GROUP AGREEMENT

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Calpers

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Large Group
Traditional Plan
Evidence of Coverage

Group Name: Calpers

Group Number: 4670-001-004

This *Evidence of Coverage* is effective 1/1/2022 through 12/31/2022

Printed: Monday, January 3, 2022

Member Services

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

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

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TRADITIONAL PLAN BENEFIT SUMMARY

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

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

Out-of-Pocket Maximum	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$1,500
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$1,500
Family Out-of-Pocket Maximum per Year (for an entire Family)	$3,000
(Note: All Copayments and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise indicated in this *EOC*.)	
Preventive Care Services	**You Pay**
Routine preventive physical exam (includes adult, well baby, and well child)	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	**You Pay**
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)	$15
Specialty care visit (includes routine hearing exams, health education Services and diabetic outpatient self-management training and education, including medical nutrition therapy)	$15
TMJ therapy visit	$15
Routine eye exam (covered until the end of the month in which Member turns 19 years of age)	$15
Routine eye exam (for Members 19 years and older)	$15
Nurse treatment room visits to receive injections	$15
Administered medications, including injections (all outpatient settings)	$0
Urgent Care visit	$15
Emergency department visit	$75 (Waived if admitted)
Outpatient surgery visit	$15
Vasectomy	$0
Interrupted pregnancy surgery	$0
Chemotherapy/radiation therapy visit	$15
Respiratory therapy visit	$15

Cardiac rehabilitative therapy visit	$15
Inpatient Hospital Services	**You Pay**
Room and board, surgery, anesthesia, X-ray, imaging, laboratory, and drugs	$0
Vasectomy	$0
Interrupted pregnancy surgery	$0
Ambulance Services	**You Pay**
Per transport	$0
Bariatric Surgery Services	**You Pay**
Inpatient hospital Services	$0
Chemical Dependency Services	**You Pay**
Outpatient Services	$10 per visit
Inpatient hospital Services	$0
Residential Services	$0
Day treatment Services	$10 per day
Dialysis Services	**You Pay**
Outpatient dialysis visit	$15
Home dialysis	$0
External Prosthetic Devices and Orthotic Devices	**You Pay**
External Prosthetic Devices	20% Coinsurance
Orthotic Devices	20% Coinsurance
Habilitative Services (Visit maximums do not apply to habilitative Services for treatment of mental health conditions.)	**You Pay**
Outpatient physical, speech, and occupational therapies	$15
Inpatient Services	$0
Hearing Aid Services for Dependents	**You Pay**
Hearing exams, testing, and visits for hearing loss Services	$15
Hearing aids and hearing assistive technologies (for Members who are under the Dependent Limiting Age), limited to once per hearing impaired ear every 36 months.	20% Coinsurance
Home Health Services	**You Pay**
Home health (up to 130 visits per Year)	$0
Hospice Services	**You Pay**
Hospice Services (Respite care is limited to no more than five consecutive days in a 30-day period.)	$0
Infertility Diagnosis Services	**You Pay**
Office visit	50% Coinsurance
Diagnostic imaging and laboratory tests	50% Coinsurance
Limited Outpatient Prescription Drugs and Supplies	**You Pay**
Certain preventive medications (including, but not limited to, aspirin, fluoride, and liquid iron for infants)	$0
Certain self-administered IV drugs, fluids, additives, and nutrients including the supplies and equipment required for their administration	$0
Blood glucose test strips	Refer to your Outpatient Prescription Drug Rider

Contraceptive drugs or devices	$0
Insulin	Subject to the applicable drug tier Copayment or Coinsurance shown in your Outpatient Prescription Drug Rider, up to $75 for each 30-day supply
Post-surgical immunosuppressive drugs after covered transplant Services	Refer to your Outpatient Prescription Drug Rider
Self-administered chemotherapy medications used for the treatment of cancer	Refer to your Outpatient Prescription Drug Rider
Tobacco use cessation drugs	$0
Maternity and Newborn Care	**You Pay**
Scheduled prenatal care visits and postpartum visits	$0
Maternal diabetes management (Medically Necessary Services beginning with conception and ending through six weeks postpartum)	$0
Inpatient hospital Services	$0
Newborn nurse home visiting Services	$0
Medical Foods and Formula	**You Pay**
Medical foods and formula	20% Coinsurance
Mental Health Services	**You Pay**
Outpatient Services	$10 per visit
Intensive outpatient Services	$10 per day after Deductible
Partial hospitalization	$10 per day after Deductible
Assertive Community Treatment (ACT) Services	$0
Inpatient hospital Services	$0
Residential Services	$0
Naturopathic Medicine	**You Pay**
Evaluation and treatment	$15
Out-of-Area Coverage for Dependents	**You Pay**
Limited office visits, laboratory, diagnostic X-rays, and prescription drug fills as described in the *EOC* under "Out-of-Area Coverage for Dependents" in the "How to Obtain Services" section.	20% of the actual fee the provider, facility, or vendor charged for the Service
Outpatient Durable Medical Equipment (DME)	**You Pay**
Outpatient Durable Medical Equipment (DME)	$0
Enteral pump, and supplies; CADD (continuous ambulatory drug delivery) pumps; osteogenic bone stimulators; osteogenic spine stimulators; and ventilators	$0
Home ultraviolet light therapy equipment	$0
Peak flow meters, blood glucose monitors, and lancets	$0
Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures	**You Pay**
Laboratory	$0 per department visit
Genetic testing	$0 per department visit
X-ray, imaging, and special diagnostic procedures	$0 per department visit
CT, MRI, PET scans	$50 per department visit

Reconstructive Surgery Services	**You Pay**
Inpatient hospital Services	$0
Outpatient surgery visit	$15
Rehabilitative Therapy Services (Visit maximums do not apply to rehabilitative therapy Services for treatment of mental health conditions.)	**You Pay**
Outpatient physical, speech, and occupational therapies	$15
Inpatient Services	$0
Skilled Nursing Facility Services	**You Pay**
Inpatient skilled nursing Services (up to 100 days per Year)	$0
Telemedicine Services	**You Pay**
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INTRODUCTION

This *Evidence of Coverage* (*EOC*), including the "Benefit Summary" and any benefit riders attached to this *EOC*, describes the health care benefits of this Large Group Traditional Plan provided under the *Group Agreement* (*Agreement)* between Kaiser Foundation Health Plan of the Northwest and your Group. 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.

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.

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

Term of this *EOC*

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

About Kaiser Permanente

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

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

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

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

For more information, see the "How to Obtain Services" section or contact Member Services. If you would like additional information about your benefits, other products or Services, please call Member Services or you may also 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.

Behavioral Health Assessment. Behavioral Health Assessment means an evaluation in person or using telemedicine, to determine a patient's need for immediate crisis stabilization, by a provider as listed in the "Mental Health Services" section.

Behavioral Health Crisis. Behavioral Health Crisis means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.

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 Copayment or Coinsurance from its payment, the amount Company would have paid if it did not subtract the Copayment or Coinsurance).

Chemical Dependency. An addictive relationship with any drug or alcohol agent characterized by either a psychological or physical relationship, or both, that interferes with your social, psychological, or physical adjustment to common problems on a reoccurring basis.

Coinsurance. The percentage of Charges that you must pay when you receive a covered Service.

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

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

Cost Share. The Copayment or Coinsurance you must pay for covered Services.

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 (the student Dependent Limiting Age is for students, and the general Dependent Limiting Age is for non-students).

Durable Medical Equipment (DME). A 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. An Emergency Medical Condition means 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.
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.
- That is a Behavioral Health Crisis.

Emergency Medical Service Provider. A person who has received formal training in prehospital and emergency care, and is licensed to attend any person who is ill or injured or who has a disability. Police officers, firefighters, funeral home employees and other persons serving in a dual capacity, one of which meets this definition, are considered Emergency Medical Services Providers.

Emergency Medical Services Transport. An Emergency Medical Service Provider's evaluation and stabilization of an individual experiencing an Emergency Medical Condition and the transportation of the individual to the nearest medical facility capable of meeting the needs of the individual.

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

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

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

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

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 their Dependents.

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

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

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

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

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

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

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

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

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

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

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 Provider. A physician or other health care provider, facility, business, or vendor regulated under state law to provide health or health-related services or otherwise providing health care services within the scope of licensure or certification consistent with state law that does not have a written agreement with Kaiser Permanente to participate as a health care provider for this Plan.

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 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 contracts directly or indirectly with Medical Group. Participating Physicians are subject to change.

Participating Provider. Any person who is a Participating Physician; or a physician or other health care provider, facility, business, or vendor regulated under state law to provide health or health-related services or otherwise providing health care services within the scope of licensure or certification consistent with state law and which contracts directly or indirectly with Kaiser Permanente to provide Services to Members enrolled in this Plan. Participating Providers are subject to change.

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.

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

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

Premium. Monthly membership charges paid by Group.

Service Area. Our Service Area consists of certain geographic areas in the Northwest which we designate by ZIP code. Our Service Area may change. Contact Member Services for a complete listing of our Service Area ZIP codes.

Services. Health care services, supplies, or items.

Specialist. Any licensed Participating Provider 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.

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

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

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

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 clinical criteria and clinical guidance, screening procedures, decision rules, and medical protocols designed to ensure that each Member is receiving Services at the appropriate level. Utilization Review is used to monitor or evaluate:

- Medical necessity, appropriateness, effectiveness, or efficiency of a specific Service, procedure, or setting.
- Appropriateness of a Service for which prior authorization is requested or for which an exception to step therapy has been requested.
- Any other coverage that we indicate is subject to Utilization Review.

When Utilization Review is required to approve certain Services in advance, this is called prior authorization. Utilization Review to approve an ongoing course of treatment to be provided over a period of time or number of treatments is called concurrent review.

Year. A period of time that is either a) a calendar year beginning on January 1 of any year and ending at midnight December 31 of the same year, or b) a plan year beginning on an effective date and ending at midnight prior to the anniversary date agreed to by Company and Group. The "Benefit Summary" shows which period is applicable to this Plan.

PREMIUM, ELIGIBILITY, AND ENROLLMENT

Premium

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

Who Is Eligible

General

To be eligible to enroll and to remain enrolled under this employer's *Agreement*, you must meet all of the following requirements:

- You must meet your Group's eligibility requirements that we have approved. (Your Group is required to inform Subscribers of its eligibility requirements.)
- You must meet the Subscriber or Dependent eligibility requirements described below unless your Group has different eligibility requirements that we have approved.

Subscriber

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

- You are an employee of your Group; or
- You are otherwise entitled to coverage through your Group under a trust agreement, retirement benefit program, employment contract, or the rules of a professional, trade, or bona fide association.
- You live or physically work inside our Service Area at least 50 percent of the time. 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.

Dependents

If you are a Subscriber (or if you are a subscriber under our Kaiser Permanente Senior Advantage (HMO) plan offered by your Group), the following persons are eligible to enroll as your Dependents under this *EOC*. (Note: if you are a subscriber under a Kaiser Permanente Senior Advantage plan offered by your Group, all of your Dependents who are enrolled under this or any other non-Medicare evidence of coverage offered by your Group must be enrolled under the same non-Medicare evidence of coverage. A "non-Medicare" evidence of coverage is one that does not require members to be entitled to Medicare.)

- Your Spouse.
- A person who is under the general 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 person who is over the general Dependent Limiting Age but under the student Dependent Limiting Age shown in the "Benefit Summary," who is a full-time registered student at an accredited college or accredited vocational school, and 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.

