our Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health and Human Services.
- Drugs and supplies ordered from the Mail-Order Pharmacy to addresses outside of Oregon or Washington.
- Drugs and supplies that are available without a prescription, even if the nonprescription item is in a different form or different strength (or both), except that this exclusion does not apply to nonprescription drugs or supplies that our drug formulary lists for your condition.
- Drugs, biological products, and devices that the FDA has not approved.
- Drugs used for the treatment of infertility.
- Drugs used for the treatment or prevention of sexual dysfunction disorders.
- Drugs used in weight management.
- Drugs used to enhance athletic performance.
- Extemporaneously compounded drugs, unless the formulation is approved by our Regional Formulary and Therapeutics Committee.
- Internally implanted time-release drugs, except that internally implanted time-release contraceptive drugs are covered.
- Non-formulary drugs that have not been approved (refer to the "Drug Formulary Exception Process").
- Nutritional supplements.
- Outpatient drugs that require special handling, refrigeration, or high cost drugs are not provided through the Mail-Order Pharmacy.
- Outpatient drugs that require professional administration by medical personnel or observation by medical personnel during self-administration (refer instead to the "Limited Outpatient Prescription Drugs and Supplies" section).
- Replacement of drugs and supplies due to loss, damage, or carelessness.

Outpatient Prescription Drug Rider Benefit Summary

Outpatient Prescription Drugs and Supplies	Participating Pharmacies You Pay
Generic Drugs	$10 for up to a 30-day supply
Generic Drugs from our Mail-Order Pharmacy	$10 for up to a 30-day supply $20 for a 31- to 90-day supply
Preferred Brand-Name Drugs or supplies	$20 for up to a 30-day supply
Preferred Brand-Name Drugs or supplies from our Mail-Order Pharmacy	$20 for up to a 30-day supply $40 for a 90-day supply
Non-Preferred Brand-Name Drugs or supplies	50% Coinsurance up to $100 maximum for up to a 30-day supply
Non-Preferred Brand-Name Drugs or supplies from our Mail-Order Pharmacy	50% Coinsurance up to $100 maximum for up to a 30-day supply 50% Coinsurance up to $200 maximum for a 31- to 90-day supply
Specialty Drugs or supplies	50% Coinsurance up to $150 maximum for up to a 30-day supply
Blood glucose test strips	$10 for up to a 30-day supply
Self-administered chemotherapy medications used for the treatment of cancer	20% Coinsurance after Deductible or subject to the applicable prescription drug tier Cost Share, whichever is less