MONTHLY PREMIUM

Premium Due Date is last day of the month preceding the month of membership.

For renewing Members, the Premium amount you pay is based on each Member’s age as of January 1, 2020. For new Members, the Premium amount you pay is based on each Member’s age on the effective date of their enrollment in 2020.

If you enroll more than three children under age 21 in one family account, we charge Premium only for the three oldest children.

<table>
<thead>
<tr>
<th>Member Age</th>
<th>Clark County</th>
<th>Cowlitz County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual Member</td>
<td>Individual Member</td>
</tr>
<tr>
<td></td>
<td>Non-Tobacco User</td>
<td>Tobacco User</td>
</tr>
<tr>
<td>14 and under</td>
<td>$288.13</td>
<td>$288.13</td>
</tr>
<tr>
<td>15</td>
<td>$313.74</td>
<td>$313.74</td>
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<td>18</td>
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<tr>
<td>23</td>
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<td>$548.69</td>
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<tr>
<td>35</td>
<td>$460.25</td>
<td>$552.30</td>
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<tr>
<td>Member Age</td>
<td>Clark County</td>
<td>Cowlitz County</td>
</tr>
<tr>
<td>------------</td>
<td>--------------</td>
<td>---------------</td>
</tr>
<tr>
<td></td>
<td>Individual Member Non-Tobacco User</td>
<td>Individual Member Tobacco User</td>
</tr>
<tr>
<td>36</td>
<td>$463.27</td>
<td>$555.92</td>
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<tr>
<td>37</td>
<td>$466.28</td>
<td>$559.54</td>
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<tr>
<td>38</td>
<td>$469.29</td>
<td>$563.15</td>
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<tr>
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<td>$475.32</td>
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<td>$577.62</td>
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<tr>
<td>41</td>
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<td>$588.46</td>
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<td>42</td>
<td>$499.05</td>
<td>$598.86</td>
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<td>43</td>
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<td>$613.32</td>
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<td>$526.17</td>
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<td>$652.64</td>
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<td>$564.96</td>
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<td>$588.69</td>
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<td>48</td>
<td>$615.81</td>
<td>$738.97</td>
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<tr>
<td>49</td>
<td>$642.55</td>
<td>$771.06</td>
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<tr>
<td>50</td>
<td>$672.68</td>
<td>$807.21</td>
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<tr>
<td>51</td>
<td>$702.43</td>
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<td>$735.20</td>
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<td>53</td>
<td>$768.35</td>
<td>$922.01</td>
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<tr>
<td>54</td>
<td>$804.13</td>
<td>$964.95</td>
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<tr>
<td>55</td>
<td>$839.91</td>
<td>$1,007.89</td>
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<tr>
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<td>$878.70</td>
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<tr>
<td>57</td>
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<td>$1,101.45</td>
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<td>58</td>
<td>$959.68</td>
<td>$1,151.61</td>
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<tr>
<td>59</td>
<td>$980.39</td>
<td>$1,176.47</td>
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<td>60</td>
<td>$1,022.20</td>
<td>$1,226.64</td>
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<tr>
<td>61</td>
<td>$1,058.36</td>
<td>$1,270.03</td>
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<tr>
<td>62</td>
<td>$1,082.09</td>
<td>$1,298.50</td>
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<tr>
<td>63</td>
<td>$1,111.84</td>
<td>$1,334.21</td>
</tr>
<tr>
<td>64+</td>
<td>$1,129.92</td>
<td>$1,355.90</td>
</tr>
</tbody>
</table>

**EFFECTIVE DATE:** January 1, 2020 through December 31, 2020

Kaiser Foundation Health Plan of the Northwest

[Signature]

Ruth Williams Brinkley, FACHE
President, Northwest Region
Kaiser Foundation Health Plan & Hospitals
Kaiser Permanente Individuals and Families
Deductible Plan
Evidence of Coverage

Group Number: 20002
This Evidence of Coverage is effective January 1, 2020, through December 31, 2020.

READ THIS EVIDENCE OF COVERAGE CAREFULLY. IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE INFORMATION IN THIS EVIDENCE OF COVERAGE. YOUR HEALTH PLAN COVERAGE UNDER THIS PLAN MAY BE DIFFERENT FROM THE HEALTH PLAN COVERAGE WITH WHICH YOU ARE FAMILIAR. IF YOU HAVE ANY QUESTIONS ABOUT YOUR COVERAGE, PLEASE CALL US.

10-DAY CANCELLATION POLICY:
If you are not satisfied with this Evidence of Coverage for any reason, you can rescind the contract and cancel the coverage within 10 days of the date of delivery by notifying and returning this Evidence of Coverage to us. If you cancel the coverage, your Premium and other payments, if any, will be refunded, and your coverage will be void from the beginning. As a result, you will be charged as a non-Member for Services and benefits you received during the period to which the refund applies. If we do not pay the refund within 30 days from the date that this Evidence of Coverage is returned, an additional 10 percent will be added to the refund.

Member Services
Monday through Friday (except holidays)
8 a.m. to 6 p.m.
Portland area .......... 503-813-2000
All other areas ........ 1-800-813-2000
TTY
All areas ............... 711
Language interpretation services
All areas ............... 1-800-324-8010
kp.org
DEDUCTIBLE PLAN BENEFIT SUMMARY
KP WA SILVER 3500/35

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.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-only Deductible per Year (for a Family of one Member)</td>
<td>$3,500</td>
</tr>
<tr>
<td>Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)</td>
<td>$3,500</td>
</tr>
<tr>
<td>Family Deductible per Year (for an entire Family)</td>
<td>$7,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-Pocket Maximum</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)</td>
<td>$8,150</td>
</tr>
<tr>
<td>Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)</td>
<td>$8,150</td>
</tr>
<tr>
<td>Family Out-of-Pocket Maximum per Year (for an entire Family)</td>
<td>$16,300</td>
</tr>
</tbody>
</table>

Note: All Deductible, Copayments, and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise indicated in this EOC.