  Students who suffer a severe illness or injury that causes them to lose full-time student status will continue to be considered full-time students for eligibility purposes, provided that within 31 days after the loss of full-time student status, we receive written certification from the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is Medically Necessary. Eligibility as a full-time student under this provision may then continue for up to 12 months from the date that your child's medical leave of absence began, or until your child reaches the student Dependent Limiting Age shown in the "Benefit Summary," whichever comes first.

- 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 a developmental disability, mental illness, or a physical disability that occurred prior to the person reaching the general 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 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."

  We may request proof of incapacity and dependency annually.

Children born to a Dependent other than your Spouse (for example, your grandchildren) are not eligible for coverage beyond the first 31 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; (b) they are primarily supported by you or your Spouse and you or your Spouse is their court-appointed guardian; or, (c) your Group has different eligibility requirements that we have approved.

Company will not deny enrollment of a newborn child, newly adopted child, or child for whom legal obligation is assumed in anticipation of adoption, or newly placed for adoption 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.

When You Can Enroll and When Coverage Begins

A Group is required to inform employees about when they are eligible to enroll and their effective date of coverage. The effective date of coverage for employees and their eligible Dependents is determined by the Group in accord with waiting period requirements in state and federal law. The Group is required to inform the Subscriber of the date membership becomes effective.

If an individual is eligible to be a Dependent under this *EOC* but the subscriber in their family is enrolled under our Kaiser Permanente Senior Advantage evidence of coverage offered by the Group, the subscriber must follow the rules for adding Dependents as described in this "When You Can Enroll and When Coverage Begins" section.

New Employees and Their Dependents

When a Group informs an employee that they are eligible to enroll as a Subscriber, they may enroll themselves and any eligible Dependents by submitting a Company-approved enrollment application to the Group within 30 days of eligibility for enrollment.

Open Enrollment

The Group will inform an employee of their open enrollment period and effective date of coverage. An eligible employee may enroll as a Subscriber along with any eligible Dependents if they or their Dependents were not previously enrolled. If you are an existing Subscriber, you may add eligible Dependents not previously enrolled following your Group's enrollment process during the open enrollment period.

Special Enrollment

If an eligible employee or their eligible Dependents do not enroll when they are first eligible, and later want to enroll, they can enroll only during open enrollment unless they experience a qualifying event as defined in

applicable state and federal law. Your Group will administer special enrollment rights under 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, or placement for adoption, or through a child support order or other court order.
- Loss of a Dependent through divorce or legal separation, or if the enrollee, or their 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.

The individual must notify the Group within 30 days of a qualifying event, 60 days if they are requesting enrollment due to a change in eligibility for Medicaid or Child Health Insurance Program (CHIP) coverage. The Group will determine if the individual is eligible to select or change coverage. Contact the Group for further instructions on how to enroll.

A Group may require an employee declining coverage to provide a written statement indicating whether the coverage is being declined due to other health coverage. If this statement is not provided, or if coverage is not declined due to other health coverage, the employee may not be eligible for special enrollment due to loss of other health coverage. Contact the Group for further information.

Adding New Dependents to an Existing Account

To enroll a Dependent who becomes eligible to enroll after you became a Subscriber, you must submit a Company-approved enrollment application to your Group as described in this "Adding New Dependents to an Existing Account" section.

Newborns, newly adopted children, or children newly placed for adoption are covered for 31 days after birth, adoption, or placement for adoption. In order for coverage to continue beyond this 31-day period, you must submit an enrollment application to your Group within 31 days after the date of birth, adoption, or placement for adoption if additional Premium is required to add the Dependent. If additional Premium is not required, the application requirement is waived; however, please notify your Group and Member Services, 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 to your Group within 30 days after the qualifying event.

Contact your Group for further instructions on how to enroll your newly eligible Dependent.

When Coverage Begins

Your Group will notify you of the date your coverage will begin. Membership begins at 12 a.m. PT of the effective date specified.

If an individual enrolls in, adds a Dependent, or changes health plan coverage during a special enrollment period, the membership effective date will be determined by your Group under applicable state and federal law.

HOW TO OBTAIN SERVICES

Important Information for Members Whose Benefit Plans are Subject to ERISA.

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulated employee benefits, including the claim and appeal procedures for benefit Plans offered by certain employers. If an employer's benefit Plan is subject to ERISA, each time you request Services that must be approved before the

Service is provided, you are filing a "pre-service claim" for benefits. You are filing a "post-service claim" when you ask us to pay for or cover Services that have already been received. You must follow our procedure for filing claims, and we must follow certain rules established by ERISA for responding to claims.

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 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 they receive. 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 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 their 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, naturopathic physician specializing in women's health, and advanced registered nurse practitioner, practicing within their applicable scope of practice.

Medically appropriate maternity care, 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 Provider. 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.

Healthy Resources

You have access to these value-added programs and resources at no cost, unless otherwise noted below. You can register online at **kp.org/register** or on the Kaiser Permanente mobile app. You'll need your health/medical record number, which you can find on your Kaiser Permanente ID card.

- **Sign up for healthy lifestyle programs.** With our online wellness programs, you'll get advice, encouragement, and tools to help you create positive changes in your life. Our programs can help you lose weight, eat healthier, quit smoking, reduce stress, manage ongoing conditions like diabetes or depression. Start with a Total Health Assessment, a simple online survey to give you a complete look at your health. You can also share and discuss the results with your doctor. Visit **kp.org/healthylifestyles**.
- **Get a wellness coach.** If you need a little extra support, we offer Wellness Coaching by Phone. You'll work one-on-one with your personal coach to make a plan to help you reach your health goals. Visit kp.org/**wellnesscoach**.
- **Join health classes.** You can sign up for health classes and support groups. Classes vary at each location and some may require a fee. Visit **kp.org/classes**.
- **Enjoy reduced rates.** Get reduced rates on a variety of health-related products and services through The ChooseHealthy® program. These include:
  - Active&Fit Direct – You pay $25 per month (plus a one-time $25 enrollment fee) for access to a national network of more than 10,000 fitness centers.
  - Up to 25% off a contracted provider's regular rates for acupuncture, chiropractic care, and massage therapy.*

  Visit **kp.org/choosehealthy**. *Please note that the ChooseHealthy program is not insurance. You should check your benefits before using this discount program, as those benefits may result in lower costs to you than using this discount program.

- **Self-care.** Manage stress, improve your mood, sleep better, and more with the help of wellness apps, available to adult members. Visit **kp.org/selfcareapps**.
- **Health guides.** Stay informed on popular health subjects or discover something new through our healthy living guides. Visit **kp.org/livehealthy**.

The programs and resources described above are not covered under your health plan benefits and are not subject to the terms set forth in this *EOC* or other plan documents. Programs and resources are provided by third-party entities and may be discontinued at any time. If you would like additional information about these programs and resources, call Member Services.

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. PT.

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. 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).
- Social Services.

Referrals to Non-Participating Providers and Non-Participating Facilities

If your Participating Provider decides that you require Services not available from Participating Providers or Participating Facilities, they will recommend to Medical Group and Company that you be referred to a Non-Participating Provider or Non-Participating Facility. If the Medical Group's assigned Participating Provider determines that the Services are Medically Necessary and are not available from a Participating Provider or Participating Facility and Company determines that the Services are covered Services, Company will authorize your referral to a Non-Participating Provider or Non-Participating Facility for the covered Services. You pay the same Cost Share for authorized referral Services that you would pay if you received the Services from a Participating Provider or at a Participating Facility. You will need written authorization in advance in order for the Services to be covered. If Company authorizes the Services, you will receive a written "Authorization for Outside Medical Care" approved referral to the Non-Participating Provider or Non-Participating Facility, and only the Services and number of visits that are listed on the written referral will be covered, subject to any benefit limitations and exclusions applicable to these Services.

Prior Authorization Review Requirements

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 notify you and the requesting Participating Provider of the decision within two business days of the request. The decision letter will explain the reason for the determination along with instructions for filing an appeal.

If more information is needed to make a decision, we will notify you and the requesting Participating Provider in writing, of the specific additional information needed to make the determination, before the initial decision period ends.

We will make a decision and send notification within two business days after we receive the first piece of information (including documents) we requested.

If we do not receive any of the requested information, we will make a decision based on the information we have, 15 days after the date of the request for additional information.

Approved requests for prior authorization of a treatment, other than a prescription drug, are binding on us for a period ending on the later of the following:

- The reasonable duration of the treatment based on clinical standards; or
- Sixty (60) days after the date that the treatment begins following our approval of the prior authorization request.

You may request a copy of the complete Utilization Review criteria used to make the determination. Please contact Member Relations at 503-813-4480.

If you disagree with the prior authorization review decision made by Company, you may appeal the decision, by following the course of grievances and appeals as outlined in the "Grievances, Claims, Appeals and External Review" section.

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

- Bariatric surgery Services.
- Breast reduction surgery.
- Dental and orthodontic Services for the treatment of craniofacial anomalies.
- Drug formulary exceptions.
- Durable Medical Equipment.
- External Prosthetic Devices and Orthotic Devices.
- Gender Affirming Treatment.
- General anesthesia and associated hospital or ambulatory surgical facility Services provided in conjunction with non-covered dental Services.
- Habilitative Services.
- Hospice and home health Services.
- Inpatient hospital Services.
- Inpatient and residential Chemical Dependency Services.
- Inpatient, residential, and Assertive Community Treatment (ACT) mental health Services.
- Non-emergency medical transportation.
- Open MRI.
- Plastic surgery.
- Referrals for any Non-Participating Facility Services or Non-Participating Provider Services.
- Referrals to Specialists who are not employees of Medical Group.
- Rehabilitative therapy Services.
- Routine foot Services.
- Skilled nursing facility Services.
- Transplant Services.
- Travel and lodging expenses.

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.

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.

You may also choose to submit a request for Services that you have not yet received, as described under "Pre-service Claims and Appeals" in the "Grievances, Claims, Appeals, and External Review" section.

Except in the case of misrepresentation, prior authorization determinations that relate to your membership eligibility are binding on us if obtained no more than five business days before you receive the Service. Prior authorization determinations that relate to whether the Service is Medically Necessary or are covered under the Plan are binding on us if obtained no more than 60 days before you receive the Service. We may revoke or amend an authorization for Services you have not yet received if your membership terminates or your coverage changes or you lose your eligibility.

Participating Providers and Participating Facilities Contracts

Participating Providers and Participating Facilities may be paid in various ways, including salary, per diem rates, case rates, fee-for-service, incentive payments, and capitation payments. Capitation payments are based on a total number of Members (on a per-Member per-month basis), regardless of the amount of Services provided. 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 because of 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 you satisfy all of the following requirements, you may qualify for this continuity of care:

- You are a Member on the date you receive the Services.
- You are undergoing an active course of treatment that is Medically Necessary and you and the Participating Provider agree that it is desirable to maintain continuity of care.
- We would have covered the Services if you had received them from a Participating Provider.

- The provider agrees to adhere to the conditions of the terminated contract between the provider and Company or its designee.

Except for the pregnancy situation described below, this extension will continue until the earlier of the following:

- The day following the completion of the active course of treatment giving rise to your exercising your continuity of care right; or
- The 120th day from the date we notify you about the contract termination.

