



Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Evidence of Coverage

Public Employees Benefits Board (PEBB) Program 2025 Medical Benefits – Consumer-Directed Health Plan

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BENEFIT SUMMARY

Deductible

All Services except preventive care, vision hardware, and health education classes are subject to the Deductible.

Self-only Deductible per Year (for a Family of one Member)	\$1,650
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Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	\$3,300
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Family Deductible per Year (for an entire Family)	\$3,300
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Out-of-Pocket Maximum

Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	\$5,100
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Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	\$5,100
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Family Out-of-Pocket Maximum per Year (for an entire Family)	\$10,200
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Note: All Deductible, Copayment and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise noted in this EOC. The Deductible and Out-of-Pocket Maximum amounts are subject to increase if the U.S. Department of Treasury changes the minimum Deductible and Out-of-Pocket Maximum amounts required for High Deductible Health Plans.

Benefits will be provided at the payment levels specified below and in the “Benefit Details” section of this EOC up to the benefit maximum limits. The numbered Services below correspond with the benefit descriptions in the “Benefit Details” section of this EOC. Please read the “Benefit Details” and the “Benefit Exclusions and Limitations” sections for specific benefit limitations, maximums, and exclusions. For a list of defined terms, refer to the “Definitions” section of this EOC.

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

COVERED SERVICE	BENEFIT
1. Accidental Injury to Teeth	100% subject to a \$20 Copayment after Deductible per visit
2. Administered Medications	100% after Deductible
3. Acupuncture Services	
Self-referred acupuncture (up to 12 visits per Year)	100% subject to \$30 Copayment after Deductible per visit
Physician-referred acupuncture	100% subject to \$30 Copayment after Deductible per visit
4. Ambulance Services	
Air ambulance	100% subject to 15% Coinsurance after Deductible per trip
Ground ambulance	100% subject to 15% Coinsurance after Deductible per trip
5. Bariatric Surgery Services and Weight Control and Obesity Treatment	
Inpatient hospital Services	100% subject to 15% Coinsurance after Deductible per trip
Outpatient surgery visit	100% subject to 15% Coinsurance after Deductible per trip

COVERED SERVICE	BENEFIT
6. Clinical Trials	
Services provided in connection with clinical trials (See criteria details under the “Services Provided in Connection with Clinical Trials” section)	Payment levels are determined by the setting in which the Service is provided.
7. Diabetic Education	
	100% subject to \$20 primary care office visit Copayment after Deductible per visit; (100% after Deductible for Members age 17 years and younger) 100% subject to \$30 specialty care office visit Copayment after Deductible per visit
8. Diagnostic Testing, Laboratory, Mammograms, and X-ray	
Laboratory	100% subject to 15% Coinsurance after Deductible per visit, 100% for preventive tests
Genetic Testing	100% subject to 15% Coinsurance after Deductible per visit, 100% for preventive tests
X-ray, imaging and special diagnostic procedures	100% subject to 15% Coinsurance after Deductible per visit, 100% for preventive tests
Diagnostic and supplemental breast imaging	100% after meeting \$1,650 of the self-only or \$3,300 of the individual Family Member Deductible or the Family Deductible (whichever applies)
CT, MRI, PET scans	100% subject to 15% Coinsurance after Deductible per visit, 100% for preventive tests
9. Dialysis	
Outpatient dialysis visit	100% subject to \$30 Copayment after Deductible per visit
Home dialysis	100% after Deductible
10. Durable Medical Equipment (DME) and External Prosthetic Devices and Orthotic Devices	
Outpatient Durable Medical Equipment (DME)	100% subject to 20% Coinsurance after Deductible
External Prosthetic Devices	100% subject to 20% Coinsurance after Deductible
Orthotic Devices	100% subject to 20% Coinsurance after Deductible
Home ultraviolet light therapy equipment	100% after Deductible
Peak flow meters, blood glucose monitors, and lancets	100% subject to 20% Coinsurance
11. Emergency Services	
Emergency department visit	100% subject to 15% Coinsurance after Deductible

COVERED SERVICE	BENEFIT
12. Habilitative Services (Visit maximums do not apply to habilitative Services for treatment of mental health conditions.)	
Outpatient Services (limited to 60 visits combined physical, speech, and occupational therapies per Year)	100% subject to \$30 Copayment after Deductible per visit
Inpatient Services	100% subject to 15% Coinsurance after Deductible
13. Hearing Instruments	
Visits for hearing instrument Services, such as assessment, fitting, adjustment, and auditory training	100% subject to \$30 Copayment after meeting \$1,650 of the self-only Deductible or \$3,300 of the individual Family Member or Family Deductible (whichever applies) per exam
Hearing instruments \$3,000 allowance for each hearing instrument per ear every 36 months	After meeting \$1,650 of the self-only Deductible or \$3,300 of the individual Family Member or Family Deductible (whichever applies), then any amount by which price exceeds allowance
Ear molds	100% subject to 20% Coinsurance after meeting \$1,650 of the self-only Deductible or \$3,300 of the individual Family Member or Family Deductible (whichever applies)
14. Home Health Services (up to 130 visits per Year)	100% after Deductible subject to 15% Coinsurance after Deductible
15. Hospice Services (including respite care)	
Hospice Services (respite care limited to no more than five consecutive days in a three-month period of hospice care)	100% after Deductible
16. Hospital Services	
Inpatient hospital Services	100% subject to 15% Coinsurance after Deductible
Inpatient professional Services	100% subject to 15% Coinsurance after Deductible
Outpatient hospital Services	100% subject to 15% Coinsurance after Deductible
Outpatient surgery professional Services	100% subject to 15% Coinsurance after Deductible
17. Interrupted Pregnancy Surgery	100% after meeting \$1,650 of the self-only Deductible or \$3,300 of the individual Family Member or Family Deductible (whichever applies)

COVERED SERVICE	BENEFIT
18. Massage Therapy (up to 12 visits per Year)	100% subject to \$25 Copayment after Deductible per visit
19. Medical Foods and Formula	100% subject to 20% Coinsurance after Deductible
20. Mental Health Services	
Inpatient and residential	100% subject to 15% Coinsurance after Deductible
Outpatient and intensive outpatient Services	100% subject to \$20 Copayment after Deductible per office visit or per day (100% after Deductible for Members age 17 years and younger)
Partial hospitalization	100% subject to \$20 Copayment after Deductible per office visit or per day (100% after Deductible for Members age 17 years and younger)
21. Naturopathic Medicine	
Evaluation and treatment	100% subject to \$20 Copayment after Deductible (100% after Deductible for Members age 17 years and younger)
22. Obstetrics, Maternity and Newborn Care	
Scheduled prenatal care visits and postpartum visits	100%
Inpatient hospital Services	100% subject to 15% Coinsurance after Deductible
Home birth obstetrical care and delivery	100% subject to \$30 Copayment after Deductible per visit
23. Office Visits	
Primary care visits	100% subject to \$20 Copayment after Deductible per visit (100% after Deductible for Members age 17 years and younger)
Specialty care visits	100% subject to \$30 Copayment after Deductible per visit
Urgent Care visits	100% subject to \$40 Copayment after Deductible per visit
Nurse treatment room visits to receive injections	100% subject to \$10 Copayment after Deductible per visit
24. Organ Transplants	
Inpatient facility Services	100% subject to 15% Coinsurance after Deductible
Inpatient professional Services	100% subject to 15% Coinsurance after Deductible
25. Out-of-Area Coverage for Dependents	
Limited office visits, laboratory, diagnostic X-rays, and prescription drug fills as described in the <i>EOC</i> under “Out-of-Area Coverage for Dependents” in the “Benefit Details” section. (Coinsurance is based on the actual fee the provider, facility or vendor charged for the Service).	100% subject to 20% Coinsurance after Deductible
26. Outpatient Surgery Visit	100% subject to 15% Coinsurance after Deductible

COVERED SERVICE	BENEFIT
27. Prescription Drugs, Insulin, and Diabetic Supplies	
Certain inhaled corticosteroids for the treatment of asthma	Subject to the applicable drug tier Copayment or Coinsurance, not subject to the Deductible, up to \$35 for each 30-day supply. Any Cost Share paid will apply toward the Deductible.
Certain preventive medications (including, but not limited to, aspirin, fluoride, liquid iron for infants, and tobacco use cessation drugs)	100%
Certain self-administered IV drugs, fluids, additives, and nutrients including the supplies and equipment required for their administration	100% after Deductible
Blood glucose test strips	Subject to the generic drug tier Copayment or Coinsurance
Epinephrine autoinjectors for the treatment of allergic reactions	Subject to the applicable drug tier Copayment or Coinsurance up to \$35 after meeting \$1,650 of the self-only Deductible or \$3,300 of the individual Family Member or Family Deductible (whichever applies). Any Cost Share paid will apply toward the Deductible.
FDA approved prescription and over-the-counter contraceptive drugs or devices	100%
HIV post-exposure prophylaxis (PEP) drugs	100% after meeting \$1,650 of the self-only or \$3,300 of the individual Family Member Deductible or the Family Deductible (whichever applies)
Insulin	Subject to the applicable drug tier Copayment or Coinsurance, not subject to the Deductible, up to \$35 for each 30-day supply. Any Cost Share paid will apply toward the Deductible.
Male condoms	100% after meeting \$1,650 of the self-only or \$3,300 of the individual Family Member Deductible or the Family Deductible (whichever applies)
Self-administered chemotherapy medications used for the treatment of cancer	100% after Deductible or subject to the applicable prescription drug tier Cost Share, whichever is less
<i>Retail—up to a 30-day supply</i>	
Generic Drugs	100% subject to \$15 Copayment after Deductible per prescription or refill
Preferred Brand-Name Drugs or supplies	100% subject to \$40 Copayment after Deductible per prescription or refill
Non-Preferred Brand-Name Drugs or supplies	100% subject to \$75 after Deductible Copayment per prescription or refill
Specialty Drugs or supplies	100% subject to 50% Coinsurance after Deductible up to \$150 per prescription or refill
Preventive drugs or supplies	100%

COVERED SERVICE	BENEFIT
<i>Mail-Order—up to a 90-day supply</i>	
Generic Drugs	100% subject to \$30 Copayment after Deductible per prescription or refill
Preferred Brand-Name Drugs or supplies	100% subject to \$80 Copayment after Deductible per prescription or refill
Non-Preferred Brand-Name Drugs or supplies	100% subject to \$150 Copayment after Deductible per prescription or refill
Specialty Drugs or supplies	(Most specialty drugs are not available for Mail-Order)
Preventive drugs or supplies	100%
28. Preventive Care Services	100%
29. Radiation and Chemotherapy Services	100% after Deductible
30. Reconstructive Surgery Services	Payment levels are determined by the setting in which the Service is provided
31. Rehabilitative Physical, Occupational, Speech, and Massage Therapies (Visit maximums do not apply for treatment of mental health conditions.)	
Inpatient	100% subject to 15% Coinsurance after Deductible
Outpatient (up to 60 visits per Year for all therapies combined)	100% subject to \$30 Copayment after Deductible per visit
32. Skilled Nursing Facility Services (up to 150 days per Year)	100% subject to 15% Coinsurance after Deductible
33. Spinal and Extremity Manipulation Therapy Services	
Self-referred Spinal and Extremity Manipulation therapy (up to 12 visits per Year)	100% subject to \$30 Copayment after Deductible per visit
Physician-referred Spinal and Extremity Manipulation therapy	100% subject to \$30 Copayment after Deductible per visit
34. Substance Use Disorder Services	
Inpatient and residential	100% subject to 15% Coinsurance after Deductible
Outpatient	100% subject to \$20 Copayment after Deductible per visit (100% after Deductible for Members age 17 years and younger)
Day treatment Services	100% subject to \$20 Copayment after Deductible per day (100% after Deductible for Members age 17 years and younger)
35. Telehealth Services	
Telemedicine Services, telephone visits, and e-visits	100% after Deductible
36. Temporomandibular Joint Dysfunction (TMJ)	
Non-surgical Services	100% subject to \$30 Copayment per visit after Deductible
Inpatient and outpatient surgical Services	Payment levels are determined by the setting in which the Service is provided.
37. Tobacco Use Cessation	100%