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Services</td>
<td></td>
</tr>
<tr>
<td>Routine preventive physical exam (includes adult, well baby, and well child)</td>
<td>$0</td>
</tr>
<tr>
<td>Immunizations</td>
<td>$0</td>
</tr>
<tr>
<td>Preventive tests</td>
<td>$0</td>
</tr>
</tbody>
</table>

Outpatient Services

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td>$35</td>
</tr>
<tr>
<td>Specialty care visit (includes routine hearing exams, health education Services and diabetic outpatient self-management training and education, including medical nutrition therapy)</td>
<td>$65</td>
</tr>
<tr>
<td>TMJ therapy visit</td>
<td>$65 after Deductible</td>
</tr>
<tr>
<td>Nurse treatment room visits to receive injections</td>
<td>$30</td>
</tr>
<tr>
<td>Administered medications, including injections (all outpatient settings)</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Urgent Care visit</td>
<td>$50</td>
</tr>
<tr>
<td>Emergency department visit</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Outpatient surgery visit</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>$0</td>
</tr>
<tr>
<td>Chemotherapy/radiation therapy visit</td>
<td>$65 after Deductible</td>
</tr>
<tr>
<td>Respiratory therapy visit</td>
<td>$65 after Deductible</td>
</tr>
<tr>
<td>Service Description</td>
<td>Cost after Deductible</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Cardiac rehabilitative therapy visit</td>
<td>$65 after Deductible</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td></td>
</tr>
<tr>
<td>Room and board, surgery, anesthesia, X-ray, imaging, laboratory, and drugs</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Acupuncture Services</strong></td>
<td></td>
</tr>
<tr>
<td>Self-referred acupuncture (after 12 visits, additional visits require prior authorization)</td>
<td>$65</td>
</tr>
<tr>
<td>Physician-referred acupuncture</td>
<td>$65</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td></td>
</tr>
<tr>
<td>Per transport</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>Chemical Dependency Services</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>$35</td>
</tr>
<tr>
<td>Inpatient hospital Services</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Residential Services</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Day treatment Services</td>
<td>$35 per day</td>
</tr>
<tr>
<td><strong>Dialysis Services</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient dialysis visit</td>
<td>$65 after Deductible</td>
</tr>
<tr>
<td>Home dialysis</td>
<td>$0</td>
</tr>
<tr>
<td><strong>External Prosthetic Devices and Orthotic Devices</strong></td>
<td></td>
</tr>
<tr>
<td>External Prosthetic Devices and Orthotic Devices</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>Habilitative Services</strong> (Visit or day maximums do not apply to habilitative Services for treatment of mental health conditions.)</td>
<td></td>
</tr>
<tr>
<td>Outpatient Services (Limited to 25 visits combined physical, speech, and occupational therapies per Year; additional 25 visits per Year for neurological conditions,)</td>
<td>$40</td>
</tr>
<tr>
<td>Inpatient Services (Limited to 30 days per Year.)</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>Home Health Services</strong></td>
<td></td>
</tr>
<tr>
<td>Home health (up to 130 visits per Year)</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>Hospice Services</strong></td>
<td></td>
</tr>
<tr>
<td>Hospice Services (inpatient or outpatient respite care limited to a maximum of 14 days per lifetime)</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Infertility Services</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnosis office visit</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>Diagnosis laboratory procedures</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td><strong>Maternity and Newborn Care</strong></td>
<td></td>
</tr>
<tr>
<td>Scheduled prenatal care visits and postpartum visits</td>
<td>$0</td>
</tr>
<tr>
<td>Inpatient hospital Services</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Home birth obstetrical care and delivery</td>
<td>$65</td>
</tr>
<tr>
<td>Medical Foods and Formula</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Medical foods and formula</td>
<td>30% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services</td>
<td>$35 per visit</td>
</tr>
<tr>
<td>Intensive outpatient Services</td>
<td>$35 per day</td>
</tr>
<tr>
<td>Assertive Community Treatment (ACT) Services</td>
<td>$0</td>
</tr>
<tr>
<td>Inpatient hospital Services</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Residential Services</td>
<td>30% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Naturopathic Medicine</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-referred evaluation and treatment (up to 6 visits per Year)</td>
<td>$65</td>
</tr>
<tr>
<td>Physician-referred evaluation and treatment</td>
<td>$65</td>
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</table>

<table>
<thead>
<tr>
<th>Out-of-Area Coverage for Dependents</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited office visits, 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.</td>
<td>20% of the actual fee the provider, facility, or vendor charged for the Service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Durable Medical Equipment (DME)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Durable Medical Equipment (DME)</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Lancets and injection aids</td>
<td>30% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Laboratory, X-ray, Imaging, and Special Diagnostic Procedures</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Genetic testing</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td>X-ray, imaging, and special diagnostic procedures</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td>CT, MRI, PET scans</td>
<td>30% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Prescription Drugs and Supplies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Certain preventive medications (including, but not limited to, aspirin, fluoride, liquid iron for infants, and tobacco use cessation drugs)</td>
<td>$0</td>
</tr>
<tr>
<td>Certain self-administered IV drugs, fluids, additives, and nutrients including the supplies and equipment required for their administration</td>
<td>$0</td>
</tr>
<tr>
<td>FDA-approved prescription and over-the-counter contraceptive drugs or devices</td>
<td>$0</td>
</tr>
<tr>
<td>Self-administered chemotherapy medications used for the treatment of cancer</td>
<td>20% Coinsurance or subject to the applicable drug tier Copayment or Coinsurance, whichever is less.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Generic Drugs</th>
<th>$25 for up to a 30-day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs from our Mail-Order Pharmacy</td>
<td>$25 for up to a 30-day supply</td>
</tr>
<tr>
<td>$50 for a 31- to 90-day supply</td>
<td></td>
</tr>
<tr>
<td>Preferred Brand-Name Drugs or supplies</td>
<td>$65 for up to a 30-day supply</td>
</tr>
<tr>
<td>Preferred Brand-Name Drugs or supplies from our Mail-Order Pharmacy</td>
<td>$65 for up to a 30-day supply</td>
</tr>
<tr>
<td>$130 for a 31- to 90-day supply</td>
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</tr>
<tr>
<td>Service</td>
<td>You Pay</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Non-Preferred Brand-Name Drugs or supplies</td>
<td>50% Coinsurance for up to a 30-day supply after Deductible</td>
</tr>
<tr>
<td>Non-Preferred Brand-Name Drugs or supplies from our Mail-Order Pharmacy</td>
<td>50% Coinsurance for up to a 30-day supply after Deductible</td>
</tr>
<tr>
<td>50% Coinsurance for a 31- to 90-day supply after Deductible</td>
<td></td>
</tr>
<tr>
<td>Specialty Drugs or supplies</td>
<td>50% Coinsurance for up to a 30-day supply after Deductible</td>
</tr>
<tr>
<td><strong>Pediatric Vision Services (covered until the end of the month in which Member turns 19 years of age)</strong></td>
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</tr>
<tr>
<td>Routine vision screening</td>
<td>$0</td>
</tr>
<tr>
<td>Comprehensive eye exam (limited to one exam per Year)</td>
<td>$0</td>
</tr>
<tr>
<td>Low vision evaluation and/or follow up exams (evaluations limited to once every five years; follow up exams limited to four exams every five years)</td>
<td>$35</td>
</tr>
<tr>
<td>Eyeglasses (limited to one pair per Year)</td>
<td>$0</td>
</tr>
<tr>
<td>Conventional or disposable contact lenses in lieu of eyeglasses (limited to one pair per Year for conventional contact lenses or up to a 12-month supply of disposable contact lenses per Year)</td>
<td>$0</td>
</tr>
<tr>
<td>Medically Necessary contact lenses (limited to one pair per Year for conventional contact lenses or up to a 12-month supply of disposable contact lenses per Year, prior authorization required)</td>
<td>$0</td>
</tr>
<tr>
<td>Low vision aids (limited to one device per Year, prior authorization required)</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Reconstructive Surgery Services</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital Services</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Outpatient surgery visit</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>Rehabilitative Therapy Services</strong> (Visit or day maximums do not apply to rehabilitative therapy Services for treatment of mental health conditions.)</td>
<td></td>
</tr>
<tr>
<td>Outpatient Services (Limited to 25 visits combined physical, speech, and occupational therapies per Year; additional 25 visits per Year for neurological conditions.)</td>
<td>$40</td>
</tr>
<tr>
<td>Inpatient Services (Limited to 30 days per Year.)</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Services</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient skilled nursing Services (up to 60 days per Year)</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>Spinal and Extremity Manipulation Therapy Services</strong></td>
<td></td>
</tr>
<tr>
<td>Self-referred Spinal and Extremity Manipulation therapy (after 10 visits, additional visits require prior authorization)</td>
<td>$65</td>
</tr>
<tr>
<td>Physician-referred Spinal and Extremity Manipulation therapy</td>
<td>$65</td>
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<tr>
<td><strong>Transplant Services</strong></td>
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<tr>
<td>Inpatient hospital Services</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td><strong>Dependent Limiting Age</strong></td>
<td>Limiting Age</td>
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<td>Dependent Limiting Age</td>
<td>26</td>
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INTRODUCTION