If you are in the second trimester of pregnancy this extension will continue until the later of the following dates:

- The 45th day after the birth; or
- As long as you continue under an active course of treatment, but no later than the 120th day from the date we notify you about the contract termination.

Receiving Care in Another Kaiser Foundation Health Plan Service Area

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

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

Out-of-Area Coverage for Dependents

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

We cover certain Medically Necessary Services that a Dependent child receives from Non-Participating Providers inside the United States (which for the purpose of this benefit means the 50 states, the District of Columbia, and United States territories). These out-of-area benefits are limited to the following Services as otherwise covered under this *EOC*. Any other Services not specifically listed as covered are excluded under this out-of-area benefit.

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

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

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

- "Receiving Care in Another Kaiser Foundation Health Plan Service Area."

- Services covered in the "Emergency, Post-Stabilization, and Urgent Care" section and under "Your Primary Care Participating Provider" in the "How to Obtain Services" section.
- "Transplant Services."

POST-SERVICE CLAIMS – SERVICES ALREADY RECEIVED

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

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

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

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

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

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

You must submit a claim for a Service within 12 months after receiving that Service. If it is not reasonably possible to submit a claim within 12 months, then you must submit a claim as soon as reasonably possible, but in no case more than 15 months after receiving the Service, except in the absence of legal capacity.

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

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

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

EMERGENCY, POST-STABILIZATION, AND URGENT CARE

Coverage, Cost Share, and Reimbursement

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

If you receive Emergency Services, Post-Stabilization Care, or Urgent Care from a Non-Participating Provider

or Non-Participating Facility, we cover those Services only if they meet both of the following requirements:

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

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

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

Emergency Services

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

If you have an Emergency Medical Condition, we cover the Services of an Emergency Medical Service (EMS) Provider and transportation to the nearest medical facility that meets your needs. Emergency transportation may be by air, ground, or water.

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 from a Non-Participating Provider or Non-Participating Facility is limited to the Allowed Amount. In addition to the applicable Cost Share, you are responsible for paying any amount over the Allowed Amount, and any such payments do not count toward the Out-of-Pocket

Maximum. You are not responsible for paying any amount over the Allowed Amount for Post-Stabilization Care from a Non-Participating Provider at a Participating Facility.

To request prior authorization for your receiving Post-Stabilization Care from a Non-Participating Provider 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 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

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. If we must bill you, an accounting fee may be added to offset handling costs.

Out-of-Pocket Maximum

There is a maximum to the total dollar amount of 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 Copayments and Coinsurance count toward the Out-of-Pocket Maximum, unless otherwise indicated. After you reach the Out-of-Pocket Maximum, you are not required to pay Copayments and Coinsurance for these Services for the remainder of the Year. Member Services can provide you with the amount you have paid toward your Out-of-Pocket Maximum.

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

- Payments for Services that are not covered under this *EOC*.
- Payments that you make because we already covered the benefit maximum amount or the maximum number of days or visits for a Service.
- Payments for Services under the "Adult Vision Hardware and Optical Services Rider," if purchased by your Group.
- Payments for Services under the "Hearing Aid Rider," if purchased by your Group.
- Payments for enhanced benefit Services under the "Pediatric Vision Hardware and Optical Services Enhanced Benefit Rider," if purchased by your Group.
- Amounts recovered from a liability claim against another party subject to reimbursement under the "Injuries or Illnesses Alleged to be Caused by Other Parties" 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 Provider 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 Authorization Review Requirements" in the "How to Obtain Services" section.

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

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

The benefits under this Plan are not subject to a pre-existing condition waiting period.

Preventive Care Services

We cover a variety of preventive care Services, which are Services to keep you healthy or to prevent illness, and are not intended to diagnose or treat a current or ongoing illness, injury, sign or symptom of a disease, or condition. These preventive care Services are subject to all coverage requirements described in this "Benefits" section and all provisions in the "Exclusions and Limitations" section.

Preventive care Services include:

- Services recommended by, and rated A or B by, the U.S. Preventive Services Task Force (USPSTF). You can access the list of preventive care Services at **www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**.

- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC.
- Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
- Preventive care and screenings for women supported by HRSA. You can access the list of women's preventive care Services at **www.hrsa.gov/womens-guidelines/**.
- Any additional reproductive health preventive Services for all Members as required by applicable state law.

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

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

- Bone densitometry.
- Cervical cancer screening.
- Chlamydia test.
- Cholesterol tests (all types).
- Colorectal cancer screening, including exam, bowel preparation medications, colonoscopy, sigmoidoscopy, and fecal occult test.
- Contraceptive services and supplies, including insertion/removal of IUD or implanted birth control drugs and devices.
- Diabetic retinopathy screening.
- 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).
- Transabdominal and transcervical sterilization procedures.

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

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

Benefits for Outpatient Services

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

- Allergy testing and treatment materials.
- Biofeedback.
- Cardiac rehabilitative therapy visits.
- Chemotherapy and radiation therapy Services.

- Child abuse medical assessment including Services provided by an Oregon children's advocacy center that reports to the Child Abuse Multidisciplinary Intervention Program. Services may include, but are not limited to, a physical exam, forensic interview and mental health treatment.
- Diagnostic Services and scope insertion procedures, such as colonoscopy, endoscopy, and laparoscopy.
- Drugs, injectables, and radioactive materials used for therapeutic or diagnostic purposes, if they are administered to you in a Participating Medical Office or during home visits, subject to the drug formulary and exclusions described under the "Limited Outpatient Prescription Drugs and Supplies" section.
- Emergency department visits.
- Gender Affirming Treatment.
- Internally implanted devices, including bilateral cochlear implants and bone-anchored hearing aids, except for internally implanted insulin pumps, artificial hearts, and artificial larynx.
- Interrupted pregnancy surgery performed in an outpatient setting.
- Nurse treatment room visits to receive injections, including allergy injections.
- Outpatient surgery and other outpatient procedures.
- 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.
- Routine hearing exams.
- Specialty care visits.
- 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:

- "Ambulance Services."
- "Chemical Dependency Services."
- "Dialysis Services."
- "External Prosthetic Devices and Orthotic Devices."
- "Habilitative Services."
- "Health Education Services."
- "Hearing Aid Services for Dependents."
- "Home Health Services."
- "Hospice Services."
- "Infertility Diagnosis Services."
- "Limited Dental Services."
- "Limited Outpatient Prescription Drugs and Supplies."

- "Mental Health Services."
- "Outpatient Durable Medical Equipment (DME)."
- "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures."
- "Preventive Care Services."
- "Reconstructive Surgery Services."
- "Rehabilitative Therapy Services."
- "Services Provided in Connection with Clinical Trials."
- "Telemedicine Services."
- "Transplant Services."

Benefits for Inpatient Hospital Services

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

- Anesthesia.
- Blood, blood products, blood storage, and their administration, including the Services and supplies of a blood bank.
- Chemotherapy and radiation therapy Services.
- Dialysis Services (this benefit is subject to the benefit limitations described under "Dialysis Services" in this "Benefits" section).
- Drugs and radioactive materials used for therapeutic purposes, except for the types of drugs excluded under the "Limited Outpatient Prescription Drugs and Supplies" section.
- Durable Medical Equipment and medical supplies.
- Emergency detoxification.
- Gender Affirming Treatment.
- General and special nursing care Services.
- Internally implanted devices, including bilateral cochlear implants and bone-anchored hearing aids, except for internally implanted insulin pumps, artificial hearts, and artificial larynx.
- 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 Provider's Services, including consultation and treatment by Specialists.
- Prescription drugs, including injections.
- Rehabilitative therapy Services such as physical, occupational and speech therapy Services.
- Respiratory therapy.

- Room and board, including a private room if Medically Necessary.
- Specialized care and critical care units.
- Temporomandibular joint (TMJ) surgery for the treatment of TMJ disorders subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.
- Vasectomy.

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

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

Ambulance Services

We cover licensed ambulance Services:

- For Emergency Medical Services Transport, or
- If we give prior authorization for an ambulance to transport you to or from a location where you receive covered Services.

Covered Emergency Medical Services Transport includes air, ground and water transportation.

Ambulance Services Exclusions

- Ambulance Services for personal comfort or convenience.

Bariatric Surgery Services

We cover bariatric surgery procedures and related pre-surgery and post-surgery Services for clinically severe obesity in adults, subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

You may request Utilization Review criteria, and a list of the approved surgical procedures we cover when criteria is met, by calling Member Services.

In addition to Utilization Review, you must meet one of the following requirements:

- You fully comply with the Kaiser Permanente Severe Obesity Evaluation and Management Program's contract for participation approved by Company; or,
- You receive the Service at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).

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. The benefits described in this "Chemical Dependency Services" section comply with the Mental Health Parity and Addiction Equity Act.

Outpatient Services for Chemical Dependency

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

Inpatient Hospital Services for Chemical Dependency

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

Residential Services

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

Day Treatment Services

We cover day treatment Services in a day treatment program.

Dialysis Services

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

We cover treatment at outpatient dialysis facilities.

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

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

External Prosthetic Devices and Orthotic Devices

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

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

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

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

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

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

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

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

External Prosthetic Devices and Orthotic Devices Exclusions

- Artificial hearts.
- Artificial larynx.

- 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, and speech therapy, and other Services for people with disabilities, and that:

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

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

Habilitative Services Exclusions

- Daycare.
- Exercise programs for healthy individuals (unless Medically Necessary within an applied behavior analysis (ABA) treatment plan).
- Housing.
- Recreational activities (unless Medically Necessary within an applied behavior analysis (ABA) treatment plan).
- 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. 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. For the purposes of this *EOC*, tobacco use is defined as the use of tobacco on average four or more times per week within no longer than the past six months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco.

If you receive health education Services during a primary care visit, you pay the primary care Cost Share shown in the "Benefit Summary." If you receive health education Services during a specialty care visit, you pay the specialty care Cost Share shown in the "Benefit Summary."

Some Health Education Services may also be covered under the "Preventive Care Services" section.

There are fees for some health education classes. For more information about in-person and online health education programs, see our *Healthy Living* catalog, call Member Services, or visit **kp.org** and select Health & Wellness. To register by phone, call 503-286-6816 or 1-866-301-3866 (toll free) and select option 1.

Hearing Aid Services for Dependents

We cover Medically Necessary Services for the treatment of hearing loss as described in this "Hearing Aid Services for Dependents" section when prescribed by a Participating Provider and obtained from a Participating Provider. You pay the Cost Share shown in the "Benefit Summary." These Services are limited to Dependent children who are under the Dependent Limiting Age shown in the "Benefit Summary." You may have additional coverage if your Group has purchased a "Hearing Aid Rider."

Hearing Exam

We cover exams to determine the need for hearing correction, diagnostic hearing tests appropriate to the Member's age or developmental need, and aided testing. Medically Necessary diagnostic and treatment exams are covered at least twice per Year for Members who are younger than four years of age, and at least once per Year for Members who are four years of age or older. In addition, we cover visits to determine the appropriate hearing aid model, visits to verify that the hearing aid conforms to the prescription, and visits for fitting, counseling, adjustment, cleaning, and inspection.

Hearing Aids

We cover one hearing aid per impaired ear, hearing assistive technology systems, and bone conduction sound processors for the treatment of hearing loss, as shown in the "Benefit Summary" or, for hearing aids, more frequently if modifications to an existing hearing aid will not meet the needs of the Member.

A hearing aid is any non-disposable, wearable electronic instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments, batteries, or accessory necessary to the function of the hearing aid, except cords.