COVERED SERVICE	BENEFIT
38. Vasectomy Services	100% after meeting \$1,650 of the self-only Deductible or \$3,300 of the individual Family Member or Family Deductible (whichever applies)

INTRODUCTION

This *Evidence of Coverage (EOC)*, including the “Benefit Summary,” describes the health care benefits of this Plan provided under the *Administrative Services Contract (Contract)* between Kaiser Foundation Health Plan of the Northwest and the Washington State Health Care Authority (HCA) for the Public Employees Benefits Board (PEBB) Program. In the event of a conflict in language between the Plan *Contract* and the *EOC*, the *EOC* will govern. For benefits provided under any other Plan, refer to that Plan’s evidence of coverage.

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

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

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

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

The provider network for this High Deductible Health Plan is the Classic network.

Kaiser Foundation Health Plan of the Northwest uses health care benefit managers to administer this Plan. For a current list of the health care benefit managers, we use and the services they provide, please visit kp.org/disclosures; look under “Choose your region”; select Oregon / SW Washington; click on “Coverage information”; expand the “Getting care” list; and open the document titled *List of Health Care Benefit Managers*.

The provisions of this *EOC* must be considered together to fully understand the benefits available under the *EOC*. In this *EOC*, Kaiser Foundation Health Plan of the Northwest is sometimes referred to as “Kaiser,” “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.

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

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.

If you would like additional information about your benefits, important health plan disclosures, or other products and services, please call Member Services or you may also e-mail us by registering at kp.org/register.

DEFINITIONS

Allowed Amount. The lower of the following amounts:

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

Ancillary Service. Services that are:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner.
- Provided by assistant surgeons, hospitalists, and intensivists.
- Diagnostic Services, including radiology and laboratory Services.
- Provided by a Non-Participating Provider if there is no Participating Provider who can furnish such Service at the facility.
- Provided as a result of unforeseen, urgent medical needs that arise at the time the Service is provided, regardless of whether the Non-Participating Provider or Non-Participating Facility satisfies the notice and consent requirements under federal law.

Annual Open Enrollment. A period of time defined by HCA when a Subscriber may change to another health plan offered by the PEBB Program and make certain other account changes for an effective date beginning January 1 of the following year.

Behavioral Health Emergency Services Provider. Emergency Services provided in any of the following settings, which are licensed or certified by the Washington Department of Health:

- A crisis stabilization unit.
- An evaluation and treatment facility that can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder.
- An agency certified to provide outpatient crisis services.
- A triage facility.
- An agency certified to provide medically managed or medically monitored withdrawal management services.
- A mobile rapid response crisis team that is contracted with a behavioral health administrative services organization operating to provide crisis response services in the behavioral health administrative services organization's service area.

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

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

Charges. Charges means the following:

- For Services provided by Medical Group and Kaiser Foundation Hospitals, the amount in Kaiser'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 amount in the schedule of charges that Kaiser negotiates with the capitated provider.
- For Services received from other Participating Providers or Participating Facilities we contract with, the amount the provider or facility has agreed to accept as payment.
- 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 Kaiser.)
- For Emergency Services received from a Non-Participating Provider or Non-Participating Facility (including Post-Stabilization Care that constitutes Emergency Services under federal law), the amount required to be paid by Kaiser pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process.
- For all other Services received from a Non-Participating Provider or Non-Participating Facility (including Post-Stabilization Services that are not Emergency Services under federal law), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process, or (2) in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the Non-Participating Provider and Kaiser or, absent such an agreement, the Allowed Amount.

Coinsurance. The percentage of Charges that Members pay when the Plan provides benefits at less than 100% coverage.

Continuation Coverage. Temporary continuation of PEBB benefits available to Enrollees under the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), or PEBB policies.

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

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

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

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

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

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

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

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

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

- A medical screening examination (as required under the federal Emergency Medical Treatment and Active Labor Act, “EMTALA”) that is within the capability of the emergency department of a hospital, or of an Independent Freestanding Emergency Department, including Ancillary Services and patient observation routinely available to the emergency department to evaluate the Emergency Medical Condition.
- A behavioral health screening examination that is within the capability of a Behavioral Health Emergency Services Provider, including Ancillary Services routinely available to the Behavioral Health Emergency Services Provider to evaluate the Emergency Medical Condition.
- Further examination and treatment, within the capabilities of the staff and facilities available at the emergency department of a hospital, or Independent Freestanding Emergency Department, or Behavioral Health Emergency Services Provider to stabilize the patient, as required under EMTALA (or would be required under EMTALA if it applied to each of these settings).
- Covered Services provided by a Non-Participating Provider (including staff or facilities at the emergency department of a hospital or Independent Freestanding Emergency Department, or Behavioral Health Emergency Services Provider) after you are Stabilized, and that are part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and Stabilization Services have been furnished, if the Non-Participating Provider determines that, taking into account your medical or behavioral health condition, you are not able to travel to an available Participating Provider within a reasonable travel distance, using non-medical transportation or non-emergency transportation.

Employer group for the Public Employees Benefits Board (PEBB) Program means those counties, municipalities, political subdivisions, the Washington health benefits exchange, tribal governments, and employee organizations representing state civil service employees obtaining employee benefits through a contractual agreement.

Employer Group. An employee organization representing school employees and a tribal school as defined in state statute and rules, obtaining school employee benefits through a contractual agreement with the Health Care Authority (HCA) to participate in benefit plans developed by the SEB board.

Employing Agency. A division, department, or separate agency of state government, including an institution of higher education; a county, municipality, or other political subdivision; and a tribal government covered by HCA statute.

Enrollee. A person who is eligible and enrolled under this *EOC*, and for whom Kaiser has received applicable premium. This *EOC* sometimes refers to an Enrollee as “you” or “Member.” The term Enrollee may include the Subscriber, their Dependent, or other individual who is eligible for and enrolled under this *EOC*.

Essential Health Benefits. Essential Health Benefits means benefits that the U.S. Department of Health and Human Services (HHS) Secretary defines as essential health benefits. Essential Health Benefits must be equal to the scope of benefits provided under a typical employer plan, except that they must include at least

the following: ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and Substance Use Disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

External Prosthetic Devices. External prosthetic devices are rigid or semi-rigid external devices required to replace all or any part of a body organ or extremity, and designated by CMS in the “L codes” of the Healthcare Common Procedure Coding System.

Family. A Subscriber and all of their enrolled Dependents.

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

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

Gender Affirming Treatment. Medically Necessary Services that a Participating Provider prescribes, in accordance with generally accepted standards of care, to treat any condition related to a Member’s gender expression or gender identity.

Group. Washington Public Employees Benefits Board (PEBB) Program.

Health Care Authority (HCA). The Washington State Agency that administers the PEBB and SEBB Programs.

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

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

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

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

Independent Freestanding Emergency Department. A health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and that provides Emergency Services.

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

Kaiser Permanente. Kaiser, Kaiser Foundation Hospitals (a California nonprofit corporation), and Medical Group.

Medical Facility Directory. The *Medical Facility Directory* includes addresses, maps, and telephone numbers for Participating Medical Offices and other Participating Facilities; and provides general information about getting care at Kaiser Permanente. After you enroll, you will receive an e-mail or flyer that explains how you

may either download an electronic copy of the *Medical Facility Directory* or request that the *Medical Facility Directory* be mailed to you.

Medical Group. Northwest Permanente, P.C., Physicians and Surgeons, a professional corporation of physicians organized under the laws of the state of Oregon. Medical Group contracts with Kaiser 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 Kaiser has received applicable premium. This *EOC* sometimes refers to a Member as “you” or “Enrollee.” The term Member may include the Subscriber, their Dependent, or other individual who is eligible for and enrolled under this *EOC*.

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

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

Non-Participating 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, Coinsurance and Deductible 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 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 Kaiser. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Participating Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily custodial care, including training in routines of daily living. A "Participating Skilled Nursing Facility" may also be a unit or section within another facility (for example, a Participating Hospital) as long as it continues to meet the definition above. Participating Skilled Nursing Facilities are subject to change.

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

Plan. The Public Employee Benefits Board (PEBB) Program health benefit plan of coverage agreed to between PEBB and Kaiser Foundation Health Plan of the Northwest (Kaiser). In the eligibility sections "plan" may mean a plan other than Kaiser not sponsored by the PEBB Program.

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

Premium. Monthly membership charges paid by Group.

Primary Care Provider (PCP). A Participating Provider who provides, prescribes, or directs all phases of a Member's care, including appropriate referrals to Non-Participating Providers. The PCP has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for Specialist care, and maintaining the continuity of Member care. PCPs, as designated by Medical Group, may include, but are not limited to, Pediatricians, Family Practitioners, General Practitioners, Internists, Physician's Assistant (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP).

Public Employees Benefits Board (PEBB). A group of representatives, appointed by the governor, who approves insurance benefit plans for employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.

Public Employees Benefits Board (PEBB) Program. Is the HCA program that administers PEBB benefit eligibility and enrollment.

Retired Employee of a Former Employer Group includes a retired employee from a PEBB Employer Group and a retired school employee from a SEBB Employer Group continuing enrollment in PEBB health

plan coverage after losing eligibility due to the Employer Group ending participation in insurance plans and contracts with the Health Care Authority (HCA).

School Employees Benefits Board (SEBB). A group of representatives, appointed by the governor, who designs and approves insurance benefit plans for school employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.

School Employees Benefits Board (SEBB) Organization. A public school district or educational service district or charter school established under Washington State statute that is required to participate in benefit plans provided by the School Employees Benefits Board (SEBB).

School Employees Benefits Board (SEBB) Program. Is the program within HCA that administers insurance and other benefits for eligible school employees, eligible dependents, and eligible school board members.

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

In Oregon:

Benton: 97330, 97331, 97333, 97339, 97370, 97456.

Clackamas: All ZIP codes.

Columbia: All ZIP codes.

Hood River: 97014.

Lane: All ZIP codes.

Linn: 97321, 97322, 97335, 97348, 97355, 97358, 97360, 97374, 97377, 97389, 97446.