This Evidence of Coverage (EOC), including the “Benefit Summary,” describes the health care benefits of this Kaiser Permanente Individuals and Families Deductible Plan. Members are entitled to covered Services only at Participating Facilities and from Participating Providers, except as noted in this EOC. 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

Medical benefit coverage under this EOC for the effective period stated on the cover page will be provided only for the period for which Company has received the applicable Premium.

Renewal

This EOC is guaranteed renewable during the effective period subject to receipt of applicable Premium and will not be terminated, except as described in the “Termination of Membership” section.

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.

**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.

**Dependent.** A Member who meets the eligibility requirements for a Dependent as described in the “Who Is Eligible” section.
**Dependent Limiting Age.** The “Premium, Eligibility, and Enrollment” section requires that most types of Dependents (other than Spouses) be under the Dependent Limiting Age in order to be eligible for membership. The “Benefit Summary” shows the Dependent Limiting Age.

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

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

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

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


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

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

**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.

**HIPAA-eligible Individual.** A HIPAA-eligible Individual meets the following conditions: 1) has at least 18 months of Creditable Coverage as of the application date; 2) the most recent prior Creditable Coverage was under a group health Plan, governmental Plan, or church Plan or health insurance coverage offered in connection with any of these Plans; 3) does not have other health insurance coverage; 4) the individual’s most
recent coverage was not terminated because of nonpayment of Premium or fraud; 5) the individual has elected and exhausted continuation coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA) or a similar state program; and 6) the individual is not eligible for a group health Plan, Medicare Part A or B, or a state Medicaid Plan.

**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; 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 an item or service does not, in itself, make such item or 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 or recurrent condition for which you have not been treated by the Participating Provider 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.

**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.

**Patient Protection and Affordable Care Act of 2010.** Means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) 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 or on behalf of each Member. Premium is in addition to any Deductible, Copayment, or Coinsurance.

Premium Due Date. Last day of the month preceding the month of membership.

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 legally recognized as your domestic partner in a valid Certificate of State Registered Domestic Partnership issued by the state of Washington or who is validly registered as your domestic partner under the laws of another state.

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 and for whom we have received applicable Premium.

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 http://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

Premium

Only Members for whom Company has received the applicable Premium are entitled to membership under this EOC, and then only for the period for which Company has received the applicable Premium.
**Monthly Premium**
Subscriber must pay Company the applicable Premium for each month so that Company receives it on or before the Premium Due Date.

[If we receive advance payment of the premium tax credit on your behalf, then you are responsible for paying the portion of the monthly Premium that equals the full Premium minus the advance payment of the premium tax credit that we receive on your behalf for that month.]

**Who Is Eligible**

**Subscriber**
To be eligible to enroll and to remain enrolled as a Subscriber, you must meet all of the following requirements:

- You enroll during an annual open enrollment period or special enrollment period, as described under “Annual Open Enrollment Period” and “Special Enrollment” in this “Premium, Eligibility, and Enrollment” section.
- You submit a completed application.
- You live in our Washington Service Area. For assistance about the Service Area or eligibility, please contact Member Services. The Subscriber’s or the Subscriber’s Spouse’s otherwise eligible children are not ineligible solely because they live outside our Service Area or in another Kaiser Foundation Health Plan service area.
- You are not entitled to Medicare Part A or enrolled in Medicare Part B. If you are eligible for or enrolled in Medicare coverage, contact Member Services for Medicare coverage information.

**Dependents**
In addition to meeting the same requirements as the Subscriber, the individuals defined below are eligible to enroll as your Dependents under this EOC:

- Your Spouse.
- A person who is under the Dependent Limiting Age shown in the “Benefit Summary” and who is any of the following:
  - Your or your Spouse’s child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed a legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian.
- A child placed with you or your Spouse for foster care.
- A person of any age who is primarily dependent upon you or your Spouse for support and maintenance if the person is incapable of self-sustaining employment by reason of developmental disability or physical handicap which occurred prior to his or her reaching the Dependent Limiting Age shown in the “Benefit Summary,” if the person is any of the following:
  - Your or your Spouse’s child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed a legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian and was a court-appointed guardian prior to the person reaching the Dependent Limiting Age shown in the “Benefit Summary.”
You must provide proof of incapacity and dependency annually upon request, but only after the two-year period following attainment of the Dependent Limiting Age shown in the “Benefit Summary.”

Children born to a Dependent other than your Spouse (for example, your grandchildren) are not eligible for coverage beyond the first 21 days of life, including the date of birth, unless: (a) you or your Spouse adopts them or assumes a legal obligation in anticipation of adoption; or, (b) they are primarily supported by you or your Spouse and you or your Spouse is their court-appointed guardian.

Company will not deny enrollment of a newborn child, newly adopted child, child for whom legal obligation is assumed in anticipation of adoption, or newly placed foster child, solely on the basis that: (a) the child was born out of wedlock; (b) the child is not claimed as a dependent on the parent’s federal tax return; (c) the child does not reside with the child’s parent or in our Service Area; or (d) the mother of the child used drugs containing diethylstilbestrol prior to the child’s birth. Also, Company does not discriminate between married and unmarried persons, or between children of married or unmarried persons.