Hearing assistive technology systems are devices used with or without hearing aids or cochlear implants to improve the ability of a user with a hearing loss to hear in various listening situations, such as being located a distance from a speaker, in an environment with competing background noise, or in a room with poor acoustics or reverberation.

The date we cover a hearing aid or hearing assistive technology system is the date on which you are fitted for the device. Therefore, if you are fitted for a device while you are covered under this *EOC*, and if we would otherwise cover the device, we will provide the device even if you do not receive it until after you are no longer covered under this *EOC*.

We cover cochlear implants for one or both ears if Medically Necessary for the treatment of hearing loss, including programming, reprogramming, and repair and replacement parts necessary for the device to

function correctly for the Member. Devices such as bone-anchored hearing systems, cochlear implants, and osseointegrated hearing devices that are internally implanted during a surgical procedure are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company, and are not covered under this "Hearing Aid Services for Dependents" benefit. Please refer to internally implanted devices in the "Benefits for Outpatient Services" and "Benefits for Inpatient Hospital Services" sections.

Hearing Aid Services for Dependents Limitations

- Hearing aids are limited to one of the following digital models from a specified collection of hearing aids: (i) in the ear; (ii) behind the ear; (iii) on the body (Body Aid Model); or (iv) canal/CIC aids.
- Ear molds and replacement ear molds are limited to four times per Year for Members seven years of age or younger and limited to once per Year for Members eight years of age or older.
- Replacement batteries are limited to one box per Year for each hearing aid.

Hearing Aid Services for Dependents Exclusions

- Internally implanted hearing devices.
- Replacement of lost hearing devices.

Home Health Services

Home health Services are Services provided in the home by nurses, medical social workers, 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:

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

Home Health Services Exclusions

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

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

Hospice Services

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

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

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

We cover the following hospice Services:

- Counseling and bereavement Services for up to one year.
- Durable Medical Equipment (DME).
- Home health aide Services.
- Medical social Services.
- Medication and medical supplies and appliances.
- Participating Provider 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 Diagnosis Services

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

Infertility Diagnosis 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.
- Dental Services for Members who are potential transplant recipients and require Medically Necessary pre-transplant dental evaluation and clearance before being placed on the waiting list for a covered transplant. Covered Services are routine dental Services necessary to ensure the oral cavity is clear of infection, and may include oral examination, dental x-rays, prophylaxis (dental cleaning), fluoride treatment, fillings, and dental extractions. In the case of urgent transplantation, we will cover these Services when performed post-transplant.
- 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 Provider determines would place you at undue risk if the dental procedure were performed in a dental office; or
    - are physically or developmentally disabled.

Covered Services may be provided by a licensed dentist or other person who is regulated under state law to practice dental or dental-related Services or otherwise practicing dental care Services consistent with state law,

including an expanded practice dental hygienist, denturist, dental therapist, or pediatric dental assistant. You pay the Cost Share you would pay if the Services were not related to a covered dental Service.

Limited Dental Services Exclusions

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

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

Limited Outpatient Prescription Drugs and Supplies

We cover limited outpatient prescription drugs and supplies as described in this "Limited Outpatient Prescription Drugs and Supplies" section. You may have additional coverage if your Group has purchased an "Outpatient Prescription Drug Rider."

Covered drugs or supplies must be prescribed by a Participating Provider or any licensed dentist in accordance with our drug formulary guidelines. Covered drugs and supplies include those that the law requires to bear the legend "Rx only" and non-prescription items that our drug formulary lists for certain conditions, such as certain preventive medications or drugs or supplies prescribed for the treatment of diabetes.

You must obtain drugs or supplies 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 a drug or supply at any Participating Pharmacy. All refills must be obtained through a pharmacy owned and operated by Kaiser Permanente (including our Mail-Order Pharmacy), or at another Participating Pharmacy that we designate for covered refills. See your *Medical Facility Directory*, visit **kp.org/directory/nw**, or contact Member Services.

Covered Drugs and Supplies

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

- Certain preventive medications (including, but not limited to, aspirin, fluoride, folic acid supplements, liquid iron for infants, and tobacco use 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.
- Contraceptive drugs and devices approved by the U.S. Food and Drug Administration (FDA), including injectable contraceptives and internally implanted time-release contraceptive drugs, emergency contraceptives, and contraceptive devices such as intrauterine devices, diaphragms, and cervical caps. Over-the-counter contraceptive drugs, devices, and products approved by the FDA do not require a prescription in order to be covered. You may receive a three-month supply for a first dispensing of a contraceptive drug and a 12-month supply of a subsequent dispensing of the same contraceptive drug, unless you request a smaller supply. You pay the Cost Share as shown in the "Benefit Summary."

- Drugs, injectables, and radioactive materials used for therapeutic or diagnostic purposes, if they are administered to you in a Participating Medical Office or during home visits. We cover these items upon payment of the administered medications Cost Share shown under "Outpatient Services" in the "Benefit Summary."
- 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.

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

Day Supply Limit

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

You may receive a three-month supply for a first dispensing of a contraceptive drug and a 12-month supply of a subsequent dispensing of the same contraceptive drug, unless you request a smaller supply.

How to Get Covered Drugs or Supplies

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

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

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

About Our Drug Formulary

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

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

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

If a formulary change affects a prescription drug you are taking, we encourage you to discuss any questions or concerns with your Participating Provider or another member of your health care team.

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

Drug Formulary Exception Process

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

A Participating Provider or any licensed dentist may request an exception if they determine 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. We will approve the exception if all of the following requirements are met:

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

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

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

Limited Outpatient Prescription Drugs and Supplies Exclusions

- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.
- Drugs prescribed for an indication if the FDA has determined that use of the drug for that indication is contraindicated.
- Drugs prescribed for an indication if the FDA has not approved the drug for that indication, except that this exclusion does not apply if the Oregon Health Evidence Review Commission or our Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health and Human Services.

- Drugs and supplies 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, biological products, and devices that the FDA has not approved.
- Drugs used to enhance athletic performance.
- Extemporaneously compounded drugs, unless the formulation is approved by our Regional Formulary and Therapeutics Committee.
- Injectable drugs that are self-administered (except insulin).
- Mail-order drugs for anyone who is not a resident of Oregon or Washington.
- Nutritional supplements.
- Replacement of drugs and supplies due to loss, damage, or carelessness.
- The following are excluded, but you may have coverage for them if your Group purchased an "Outpatient Prescription Drug Rider":
    - Prescription drugs and supplies that are dispensed on an outpatient basis, except those listed under "Covered Drugs and Supplies" of this "Limited Outpatient Prescription Drugs and Supplies" section.
    - Drugs for treatment of infertility.
    - Drugs and supplies to treat sexual dysfunction are excluded except for drugs that are FDA-approved to treat mental health symptoms of sexual dysfunction.
    - Drugs used in weight management.

Maternity and Newborn Care

We cover the following maternity and newborn care Services:

- Prenatal care visits and postpartum visits.
- Maternal diabetes management (Medically Necessary Services beginning with conception and ending through six weeks postpartum).
- Maternity hospital care for mother and baby, including Services for complications of pregnancy.
- Obstetrical care and delivery (including cesarean section).
- Newborn medical Services following birth and initial physical exam.
- Newborn nurse home visiting Services for Dependent children up to six months of age, if available in your area.
- 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 31 days of life and are subject to their own Cost Share. In order for coverage to continue beyond this 31-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

- Birthing center Services.
- Home birth Services.

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 Medically Necessary applied behavior analysis (ABA) for autism spectrum disorder, and Medically Necessary treatment for pervasive developmental disorder (PDD), when they are necessary for:

- Crisis intervention.
- Evaluation.
- Treatment of mental disorders or chronic conditions that a mental health Participating Provider 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.
- A licensed psychologist.
- An advanced practice psychiatric nurse.
- A certified nurse practitioner with a specialty in psychiatric mental health.
- A licensed clinical social worker.
- A certified clinical social work associate.
- A licensed mental health counselor.
- A licensed professional counselor.
- A licensed marriage and family therapist.
- A licensed behavioral analyst.
- A licensed assistant behavioral analyst or registered behavioral analyst interventionist.

- An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field.
- Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

The benefits described in this "Mental Health Services" section comply with the Mental Health Parity and Addiction Equity Act.

Outpatient Services

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

Inpatient Hospital Services

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

Residential Services

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

Psychological Testing

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

Naturopathic Medicine

We cover outpatient visits for naturopathic medicine Services when provided by a Participating Provider in the Participating Provider's office. You do not need a referral or prior authorization.

Naturopathic medicine is a natural approach to health and healing which emphasizes a holistic approach to the diagnosis, treatment and prevention of illness. Naturopathic physicians diagnose and treat patients by using natural modalities such as clinical nutrition, herbal medicine, and homeopathy.

Covered Services include:

- Evaluation and management.
- Health condition related treatments.
- Physical therapy modalities such as hot and cold packs.

To locate a Participating Provider, visit **www.chpgroup.com**. If you need assistance searching for a Participating Provider, or to verify the current participation status of a provider, or if you do not have access to the online directory, please contact Member Services.

Outpatient Durable Medical Equipment (DME)

We cover outpatient Durable Medical Equipment (DME) subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

DME must be for use in your home (or a place of temporary or permanent residence used as your home).

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

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

Covered DME includes, but is not limited to:

- Bilirubin lights.
- CADD (continuous ambulatory drug delivery) pumps.
- Diabetic equipment and supplies including external insulin pumps, infusion devices, blood glucose monitors, continuous glucose monitors, lancets, and injection aids.
- Enteral pumps and supplies.
- Home ultraviolet light therapy equipment for treatment of certain skin conditions such as cutaneous lymphoma, eczema, psoriasis, and scleroderma.
- Osteogenic bone stimulators.
- Osteogenic spine stimulators.
- Oxygen and oxygen supplies.
- Peak flow meters.
- Ventilators.
- Wheelchairs.
- Wigs following chemotherapy or radiation therapy, limited to one synthetic wig per Year.

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

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

Outpatient Durable Medical Equipment (DME) Exclusions

- Comfort, convenience, or luxury equipment or features.
- Devices for testing blood or other body substances unless specifically listed as covered in this "Outpatient Durable Medical Equipment (DME)" section.
- Exercise or hygiene equipment.
- Modifications to your home or car.
- More than one corrective appliance or artificial aid or item of Durable Medical Equipment, serving the same function or the same part of the body, except for necessary repairs, adjustments and replacements as specified 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 45 or older or for younger Members who are at high risk, covered preventive colorectal screening tests include one fecal occult blood test per year plus one flexible sigmoidoscopy every five years, one colonoscopy every 10 years, or one double contrast barium enema every five years. These tests are covered more frequently if your Participating Provider recommends them because you are at high risk for colorectal cancer or disease.

We cover prostate screening examinations once every two years for men 50 years of age or older or for younger Members who are at high risk, and more frequently if your Participating Provider recommends it because you are at high risk for prostate cancer or disease.

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

Laboratory, X-ray, and Imaging

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

- Bone densitometry.
- Cardiovascular testing.
- Cultures.
- Glucose tolerance.
- X-ray.
- Ultrasound imaging.
- Urinalysis.

Special Diagnostic Procedures

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

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

- Sleep studies.

You must receive prior authorization by Company for MRI, CT scans, PET scans, and bone density/DXA scans. (See "Prior Authorization Review Requirements" in the "How to Obtain Services" section.)