Marion: All ZIP codes.

Multnomah: All ZIP codes.

Polk: All ZIP codes.

Washington: All ZIP codes.

Yamhill: All ZIP codes.

Services. Health care services, supplies, or items.

Specialist. Any licensed Participating 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.

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

Spouse. The person to whom you are legally married under applicable law.

Stabilize. With respect to an Emergency Medical Condition, to provide the medical treatment of the 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 person who is having contractions, when there is inadequate time to safely transfer them to another hospital before delivery (or the transfer may pose a threat to the health or safety of them or their unborn child), “Stabilize” means to deliver the infant (including the placenta).

State Agency: An office, department, board, commission, institution, or other separate unit or division, however designated, of the Washington state government. It includes the legislature, executive branch, and

agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.

State-Registered Domestic Partner. An adult who meets the requirements for a valid state-registered domestic partnership and has been issued a certificate of state-registered domestic partnership by the Washington State Secretary of State, or an adult whose legal union (other than a marriage) is validly formed in another jurisdiction and is substantially equivalent to a domestic partnership under Washington law.

Subscriber. An employee, Continuation Coverage Enrollee, or a Retired Employee of a Former Employer Group who has been determined eligible and is enrolled in this plan and is the individual to whom the PEBB Program or Kaiser will issue notices, information, requests, and premium bills on behalf of an Enrollee.

Substance Use Disorder. A substance-related or addictive disorder listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association.

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

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

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

MEDICAL PLAN ELIGIBILITY AND ENROLLMENT FOR EMPLOYEES, CONTINUATION COVERAGE AND RETIRED EMPLOYEES OF A FORMER EMPLOYER GROUP

In these sections, “health plan” is used to refer to a plan offering medical or dental, vision, or any combination of these coverages developed by the Public Employees Benefits Board (PEBB) and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

Eligibility for Subscribers and Dependents

Employee Eligibility

The employee’s State Agency will inform the employee in writing whether they are eligible for PEBB benefits upon employment and whenever their eligibility status changes. The written notice will include information about the employee’s right to appeal eligibility and enrollment decisions.

An employee of an employer group (such as a county, city, port, water district, etc.) that contracts with HCA for PEBB benefits should contact their payroll or benefits office for eligibility criteria.

Employees have the right to appeal eligibility and enrollment decisions. Information about appeals can be found under “Appeal Rights.”

Continuation Coverage Eligibility

The PEBB Program determines whether Subscribers are eligible for Continuation Coverage (COBRA or Unpaid Leave) upon receipt of their election to enroll. If the Subscriber requests to enroll in and is not eligible for Continuation Coverage, the PEBB Program will notify them of their right to appeal. Information about appeals can be found under “Appeal Rights.”

Retired employee of a former employer group eligibility

The PEBB Program determines whether a retired employee or a retired school employee of a former employer group is eligible to self-pay coverage in PEBB Continuation Coverage (Employer Group Ended

Participation) upon receipt of their election to enroll. If the retired employee or the retired school employee requests to enroll and is not eligible, the PEBB Program will notify them of their right to appeal. Information about appeals can be found under “Appeal rights.”

Dependent Eligibility

The following are eligible Dependents:

- Legal Spouse
- State-Registered Domestic Partner and substantially equivalent legal unions from jurisdictions as defined in Washington State statute. Individuals in a state-registered domestic partnership are treated the same as a legal spouse except when in conflict with federal law.
- Children, through the last day of the month in which their 26th birthday occurred regardless of marital status, student status, or eligibility for coverage under another plan. It also includes children age 26 or older with a disability as described below in “Children of any age with a developmental or physical disability.” Children are defined as the Subscriber’s:
 - **Children based on establishment of a parent-child relationship**, as described in Washington State statutes, except when parental rights have been terminated.
 - **Children of the Subscriber’s Spouse**, based on the Spouse’s establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild’s relationship to the Subscriber (and eligibility as a Dependent) ends on the same date the marriage with the Spouse ends through divorce, annulment, dissolution, termination, or death.
 - **Children for whom the Subscriber has assumed a legal obligation** for total or partial support in anticipation of adoption of the child.
 - **Children of the Subscriber’s State-Registered Domestic Partner**, based on the State-Registered Domestic Partner’s establishment of a parent-child relationship, except when parental rights have been terminated. The child’s relationship to the Subscriber (and eligibility as a Dependent) ends on the same date the Subscriber’s legal relationship with the State-Registered Domestic Partner ends through divorce, annulment, dissolution, termination, or death.
 - **Children specified in a court order or divorce decree** for whom the Subscriber has a legal obligation to provide support or health care coverage.
 - **Extended Dependent** in the legal custody or legal guardianship of the Subscriber, the Subscriber’s Spouse, or the Subscriber’s State-Registered Domestic Partner. The legal responsibility is demonstrated by a valid court order and the child’s official residence with the custodian or guardian. Extended Dependent child does not include foster children unless the Subscriber, the Subscriber’s Spouse, or the Subscriber’s State-Registered Domestic Partner has assumed a legal obligation for total or partial support in anticipation of adoption.
 - **Children of any age with a developmental or physical disability** that renders them incapable of self-sustaining employment and chiefly dependent upon the Subscriber for support and maintenance, provided such condition occurs before the age of 26. The following requirements apply to a Dependent child with a disability:
 - The Subscriber must provide proof of the disability and dependency within 60 days of the child’s attainment of age 26.
 - The Subscriber must notify the PEBB Program in writing when the child is no longer eligible under this subsection.
 - A child with a developmental or physical disability who becomes self-supporting is not eligible as of the last day of the month in which they become capable of self-support.

- o A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility if they later become incapable of self-support.
- o The PEBB Program, with input from the medical plan will periodically verify the eligibility of a Dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday. Verification will require renewed proof of disability and dependence from the Subscriber.

Enrollment for Subscribers and Dependents

For All Subscribers and Dependents

- To enroll at any time other than during the initial enrollment period, see “Making Changes.”
- Any Dependents enrolled in PEBB medical will be enrolled in the same medical Plan as the Subscriber. Exceptions may apply if there are both Medicare and non-Medicare enrollees on the account.

Employee Enrollment

An employee must reside in the Plan's Service Area. An employee's dependent must also reside in the plan's service area, except for temporary residency outside the Service Area for purposes of attending school, court-ordered coverage for Dependents or other unique family arrangements, when approved in advance by KFHPNW. KFHPNW has the right to verify eligibility.

An employee must use Benefits 24/7, the online enrollment system, or submit a *PEBB Employee Enrollment/Change* or PEBB Employee Enrollment/Change (for Medical Only Groups) form and any supporting documents to their Employing Agency when they become newly eligible or regain eligibility for PEBB benefits. The online enrollment must be completed or the form must be received no later than 31 days after the date the employee becomes eligible or regains eligibility.

- If the employee does not enroll online or return the form by the deadline, the employee will be enrolled in Uniform Medical Plan Classic and a tobacco use premium surcharge will be incurred. Consequently, Dependents cannot be enrolled until the PEBB Program's next Annual Open Enrollment or when a qualifying event occurs that creates a special open enrollment for enrolling a Dependent.

Waiving Medical Enrollment

An eligible employee may waive enrollment in PEBB medical if they are enrolled in other employer-based group medical, a TRICARE plan, or Medicare. They may not waive enrollment in PEBB medical if they are enrolled in PEBB retiree insurance coverage. When a retiree becomes eligible for the employer contribution toward PEBB benefits, PEBB retiree insurance coverage will be automatically deferred.

If an employee waives enrollment in PEBB medical, the employee cannot enroll eligible Dependents. For information on when an eligible employee may waive medical plan enrollment after their initial enrollment period, or to enroll after having waived, see “Making Changes.”

Continuation Coverage and retired employees of a former employer group Enrollment

A Subscriber enrolling in PEBB Continuation Coverage (COBRA or Unpaid Leave) and a retired employee or retired school employee of a former employer group may enroll by using Benefits 24/7, the online enrollment system, or by submitting the applicable PEBB *Continuation Coverage Election/Change* form and any supporting documents to the PEBB Program.

For PEBB Continuation Coverage (COBRA or Unpaid Leave), the online enrollment must be completed or the PEBB Program must receive the election form no later than 60 days from the date the Enrollee's PEBB health plan coverage ended or from the postmark date on the PEBB *Continuation Coverage Election Notice* sent by the PEBB Program, whichever is later. For retired employees of a former employer group, the online

enrollment must be completed or the PEBB Program must receive the required form no later than 60 days after the employer group's date of termination.

Premiums and applicable premium surcharges associated with continuing PEBB medical must be made directly to HCA. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends as described above. For more information, see "Options for Continuing PEBB Medical Coverage" and the *PEBB Continuation Coverage Election Notice*.

Enrollment in the Kaiser Permanente NW Senior Advantage with Part D plan may not be retroactive. If a subscriber is eligible for and elects this plan and the online enrollment or the required forms are received by the PEBB Program after the date PEBB health plan coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a transitional Kaiser Permanente NW plan during the gap month(s) prior to when the Kaiser Permanente NW Senior Advantage with Part D plan begins.

Dependent Enrollment

To enroll an eligible Dependent, the Subscriber must include the Dependent's information using Benefits 24/7, the online enrollment system, on the applicable enrollment form and provide the required document(s) as proof of the Dependent's eligibility. The Dependent will not be enrolled in PEBB health plan coverage if the PEBB Program or the Employing Agency is unable to verify their eligibility within the PEBB Program enrollment timelines.

National Medical Support Notice (NMSN)

When a National Medical Support Notice (NMSN) requires a Subscriber to provide health plan coverage for a Dependent child, the following provisions apply:

The Subscriber may enroll their Dependent child and request changes to their health plan coverage as described under "Changes to health plan coverage or enrollment are allowed as directed by the NMSN," below.

- An employee must use Benefits 24/7 or submit the required form(s) to their Employing Agency.
- Any other Subscriber must use Benefits 24/7 or submit the required form(s) to the PEBB Program.

If the Subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN, the Employing Agency or the PEBB Program may make enrollment or health plan coverage changes according to "Changes to health plan coverage or enrollment are allowed as directed by the NMSN," below, upon request of:

- The child's other parent.
- A child support enforcement program.

Changes to health plan coverage or enrollment are allowed as directed by the NMSN:

- The Dependent will be enrolled under the Subscriber's health plan coverage as directed by the NMSN.
- An employee who has waived PEBB medical will be enrolled in medical as directed by the NMSN, in order to enroll the Dependent.
- The Subscriber's selected health plans will be changed if directed by the NMSN.
- If the Dependent is already enrolled under another PEBB Subscriber, the Dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN.
- If the Dependent is enrolled in both PEBB medical and School Employee Benefits Board (SEBB) medical as a Dependent and there is an NMSN in place, enrollment will be in accordance with the NMSN.

- If the Subscriber is eligible for and elects Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or other Continuation Coverage, the NMSN will be enforced, and the Dependent must be covered in accordance with the NMSN.

Changes to health plan coverage or enrollment as described above in this section will begin the first day of the month following receipt of the NMSN. If the NMSN is received on the first day of the month, the change to health plan coverage or enrollment begins on that day.