Members with Medicare
If, during the term of this EOC, you become entitled to or enroll in Medicare (Part A or Part B) due to age, disability, or end-stage renal disease, promptly contact Member Services to provide notice of this change and to receive information about our Kaiser Permanente Senior Advantage (HMO) Plans.

When You Can Enroll and When Coverage Begins
An individual may enroll for coverage in a Kaiser Permanente Individuals and Families Plan during the annual open enrollment period, or within 60 days after a qualifying event occurs as defined in applicable state and federal law.

There are requirements that you must meet to take advantage of a special enrollment period, including providing proof of your own or your Dependent’s qualifying event. To learn more about qualifying events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Company, and other requirements, contact Member Services or visit kp.org/specialenrollment to obtain a copy of our Special Enrollment Guide.

Note: During the enrollment process if we discover that you or someone on your behalf intentionally provided incomplete or incorrect material information on your enrollment application, we will rescind your membership. This means that we will completely cancel your membership so that no coverage ever existed. You will be responsible for the full Charges of any Services received by you or your Dependents. Please refer to “Rescission of Membership” in the “Termination of Membership” section for details.

Annual Open Enrollment Period
An individual may apply for enrollment as a Subscriber, and may also apply to enroll eligible Dependents, by submitting an application form to Washington Healthplanfinder (wahealthplanfinder.org) during the annual open enrollment period. If Washington Healthplanfinder accepts the application, Washington Healthplanfinder will notify the individual of the date coverage begins. Membership begins at 12 a.m. (PT) of the effective date specified in the notice.

Annual Open Enrollment Period
An individual may apply for enrollment as a Subscriber, and may also apply to enroll eligible Dependents, by submitting an application form to us during the annual open enrollment period. If we accept the application, we will notify the individual of the date coverage begins. Membership begins at 12 a.m. (PT) of the effective date specified in the notice.]
**Special Enrollment**

A special enrollment period is open to individuals who experience a qualifying event, as defined in applicable state and federal law. We will administer special enrollment rights consistent with applicable state and federal law.

Examples of qualifying events include, but are not limited to:

- Loss of minimum essential coverage for any reason other than nonpayment of Premium, rescission of coverage, misrepresentation, fraud or voluntary termination of coverage.
- Gaining a Dependent through marriage or entering into a domestic partnership, birth, adoption, placement for adoption or placement for foster care, or through a child support order or other court order.
- Loss of a Dependent through divorce or legal separation, or if the enrollee, or his or her Dependent dies.

Note: If the individual is enrolling as a Subscriber along with at least one eligible Dependent, only one enrollee must meet one of the requirements for a qualifying event.

An individual may apply for enrollment as a Subscriber, and may also apply to enroll eligible Dependents, by submitting an application to [Washington Healthplanfinder (wahealthplanfinder.org)](http://wahealthplanfinder.org) within 60 days after a qualifying event as defined in applicable state and federal law.

There are requirements that you must meet to take advantage of a special enrollment period, including providing proof of your own or your Dependent’s qualifying event. To learn more, contact Member Services or visit [kp.org/specialenrollment](http://kp.org/specialenrollment).

**Adding New Dependents to an Existing Account**

To enroll a Dependent who first becomes eligible to enroll after you became a Subscriber, you must submit an enrollment application as described in this “Adding New Dependents to an Existing Account” section.

Newborns, newly adopted children, children newly placed for adoption, or newly placed foster children are covered for the first 21 days after birth, adoption, placement for adoption, or placement for foster care. In order for coverage to continue beyond this 21-day period, you must submit an enrollment application within 60 days after the date of birth, adoption, placement for adoption, or placement for foster care, if additional Premium is required to add the Dependent. If additional Premium is not required, the application requirement is waived; however, please notify [Washington Healthplanfinder and Member Services](http://kp.org/specialenrollment) to add the child to your Plan.

To add all other newly eligible Dependents (such as a new Spouse), you must submit an enrollment application within 60 days after the qualifying event. Enrollment in this Plan is subject to [Washington Healthplanfinder’s verification of your eligibility](http://kp.org/specialenrollment).

**Selecting and Switching Your Benefit Plan**

If you are currently a Member on a Kaiser Permanente Individuals and Families Plan you may switch to another Kaiser Permanente Individuals and Families Plan that we offer during the annual open enrollment period, or if you experience a qualifying event as defined in applicable state and federal law.

**When Coverage Begins**

[Washington Healthplanfinder](http://wahealthplanfinder.org) will notify the enrollee of the date coverage will begin. Membership begins at 12 a.m. (PT) of the effective date specified in the notice.

If an individual enrolls in, adds a Dependent, or changes health plan coverage during the annual open enrollment period, or a special enrollment period, the membership effective date will be determined in compliance with applicable state and federal law.
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.
- Optometry (routine eye exams are covered until the end of the month in which the Member turns 19 years of age).
- 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. The Deductible, Copayment, or Coinsurance for these approved referral Services are the same as those required for Services provided by a Participating Provider or Participating Facility. You will need written authorization in advance in order for the Services to be covered. If 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 Participating Provider will request prior or concurrent authorization when necessary. The following are examples of Services that require prior or concurrent 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 prior or concurrent authorization.
- 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 (physician-referred).
- 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 prior or concurrent 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 Deductible, Copayment, or Coinsurance, 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 Deductible, Copayment, or Coinsurance 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 mental health and chemical dependency Services, and allergy injections – limited to five visits combined per Year.
- Diagnostic X-rays – limited to five visits per Year. This benefit does not include special diagnostic procedures such as CT, MRI, or PET scans.
- Prescription drug fills – limited to five fills per Year.

You pay the Deductible, Copayment, or Coinsurance 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.

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

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

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

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

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

**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.

**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.
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 Alternative Care referred Services, which may include acupuncture and naturopathic medicine Services.
- Payments for Services under the “Infertility Services” 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 Deductible, Copayment, or Coinsurance 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, symptom, 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 http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC.
- Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
- Preventive care and screenings for women supported by HRSA. You can access the list of women’s preventive care Services at http://www.hrsa.gov/womensguidelines/.

Services received for a current or ongoing illness, injury, sign, symptom, or condition during a preventive care examination or procedure may be subject to the applicable Deductible, Copayment, or Coinsurance.

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 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.
- Fasting glucose test.
- Healthy diet counseling and counseling for obesity and weight management.
- Immunizations.
- Mammography.
- Routine preventive physical exam (adult, well-child, and well-baby).
- 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 Deductible, Copayment, or Coinsurance 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 “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 eye exams are covered until the end of the month in which the Member turns 19 years of age.
- 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.”
- “Mental Health Services.”
- “Naturopathic Medicine.”
- “Outpatient Durable Medical Equipment (DME).”
• “Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures.”
• “Outpatient Prescription Drugs and Supplies.”
• “Pediatric Vision Services.”
• “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 “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, subject to the benefit limitations described under the “Rehabilitative Therapy Services” section of the “Benefit Summary.”