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

Reconstructive Surgery Services

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

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

With respect to maxillofacial prosthetic services, coverage is limited to the least costly clinically appropriate treatment as determined by a Participating Provider. We cover maxillofacial prosthetic Services 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 any of the following:

- Controlling or eliminating infection.
- Controlling or eliminating pain.
- Restoring facial configuration or functions such as speech, swallowing, or chewing, but not including cosmetic procedures rendered to improve the normal range of conditions.

We also cover:

- All stages of reconstruction of the breast on which a mastectomy was performed, including but not limited to nipple reconstruction, skin grafts, and stippling of the nipple and areola.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Mastectomy-related prostheses.
- Treatment of physical complications of the mastectomy, including lymphedemas.
- Inpatient care related to the mastectomy and post-mastectomy Services.

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, 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. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

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 Authorization Review Requirements" 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 or to outpatient rehabilitative therapy Services to treat mental health conditions covered under this *EOC*.

Outpatient Rehabilitative Therapy Services Limitations

- Physical therapy Services 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.
- 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.

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 Authorization Review Requirements" in the "How to Obtain Services" section.

Rehabilitative Therapy Services Exclusions

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

Services Provided in Connection with Clinical Trials

We cover routine costs of Medically Necessary conventional 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, 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, and it meets one of the following requirements:
  - The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA).
  - The study or investigation is a drug trial that is exempt from having an investigational new drug application.

- The study or investigation is approved or funded by at least one of the following:
  - The National Institutes of Health.
  - The Centers for Disease Control and Prevention.
  - The Agency for Health Care Research and Quality.
  - The Centers for Medicare & Medicaid Services.
  - A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
    - It is comparable to the National Institutes of Health system of peer review of studies and investigations.
    - It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

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

Services Provided in Connection with Clinical Trials Exclusions

- The investigational Service.
- Services provided solely for data collection and analysis and that are not used in your direct clinical management.
- Services required solely for the clinically appropriate monitoring of the Service being tested in the clinical trial.
- Services customarily provided by a clinical trial sponsor free of charge to any participant in the clinical trial.
- Services that would not be covered outside of the clinical trial.

Skilled Nursing Facility Services

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

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

We cover the following:

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

Telemedicine Services

Telemedicine is a means of delivering health care Services using information and telecommunication technologies to provide consultation and education, or to facilitate diagnosis, treatment, care management or self-management of your health care.

We cover telemedicine Services at the applicable "Telemedicine Services" Cost Share shown in your "Benefit Summary" if:

- The Service is otherwise covered under this EOC if received in person;
- The Service is Medically Necessary;
- The Service is determined to be safely and effectively provided using telemedicine, according to generally accepted health care practices and standards; and
- The application and technology used to provide the Service meets all standards required by state and federal laws governing the privacy and security of protected health information.

During a state of emergency, we will cover telemedicine provided to Members residing in the geographic area specified in the declaration of the state of emergency, if the telemedicine Service is delivered using any commonly available technology, regardless of whether the technology meets all standards required by state and federal laws governing the privacy and security of protected health information.

Covered telemedicine applications and technologies may include:

- Landlines, wireless communications, internet and telephone networks; and
- Synchronous or asynchronous transmission using audio only, video only, audio and video and transmission of data from remote monitoring devices.

You may choose to receive a covered health Service in person or via telemedicine. You are not required to have an established patient-provider relationship with a Participating Provider to receive telemedicine Services from the provider.

Telephone and Video Visits

We cover scheduled telephone visits and video visits.

If you have a minor condition that does not require an in-person medical exam, you have the option to schedule a telephone visit. If you prefer to meet face-to-face with a provider online by computer, smartphone or tablet, you may set up a video visit just as you would with an in-person appointment.

Telephone visits and video visits are appropriate for routine care such as medication management and test results; and urgent care such as cough, cold, flu, bug bite, fever, earache, minor sprain, urinary tract infection,

wounds or burns. Video visits are also appropriate for specialty care such as post-op follow-up, mental health appointments, dermatology and speech therapy.

To schedule a telephone visit or video visit, sign on to **kp.org** or the Kaiser Permanente app, then select "Appointments" or call Member Services.

E-Visits

We cover e-visits for common conditions such as cough/cold, nausea/vomiting, pink eye, urinary tract infection, sore throat, sinus problems, constipation or diarrhea. To access an e-visit, log in to your **kp.org** member account on your desktop, laptop, or tablet and fill out a questionnaire about your symptoms. A nurse will get back to you with a care plan, usually within six hours. If needed, a prescription may be sent to your pharmacy. E-visits may include secure chat instant messaging.

To learn more about telephone, video and e-visits, including a short instructional video and troubleshooting tips, visit **kp.org/telehealth/northwest**.

Transplant Services

We cover inpatient and outpatient Services for the transplants listed in this "Transplant Services" section. These Services are covered only when received from Participating Providers and Participating Facilities, and only at National Transplant Network facilities we designate. Services are subject to Utilization Review criteria developed by Medical Group and approved by Company.

You pay the applicable Cost Share you would pay if the Services were not related to a transplant. Inpatient Services associated with a covered transplant are covered at the "Inpatient Hospital Services" Cost Share shown on your "Benefit Summary." Outpatient Services associated with a covered transplant are covered at the applicable Cost Share shown on your "Benefit Summary" for the corresponding benefit, for example, "Outpatient Services," "Outpatient Durable Medical Equipment," and "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures."

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 Oregon).

We cover only the following transplants at National Transplant Network facilities:

- 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, and Participating Providers are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor.
- 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 coverage of Services for living transplant donors are available by calling Member Services.
- If we refer you for or preauthorize transplant Services at a distant location (farther away than the normal community patterns of care) and you choose to obtain your transplant at this distant location, we cover appropriate travel and lodging expenses for you and a caregiver. Your transplant coordinator can provide information about covered expenses.

Transplant Services Exclusions

- Non-human and artificial organs and tissues, 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*.

Acupuncture. Services for acupuncture are excluded unless your employer Group has purchased an "Alternative Care Services Rider" that includes coverage for self-referred acupuncture Services.

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, or (c) court ordered or required for parole or probation. This exclusion does not apply to Medically Necessary court-ordered Services that are covered under "Chemical Dependency Services" or "Mental Health Services" in the "Benefits" section.

Chiropractic Services. Chiropractic and related Services are excluded, unless your employer Group has purchased an "Alternative Care Services Rider" that includes coverage for self-referred chiropractic Services.

Cosmetic Services. Services that are intended primarily to change or maintain your appearance and will not result in significant improvement of the condition being treated. This exclusion does not apply to Medically Necessary Services that are covered under "Reconstructive Surgery Services" in the "Benefits" section, Medically Necessary Gender Affirming Treatment, or any other Services that are Medically Necessary.

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.

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 are excluded, unless your Group has purchased the "Hearing Aid Rider." This exclusion does not apply to Services that are covered under "Hearing Aid Services for Dependents" in the "Benefits" section.

Hypnotherapy. All Services related to hypnotherapy.

Intermediate Services. Services in an intermediate care facility are excluded.

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

Massage Therapy Services. Massage therapy and related Services are excluded, unless your employer Group has purchased an "Alternative Care Services Rider" that includes coverage for self-referred massage therapy Services.

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

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

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

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

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

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

- Teaching manners and etiquette.
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning.

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

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

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

Travel and Lodging. Transportation or living expenses for any person, including the patient, are limited to travel and lodging expenses needed for Member to receive covered Services at Non-Participating Facilities, subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

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

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

REDUCTIONS

Coordination of Benefits

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules governs 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 policy 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.

Definitions

A. 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.

(1) Plan includes: group and individual health insurance contracts, health maintenance organization (HMO) contracts, group or individual closed panel Plans, other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; Medicare or any other federal governmental Plan, as permitted by law; and group and individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

(2) Plan does not include: independent, non-coordinated hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental Plans, unless permitted by law.

Each contract for coverage under (1) or (2) 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.

B. This Plan means, in a COB provision, 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.

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

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100 percent of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of Services, the reasonable cash value 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. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

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

(1) 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.

(2) 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 methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) 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 is not an Allowable expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement

methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel Plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. 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 person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) 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 shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel Plan to provide out-of-network benefits.

C. 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.

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

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree 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 other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is the Secondary Plan and the other Plan is the Primary plan.

(2) 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:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) 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 plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits;

(iii) 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 provisions of subparagraph (a) above shall determine the order of benefits; or

(iv) 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; and then
4. The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(d) For a dependent child:

(i) Who has coverage under either or both parents' plans and also has coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent and the dependent's spouse.

(3) 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 rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to 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 rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the 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 do not exceed the total Allowable expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel Plan, COB shall not apply between that Plan and other Closed panel Plans.

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 need not tell, or get 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

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, it may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by This Plan is more than it should have paid under this COB provision, This Plan may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered

person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Questions About Coordination of Benefits?
Contact Your State Insurance Department

Hospitalization on Your Effective Date

If you are an inpatient in a hospital on your membership effective date but had other Group coverage on the day before your membership effective date, your other Group coverage will be responsible for covering the Services you receive until you are released from the hospital, or until you have exhausted your benefit with the other Group coverage and the benefits available under this Plan will be reduced accordingly.

Injuries or Illnesses Alleged to be Caused by Other Parties

This "Injuries or Illnesses Alleged to be Caused by Other Parties" section applies if you receive covered Services for an injury or illness alleged to be any of the following:

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

Subject to applicable law, if you obtain a settlement, award, or judgment from or on behalf of another party or insurer, you must ensure we are reimbursed for covered Services that you receive for the injury or illness, except that:

- for injuries caused by a motor vehicle accident, we will not collect to the extent that the payment would leave you less than fully compensated for your injury or illness; and
- for injuries or illnesses that are not caused by a motor vehicle accident, we will not collect more than the amount you receive from or on behalf of the other party.

This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to pay any applicable Cost Share for these covered Services. The amount of reimbursement due to the Plan is not limited by or subject to the Out-of-Pocket Maximum.

If you do not recover anything from or on behalf of the other party, then you are responsible only for any applicable Cost Share.

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

To secure our rights, we will have a lien on the proceeds of any judgment, award, or settlement you or we (when we subrogate) obtain against another party, regardless of how those proceeds may be characterized or designated. Subject to applicable law, the proceeds of any judgment, award, or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. In the case of motor vehicle accidents, the proceeds shall only be applied to satisfy our lien after you are reimbursed the total amount of the actual losses and damages you incurred.

You must make all reasonable efforts to pursue any claim you may have against another party. After submitting or filing a claim or legal action against another party, you must send written notice of the claim or legal action by personal service or by registered or certified mail to us at:

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

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

You must provide us written notice before you settle a claim or obtain a judgment or award, or if it appears you will make a recovery of any kind. Subject to applicable law, if you recover any amounts from another party or any insurer based on your injury or illness, you must pay us or place sufficient funds to satisfy our claims in a specifically identifiable account. Pending final resolution of the claims, you must retain control over the recovered amounts to which we may assert a right.

In addition to the rights set forth above, we shall also be entitled to all of the remedies, benefits, and other rights of sections 742.520 – 742.544, Oregon Revised Statutes.