A Dependent will be removed from the Subscriber's health plan coverage as described above in this section the last day of the month the NMSN is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

When a NMSN requires a Subscriber's Spouse, former Spouse, or other individual to provide health plan coverage for a Dependent who is already enrolled in the Subscriber's PEBB coverage, and that health plan coverage is in fact provided, the Dependent may be removed from the Subscriber's PEBB health plan coverage prospectively.

Dual Enrollment

A Subscriber and their Dependents may each be enrolled in only one PEBB medical plan.

An employee or their Dependent who is eligible to enroll in both the PEBB Program and the School Employees Benefits Board (SEBB) Program is limited to a single enrollment in either the PEBB or SEBB Program.

For example:

- A child who is an eligible Dependent under two parents enrolled in PEBB Program benefits may be enrolled as a Dependent under both parents but is limited to a single enrollment in PEBB medical.
- A child who is an eligible Dependent of an employee in the PEBB Program and a school employee in the SEBB Program may only be enrolled as a Dependent under one parent in either the PEBB or SEBB Program.

Medicare Eligibility and Enrollment

Employee and Dependent

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

An employee or their Dependent are deemed eligible for Medicare when they have the option to receive Medicare Part A benefits. An employee that chooses to enroll in Medicare Part A is no longer eligible to contribute to a health savings account. If an employee continues to do so, they will be liable for any tax penalties resulting from contributions made when they are no longer eligible. If an employee or their Dependent chooses to enroll in Medicare Part A, Medicare regulations and guidelines will determine whether Medicare is the primary or secondary payer.

An employee or their Dependent who is enrolled in Medicare may remain enrolled in PEBB medical. However, an employee may choose to waive their PEBB medical or remove their Dependent from their PEBB medical and choose Medicare as their primary insurer. If an employee does so, neither the employee nor their Dependent can enroll in PEBB medical except during the Annual Open Enrollment or a special open enrollment.

In most situations, an employee and their Dependent can defer Medicare Part B enrollment without a penalty while enrolled in PEBB medical. When the employee terminates employment, the employee and the Dependent can enroll in Medicare Part B during a special enrollment period. If Medicare eligibility is due to a

disability, the employee or their Dependent must contact the Social Security Administration about deferring enrollment in Medicare Part B.

Upon retirement, Medicare will become the primary insurance payer, and the PEBB medical plan will become secondary. See “PEBB Retiree Insurance Coverage.”

Continuation Coverage Subscriber, a retired employee of a former employer group, or their Dependent

If a Continuation Coverage Subscriber, a retired employee of a former employer group, or their Dependent becomes eligible for Medicare, federal regulations allow enrollment in Medicare three months before they turn age 65. If they do not enroll within three months before the month they turn age 65, enrollment in Medicare may be delayed. If enrollment in Medicare does not occur when the Subscriber or their Dependent is first eligible, a late enrollment penalty may apply.

When Medical Coverage Begins

Employees and Dependents

For a newly eligible employee and their eligible Dependents, medical coverage begins the first day of the month following the date the employee becomes eligible. If the employee becomes eligible on the first working day of the month, then coverage begins on that date.

If the eligible employee is a faculty member hired on a quarter-to-quarter or semester-to-semester basis, medical coverage begins the first day of the month following the beginning of the second consecutive quarter or semester. If the first day of the second consecutive quarter or semester is the first working day of the month, medical coverage begins on that day.

For an employee regaining eligibility, including following a period of leave or after being between periods of leave as described in PEBB Program rules, and their eligible Dependents, medical coverage begins the first day of the month the employee is in pay status eight or more hours. If the employee is a faculty member regaining eligibility no later than the 12th month after the month in which they lost eligibility for the employer contribution toward PEBB benefits, medical coverage begins the first day of the month in which the quarter or semester begins.

Note: When an employee who is called to active duty in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act (USERRA) loses eligibility for the employer contribution toward PEBB benefits, they regain eligibility for the employer contribution toward PEBB benefits the day they return from active duty. Medical coverage begins the first day of the month in which the employee returns from active duty.

Continuation Coverage Subscribers and Dependents

For a Continuation Coverage Subscriber and their eligible Dependents enrolling when newly eligible due to a qualifying event, medical coverage begins the first day of the month following the day they lost eligibility for PEBB medical.

Retired employees of a former employer group and dependents

For a retired employee of a former employer group and their eligible dependents enrolling when newly eligible, medical coverage begins the first day of the month following the day they lost eligibility for PEBB retiree insurance coverage.

All Subscribers and Dependents

For a Subscriber or their eligible Dependents enrolling during the PEBB Program’s Annual Open Enrollment, medical coverage begins January 1 of the following year.

For a Subscriber or their eligible Dependents enrolling during a special open enrollment, medical coverage begins the first day of the month following the later of the event date or the date the online enrollment election using Benefits 24/7 or the required form is received. If that day is the first of the month, medical coverage begins on that day.

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

- **For an employee**, medical coverage will begin the first day of the month in which the event occurs.
- **For a newly born child**, medical coverage will begin the date of birth.
- **For a newly adopted child**, medical coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier.
- **For a Spouse or State-Registered Domestic Partner** of a Subscriber, medical coverage will begin the first day of the month in which the event occurs.

If the special open enrollment is due to the enrollment of an **extended Dependent or a Dependent child with a disability**, medical coverage will begin the first day of the month following the event date or eligibility certification, whichever is later.

Making changes

Removing a Dependent Who is No Longer Eligible

A Subscriber must provide notice to remove a Dependent who is no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a Dependent ceasing to be eligible as a Dependent child as described under “Dependent Eligibility.” The notice must be received within 60 days of the last day of the month the Dependent no longer meets the eligibility criteria.

- **An employee** must provide notice online using Benefits 24/7 or by submitting a written request to their Employing Agency.
- **Any other Subscriber** must provide notice online using Benefits 24/7) or by submitting a written request to the PEBB Program.

Consequences for not submitting notice within the required 60 days may include, but are not limited to:

- The Dependent may lose eligibility to continue PEBB medical under one of the Continuation Coverage options described in “Options for Continuing PEBB Medical Coverage.”
- The Subscriber may be billed for claims paid by the medical plan for Services that were rendered after the Dependent lost eligibility.
- The Subscriber may not be able to recover Subscriber-paid insurance premiums for the Dependent that lost eligibility.
- The Subscriber may be responsible for premiums paid by the state for the Dependent’s medical plan coverage after the Dependent lost eligibility.

Voluntary Termination for Continuation Coverage Subscribers or retired employees of a former employer group

A Continuation Coverage Subscriber or a retired employee of a former employer group may voluntarily terminate enrollment in a medical plan at any time by submitting a request online using Benefits 24/7 or in writing to the PEBB Program. Enrollment in the medical plan will be terminated the last day of the month in which the request was received online or by the PEBB Program, or on the last day of the month specified in

the termination request, whichever is later. If the request is received on the first day of the month, medical plan enrollment will be terminated on the last day of the previous month.

Making Changes during Annual Open Enrollment and Special Open Enrollment

A Subscriber may make certain changes to their enrollment during the Annual Open Enrollment and if a specific life event creates a special open enrollment period.

Annual Open Enrollment Changes

An employee may make the following changes to their enrollment during the PEBB Program's Annual Open Enrollment period:

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

An employee must submit the election change online using Benefits 24/7 or submit the required *PEBB Employee Enrollment/Change* form and any supporting documents to their Employing Agency. The change must be completed online, or the forms received no later than the last day of the Annual Open Enrollment period. The change will be effective January 1 of the following year.

Any other Subscriber may make the following changes to their enrollment during the PEBB Program's Annual Open Enrollment period:

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

They must submit the election change online using Benefits 24/7 or submit the required *PEBB Continuation Coverage Election/Change* form (as appropriate) and any supporting documents to the PEBB Program. The change must be completed online, or the forms received, no later than the last day of the Annual Open Enrollment period. The change will be effective January 1 of the following year.

Special Open Enrollment Changes

A Subscriber may change their enrollment outside of the Annual Open Enrollment period if a qualifying event creates a special open enrollment period. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations and correspond to and be consistent with the event that creates the special open enrollment for the Subscriber, their Dependent, or both.

A special open enrollment event must be other than an employee gaining initial eligibility or regaining eligibility for PEBB benefits. The Subscriber must provide evidence of the event that created the special open enrollment.

A special open enrollment may allow a Subscriber to make the following changes:

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

To request a special open enrollment:

- **An employee** must make the change online using Benefits 24/7 (once available) or submit the required *PEBB Employee Enrollment/Change* form and any supporting documents to their Employing Agency.
- **Any other subscriber** must make the change online using Benefits 24/7 (once available) or submit the required *PEBB Continuation Coverage Election/Change* form (as appropriate) and any supporting documents to the PEBB Program.

The change must be completed online, or the forms must be received, no later than 60 days after the event that creates the special open enrollment. In addition, the PEBB Program or the Employing Agency will require the Subscriber to provide proof of a Dependent’s eligibility, evidence of the event that created the special open enrollment, or both.

Exceptions:

- If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption in PEBB health plan coverage, the subscriber should complete the request online or notify their employing agency or the PEBB Program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the request must be received online, or the required forms must be received, no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

A continuation coverage subscriber or a retired employee of a former employer group:

- Has six months from the date of their or their Dependent’s enrollment in Medicare Part B to change their enrollment to a PEBB Medicare Supplement Plan. The change must be made online using Benefits 24/7 or the PEBB Program must receive the required form(s) no later than six months after the enrollment in Medicare Part B for either the Subscriber or their Dependent.
- Has seven months to enroll in a Medicare Advantage Prescription Drug (MAPD) plan or Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP) that begins three months before they or their Dependent first enrolled in both Medicare Part A and Part B and ends three months after the month of Medicare eligibility. They may also enroll themselves or their Dependent in MAPD plan or UMP Classic Medicare with Part D (PDP) before their last day of the Medicare Part B initial enrollment period. The change must be made online in Benefits 24/7, or the forms must be received by the PEBB Program, no later than the last day of the month prior to the month they or their Dependent enrolls in the MAPD plan or UMP Classic Medicare with Part D (PDP).

Special open enrollment events that allow for a change in health plans

A Subscriber may not change their health plan during a special open enrollment if their State-Registered Domestic Partner or State-Registered Domestic Partner’s child is not a tax dependent.

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

- Subscriber gains a new Dependent due to:
 - Marriage or registering a state-registered domestic partnership.
 - Birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
 - A child becoming eligible as an extended Dependent through legal custody or legal guardianship.
- Subscriber or their Dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.