- 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:

- “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:

- Acupuncture.
- Electro-acupuncture.

**Self-referred Acupuncture Services**

We cover a limited number of visits for self-referred acupuncture 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 [http://www.chpgroup.com](http://www.chpgroup.com).
The “Benefit Summary” shows a visit maximum for covered self-referred visits for acupuncture 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 for self-referred acupuncture Services, you must get prior authorization from The CHP Group at least 72 hours in advance in order to receive coverage for additional visits during that Year. To request prior authorization, call The CHP Group at 1-800-449-9479, 8 a.m. to 5 p.m., Monday through Friday. Additional visits will be covered only if determined by The CHP Group to be Medically Necessary in accordance with Utilization Review standards adopted by The CHP Group and approved by Company.

Physician-referred Acupuncture Services
We cover physician-referred 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 prior 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 http://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.
- 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/creatinine 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.
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 by referral). Emergency detoxification for medical conditions associated with acute alcohol, drug, or other substance abuse is covered without prior authorization.

We cover acupuncture treatment for Chemical Dependency. Acupuncture visit limits do not apply to acupuncture treatment for Chemical Dependency.

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. Coverage includes drugs that medical personnel administer to you in an acute care general hospital facility that is a Participating Facility. A Participating Provider must prescribe the drugs as part of your plan of care in the inpatient hospital facility.

Residential Services
We cover residential Services in a residential program. Coverage includes drugs that medical personnel administer to you in a residential facility that is a Participating Facility. A Participating Provider must prescribe the drugs as part of your plan of care in a 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 Deductible, Copayment, or Coinsurance 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 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.

Unless otherwise indicated below, covered External Prosthetic Devices and Orthotic Devices include:

• 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.

**DME Formulary**

Our DME formulary includes the list of External Prosthetic Devices and Orthotic Devices that have been approved by our DME Advisory Committee for our Members. The DME formulary was developed and is maintained by a multidisciplinary clinical and operational workgroup with review and input from Medical Group physicians and medical professionals with DME expertise (for example, physical, respiratory, and enterostomal therapists and home health practitioners) with Medicare criteria used as a basis for this
formulary. Our DME formulary is periodically updated to keep pace with changes in medical technology and clinical practice. To find out whether a particular item is included in our DME formulary, please call Member Services.

Our formulary guidelines allow you to obtain non-formulary items (those not listed on our DME formulary for your condition) if Medical Group’s designated DME review physician determines that it is Medically Necessary and that there is no formulary 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 Deductible, Copayment, or Coinsurance shown in the “Benefit Summary.” The “Benefit Summary” also shows a visit or day maximum for habilitative Services. That visit or day maximum will be exhausted (used up) for a Year when the number of visits or days that we covered during the Year under this EOC, plus any visits or 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 visit or day maximum. After you reach the visit or day maximum, we will not cover any more visits or days for the remainder of the Year. Visit or day 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 Copayment or Coinsurance shown in the “Benefit Summary.” If you receive health education Services during a specialty care visit, you pay the specialty care Copayment or Coinsurance 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, homemaking 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 Deductible, Copayment, or Coinsurance 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.

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 eight, or are physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office.

You pay the Deductible, Copayment, or Coinsurance 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.

**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 Deductible, Copayments, and Coinsurance. In order for coverage to continue beyond this 21-day period, you must follow the rules for adding Dependents as described under “Adding New Dependents to an Existing Account” in the “When You Can Enroll and When Coverage Begins” 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, 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. Prior authorization is not required for Members who are involuntarily committed and subsequently treated in a state hospital. Coverage includes drugs that medical personnel administer to you in an acute care general hospital facility that is a Participating Facility. A Participating Provider must prescribe the drugs as part of your plan of care in the inpatient hospital facility.

**Residential Services**

We cover residential Services in a residential facility. Coverage includes drugs that medical personnel administer to you in a residential facility that is a Participating Facility. A Participating Provider must prescribe the drugs as part of your plan of care in a 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.

**Self-referred Naturopathic Medicine**

We cover a limited number of visits for self-referred naturopathic medicine 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 http://www.chpgroup.com.

The “Benefit Summary” shows a visit maximum for covered self-referred visits for naturopathic medicine 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.

**Physician-referred Naturopathic Medicine**

We cover physician-referred naturopathic medicine 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 http://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.
- 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) according to the DME formulary guidelines. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. DME must be for use in your primary residence (or another location used as your primary residence). Coverage is limited to the standard supply or equipment that adequately meets your medical needs. 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 when necessary.

Our DME formulary guidelines allow certain DME (such as crutches and canes) for use in your home to be picked up from Participating Providers. To find out whether we will cover a particular DME item, call Member Services.

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

Covered DME includes the following:
- Bilirubin lights.
- CADD (continuous ambulatory drug delivery) pumps.
- Diabetic equipment and supplies including external insulin pumps, infusion devices, glucose monitors, lancets, and injection aids.
- Enteral pumps and supplies.
- Osteogenic bone stimulators.
- Osteogenic spine stimulators.
- Oxygen and oxygen supplies.
- Ventilators.
- Wheelchairs.

**DME Formulary**

Our DME formulary includes the list of Durable Medical Equipment that has been approved by our DME Advisory Committee for our Members. The DME formulary was developed and is maintained by a multidisciplinary clinical and operational workgroup with review and input from Medical Group physicians and medical professionals with DME expertise (for example, physical, respiratory, and enterostomal therapists and home health practitioners) with Medicare criteria used as a basis for this formulary. Our DME formulary
Our formulary guidelines allow you to obtain non-formulary DME items (those not listed on our DME formulary for your condition) if Medical Group’s designated DME review physician determines that it is Medically Necessary and that there is no formulary 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 (except diabetes blood glucose monitors and their supplies).
- 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 under 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 Copayment or Coinsurance, 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.

**Outpatient Prescription Drugs and Supplies**

We cover outpatient prescription drugs and supplies as described in this “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 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, or contact Member Services.

Items covered under this “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 and teaching doses, subject to the limitation under “Outpatient Prescription Drug Limitations.”

- Drugs for the treatment of Hepatitis C.
- 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 Copayment or Coinsurance 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.
- 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.
- Post-surgical immunosuppressive drugs after covered transplant Services.
- Prescription medications purchased in a foreign country when associated with an Emergency Medical Condition.

**Copayments and Coinsurance 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 Copayment or Coinsurance as shown in the “Benefit Summary.” This applies for each prescription consisting of up to the day supply shown in the “Benefit Summary.”