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

Surrogacy Arrangements

If you enter into a Surrogacy Arrangement, whether traditional or gestational, you must ensure we are reimbursed for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services"), except that the amount we collect will not exceed the payments or other compensation you and any other payee are entitled to receive under the Surrogacy Arrangement. A "Surrogacy Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. This includes any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and includes both traditional surrogacy and gestational carriers. Note: This "Surrogacy Arrangements" section does not affect your obligation to pay any applicable Cost Share, or other amounts you are required to pay for these Services. After you surrender a baby to the legal parents, you are not obligated to pay Charges for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

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

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

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee

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

You must send this information to:

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

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

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

Workers' Compensation or Employer's Liability

We will not reimburse for Services for any illness, injury, or condition to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a financial benefit, but we may recover Charges for any such Services from the following sources:

- Any source providing a financial benefit or from whom a financial benefit is due.
- You, to the extent that a financial benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the financial benefit under any workers' compensation or employer's liability law.

GRIEVANCES, CLAIMS, APPEALS, AND EXTERNAL REVIEW

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

A claim is a request for us to:

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

An adverse benefit determination is our denial, reduction, or termination of a Service, or our failure or refusal to provide or to make a payment in whole or in part for a Service that is based on a:

- Denial or termination of enrollment of an individual in a health benefit plan;

- Rescission or cancellation of a policy;
- Imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered Services;
- Determination that a Service is experimental or investigational or not Medically Necessary or appropriate;
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care; or
- Denial, in whole or in part, of a request for prior authorization, a request for an exception to step therapy or a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to Utilization Review requirements.

A grievance is communication expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:

- In writing, for an internal appeal or an external review;
- In writing or orally for an expedited response or an expedited external review; or
- A complaint regarding the:
  - Availability, delivery, or quality of a Service;
  - Claims payment, handling or reimbursement for Services and, unless a request for an internal appeal has not been submitted, the complaint is not disputing an adverse benefit determination; or
  - Matters pertaining to the contractual relationship between the Member and Company.

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).

Member Satisfaction Procedure

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

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 complaint, 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 503-813-2000; 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.

We want you to be satisfied with our facilities, Services, and Participating Providers. Using this Member satisfaction 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.

Language and Translation Assistance

If we send you grievance or adverse benefit determination correspondence, 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 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 file a complaint or seek other assistance from the Consumer Advocacy Section of the Division of Financial Regulation. Contact them by mail, e-mail, telephone, fax, or online at:

Department of Consumer and Business Services
Division of Financial Regulation
Consumer Advocacy Section
P.O. Box 14480
Salem, OR 97309-0405
E-mail: DFR.InsuranceHelp@oregon.gov
Phone: 503-947-7984
Toll Free: 1-888-877-4894
Fax: 503-378-4351
https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx

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.

Providing Additional Information Regarding Your Claim

When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not

provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please send or fax all additional information to:

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

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

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

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

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

Sharing Additional Information That We Collect

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

Internal Claims and Appeals Procedures

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

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

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

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

Pre-service Claims and Appeals

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

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

Non-Urgent Pre-service Claim

- You may request a pre-service benefit determination on your own behalf. Tell us in writing 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 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
  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, the life or health of a fetus, or your 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; (c) your attending provider requests that your claim be treated as urgent; or (d) involves a request concerning admissions, continued stay, or other health care Services if you have received Emergency Services but have not been discharged from a facility.

- 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 no later than two business days after we receive your claim.

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

  If more information is needed to make a decision, we will ask you for the information in writing within two business days after we receive your claim, and we will give you 15 calendar days to send the information.

  We will make a decision and send notification within two business 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 15 calendar days after we send our request, we will make a decision based on the information we have no later than 15 calendar days following the date the additional information was requested.

  If we notify you of our decision orally, we will send you written confirmation no later than two business days after the oral notification.

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

Urgent Pre-service Claim

- If your pre-service claim was considered on an urgent basis, we will notify you of our decision orally or in writing within a timeframe appropriate to your clinical condition, but no later than two business days after we receive your claim.

- We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial decision period.
- If more information is needed to make a decision, we will ask you for the information in writing within 2 business days after we receive your claim, and we will give you 15 calendar days to send the information.
- We will make a decision and send notification within two business 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 15 calendar days after we send our request, we will make a decision based on the information we have no later than 15 calendar days following the date the additional information was requested.

  If we notify you of our decision orally, we will send you written confirmation no later than two business 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 calendar days after you receive our adverse benefit determination notice, you must tell us in writing 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 or fax your appeal to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239
- We will acknowledge your appeal in writing within five calendar days 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 30 calendar days after we receive your appeal.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, which may be available to you.

Urgent Pre-service Appeal

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

  (1) Your name and health record number;

  (2) Your medical condition or relevant symptoms;

  (3) The specific Service that you are requesting;

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

  (5) All supporting documents.

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

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

- When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Grievances, Claims, Appeals, and External Review" section), if our internal appeal decision is not in your favor.
- We will decide whether your appeal is urgent or non-urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life or health, the life or health of a fetus, or your 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; (c) your attending provider requests that your claim be treated as urgent; or (d) involves a request concerning admissions, continued stay, or other health care Services if you have received Emergency Services but have not been discharged from a facility.
- 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 no 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 calendar 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.

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 may have to pay for the Services that we decide are not covered.

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

Non-Urgent Concurrent Care Claim

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

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Phone: 1-800-813-2000
  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, the life or health of a fetus, or your 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; (c) your attending provider requests that your claim be treated as urgent; or (d) involves a request concerning admissions, continued stay, or other health care Services if you have received Emergency Services but have not been discharged from a facility.

- We will review your claim, and if we have all the information we need, we will make a decision within a reasonable period of time.

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

  If your authorized care ended before you submitted your claim, we will make our decision, but no later than 15 calendar days after we receive your claim.

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

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

  We will make our decision as soon as possible, if your care has not ended, or within 15 calendar days after we first receive any information (including documents) we requested.

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

If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 calendar days following the end of the timeframe we gave you for sending the additional information.

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

Urgent Concurrent Care Claim

- If we consider your concurrent care claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but no 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 calendar days after the oral notification.
- If more information is needed to make a decision, we will give you seven calendar days to send the information.
- 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 notify you of our decision within 48 hours of receiving the first piece of requested information or by the deadline for receiving the information, whichever is sooner.
- 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 calendar days after you receive our adverse benefit determination notice, you must tell us in writing 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 mail or fax your appeal to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  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 no later than 30 calendar days after we receive your appeal.

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

Urgent Concurrent Care Appeal

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

  (1) Your name and health record number;

  (2) Your medical condition or relevant symptoms;

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

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

  (5) All supporting documents.

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

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

- When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Grievances, Claims, Appeals, and External Review" section).
- We will decide whether your appeal is urgent or non-urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life or health, the life or health of a fetus, or your 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; (c) your attending provider requests that your claim be treated as urgent; or (d) involves a request concerning admissions, continued stay, or other health care Services if you have received Emergency Services but have not been discharged from a facility.
- 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 calendar 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, that may be available to you.

Post-service Claims and Appeals

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

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

Post-service Claim

- Within 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, including medical records.

  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 calendar days after we receive your claim.

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

  If more information is needed to make a decision, we will ask you for the information in writing before the initial decision period ends, and we will give you 45 calendar days to send us the information.

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

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

  If we do not receive any of the requested information (including documents) within 45 calendar days after we send our request, we will make a decision based on the information we have within 15 calendar days following the end of the 45 calendar 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 calendar days after you receive our adverse benefit determination, tell us in writing 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 either mail or fax your appeal to us at:

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

- We will acknowledge your appeal in writing within five calendar days 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 30 calendar days after we receive your appeal.
- If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

External Review

If you are dissatisfied with our final adverse benefit determination, you have a right to request an external review. For example, you have the right to request external review of an adverse decision that is based on any of the following:

- Whether a course or plan of treatment is Medically Necessary, experimental, or investigational.
- Whether a course or plan of treatment is an active course of treatment for purposes of continuity of care when a Participating Provider's contract with us is terminated.
- Whether a course or plan of treatment is delivered in an appropriate health care setting and with the appropriate level of care.
- Whether an exception to the prescription drug formulary or step therapy prescribing criteria should be granted.

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.

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 independent review organization (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.

Within 180 calendar days after the date of our appeal denial letter you must send your request for external review to Member Relations in writing (via mail, fax, or online through our website at **kp.org**). If you wish to mail or fax your request, you may send it to us 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

In order to proceed with your request for external review, you must also provide us with a signed waiver form that enables us to disclose your protected health information, including pertinent medical records, to the IRO that will evaluate your request. The appeal denial letter that we send to you explains the external review process and how you may obtain the waiver form. Member Relations will forward your request and signed waiver form to the director of the Oregon Department of Consumer and Business Services (DCBS) within two business days after receiving your request. Your request for external review will be assigned to one of the nationally accredited IROs contracted by DCBS along with any necessary authorizations no later than the next business day after the director receives your request for external review from us.

Within two business days of receiving notice of your request, DCBS will send you a written description of the IRO they selected along with more information about the process. They will also notify us of the IRO they selected, and within five business days after receiving notification from DCBS, we will send the IRO any documents and information we considered in making our adverse benefit determination.

If we do not have the required signed waiver form upon receipt of your request for external review, we will send you a waiver form and a letter within two business days of receiving your request for external review, describing the need for the waiver and instructions on where to send it. Unless your external review is expedited, we will also call you within five business days of receiving your request for external review to remind you that we need the signed waiver. If your external review is expedited, we will call you to request that you immediately fax us the completed waiver form. The "Authorization for Kaiser Permanente to Use/Disclose Protected Health Information" form is also available at **info.kaiserpermanente.org/northwest/roi/forms.html**.

If we do not receive the signed waiver within five business days after we receive notification of the IRO assignment from DCBS, your request is considered ineligible for external review, and we will be unable to proceed with the external review process at that time. However, if you supply the signed waiver after the end of the five business days but before the end of the 180 calendar day eligibility period for external review, we will accept it, proceed with the external review, and send the relevant information to the IRO.

You or your provider may also forward additional information directly to the IRO. The IRO will have one business day after receiving this information to forward that information to us. We may also forward additional information directly to the IRO. The IRO will have one business day after receiving the additional information to forward that information to you.

Unless your external review is expedited, the IRO will issue a decision within 30 calendar days after the date when we receive your request for external review. The IRO will notify you and us of its decision no later than five calendar days after the decision is issued.

You may also contact DCBS directly to request an external review. If DCBS receives a request for external review directly from you, they will notify us of your request no later than the next business day. Upon receipt of your request from DCBS, we will follow the process described above. You may contact the Oregon DCBS by mail, e-mail, telephone, or online at:

Department of Consumer and Business Services
Division of Financial Regulation
Consumer Advocacy Section
P.O. Box 14480
Salem, OR 97309-0405
E-mail: DFR.InsuranceHelp@oregon.gov
Phone: 503-947-7984
Toll Free: 1-888-877-4894
https://dfr.oregon.gov/help/Pages/index.aspx

Expedited External Review

We shall expedite the external review:

- If the adverse benefit determination concerns an admission, the availability of care, a continued stay or a health care Service for a medical condition for which the enrollee received Emergency Services and has not been discharged from a health care facility; or
- If a provider you have an established relationship with certifies in writing and provides supporting documentation that the ordinary time period for external review would (a) seriously jeopardize your life or health, the life or health of a fetus, or your ability to regain maximum function; (b) 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; (c) your attending provider requests that your claim be treated as urgent; or (d) involves a request concerning admissions, continued stay, or other health care Services if you have received Emergency Services but have not been discharged from a facility.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

TERMINATION OF *AGREEMENT*

If the *Agreement* terminates and Group does not replace this coverage with another Plan, Company will give Group written notice of termination no later than 10 working days after the termination date and will explain the rights of Members regarding continuation of coverage as provided by federal and state law.