- Subscriber's Dependent has a change in their own employment status that affects their eligibility or their Dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the Dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their Dependent has a change in residence that affects health plan availability. If the Subscriber has a change in residence and their current medical plan is no longer available, the Subscriber must select a new medical plan as described in PEBB Program rules. If the subscriber does not elect a new medical plan as required, they will be enrolled in a PEBB medical plan designated by the director of HCA or their designee.
- A court order requires the Subscriber or any other individual to provide insurance coverage for an eligible Dependent of the Subscriber (a former Spouse or former State-Registered Domestic Partner is not an eligible Dependent).
- Subscriber or their Dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the Subscriber or their Dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their Dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber or their Dependent enrolls in coverage under Medicare, or the Subscriber or their Dependent loses eligibility for coverage under Medicare or enrolls in or terminates enrollment in a Medicare Advantage-Prescription Drug or a Part D plan. If the Subscriber's current medical plan becomes unavailable due to the Subscriber or their Dependents' enrollment in Medicare, the Subscriber must select a new medical plan.
- Subscriber or their Dependent's current medical plan becomes unavailable because the Subscriber or enrolled Dependent is no longer eligible for a health savings account (HSA).
- Subscriber or their Dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the Subscriber or their Dependent. The Subscriber may not change their health plan election because the Subscriber or Dependent's physician stops participation with the Subscriber's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but not limit its consideration to the following:
 - Active cancer treatment, such as chemotherapy or radiation therapy
 - Treatment following a recent organ transplant.
 - A scheduled surgery
 - Recent major surgery still within the postoperative period
 - Treatment for a high-risk pregnancy
- The PEBB Program determines that there has been a substantial decrease in the providers available under a PEBB medical plan.

Note: The Plan cannot guarantee that any physician, hospital, or other provider will be available or remain under contract with the Plan. An Enrollee may not change medical plans simply because their provider or health care facility discontinues participation with this medical plan until the PEBB Program's next Annual Open Enrollment or when another qualifying event creates a special open enrollment for changing health plans, unless the PEBB Program determines that a continuity of care issue exists or there has been a substantial decrease in the providers available under the plan.

Special open enrollment events that allow adding or removing a Dependent

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

- Subscriber gains a new Dependent due to:
 - Marriage or registering a state-registered domestic partnership.
 - Birth, adoption, or when the Subscriber has assumed a legal obligation for total or partial support in anticipation of adoption.
 - A child becoming eligible as an extended Dependent through legal custody or legal guardianship.
- Subscriber or their Dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber's Dependent has a change in their own employment status that affects their eligibility or their Dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the Dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their Dependent has a change in enrollment under an employer-based group health plan during its Annual Open Enrollment that does not align with the PEBB Program's Annual Open Enrollment.
- Subscriber's Dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the Dependent losing their health insurance.
- A court order requires the Subscriber or any other individual to provide insurance coverage for an eligible Dependent of the Subscriber (a former Spouse or former State-Registered Domestic Partner is not an eligible Dependent).
- Subscriber or their Dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the Subscriber or their Dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their Dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber's Dependent enrolls in Medicare or loses eligibility for Medicare.

Special open enrollment events that allow waiving medical enrollment and enrolling after waiving

An employee may waive PEBB medical during a special open enrollment if they are enrolled in other employer-based group medical, a TRICARE plan, or Medicare. An employee may not waive enrollment in PEBB medical if they are enrolled in PEBB retiree insurance coverage.

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

- Employee gains a new Dependent due to:
 - Marriage or registering a state-registered domestic partnership.
 - Birth, adoption, or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption.
 - A child becoming eligible as an extended Dependent through legal custody or legal guardianship.
- Employee or their Dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the HIPAA.

- Employee has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group medical.
- Employee's Dependent has a change in their own employment status that affects their eligibility or their Dependent's eligibility for the employer contribution under their employer-based group medical. "Employer contribution" means contributions made by the Dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Employee or their Dependent has a change in enrollment under an employer-based group medical plan during its Annual Open Enrollment that does not align with the PEBB Program's Annual Open Enrollment.
- Employee's Dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and the change in residence resulted in the Dependent losing their health insurance.
- A court order requires the employee or any other individual to provide a health plan for an eligible Dependent of the employee (a former Spouse or former State-Registered Domestic Partner is not an eligible Dependent).
- Employee or their Dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the employee or their Dependent loses eligibility for coverage under Medicaid or CHIP. **Note:** An employee may only return from having waived PEBB medical for the events described in this paragraph. An employee may not waive their PEBB medical for the events described in this paragraph.
- Employee or their Dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Employee or their Dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan.
- Employee becomes eligible and enrolls in Medicare or loses eligibility for Medicare.

When Medical Coverage Ends

Termination Dates

Medical coverage ends on the following dates:

- On the last day of the month when any Enrollee ceases to be eligible,
- On the date a medical plan terminates due to a change in contracted Service area or when the group policy ends. If that should occur, the Subscriber will have the opportunity to enroll in another PEBB medical plan.
- **For an employee** and their Dependents, on the last day of the month the employment relationship is terminated. The employment relationship is considered terminated:
 - On the date specified in an employee's letter of resignation.
 - On the date specified in any contract or hire letter.
 - On the effective date of an employer-initiated termination notice.

Note: If the Employing Agency deducted the employee's premium for PEBB insurance coverage after the employee was no longer eligible for the employer contribution, medical coverage ends the last day of the month that employee premiums were deducted.

- **For a Continuation Coverage Subscriber or a retired employee of a former employer group** who submits a request to terminate medical coverage, enrollment in medical coverage will be terminated the

last day of the month in which the request was received online using Benefits 24/7 or by the PEBB Program, or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, medical coverage will be terminated on the last day of the previous month.

A Subscriber will be responsible for payment of any Services received after the date medical coverage ends as described above.

Final Premium Payments

Premium payments and applicable premium surcharges are not prorated during any month, for any reason, even if an Enrollee dies or asks to terminate their medical plan before the end of the month.

If the monthly premium or applicable premium surcharges remain unpaid for 30 days, the account will be considered delinquent. A Subscriber is allowed a grace period of 30 days from the date the monthly premiums or applicable premium surcharges become delinquent to pay the unpaid premium balance and applicable premium surcharges. If the Subscriber's premium balance or applicable premium surcharges remain unpaid for 60 days from the original due date, the Subscriber's medical coverage (including enrolled Dependents) will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges were paid.

If an Enrollee is Hospitalized

An Enrollee who is receiving covered Services in a hospital on the date medical coverage ends will continue to be eligible for covered Services while an inpatient for the condition which the Enrollee was hospitalized, until one of the following events occur:

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

This provision will not apply if the Enrollee is covered under another agreement that provides benefits for the hospitalization at the time medical coverage ends, except as set forth in this section, or if the Enrollee is eligible for PEBB Continuation Coverage as described in the section titled "Options for Continuing PEBB Medical Coverage."

Options for Continuing PEBB Medical Coverage

When medical coverage ends, the Subscriber and their Dependents covered by this medical plan may be eligible to continue PEBB medical coverage during temporary or permanent loss of eligibility.

There are three options the Subscriber and their Dependents may qualify for when coverage ends.

- PEBB Continuation Coverage (COBRA)
- PEBB Continuation Coverage (Unpaid Leave)
- PEBB retiree insurance coverage

A Subscriber also has the right to convert to individual medical insurance coverage with the Plan when continuation of group medical insurance coverage is no longer possible.

PEBB Continuation Coverage

The PEBB Program administers the following Continuation Coverage options to temporarily extend group insurance coverage when the Enrollee's PEBB medical plan coverage ends due to a qualifying event:

- **PEBB Continuation Coverage (COBRA)** includes eligibility and administrative requirements under federal COBRA laws and regulations. Some Enrollees who are not qualified beneficiaries under federal COBRA, may also qualify for PEBB Continuation Coverage (COBRA).
- **PEBB Continuation Coverage (Unpaid Leave)** is an option created by the PEBB Program with wider eligibility criteria and qualifying event types than COBRA.

An Enrollee who qualifies for both types of PEBB Continuation Coverage (COBRA and Unpaid Leave) may enroll in only one of these options. See "Continuation Coverage Enrollment" and the *PEBB Continuation Coverage Election Notice*.

Premium Payments for PEBB Continuation Coverage

If a Subscriber enrolls in Continuation Coverage, the Subscriber is responsible for timely payment of premiums and applicable premium surcharges.

PEBB Retiree Insurance Coverage

The following are eligible to continue enrollment or defer enrollment in PEBB retiree insurance coverage if they meet procedural and substantive eligibility requirements:

- Retiring employee
- Retiring school employee
- Eligible elected or full-time appointed official of the legislative or executive branch of state government leaving public office.
- Dependent becoming eligible as a survivor.
- Retiree or survivor enrolled in PEBB retiree insurance coverage.

For details, see the *PEBB Retiree Enrollment Guide*.

Family and Medical Leave Act of 1993

An employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward PEBB benefits in accordance with the federal FMLA.

The Employing Agency determines if the employee is eligible for leave and the duration of the leave under FMLA. The employee must continue to pay their monthly premium contribution and applicable premium surcharges during this period to maintain eligibility.

If an employee exhausts the period of leave approved under FMLA, they may continue PEBB insurance coverage by self-paying the monthly premium and applicable premium surcharges set by HCA, with no contribution from the Employing Agency. See "Options for Continuing PEBB Medical Coverage."

Paid Family and Medical Leave Act

An employee on approved leave under the Washington State Paid Family and Medical Leave (PFML) Program may continue to receive the employer contribution toward PEBB benefits. The Employment Security Department determines if the employee is eligible for leave under PFML. The employee must continue to pay their monthly premium contribution and applicable premium surcharges during this period to maintain eligibility.

If an employee exhausts the period of leave approved under PFML, they may continue PEBB insurance coverage by self-paying the monthly premium and applicable premium surcharges set by HCA, with no contribution from the Employing Agency. See “Options for continuing PEBB Medical Coverage.”

Conversion of Coverage

An Enrollee (including a Dependent of a Subscriber terminated for cause) has the right to switch from PEBB group medical to an individual conversion plan offered by this Plan when they are no longer eligible to continue the PEBB group medical plan and are not eligible for Medicare or covered under another group insurance coverage that provides benefits for hospital or medical care.

An Enrollee must apply for conversion coverage and pay the first month’s premium no later than 31 days after their group medical plan ends or within 31 days from the date the notice of termination of coverage is received, whichever is later.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage, and eligibility requirements of this conversion plan differ from those of the Enrollee’s current group medical plan. To receive detailed information on conversion options under this medical plan, call us at 1-800-200-1004.

General provisions for eligibility and enrollment

Payment of Premiums During a Labor Dispute

Any employee or Dependent whose monthly premiums are paid in full or in part by the Employing Agency may pay premiums directly to HCA if the employee’s compensation is suspended or terminated directly or indirectly because of a strike, lockout, or any other labor dispute, for a period not to exceed six months.

When the employee’s compensation is suspended or terminated, HCA will notify the employee immediately, by mail at the last address of record, that the employee may pay premiums as they become due.

If coverage is no longer available to the employee under this *Evidence of Coverage*, then the employee may be eligible to purchase an individual medical plan from this Plan consistent with premium rates filed with the Washington State Office of the Insurance Commissioner.

Termination for Just Cause

The purpose of this provision is to allow for a fair and consistent method to process the plan-designated provider’s request to terminate coverage from this Plan for just cause.