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

If Charges for the drug or supply are less than your Copayment or Coinsurance, 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 Copayment or Coinsurance 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.
**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 Drugs and Supplies” section 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.** The first approved version of a drug or supply that Company’s Regional Formulary and Therapeutics Committee has approved. Marketed and sold under a proprietary, trademark-protected name by the pharmaceutical company that holds the original patent.

- **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. 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 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 “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.

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 Copayment or Coinsurance amount 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.

**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.

If the exception request is approved through this exception process, then we will cover the drug or supply at the applicable Deductible, Copayment, or Coinsurance shown in the “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.

An emergency fill must be received at a Participating Pharmacy and is subject to the applicable Deductible, Copayment, or Coinsurance shown in the “Benefit Summary.” An emergency fill is limited to no more than a seven-day supply or the minimum packaging size available.

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.

**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.

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 Deductible, Copayment, or Coinsurance 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.

**Medication Management Program**
We have a Medication Management Program. The program’s primary focus is on reducing cardiovascular risk, especially by controlling lipid levels and high blood pressure. Participating Providers, including pharmacists, nurse care managers and other staff work with Members to educate, and monitor and adjust medication doses. There is no extra Copayment or Coinsurance for the Medication Management Program.

**Outpatient Prescription Drug 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.
- Teaching doses of self-administrable injectable drugs, fluids, additives, and nutrients are limited to three doses per medication per lifetime.
- The Participating Pharmacy may reduce the day supply dispensed at the Copayment or Coinsurance 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 Drugs and Supplies 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 “Prior Authorization and Step Therapy Prescribing Criteria” section.
- Drugs for treatment of infertility.
- Drugs prescribed for an indication if the U.S. Food and Drug Administration (FDA) has determined that use of the drug for that indication is contraindicated.
- Drugs and supplies from the Mail-Order Pharmacy to addresses outside of Oregon or Washington.
- 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 non-prescription drugs or supplies that our drug formulary lists for your condition.
- Drugs that the FDA has not approved.
- 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 mail-order.
- Replacement of drugs and supplies due to loss, damage, or carelessness.

**Pediatric Vision Services**

We cover pediatric vision Services at Participating Facility optical centers, when prescribed by a Participating Provider or a Non-Participating Provider, until the end of the month in which the Member turns 19 years of age. The “Benefit Summary” describes your benefits and lists any Deductible, Copayment, or Coinsurance amounts, as well as any visit and/or additional limitations, under “Pediatric Vision Services.” After you reach the visit and/or device limitation, we will not cover any more Services for the remainder of the Year, or other identified benefit period.

**Examinations**

We cover routine vision screenings and a comprehensive eye examination with refraction, including dilation when determined to be Medically Necessary, as shown under “Pediatric Vision Services” in the “Benefit Summary.”

**Eyeglass Lenses/Frames or Contact Lenses**

We cover eyeglass lenses (single vision, bifocal, trifocal, or lenticular, including polycarbonate lenses and scratch resistant coating) determined by your Participating Provider and a frame, or contact lenses in lieu of eyeglasses, as shown under “Pediatric Vision Services” in the “Benefit Summary.” The date we cover any of these items is the date on which you order the item.

**Medically Necessary Contact Lenses**

Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of the following conditions:
- Keratoconus.
- Pathological myopia.
- Aphakia.
- Anisometropia.
- Aniseikonia.
- Aniridia.
- Corneal disorders.
Post-traumatic disorders.

Irregular astigmatism.

The evaluation, fitting, and follow-up is covered for Medically Necessary contact lenses. Medically Necessary contact lenses are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

**Low Vision Aids**

We cover low vision evaluations and follow-up care visits, as well as low vision aids and devices (high-power spectacles, magnifiers, and telescopes) as shown under “Pediatric Vision Services” in the “Benefit Summary.” These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

**Pediatric Vision Services Exclusions**

- Non-prescription products (other than eyeglass frames), such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans; and lens add-on features such as lens coatings (other than scratch resistant coating or ultraviolet protection coating). Some non-prescription products and add-on features may be purchased at Participating Facility optical centers.
- Non-prescription sunglasses.
- No-line or progressive bifocal and trifocal lenses.
- Optometric vision therapy and orthoptics (eye exercises).
- Plano contact lenses or glasses (non-prescription).
- Replacement of lost, broken, or damaged lenses or frames.
- Two pairs of glasses in lieu of bifocals.

**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 prior 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 outpatient rehabilitative therapy Services. 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. Visit maximums do not apply 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.
Inpatient rehabilitative therapy Services provided in a Participating Skilled Nursing Facility will not reduce the covered days of Service under this “Inpatient Rehabilitative Therapy Services” section.

The “Benefit Summary” shows a combined day maximum for inpatient Services. That combined day maximum will be exhausted (used up) for the 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 combined day maximum. After you reach the combined day maximum, we will not cover any more days for the remainder of the Year. Day maximums do not apply to inpatient rehabilitative therapy Services to treat mental health conditions covered under this EOC.

**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.
  - The study or investigation is a drug trial that is exempt from having an investigational new drug application.
  - The study or investigation is approved or funded by at least one of the following:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system
of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:

- It is comparable to the National Institutes of Health system of peer review of studies and investigations.
- It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

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

**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. 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.
- Drugs prescribed by a Participating Physician as part of your plan of care in the Participating Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Participating Skilled Nursing Facility by medical personnel.
- 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 a limited number of 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 http://www.chpgroup.com.

The “Benefit Summary” shows a visit maximum for covered self-referred visits for Spinal and Extremity Manipulation therapy. 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 for self-referred Spinal and Extremity Manipulation therapy Services, you must get prior authorization from The CHP Group at least 72 hours in advance in order to receive coverage for additional visits during that Year. To request prior authorization, call The CHP Group at 1-800-449-9479, 8 a.m. to 5 p.m., Monday through Friday. Additional visits will be covered only if determined by The CHP Group to be Medically Necessary in accordance with Utilization Review standards adopted by The CHP Group and approved by Company.

A professional services coordinator at The CHP Group will review your proposed course of treatment to verify that it is medically appropriate, and will either:

- Give prior authorization for treatment, and send a confirmation of prior authorization, or
- Contact your Participating Provider to discuss alternative forms of treatment. The CHP Group will send you and your Participating Provider a letter if The CHP Group does not agree with the proposed course of treatment.

Following a prior authorization by The CHP Group, your treatment may begin. If your course of treatment is longer than approved by The CHP Group, The CHP Group will consult with you and your Participating Provider about a possible extension of your course of treatment.

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 a prior 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.

If you disagree with the prior-authorization review decision made by The CHP Group, you may appeal the decision, by following the course of appeals and grievances as outlined in the “Grievances, Claims, Appeals, and External Review” section.

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 prior 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 http://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 Deductible, Copayment, or Coinsurance 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.

**Transplant Services Limitations**

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.