TERMINATION OF MEMBERSHIP

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

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

Termination During Confinement in a Hospital

If you are hospitalized on the date when your membership terminates, we will continue to cover otherwise covered Services in that hospital if all of the following conditions are met:

- The coverage under this *EOC* is being immediately replaced by another insured group health insurance policy.
- You are an inpatient receiving covered Services on the date your membership ends.
- You must continue to pay any applicable Cost Share.

Your coverage under this provision continues until the earlier of:

- Your discharge from the hospital or
- Your exhaustion of hospital benefits under this *EOC*.

Termination Due to Loss of Eligibility

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

Termination for Cause

If you or any other Member in your Family knowingly commits fraud in connection with membership, Company, or a Participating Provider, we may terminate your membership under this employer's *Agreement* 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. Some examples of fraud include:

- Misrepresenting eligibility information about yourself or a Dependent.
- Presenting an invalid prescription or physician order for Services.
- Intentionally misusing a Company ID card (or letting someone else use your ID card to obtain Services pretending to be you).
- Giving us incorrect or incomplete material information.
- Failing to notify us of changes in Family status or Medicare coverage that may affect your eligibility or benefits.

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

If we terminate your membership for cause, we will:

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

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

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

Termination of Your Group's *Agreement* With Us

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

Termination of Certain Types of Health Benefit Plans by Us

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

CONTINUATION OF MEMBERSHIP

Strike, Lock-Out, or Other Labor Disputes

If your compensation is suspended directly or indirectly as a result of a strike, lock-out, or other labor dispute, you may continue membership under this *EOC* by paying Premium for yourself and eligible Dependents directly to the Group for up to six months. If the Group's coverage is terminated by Company, reinstatement with Company is subject to all terms and conditions of your Group's *Agreement* with Company. When your Group continuation coverage under this *EOC* stops, you and your Dependents may be eligible to purchase an individual plan offered by Company.

Illness, Temporary Plant Shut Down, or Leave of Absence

If you are off work due to illness, temporary plant shutdown, or other leave of absence authorized by your Group, you may make arrangements to make monthly payments through your Group for up to 12 weeks. The 12-week period may be extended by advance arrangements confirmed in writing by Company. Once the 12-week period is exhausted, you may also be eligible to convert to an individual plan. (See the "Conversion to an Individual Plan" section.)

Continuation of Group Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

You may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. COBRA applies to most employees (and most of their covered dependents) of most employers with 20 or more employees (however, it does not apply to church plans as defined by federal law). Please contact your Group for details about COBRA continuation coverage, such as how to elect coverage and how much you must pay your Group for the coverage.

Federal or State-Mandated Continuation of Coverage

Termination of coverage will be postponed if the Member is on a leave of absence and continuation of coverage is required by the federal or state-mandated family or medical leave act or law, as amended.

State Continuation Coverage for Surviving, Divorced, or Separated Spouses 55 or Older

If your Group has 20 or more employees, you and your Dependents may be able to continue your coverage under this *EOC* through your Group if you meet all of the following criteria:

- You are the Subscriber's Spouse.
- You are age 55 or older.
- The Subscriber died, or you divorced or are legally separated from the Subscriber.
- You are not eligible for Medicare.

To continue coverage, you must notify Member Services in writing within 60 days after legal separation or divorce, or the Group must notify us in writing within 30 days after the death of the Subscriber. Within 14 days after we receive the notice, we will send you an election form, payment information, and instructions for electing continuation coverage. You must return the completed election form no later than 60 days after the date we mailed it to you.

The first Premium payment must be paid within 45 days of your coverage election date. Your right to continue coverage as a surviving, separated, or divorced Spouse will end upon the earliest of the following events:

- You fail to pay your Premium.
- The Group's *Agreement* with us terminates.
- You become covered under another group health coverage.
- You, as a separated or divorced Spouse, remarry.
- You become eligible for Medicare.

State Continuation Coverage for Non-COBRA Groups

You may be able to continue coverage under this *EOC* for up to nine months if all of the following requirements are met:

- Your Group is not subject to COBRA law.
- The Subscriber in your Family was covered continuously under this *EOC* during the three-month period ending on the date of the qualifying event.
- You were covered under this *EOC* on the day before the qualifying event, or you are a child born to or adopted by the Subscriber while the Subscriber has continuation coverage under this "State Continuation Coverage for Non-COBRA Groups" section and you would have been covered under this *EOC* if you had been born or adopted on the day before the qualifying event. For the purposes of this "State Continuation Coverage for Non-COBRA Groups" section, "qualifying event" means the loss of membership under this *EOC* caused by one of the following:
  - Voluntary or involuntary termination of the employment of the Subscriber.
  - A reduction in hours worked by the Subscriber.
  - The Subscriber's becoming eligible for Medicare.
  - A Dependent's losing Dependent child status under this *EOC*.
  - Termination of membership in your Group resulting in loss of eligibility under the Group's evidence of coverage.
  - The death of the Subscriber.
- You are not eligible for Medicare, and you are not eligible for coverage under any other hospital or medical coverage or program that was not covering you on the day before the qualifying event.

To request continuation coverage under this "State Continuation Coverage for Non-COBRA Groups" section, you must send us a written request for this continuation coverage no later than 15 days after the later of the following:

- The date of your qualifying event.
- The date on which we sent you notice of your right to continue coverage under this *EOC*.

You must mail or fax your written request to us at:

Consolidated Service Center (CSC)
PO Box 23127
San Diego, CA 92193
Fax: 866-311-5974

Your Premium will be 100 percent of the applicable Premium. You must pay your first Premium payment to your Group within 31 days after the date of your qualifying event. Subsequent Premium payments are due on the last day of the month preceding the month of membership.

Continuation coverage under this "State Continuation Coverage for Non-COBRA Groups" section ends on the earliest of the following dates:

- The date that is nine months after your qualifying event.
- The end of the period for which we received your last timely Premium payment.
- The Premium due date coinciding with or next following the date that you become eligible for Medicare or for coverage under any other hospital or medical coverage or program that was not covering you on the day before the qualifying event.
- The date on which your Group's *Agreement* with us terminates.

If you are a surviving, divorced, or separated Spouse and are not eligible for continuation coverage under the "State Continuation Coverage for Surviving, Divorced, or Separated Spouses 55 or Older" section you may continue coverage for yourself and your Dependents under this "State Continuation Coverage for Non-COBRA Groups" section under the same terms as the Subscriber.

If you are a Subscriber who is laid off and then rehired by the same employer within nine months and you were eligible for coverage at the time of the layoff, you may not be subjected to any waiting period even if you chose not to continue coverage under this "State Continuation Coverage for Non-COBRA Groups" section.

If your Group coverage was under another evidence of coverage on the date of your qualifying event and you later became covered under this *EOC*, you may be able to continue coverage under this *EOC* if you otherwise meet the eligibility requirements in this "State Continuation Coverage for Non-COBRA Groups" section. The period of state continuation coverage includes the number of months you were covered under the previous evidence of coverage plus the number of months of coverage under this *EOC*, not to exceed nine months.

State Continuation Coverage after Workers' Compensation Claim

If you are a Subscriber and you file a workers' compensation claim for an injury or illness, you may be able to continue coverage under this *EOC* for up to six months after you would otherwise lose eligibility. Please contact your Group for details such as how to elect coverage and how much you must pay your Group for the coverage.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by federal law (USERRA).

You must submit an USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage and how much you must pay your Group for the coverage.

Conversion to an Individual Plan

After your Group notifies us to terminate your membership, we will send a termination letter to the Subscriber's address of record. The letter will include information about options that may be available to you to remain a Member. You may contact Member Services if you have questions.

Moving to Another Kaiser Foundation Health Plan Service Area

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

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

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

Agreement Binding on Members

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

Amendment of *Agreement*

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

Annual Summaries and Additional Information

Additional information that we have filed with the Oregon Department of Consumer and Business Services (DCBS) is available to you upon request. You may contact the Oregon DCBS to request the following:

- Our annual summary of grievances and appeals.
- Our annual summary of the utilization management program.
- Our annual summary of quality assurance activities.
- The results of publicly available accreditation surveys of our health plan.
- Our annual summary of health-promotion and disease-prevention activities.
- An annual summary of scope of network and accessibility of Services.

Contact the Oregon DCBS by mail, e-mail, telephone, or online at:

Department of Consumer and Business Services
Division of Financial Regulation
Consumer Advocacy Section
P.O. Box 14480
Salem, OR 97309-0405
E-mail: DFR.InsuranceHelp@oregon.gov
Phone: 503-947-7984
Toll Free: 1-888-877-4894
https://dfr.oregon.gov/help/Pages/index.aspx

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*. In the absence of fraud, all statements made by an applicant, Group, or Subscriber shall be deemed representations and not warranties. No statement made for the purpose of effecting coverage shall void coverage or reduce benefits unless contained in a written instrument signed by the Group or Subscriber, a copy of which has been furnished to the Group or Subscriber.

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 attorney fees and other expenses, except as otherwise required by law.

Exercise of Conscience

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

Governing Law

Except as preempted by federal law, this *EOC* will be governed in accord with Oregon 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*.

Group and Members not Company Agents

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

Information about New Technology

When a new medical technology or procedure needs review, our Inter-regional New Technology Committee examines and evaluates data from government agencies, medical experts, medical journals, and medical specialty societies. Recommendations from this inter-regional committee then are passed onto the local committee. The committee reviews the national recommendations to see how they apply to local medical practices. Once this review takes place, the committee makes recommendations for the new technology or procedure to become a covered benefit. In addition, the committee communicates practice guidelines to network providers and related health care providers. If the committee's recommendation is accepted, the new technology is added to the covered benefits, either immediately or when this contract renews.

No Waiver

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

Nondiscrimination

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

Notices

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

Overpayment Recovery

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

Privacy Practices

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

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

You have the right to request that Kaiser Permanente send your PHI directly to you, and not to the Subscriber of your Plan. You have the right to tell us where you want us to redirect communications containing your PHI, including a different mailing address, email address or telephone number. To make a request for confidential communication, please call Member Services and ask for a "Confidential Communication Request" form. It may take up to 30 days from the date of receipt of the form for us to process your request.

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

In the event of unusual circumstances that delay or render impractical the provision of Services, such as major disaster, epidemic, war, riot, civil insurrection, labor disputes, disability of a large share of personnel at Participating Facilities, and complete or partial destruction of Participating Facilities, we will make a good faith effort to provide or arrange for covered Services within the limitations of available personnel and

facilities. Kaiser Permanente shall have no other liability or obligation if covered Services are delayed or unavailable due to unusual circumstances.

NONDISCRIMINATION STATEMENT AND NOTICE OF LANGUAGE ASSISTANCE

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. 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 Member Services at **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, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St. Ste 100
Portland, OR 97232-2099
Phone: **1-800-813-2000** (TTY: **711**)
Fax: **1-855-347-7239**

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

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

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

Help in Your Language

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

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

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

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

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

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

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

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

ខ្មែរ (Khmer) បរយ័ត្ននៈ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សវោជំនួយជុនកែភាសា ដវោយមិនគិតឈុនួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-813-2000** (TTY: **711**)។

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

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

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

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

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

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

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

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

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

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

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

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST ALTERNATIVE CARE SERVICES RIDER

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

General Benefit Requirements

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

- Services are received from Participating Providers and provided as outpatient Services in the Participating Provider's office.
- You are required to pay the Copayment or Coinsurance amount to the Participating Provider at the time of service. You are not responsible for any fees in excess of Charges.