An eligible Dependent may have coverage terminated by HCA for the following reasons:

- Failure to comply with the PEBB Program’s procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB Program
- Knowingly providing false information
- Failure to pay the monthly premium and applicable premium surcharges when due
- Misconduct. Examples of such termination include, but are not limited to the following:
 - Fraud, intentional misrepresentation or withholding of information the Subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium
 - Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan, or other HCA contracted vendor providing PEBB insurance coverage on behalf of HCA, its employees, or other persons

The PEBB Program will enroll an employee and their eligible Dependents in another PEBB medical plan upon termination from this plan.

Appeal Rights

Any current or former employee of a State Agency or their Dependent may appeal a decision made by the State Agency regarding PEBB eligibility, enrollment, or premium surcharges to the State Agency.

Any current or former employee of an employer group, such as a county, city, port, water district, etc., that contracts with HCA for PEBB benefits, or their Dependent may appeal a decision made by an employer group regarding PEBB eligibility, enrollment, or premium surcharges to the employer group.

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

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

Learn more at hca.wa.gov/pebb-appeals.

Relationship to Law and Regulations

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

MEDICAL PLAN ELIGIBILITY AND ENROLLMENT FOR A RETIREE OR SURVIVOR

In these sections, the term “retiree” or “retiring employee” includes a retiring employee from a Public Employees Benefits Board (PEBB) employing agency or employer group, and an elected or full-time appointed official of the legislative and executive branch of state government. The term “retiree” or “retiring school employee” includes a retiring school employee from a School Employees Benefits Board (SEBB) organization or employer group. Additionally, “health plan” is used to refer to a plan offering medical, dental, vision, or any combination of these coverages developed by PEBB and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

Eligibility for Subscribers and Dependents

Retiree Eligibility

The PEBB Program determines if a retiring employee or retiring school employee is eligible to enroll in PEBB retiree insurance coverage upon receipt of their election to enroll. If the retiring employee or retiring school employee does not have substantive eligibility or does not meet the procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to appeal eligibility decisions. Information about appeals can be found under “Appeal Rights.”

Survivor Eligibility

The PEBB Program determines whether a dependent is eligible to enroll or continue enrollment in PEBB retiree insurance coverage as a survivor. If an election to enroll is required, eligibility will be determined upon receipt of **their election to enroll**. If the survivor does not meet the eligibility and procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to appeal. Information about appeals can be found under “Appeal rights.”

Dependent Eligibility

The following are eligible Dependents:

- Legal Spouse

- State-Registered Domestic Partner and substantially equivalent legal unions from jurisdictions as defined in Washington State statute. Individuals in a State-Registered Domestic Partnership are treated the same as a legal Spouse except when in conflict with federal law.
- Children, through the last day of the month in which their 26th birthday occurred regardless of marital status, student status, or eligibility for coverage under another plan. It also includes children age 26 or older with a disability as described below in “Children of any age with a developmental or physical disability.” Children are defined as the Subscriber’s:
 - **Children based on establishment of a parent-child relationship**, as described in Washington State statutes, except when parental rights have been terminated.
 - **Children of the Subscriber’s Spouse**, based on the Spouse’s establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild’s relationship to the Subscriber (and eligibility as a Dependent) ends on the same date the marriage with the Spouse ends through divorce, annulment, dissolution, termination, or death.
 - **Children for whom the Subscriber has assumed a legal obligation** for total or partial support in anticipation of adoption of the child.
 - **Children of the Subscriber’s State-Registered Domestic Partner**, based on the State-Registered Domestic Partner’s establishment of a parent-child relationship, except when parental rights have been terminated. The child’s relationship to the Subscriber (and eligibility as a Dependent) ends on the same date the Subscriber’s legal relationship with the State-Registered Domestic Partner ends through divorce, annulment, dissolution, termination, or death.
 - **Children specified in a court order or divorce decree** for whom the Subscriber has a legal obligation to provide support or health care coverage.
 - **Extended Dependents** in the legal custody or legal guardianship of the Subscriber, the Subscriber’s Spouse, or the Subscriber’s State-Registered Domestic Partner. The legal responsibility is demonstrated by a valid court order and the child’s official residence with the custodian or guardian. Extended Dependent child does not include foster children unless the Subscriber, the Subscriber’s Spouse, or the Subscriber’s State-Registered Domestic Partner has assumed a legal obligation for total or partial support in anticipation of adoption.
 - **Children of any age with a developmental or physical disability** that renders them incapable of self-sustaining employment and chiefly dependent upon the Subscriber for support and maintenance, provided such condition occurs before the age of 26. The following requirements apply to a Dependent child with a disability:
 - The Subscriber must provide proof of the disability and dependency within 60 days of the child’s attainment of age 26.
 - The Subscriber must notify the PEBB Program in writing when the child is no longer eligible under this subsection.
 - A child with a developmental or physical disability who becomes self-supporting is not eligible as of the last day of the month in which they become capable of self-support.
 - A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility if they later become incapable of self-support.
 - The PEBB Program, with input from the medical plan, will periodically verify the eligibility of a Dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child’s 26th birthday. Verification will require renewed proof of disability and dependence from the Subscriber.

A retiree, a survivor, or their enrolled Dependents are required to enroll in Medicare Part A and Part B if eligible. Any enrollee who is eligible for Medicare must enroll and stay enrolled in Medicare Part A and Part B to enroll in or continue enrollment in a PEBB retiree health plan. A subscriber must provide a copy of their or their dependent's Medicare card or Medicare benefit verification letter with Medicare Part A and Part B effective dates to the PEBB Program as proof of Medicare enrollment. If a subscriber or their dependent is not enrolled in either Medicare Part A or Part B on their 65th birthday, the subscriber must provide the PEBB Program with a copy of the denial letter from the Social Security Administration. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

Enrollment for Subscribers and Dependents

Deferring Enrollment

A retiring employee, a retiring school employee, or a dependent becoming eligible as a survivor may defer (postpone) enrollment in PEBB retiree insurance coverage if they meet the substantive eligibility requirements to enroll and also meet the procedural requirement by electing to defer enrollment using Benefits 24/7, the online enrollment system, or by submitting a **PEBB Retiree Election Form (form A)** to the PEBB Program within the enrollment timelines.

If a retiring employee, a retiring school employee, or a dependent becoming eligible as a survivor chooses to defer enrollment in PEBB medical, enrollment in PEBB dental and PEBB vision will also be deferred. Deferring enrollment in PEBB retiree insurance coverage will also defer enrollment for all eligible dependents, except as described below.

A retiring employee, a retiring school employee, or a dependent becoming eligible as a survivor who does not enroll in PEBB retiree insurance coverage is only eligible to enroll later if they have deferred enrollment. Enrollment may be deferred as follows:

- Beginning January 1, 2001, enrollment in PEBB retiree insurance coverage may be deferred when the Subscriber is enrolled in employer-based group medical insurance as an employee or the Dependent of an employee, or such medical insurance continued under Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or Continuation Coverage.
- Beginning January 1, 2001, enrollment in PEBB retiree insurance coverage may be deferred when the Subscriber is enrolled as a retiree or the Dependent of a retiree in a federal retiree medical plan.
- Beginning January 1, 2006, enrollment in PEBB retiree insurance coverage may be deferred when the Subscriber is enrolled in Medicare Parts A and B and a Medicaid program that provides creditable coverage. Eligible Dependents who are not enrolled in Medicaid coverage that provides creditable coverage may be enrolled.
- Beginning January 1, 2014, Subscribers who are not eligible for Medicare Part A and Part B may defer enrollment in PEBB retiree insurance coverage when the Subscriber is enrolled in qualified health plan coverage through a health benefit exchange developed under the Affordable Care Act.
- Beginning July 17, 2018, enrollment in PEBB retiree insurance coverage may be deferred when the Subscriber is enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).
- Beginning January 1, 2025, subscribers who are enrolled in Medicare may defer enrollment in PEBB retiree insurance coverage when they permanently live in a location outside of the United States.

Exception: A retiree may defer enrollment in PEBB retiree insurance coverage during the period of time they are enrolled as a Dependent in a medical plan sponsored by PEBB or School Employees Benefits Board (SEBB), including such coverage under COBRA or Continuation Coverage. They do not need to elect to defer enrollment online or submit a *PEBB Retiree Election Form*.

Enrollment in PEBB retiree insurance coverage is automatically deferred if a retiree or a survivor becomes eligible for the employer contribution toward PEBB or SEBB benefits. They do not need to elect to defer enrollment online or submit a PEBB Retiree Election Form.

A retiree or a survivor who deferred their enrollment in PEBB retiree insurance coverage may enroll as described in the section titled “Enrollment Following Deferral.”

Retiree and Survivor Enrollment

An eligible retiree, a survivor, or their Dependent can enroll in only one PEBB medical plan, even if eligibility criteria is met under two or more Subscribers.

An eligible retiring employee or a retiring school employee must enroll using Benefits 24/7, the online enrollment system, or submit a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. The online enrollment must be completed or the forms must be received no later than 60 days after the employee’s or the school employee’s own employer-paid coverage, COBRA coverage, or Continuation Coverage ends. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible elected or full-time appointed official must enroll using Benefits 24/7, the online enrollment system, or submit a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. The online enrollment must be completed or the forms must be received no later than 60 days after the official leaves public office. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible survivor of a retiree who is enrolled at the time of the retiree’s death will be enrolled in the same PEBB health plan coverage they were enrolled in under their own account with no gap in coverage. To make changes to their PEBB health plan coverage, they must submit a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the death of the retiree. An eligible survivor of a retiree who is not enrolled at the time of the retiree’s death, must enroll by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the death of the retiree.

An eligible survivor of an employee or school employee must enroll by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the later of the date of the employee’s or the school employee’s death, or the date the survivor’s PEBB insurance coverage, educational service district coverage, or SEBB insurance coverage ends. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible employee or school employee determined to be retroactively eligible for disability retirement must enroll using Benefits 24/7, the online enrollment system, or submit a *PEBB Retiree Election Form (form A)* along with any other required forms, supporting documents, and their formal determination letter to the PEBB Program. The online enrollment must be completed or the forms must be received no later than 60 days after the date on the determination letter. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible survivor of an emergency service personnel killed in the line of duty must enroll by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 180 days after the later of:

- The date on the letter from the Department of Retirement Systems or the Board for Volunteer Firefighters and Reserve Officers that informs the survivor that they are determined to be an eligible survivor;
- The date of the emergency service worker’s death; or

- The last day the survivor was covered under any health plan through the emergency service worker's employer or COBRA coverage from the emergency service worker's employer.

A retiree or a survivor who deferred enrollment and is enrolling in a PEBB retiree health plan, must enroll using Benefits 24/7, the online enrollment system, or submit a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program.

A retiree or a survivor who deferred enrollment while enrolled in other qualifying coverage must also submit evidence of continuous enrollment. The online enrollment must be completed or the forms must be received no later than 60 days after a loss of other qualifying coverage.

A retiree or a survivor enrolled in Medicare who deferred enrollment while permanently living outside of the United States must also submit proof of enrollment in Medicare Parts A and B; evidence of continuous enrollment in qualified coverage is waived. The online enrollment must be completed or the forms must be received no later than 60 days after the date of the permanent move or the date the retiree or survivor provides notification of such move, whichever is later.

The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends. See "Enrollment Following Deferral" for additional enrollment timelines.