**Hypnotherapy.** All Services related to hypnotherapy.

**Low-Vision Aids.** This exclusion does not apply to Services that are covered under “Pediatric Vision Services” in the “Benefits” section.

**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.** This exclusion does not apply to Services that are covered under “Pediatric Vision Services” in the “Benefits” section.

**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, 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).

**Vision Hardware and Optical Services.** Corrective lenses, eyeglasses, and contact lenses are excluded. This exclusion does not apply to Services that are covered under “Pediatric Vision Services” in the “Benefits” section.

**Weight Control or Obesity Services.** Bariatric surgery, gastric stapling, gastric bypass, gastric bands, switch duodenal, biliopancreatic diversion, weight loss programs, and any other Service for obesity or weight control, even if one of the purposes of the Service is to treat other medical conditions related to, caused by, or complicated by obesity. This exclusion does not apply to Services that are covered under “Preventive Care Services” in the “Benefits” section.

**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 determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

When This Plan is primary, 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 confined in a facility on your membership effective date as part of an inpatient stay that began prior to your effective date, no benefits are available under this EOC prior to discharge from the facility or from any other facility to which you are transferred. This provision does not apply to a child whose effective date is the date of birth or placement for adoption or a person who is a HIPAA-eligible Individual.

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

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

- Caused by a third party’s act or omission.
- Received on the premises of a third party.
- Covered by a no-fault insurance provision.

If you obtain a settlement or judgment from or on behalf of a third party or a payment under a no-fault insurance provision, you must 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 Third Parties or Covered by No-fault Insurance” section does not affect your obligation to make any applicable Deductible, Copayment, or Coinsurance payments for these covered Services.

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

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

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

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

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

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

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

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

**Surrogacy Arrangements**

If you enter into a Surrogacy Arrangement, you must 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. Note: This “Surrogacy Arrangements” section does not affect your obligation to pay your Deductible, Copayment, Coinsurance, or other amounts you are required to pay for these Services. After you surrender a baby to the legal parents, you are not obligated to pay Charges for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

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

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

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

You must send this information to:

Surrogacy Third Party Liability Supervisor
Equian
P.O. Box 36380
Louisville, KY 40233-6380
Fax: 1-502-214-1137
Phone: 1-800-552-8314

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

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

**Workers’ Compensation or Employer’s Liability**

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

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

**GRIEVANCES, CLAIMS, APPEALS, AND EXTERNAL REVIEW**

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

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

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

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

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

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

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

**Language and Translation Assistance**

If we send you an adverse benefit determination, 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
http://www.insurance.wa.gov

Reviewing Information Regarding Your Claim

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

Providing Additional Information Regarding Your Claim

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

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

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.

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission).

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

Pre-service Claim

- Tell us by mail, fax or orally that you want to make a claim for us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must mail, fax, or call your claim to us at:
  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Phone: 1-800-813-2000
  Fax: 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 we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you 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.

- 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 we tell you we need more information, 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 by mail, fax 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, fax, or call us at:

  **Kaiser Foundation Health Plan of the Northwest**
  **Member Relations Department**
  **500 NE Multnomah St., Suite 100**
  **Portland, OR 97232-2099**
  **Phone: 503-813-4480**
  **Fax: 1-855-347-7239**

- We will acknowledge your appeal within seventy-two hours after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
• We will review your appeal and send you a written decision within 14 days after we receive your appeal, unless you are notified that additional time is needed to complete the review. The extension will not delay the decision beyond 30 days without your consent.

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

**Urgent Pre-service Appeal**

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

  1. Your name and health record number;
  2. Your medical condition or relevant symptoms;
  3. The specific Service that you are requesting;
  4. All of the reasons why you disagree with our adverse benefit determination; and
  5. All supporting documents.

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

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Phone: 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 received 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 concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

**Concurrent Care Claim**

- Tell us that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either call, mail, or fax your claim to us at:
  
  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Phone: 503-813-4480
  Fax: 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 we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 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.
- 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 received 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 by mail, fax or orally that you want to appeal our adverse benefit determination. Please include the following:
  1. Your name and health record number;
  2. Your medical condition or relevant symptoms;
  3. The ongoing course of covered treatment that you want to continue or extend;
  4. All of the reasons why you disagree with our adverse benefit determination; and
  5. All supporting documents.

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

Kaiser Foundation Health Plan of the Northwest  
Member Relations Department  
500 NE Multnomah St., Suite 100  
Portland, OR 97232-2099  
Phone: 503-813-4480  
Fax: 1-855-347-7239

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

### Urgent Concurrent Care Appeal

- Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following:
  1. Your name and health record number;
  2. Your medical condition or relevant symptoms;
(3) The ongoing course of covered treatment that you want to continue or extend;
(4) All of the reasons why you disagree with our adverse benefit determination; and
(5) All supporting documents.

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

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

- We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim.

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

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

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

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

If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

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

**Post-service Appeal**

- Within 180 days after you receive our adverse benefit determination, tell us by mail, fax, or orally that you want to appeal our denial of your post-service claim. Please include the following:
  
  (1) Your name and health record number;
  (2) Your medical condition or relevant symptoms;
  (3) The specific Services that you want us to pay for;
  (4) All of the reasons why you disagree with our adverse benefit determination; and
  (5) All supporting documents.

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

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Phone: 503-813-4480
Fax: 1-855-347-7239

- We will acknowledge your appeal 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.

**Appeals of Retroactive Membership Termination (Rescission)**

We may terminate your membership retroactively (see “Rescission of Membership” in the “Termination of Membership” section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call Member Relations at 1-800-813-2000.

Here is the procedure for filing an appeal of a retroactive membership termination:

**Appeal of Retroactive Membership Termination**

• Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us, in writing, that you want to appeal our termination of your membership retroactively. Please include the following:
  
  (1) Your name and health record number;
  
  (2) All of the reasons why you disagree with our retroactive membership termination; and
  
  (3) All supporting documents.

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

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Phone: 1-800-813-2000
Fax: 1-855-347-7239

• We will fully and fairly review all available information relevant to your request 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 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.

**External Review**

If you are dissatisfied with our final adverse benefit determination, you may have a right to request an external review. An external review is a request for an independent review organization (IRO) to determine whether our internal appeal decision is correct. For example, you have the right to request external review of an adverse benefit determination that is based on medical necessity, appropriateness, health care setting, level of care, or that the requested Service is not efficacious or otherwise unjustified under evidence-based medical criteria.
Within 180 days after the date of our appeal denial letter, you must mail, fax, or call your request for external review to Member Relations at:

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

**Grievance Procedure**

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

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

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

- Contact the administrative office in the Participating Facility where you are having the problem.
- 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

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:
TERMINATION OF MEMBERSHIP

Membership continues from month to month subject to payment of applicable Premium.

If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. When a Subscriber's membership terminates, the memberships of any Dependents end at the same time.