To locate a Participating Provider, visit **www.chpgroup.com**. If you need assistance searching for a Participating Provider, or to verify the current participation status of a provider, or if you do not have access to the online directory, please contact Member Services.

Alternative Care Services

We cover the self-referred Alternative Care Services described in this "Alternative Care Services Rider." These benefits are subject to visit limits and applicable Cost Share shown in the "Alternative Care Services Rider Benefit Summary."

Acupuncture Services

Acupuncturists influence the health of the body by the insertion of very fine needles. Acupuncture treatment is primarily used to relieve pain, reduce inflammation, and promote healing. Covered Services include:

- Evaluation and management.
- Acupuncture.
- Electro acupuncture.

Chiropractic Services

Chiropractic and manual manipulation of the spine, joints or soft tissue focuses on reducing pain and improving the function and structure of the body. It is a system of therapy that involves non-invasive care promoting science-based approaches to a variety of ailments. Covered Services include:

- Evaluation and management.
- Musculoskeletal treatments.
- Physical therapy modalities such as hot and cold packs.

When prescribed, X-ray procedures are covered as described in the "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" section in the "Benefits" section of the *EOC*.

Alternative Care Services Rider Exclusions

- Dermal friction technique.
- East Asian massage and tui na.

- Laserpuncture.
- Nambudripad allergy elimination technique (NAET).
- Point injection therapy.
- Qi gong
- Services designed to maintain optimal health in the absence of symptoms.
- Sonopuncture.

Alternative Care Services Rider Benefit Summary

	You Pay
Acupuncture Services (up to 24 visits per Year)	$15 per visit
Chiropractic Services (up to 20 visits per Year)	$15 per visit

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST OUTPATIENT PRESCRIPTION DRUG RIDER

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

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

Covered Drugs and Supplies

We cover outpatient prescription drugs and supplies as described in this "Outpatient Prescription Drug Rider."

Covered drugs and supplies must be prescribed by a Participating Provider or any licensed dentist in accordance with our drug formulary guidelines.

Covered drugs and supplies include those that the law requires to bear the legend "Rx only" and non-prescription items that our drug formulary lists for certain conditions, such as certain preventive medications or drugs or supplies prescribed for the treatment of diabetes.

You must obtain drugs and supplies 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 a drug or supply at any Participating Pharmacy. All refills must be obtained through a pharmacy owned and operated by Kaiser Permanente (including our Mail-Order Pharmacy), or at another Participating Pharmacy that we designate for covered refills. See your *Medical Facility Directory*, visit **kp.org**, or contact Member Services.

Cost Share for Covered Drugs and Supplies

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

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

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

When you obtain your prescription through a pharmacy owned and operated by Kaiser Permanente (including our Mail-Order Pharmacy) you may be able to use a drug manufacturer coupon as payment for your prescription Cost Share. If the coupon does not cover the entire amount of your Cost Share, you are responsible for the additional amount up to the applicable Cost Share as shown in the "Benefit Summary." When you use a coupon for payment of your Cost Share, the coupon amount counts toward the Out-of-Pocket Maximum. For more information about the Kaiser Permanente coupon program rules and limitations, please call Member Services, or go to **kp.org/rxcoupons.**

Day Supply Limit

The prescribing provider determines how much of a drug or supply to prescribe. For purposes of day supply coverage limits, the prescribing provider determines the amount of a drug or supply that constitutes a Medically Necessary 30-day (or any other number of days) supply for you. When you pay the applicable Cost Share shown in the "Outpatient Prescription Drug Rider Benefit Summary," you will receive the prescribed

supply up to the day supply limit. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantity that exceeds the day supply limit.

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.

How to Get Covered Drugs or Supplies

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

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

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

Definitions

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

- **Brand-Name Drug.** The first approved version of a drug. Marketed and sold under a proprietary, trademark-protected name by the pharmaceutical company that holds the original patent.
- **Generic Drug.** A drug that contains the same active ingredient as a Brand-Name Drug and is approved by the U.S. Food and Drug Administration (FDA) as being therapeutically equivalent and having the same active ingredients(s) as the Brand-Name Drug. Generally, Generic Drugs cost less than Brand-Name Drugs, and must be identical in strength, safety, purity, and effectiveness.
- **Non-Preferred Brand-Name Drug.** A Brand-Name drug or supply that is not approved by Company's Regional Formulary and Therapeutics Committee and requires prior authorization for coverage.
- **Preferred Brand-Name Drug.** A Brand-Name drug or supply that Company's Regional Formulary and Therapeutics Committee has approved. Marketed and sold under a proprietary, trademark-protected name by the pharmaceutical company that holds the original patent.

About Our Drug Formulary

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

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

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

If a formulary change affects a prescription drug you are taking, we encourage you to discuss any questions or concerns with your Participating Provider or another member of your health care team.

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

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

Drug Formulary Exception Process

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

A Participating Provider or any licensed dentist may request an exception if they determine 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.

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

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

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

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

Prior Authorization and Step Therapy Prescribing Criteria

Prior authorization is required when you are prescribed certain drugs or supplies before they can be covered. A Participating Provider may request prior authorization if they determine 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.

Approved requests for prior authorization are binding on us for one year from the date that the treatment begins following our approval if the drug:

- Is prescribed as a maintenance therapy that is expected to last at least 12 months based on medical or scientific evidence;
- Continues to be prescribed throughout the 12-month period; and
- Is prescribed for a condition that is within the scope of use for the drug as approved by the FDA, or has been proven to be a safe and effective form of treatment for your medical condition based on clinical practice guidelines developed from peer-reviewed medical literature.

A list of those drugs and supplies that require prior authorization and the Utilization Review criteria we use are available online at **kp.org/formulary** 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/formulary** 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 they determine 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 Cost Share shown in the "Outpatient Prescription Drug Rider Benefit Summary."

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

Emergency Fill

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

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

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

Your Prescription Drug Rights

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

Medication Management Program

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

Outpatient Prescription Drug Rider Limitations

- If your prescription allows refills, there are limits to how early you can receive a refill. In most cases, we will refill your prescription when you have used at least 75 percent of the quantity. Prescriptions for controlled substances cannot be refilled early. Please ask your pharmacy if you have questions about when you can get a covered refill.
- The Participating Pharmacy may reduce the day supply dispensed at the applicable Cost Share to a 30-day supply in any 30-day period if it determines that the drug or supply is in limited supply in the market or for certain other items. Your Participating Pharmacy can tell you if a drug or supply you use is one of these items.
- For certain drugs or supplies we may limit the amount of a drug or supply that is covered for a specified time frame. Quantity limits are in place to ensure safe and appropriate use of a drug or supply. Drugs and supplies subject to quantity limits are indicated on our drug formulary, available at **kp.org/formulary**. You may also contact Member Services for more information.
- Not all drugs are available through mail order. Examples of drugs that cannot be mailed include controlled substances as determined by state and/or federal regulations, drugs that require special handling, and drugs affected by temperature.

Outpatient Prescription Drug Rider Exclusions

- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.
- Brand-Name Drugs for which a Generic Drug is available, unless approved. Refer to the "Prior Authorization and Step Therapy Prescribing Criteria" section.
- Drugs prescribed for an indication if the FDA has determined that use of that drug for that indication is contraindicated.
- Drugs prescribed for an indication if the FDA has not approved the drug for that indication, except that this exclusion does not apply if the Oregon Health Evidence Review Commission or our Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health and Human Services.
- Drugs and supplies ordered from the Mail-Order Pharmacy to addresses outside of Oregon or Washington.
- Drugs and supplies that are available without a prescription, even if the nonprescription item is in a different form or different strength (or both), except that this exclusion does not apply to nonprescription drugs or supplies that our drug formulary lists for your condition.

- Drugs, biological products, and devices that the FDA has not approved.
- Drugs and supplies to treat sexual dysfunction are excluded except for drugs that are FDA-approved to treat mental health symptoms of sexual dysfunction.
- 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.
- Nutritional supplements.
- Outpatient drugs that require professional administration by medical personnel or observation by medical personnel during self-administration (refer instead to the "Limited Outpatient Prescription Drugs and Supplies" section).
- Replacement of drugs and supplies due to loss, damage, or carelessness.

Outpatient Prescription Drug Rider Benefit Summary

Outpatient Prescription Drugs and Supplies	**Participating Pharmacies You Pay**
Generic Drugs	$5 for up to a 30-day supply
Generic Drugs from our Mail-Order Pharmacy	$5 for up to a 30-day supply $10 for a 31- to 90-day supply
Preferred Brand-Name Drugs or supplies	$10 for up to a 30-day supply
Preferred Brand-Name Drugs or supplies from our Mail-Order Pharmacy	$10 for up to a 30-day supply $20 for a 31- to 90-day supply
Non-Preferred Brand-Name Drugs or supplies	$25 for up to a 30-day supply
Non-Preferred Brand-Name Drugs or supplies from our Mail-Order Pharmacy	$25 for up to a 30-day supply $50 for a 31- to 90-day supply
Blood glucose test strips	Subject to the applicable drug tier Copayment or Coinsurance, not subject to Deductible
Self-administered chemotherapy medications used for the treatment of cancer	$0
Infertility drugs up to a $15,000 lifetime benefit maximum	Subject to the applicable drug tier Cost Share

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST HEARING AID RIDER

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

Hearing aid Services covered under this "Hearing Aid Rider" are only for Members age 19 years and older who are not eligible for coverage under the "Hearing Aid Services for Dependents" benefit. Dependents who are under the Dependent Limiting Age are not covered under this "Hearing Aid Rider," but are covered instead as described under "Hearing Aid Services for Dependents" in the "Benefits" section of the *EOC*.

Hearing Aids

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

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

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

Hearing Aid Exclusions

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

Hearing Aid Rider Benefit Summary

Hearing Aid Services	You Pay
Visits for hearing aid Services	$15
Hearing aids $1,000 allowance for each hearing aid per ear every three years	Any amount by which price exceeds allowance

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST INFERTILITY TREATMENT SERVICES RIDER

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

The following section is added to the *EOC* "Benefits" section:

Infertility Treatment Services

We cover treatment of involuntary infertility and artificial insemination, subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request Utilization Review criteria by calling Member Services.

Diagnosis of involuntary infertility is covered as described under the "Infertility Diagnosis Services" section in the "Benefits" section of the *EOC*.

Infertility Treatment Services Exclusions

- The cost of donor semen (including the Member's own semen), donor eggs (including the Member's own eggs), and Services related to their procurement and storage (such as cryopreservation).
- Oral and injectable drugs used for the treatment of infertility unless your Group has purchased an "Outpatient Prescription Drug Rider" that includes coverage for infertility drugs.
- Services related to conception by artificial means, such as in vitro fertilization (IVF), ovum transplants, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT), except artificial insemination is covered as indicated above.
- Services to reverse voluntary, surgically induced infertility.

Infertility Treatment Services Rider Benefit Summary

	You Pay
Infertility treatment Services	50% Coinsurance