Note: Enrollment in the Kaiser Permanente NW Senior Advantage with Part D plan may not be retroactive. If a Subscriber is eligible for and elects this Plan and the online enrollment or the required forms are received by the PEBB Program after the date PEBB retiree insurance coverage is to begin, the Subscriber and their enrolled *Dependents* will be enrolled in another Kaiser Permanente NW plan during the gap month(s) prior to when the Kaiser Permanente NW Senior Advantage with Part D plan begins.

Dependent enrollment

To enroll an eligible Dependent, the Subscriber must include the Dependent's information using Benefits 24/7 the online enrollment system, or on the applicable enrollment form and provide the required document(s) as proof of the Dependent's eligibility. The Dependent will not be enrolled in PEBB health plan coverage if the PEBB Program is unable to verify their eligibility within the PEBB Program enrollment timelines.

Dependents who are enrolled in PEBB medical must be enrolled in the same PEBB medical plan as the retiree or survivor.

Exception: If a retiree or a survivor selects the Kaiser Permanente NW Senior Advantage with Part D plan, non-Medicare Enrollees will be enrolled in the Kaiser Permanente NW Classic plan.

A retiree or a survivor may also enroll an eligible Dependent during the PEBB Program's Annual Open Enrollment or during a special open enrollment. See "Making Changes."

Medicare Eligibility and Enrollment

Medicare Part A and Part B

If a Subscriber or their enrolled Dependent becomes eligible for Medicare, they should contact the Social Security Administration to ask about Medicare enrollment.

Any Enrollee who is eligible for Medicare must enroll and stay enrolled in Medicare Part A and Part B to continue enrollment in a PEBB retiree health plan.

In most cases, Medicare will become the primary insurance coverage and the PEBB retiree medical plan will become the secondary insurance coverage.

A Subscriber must provide a copy of their or their Dependent's Medicare card or Medicare benefit verification letter from the Social Security Administration with effective dates by uploading it online using Benefits 24/7 or providing it to the PEBB Program. If a Subscriber or their Dependent is not enrolled in

either Medicare Part A or Part B on their 65th birthday, the Subscriber must upload or provide a copy of the denial letter from the Social Security Administration. If this procedural requirement is not met, eligibility will end as described in the termination notice sent by the PEBB Program. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

Medicare Part D

The PEBB Program has determined that this medical plan has prescription drug coverage that is, on average, as good as or better than the standard Medicare Part D prescription drug coverage (it is “creditable coverage”). Therefore, a Subscriber or their enrolled Dependent cannot enroll in a Medicare Part D plan and stay in this medical plan. If the Subscriber terminates this medical plan, they may contact the PEBB Program to request a certificate of creditable coverage. If creditable prescription drug coverage is not maintained, Medicare Part D premiums may be higher in the future.

If a Subscriber, or their enrolled Dependent chooses to enroll in a Medicare Part D plan, PEBB retiree insurance coverage may only be continued by enrolling in the PEBB-sponsored Medicare supplement plan.

When Medical Coverage Begins

For an eligible retiring employee or retiring school employee and their eligible Dependents, medical coverage begins the first day of the month after the retiring employee’s or retiring school employee’s own employer-paid coverage, COBRA coverage, or Continuation Coverage ends.

For an eligible employee or school employee determined to be retroactively eligible for disability retirement and their eligible Dependents, medical coverage begins on the date chosen by the employee or school employee as allowed under PEBB Program rules.

For an eligible elected or full-time appointed official and their eligible Dependents, medical coverage begins the first day of the month following the date the official leaves public office.

For an eligible survivor of a retiree and their eligible Dependents, medical coverage will be continued without a gap, subject to payment of premiums and applicable premium surcharges. If the eligible survivor is not enrolled at the time of the retiree’s death, medical coverage will begin the first day of the month following the retiree’s death.

For an eligible survivor of an employee or school employee and their eligible Dependents, medical coverage begins the first day of the month following the later of the date of the employee’s or the school employee’s death or the date the survivor’s PEBB insurance coverage or SEBB insurance coverage ends. This does not include emergency service personnel killed in the line of duty.

For an eligible survivor of an emergency service personnel killed in the line of duty and their eligible Dependents, medical coverage begins on the date chosen, as allowed under PEBB Program rules.

For a retiree or a survivor who deferred enrollment and is enrolling in a PEBB retiree health plan following loss of other qualifying coverage, medical coverage for the retiree or the survivor and their eligible Dependents begins the first day of the month after the loss of the other qualifying coverage. For a retiree or a survivor enrolled in Medicare who deferred enrollment while permanently living outside of the United States, medical coverage for the retiree or the survivor and their eligible dependents begins the first day of the month after the permanent move or the date the retiree or survivor provides notification of such move, whichever is later.

For a retiree, a survivor, or their eligible Dependents enrolling during the PEBB Program’s Annual Open Enrollment, medical coverage begins January 1 of the following year.

For a retiree, a survivor, or their eligible Dependents enrolling during a special open enrollment, medical coverage begins the first of the month following the later of the event date or the date the online

enrollment election using Benefits 24/7 or the required form is received. If that day is the first of the month, medical coverage begins on that day.

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

- For a newly born child, medical coverage will begin the date of birth;
- For a newly adopted child, medical coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier; or
- For a Spouse or state registered domestic partner of a Subscriber, medical coverage will begin the first day of the month in which the event occurs.

If the special open enrollment is due to the enrollment of an extended Dependent or a Dependent child with a disability, medical coverage will begin the first day of the month following the later of the event date or eligibility certification, whichever is later.

Making Changes

Removing a Dependent Who is No Longer Eligible

A Subscriber must provide notice to remove a Dependent who is no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a Dependent ceasing to be eligible as a Dependent child, as described under “Dependent Eligibility.” The notice must be received online using Benefits 24/7 or by written request to the PEBB Program within 60 days of the last day of the month the Dependent no longer meets the eligibility criteria.

Consequences for not submitting notice within the required 60 days may include, but are not limited to:

- The Dependent may lose eligibility to continue PEBB medical under one of the Continuation Coverage options described in “Options for Continuing PEBB Medical Coverage.”
- The Subscriber may be billed for claims paid by the medical plan for Services that were rendered after the Dependent lost eligibility.
- The Subscriber may not be able to recover Subscriber-paid insurance premiums for the Dependent that lost eligibility.
- The Subscriber may be responsible for premiums paid by the state for the Dependent’s medical plan coverage after the Dependent lost eligibility.

Voluntary Termination

An enrolled retiree or survivor may voluntarily terminate enrollment in a medical plan at any time by submitting a request online using Benefits 24/7 or in writing to the PEBB Program. Enrollment in the medical plan will be terminated the last day of the month in which the request is received online or by the PEBB Program, or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, medical plan enrollment will be terminated on the last day of the previous month.

A retiree or a survivor who voluntarily terminates their enrollment in a medical plan also terminates all other health plan enrollment and enrollment for all eligible Dependents. Once coverage is terminated, a retiree or a survivor may not enroll again in the future unless they reestablish eligibility for PEBB insurance coverage by becoming newly eligible.

Deferring Enrollment

An enrolled retiree or survivor may defer enrollment in PEBB retiree insurance coverage at any time by submitting the request online using Benefits 24/7 or the PEBB Retiree Change Form (*form E*) along with any other required forms and supporting documents to the PEBB Program. Enrollment in PEBB retiree insurance coverage will be deferred effective the first of the month following the date the request is received online or by the PEBB Program. If the request is received on the first day of the month, enrollment will be deferred effective that day. A retiree or a survivor who deferred their enrollment may enroll as described in “Enrollment Following Deferral.”

Enrollment Following Deferral

A retiree or a survivor who defers enrollment in PEBB retiree insurance coverage:

- **While enrolled in employer-based group medical or such coverage under COBRA coverage or Continuation Coverage** may enroll in a PEBB medical plan during the PEBB Program’s Annual Open Enrollment period, or no later than 60 days after the date their enrollment in employer-based group medical coverage or such coverage under COBRA coverage or Continuation Coverage ends.
- **While enrolled in a federal retiree medical plan as a retiree or Dependent** will have a one-time opportunity to enroll in a PEBB medical plan during the PEBB Program’s Annual Open Enrollment period, or no later than 60 days after their enrollment in a federal retiree medical plan ends.
- **While enrolled in Medicare Parts A and B and a Medicaid program that provides creditable coverage** may enroll in a PEBB medical plan during the PEBB Program’s Annual Open Enrollment period, or no later than 60 days after their Medicaid coverage ends, or no later than the end of the calendar year when their Medicaid coverage ends if they were also enrolled in a subsidized Medicare Part D plan.
- **While enrolled in qualified health plan coverage through a health benefit exchange** developed under the Affordable Care Act will have a one-time opportunity to enroll or reenroll in a PEBB medical plan during the PEBB Program’s Annual Open Enrollment period, or no later than 60 days after exchange coverage ends.
- **While enrolled in CHAMPVA** will have a one-time opportunity to enroll in a PEBB medical plan during the PEBB Program’s Annual Open Enrollment period, or no later than 60 days after their enrollment in a CHAMPVA medical plan ends.
- **While enrolled in Medicare and permanently living outside of the United States** and who moves back to the United States, may enroll in a PEBB medical plan during the PEBB Program’s annual open enrollment period, or no later than 60 days after the date of the permanent move or the date the retiree or survivor provides notification of such move, whichever is later.
- **While enrolled as a Dependent in a medical plan sponsored by PEBB or SEBB, including coverage under COBRA or Continuation Coverage**, may enroll in a PEBB medical plan during the PEBB Program’s Annual Open Enrollment period, or no later than 60 days after the enrollment in a medical plan sponsored by PEBB or SEBB ends, or such coverage under COBRA or Continuation Coverage ends. The evidence of continuous enrollment required to enroll as described below may include a health plan sponsored by a Washington State educational service district if enrollment was deferred prior to January 1, 2024.

Note: Enrollment in the Kaiser Permanente NW Senior Advantage with Part D plan may not be retroactive. If a Subscriber is eligible for and elects this Plan and the online enrollment or the required forms are received by the PEBB Program after the date PEBB retiree insurance coverage is to begin, the Subscriber and their enrolled Dependents will be enrolled in a transitional Kaiser Permanente NW plan during the gap month(s) prior to when the Kaiser Permanente NW Senior Advantage with Part D plan begins.

For a retiree or a survivor to enroll in a PEBB medical plan, the enrollment must be completed online using Benefits 24/7 or the PEBB Program must receive a *PEBB Retiree Election Form (form A)*, any other required forms and supporting documents during the timelines described in this section.

A retiree or a survivor who deferred enrollment while enrolled in other qualifying coverage, must also submit evidence of continuous enrollment in one or more qualifying coverages. A gap in coverage of 31 days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualifying coverage, and between each period of enrollment in qualifying coverages during the deferral period.

A retiree or a survivor enrolled in Medicare who deferred enrollment while permanently living outside of the United States must submit proof of enrollment in Medicare Parts A and B; evidence of continuous enrollment in qualified coverage is waived while the retiree or survivor enrolled in Medicare lives outside of the United States.