You will be billed as a non-Member for any Services you receive after your membership termination date. Company, Participating Providers, and Participating Facilities have no further liability or responsibility under this EOC after your membership termination date, except as provided under “Payments after Termination” in this “Termination of Membership” section.

If your membership is terminated, you have the right to file an appeal. For more information, please contact Member Services.

How You May Terminate Your Membership

[You may terminate your membership by notifying Washington Healthplanfinder at wahealthplanfinder.org. Your requested termination date may be as early as the date you submit your notice. Your membership will terminate at 11:59 p.m. on the date determined by Washington Healthplanfinder.]

[You may terminate your membership by sending written notice, signed by the Subscriber, to the address below. Your membership will terminate at 11:59 p.m. on the day we receive your written notice, or the requested termination date indicated in the notice, whichever is later. If you do not provide a requested termination date, your membership will terminate at 11:59 p.m. on the date through which we have received Premium payment.

Kaiser Foundation Health Plan of the Northwest
Membership Administration
P.O. Box 203007
Denver, CO 80220-9007]

Termination Due to Loss of Eligibility

You must immediately report to [Washington Healthplanfinder][us] any changes that affect eligibility status, such as moving out of our Service Area, a Spouse’s loss of eligibility due to divorce, or a Dependent child who has reached the Dependent Limiting Age.

If you are a Dependent child your membership will end at 11:59 p.m. on December 31 of the Year in which you reach the Dependent Limiting Age.

For all other changes that affect eligibility status, your membership will end at 11:59 p.m. on the last day of the month in which you no longer meet the eligibility requirements under “Who Is Eligible” in the “Premium, Eligibility, and Enrollment” section. For example, if you first became ineligible on January 5, your termination date would be January 31, and your last minute of coverage would be 11:59 p.m. on January 31.

If your membership ends because you are no longer eligible to be a Dependent, but you continue to meet all other eligibility requirements, you will be able to enroll as a Subscriber under the identical Kaiser Permanente Individuals and Families Plan if you request enrollment within 30 days after your membership termination date. However, you are not eligible if we terminate your membership under “Termination for Cause” in this
“Termination of Membership” section. If we approve your application and you pay the required Premium, your membership as a Subscriber will begin when your membership under this EOC ends. Your Premium may differ from that under this EOC. For information about becoming a Subscriber, call Member Services.

**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.

**Termination for Nonpayment of Premium**

If we do not receive the applicable Premium on or before the Premium Due Date, we will mail a notice of nonpayment to the Subscriber about the failure to make a timely Premium payment in full and the grace period required by applicable law. The grace period is the time frame in which the overdue Premium must be paid to avoid termination, as required by applicable law.

This notice will contain information about the date on which coverage will terminate if all Premium payments owed by the end of the grace period are not paid. During the grace period, coverage will continue in force if, and for the period, required by applicable law. We will mail the notice not less than 10 days before the end of the grace period.

If we do not receive full payment of all outstanding Premiums (including any Premiums for the grace period) on or before the last day of the grace period, we may terminate your membership retroactively. We will mail a notice to the Subscriber confirming the date on which the memberships of the Subscriber and any Dependents terminated. Membership ends at 11:59 p.m. on the date indicated in the notice.

You will be responsible for paying Company or providers, as applicable, for any Services received after the termination of your coverage.

If your coverage is terminated for nonpayment of Premium, you will not be entitled to a special enrollment period and we may require payment of any outstanding Premiums, as permitted by applicable law.

**Payments after Termination**

If we terminate your membership for cause or nonpayment of Premium, we will:

- Refund any amounts we owe the Subscriber 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.
Rescission of Membership
We may rescind your membership after it becomes effective (completely cancel your membership so that no membership ever existed) if we determine you or anyone seeking membership on your behalf did any of the following before your membership became effective:

- Performed an act, practice, or omission that constitutes fraud in connection with your enrollment or enrollment application.
- Made an intentional misrepresentation of material fact in connection with your enrollment or enrollment application, such as intentionally omitting a material fact.
- Intentionally failed to inform us of changes to the information in your enrollment application.

We will send written notice to the Subscriber at least 30 days before we rescind your membership, but the rescission will completely cancel your membership so that no membership ever existed. We will explain the basis for our decision and how you can appeal this decision. You will be required to pay as a non-Member for any Services we covered. Within 30 days, we will refund all applicable Premium except that we may subtract any amounts you owe us. You will be ineligible to re-apply for membership until the next open enrollment period.

Termination of Certain Types of Health Benefit Plans by Us
We may terminate your membership if we discontinue offering this Plan as permitted by law. If we continue to offer other non-group Plans in a market, we may terminate your membership under this Plan by sending written notice to you at least 90 days before the termination date. You will be able to enroll in any other product we offer in the non-group market if you meet all eligibility requirements.

Moving to Another Kaiser Foundation Health Plan Service Area
If you move to another Kaiser Foundation Health Plan service area, or if you move to an area outside any Kaiser Foundation Health Plan service area, your membership will be terminated. You may be able to transfer your membership to the other Kaiser Foundation Health Plan service area; however, eligibility requirements, benefits, premium, deductible, 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.

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.
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.

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.

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 only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative’s) written authorization, except as described in our Notice of Privacy Practices. Giving us this authorization is at your discretion.

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

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 Participating 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. Ste 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


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).

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

**Chinese** (中文) 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)。

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

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

**German** (Deutsch) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.

**Japanese** (日本語) 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。

**Khmer** (ឡាន) ប្រយោជន៍: ប្រឈមសំរាប់ការស្វែងរកនូវសេវាជំនួយថ្លាន់ ដែលមានប្រយោជន៍សម្រាប់អ្នក។ ចំពោះប្រឈមជំនួយ 1-800-813-2000 (TTY: 711)


**Laotian** (ປາສາດ) ບໍລິສານ: ວາວາ ບໍລິສານເພງພາສາ ວາວາ, ການບັນດັງການຊັດຊາດໃຫ້ຄົນ, ນິບຍົງລາວ, ບ້ານງານເຄີຍດ້ວຍຊາດ. ທ້າຍ 1-800-813-2000 (TTY: 711).


ਪੰ ਜ ਾ ਬ ੀ (Punjabi) ਪਿਛਾ ਤਹਿਨੀ ਨੇ ਦੋ ਤੌ ਂ ਪੰਜਾਬੀ ਭਾਸ਼ਾ ਵਿਚ ਕੇਂਦਰ ਪ੍ਰਦੇਸ਼ ਵਿੱਚ ਹਨੀ ਮੁਦੁਲੁ ਪ੍ਰਬੰਧ ਹੈ। 1-800-813-2000 (TTY: 711) ਨੇ ਬਾਜ਼ ਵਾਲੇ।

Română (Romanian) ATENŢIE: 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).


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).