A retiree or a survivor who deferred their enrollment in PEBB retiree insurance coverage as described above may also enroll in a PEBB medical plan if they receive formal notice that HCA has determined it is more cost-effective to enroll in a PEBB medical plan than a medical assistance program.

A retiree or a survivor should contact the PEBB Program or visit hca.wa.gov/pebb-retirees to get the required forms, information on premiums, and a list of available medical plans.

Making Changes during Annual Open Enrollment and Special Open Enrollment

A Subscriber may make certain changes to their enrollment during the Annual Open Enrollment and if a specific life event creates a special open enrollment period.

Annual Open Enrollment Changes

A Subscriber may make the following changes to their enrollment during the PEBB Program's Annual Open Enrollment period:

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

A Subscriber must submit the election change online using Benefits 24/7 or submit the required *PEBB Retiree Open Enrollment Election/Change Form (form A-OE)* along with any other required forms, and any supporting documents to the PEBB Program. The change must be completed online or the forms must be received no later than the last day of the Annual Open Enrollment period. The change will be effective January 1 of the following year.

Special Open Enrollment Changes

A Subscriber may change their enrollment outside of the Annual Open Enrollment period if a qualifying event creates a special open enrollment period. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations and correspond to and be consistent with the event that creates the special open enrollment for the Subscriber, their Dependent, or both.

The Subscriber must provide evidence of the event that created the special open enrollment.

To make an enrollment change, the Subscriber must submit the change online using Benefits 24/7 or submit the required *PEBB Retiree Change Form (form E)* along with any other required forms to the PEBB Program. The change must be completed online or the PEBB Program must receive the forms no later than 60 days after the event that creates the special open enrollment. In addition, the PEBB Program will require the Subscriber to provide proof of the Dependent's eligibility, evidence of the event that created the special open enrollment, or both.

Exceptions:

- A Subscriber enrolled in PEBB retiree insurance coverage has six months from the date of their or their Dependent's enrollment in Medicare Part B to change their enrollment to a PEBB Medicare Supplement Plan. The change must be made online or the PEBB Program must receive the required form(s) no later than six months after the enrollment in Medicare Part B for either the Subscriber or their Dependent.
- A subscriber enrolled in PEBB retiree insurance coverage has seven months to enroll in a Medicare Advantage Prescription Drug (MAPD) plan or Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP) that begins three months before they or their dependent first enrolled in both Medicare Part A and Part B and ends three months after the month of Medicare eligibility. A subscriber may also enroll themselves or their dependent in a MAPD plan or UMP Classic Medicare with Part D (PDP) before their last day of the Medicare Part B initial enrollment period. The change must be made online or the forms must be received by the PEBB Program no later than the last day of the month prior to the month the subscriber or their dependent enrolls in the MAPD plan or UMP Classic Medicare with Part D (PDP).
- If a Subscriber wants to enroll a newborn or child whom the Subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the Subscriber should complete the request online or notify the PEBB Program by submitting the required form(s) as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the request must be received online, or the required form(s) must be received no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

Special open enrollment events that allow for a change in health plans

A Subscriber may not change their health plan during a special open enrollment if their State-Registered Domestic Partner or State-Registered Domestic Partner's child is not a tax dependent.

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

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

“Employer contribution” means contributions made by the Dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their Dependent has a change in residence that affects health plan availability. If the Subscriber has a change in residence and their current medical plan is no longer available, the Subscriber must select a new medical plan, as described in PEBB Program rules. If the subscriber does not elect a new medical plan as required, they will be enrolled in a PEBB medical plan designated by the director of HCA or their designee.
- A court order requires the Subscriber or any other individual to provide insurance coverage for an eligible Dependent of the Subscriber (a former Spouse or former State-Registered Domestic Partner is not an eligible Dependent).

- Subscriber or their Dependent enrolls in coverage under Medicaid or a state Children’s Health Insurance Program (CHIP), or the Subscriber or their Dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their Dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber or their Dependent enrolls in coverage under Medicare, or the Subscriber or their Dependent loses eligibility for coverage under Medicare or enrolls in or terminates enrollment in a Medicare Advantage Prescription Drug or a Part D plan. If the Subscriber’s current medical plan becomes unavailable due to the Subscriber or their Dependents enrollment in Medicare, the Subscriber must select a new medical plan.
- Subscriber or their Dependent’s current medical plan becomes unavailable because the Subscriber or enrolled Dependent is no longer eligible for a health savings account (HSA).
- Subscriber or their Dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the Subscriber or their Dependent. The Subscriber may not change their health plan election because the Subscriber or Dependent’s physician stops participation with the Subscriber’s health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but not limit its consideration to the following:
 - Active cancer treatment, such as chemotherapy or radiation therapy
 - Treatment following a recent organ transplant
 - A scheduled surgery
 - Recent major surgery still within the postoperative period
 - Treatment for a high-risk pregnancy
- The PEBB Program determines that there has been a substantial decrease in the providers available under a PEBB medical plan.

Note: The Plan cannot guarantee that any physician, hospital, or other provider will be available or remain under contract with the Plan. An Enrollee may not change medical plans simply because their provider or health care facility discontinues participation with this medical plan until the PEBB Program’s next Annual Open Enrollment or when another qualifying event creates a special open enrollment for changing health plans, unless the PEBB Program determines that a continuity of care issue exists or there has been a substantial decrease in the providers available under the plan.

Special Open Enrollment Events That Allow Adding or Removing a Dependent

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

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

- Subscriber's Dependent has a change in their own employment status that affects their eligibility or their Dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the Dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their Dependent has a change in enrollment under an employer-based group health plan during its Annual Open Enrollment that does not align with the PEBB Program's Annual Open Enrollment.
- Subscriber's Dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the Dependent losing their health insurance.
- A court order requires the Subscriber or any other individual to provide insurance coverage for an eligible Dependent of the Subscriber (a former Spouse or former State-Registered Domestic Partner is not an eligible Dependent).
- Subscriber or their Dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP) or the Subscriber or their Dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their Dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber's Dependent enrolls in Medicare or loses eligibility for Medicare.

When Medical Coverage Ends

Termination dates

Medical coverage ends on the following dates:

- On the last day of the month when any Enrollee ceases to be eligible.
- On the date a medical plan terminates due to a change in contracted service area or when the group policy ends. If that should occur, the Subscriber will have the opportunity to enroll in another PEBB medical plan.
- On the last day of the month in which the monthly premium and applicable premium surcharges were paid.
- The first of the month following the date the election is received online using Benefits 24/7 or the required forms are received by the PEBB Program when an enrolled retiree or survivor requests to defer enrollment in PEBB retiree insurance coverage. If the election is received on the first day of the month, enrollment will be deferred effective that day.
- The last day of the month in which the request is received online using Benefits 24/7 (once available) or the PEBB Program receives a written request and all required forms requesting to voluntarily terminate enrollment in a medical plan. If a future date is specified, medical coverage terminates the last day of the month specified. If the termination request is received on the first day of the month, medical plan enrollment will be terminated on the last day of the previous month.

A Subscriber will be responsible for payment of any Services received after the date medical coverage ends, as described above.

Final Premium Payments

The Subscriber is responsible for timely payment of premiums and applicable premium surcharges.

Premium payments and applicable premium surcharges are not prorated during any month, for any reason, even if an Enrollee dies or asks to terminate their medical plan before the end of the month.

An exception occurs when an enrolled retiree dies on or after June 6, 2024. A state law that took effect June 6, 2024, requires HCA to waive the premium payment for medical, dental, vision, and any applicable premium surcharges for the retiree for the month in which the death occurred.

If the monthly premium or applicable premium surcharges remain unpaid for 30 days, it will be considered delinquent. A Subscriber is allowed a grace period of 30 days from the date the monthly premium or applicable premium surcharges become delinquent to pay the unpaid premium balance or applicable premium surcharges. If the Subscriber's premium balance or applicable premium surcharges remain unpaid for 60 days from the original due date, coverage will be terminated retroactive to the last day of the month for which the monthly premium and any applicable premium surcharges were paid.

If an Enrollee is Hospitalized

An Enrollee who is receiving covered Services in a hospital on the date medical coverage ends will continue to be eligible for covered Services while an inpatient for the condition which the Enrollee was hospitalized, until one of the following events occur:

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

This provision will not apply if the Enrollee is covered under another agreement that provides benefits for the hospitalization at the time medical coverage ends, except as set forth in this section, or if the Enrollee is eligible for PEBB Continuation Coverage as described in "Options for Continuing PEBB Medical Coverage."

Options for Continuing PEBB Medical Coverage

A Subscriber and their Dependents covered by this medical plan may be eligible to continue enrollment under PEBB Continuation Coverage (COBRA) if they lose eligibility. PEBB Continuation Coverage (COBRA) temporarily extends group insurance coverage if certain circumstances occur that would otherwise end the Subscriber or their Dependent's PEBB medical coverage. PEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal COBRA laws and regulations and also includes coverage for some Enrollees who are not qualified beneficiaries under federal COBRA Continuation Coverage. Refer to the *PEBB Continuation Coverage Election Notice* for details.

A subscriber and their dependents covered by this medical plan who lose eligibility for PEBB retiree insurance coverage when their employer group ends participation with the Health Care Authority, may be eligible to continue their enrollment under PEBB Continuation Coverage (Employer Group Ended Participation).

The PEBB Program administers these coverages. Call the PEBB Program at **1-800-200-1004** (TRS: 711) for details.

Options for Continuing Coverage under PEBB Retiree Insurance Coverage

A Dependent becoming eligible as a survivor of a retiree is eligible to continue enrollment or defer enrollment in PEBB retiree insurance coverage if they meet procedural and substantive eligibility requirements. See the *PEBB Retiree Enrollment Guide* for details.

Conversion of Coverage

An Enrollee (including a Dependent of a Subscriber terminated for cause) has the right to switch from PEBB group medical to an individual conversion plan offered by this Plan when they are no longer eligible to continue the PEBB group medical plan and are not eligible for Medicare or covered under another group insurance coverage that provides benefits for hospital or medical care.

An Enrollee must apply for conversion coverage and pay the first month's premium no later than 31 days after their group medical plan ends or within 31 days from the date the notice of termination of coverage is received, whichever is later.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage, and eligibility requirements of this conversion plan differ from those of the Enrollee's current group medical plan. To receive detailed information on conversion options under this medical plan, call us at 1-800-200-1004.

General provisions for eligibility and enrollment

Termination for Just Cause

The purpose of this provision is to allow for a fair and consistent method to process the Plan-designated provider's request to terminate an Enrollee's coverage from this Plan for just cause.

A retiree or an eligible Dependent may have coverage terminated by HCA for the following reasons:

- Failure to comply with the PEBB Program's procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB Program
- Knowingly providing false information
- Failure to pay the monthly premium and applicable premium surcharges when due
- Misconduct. Examples of such termination include, but are not limited to the following:
 - Fraud, intentional misrepresentation or withholding of information the Subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium.
 - Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan, or other HCA-contracted vendor providing PEBB insurance coverage on behalf of HCA, its employees, or other persons.

If a retiree's PEBB insurance coverage is terminated by HCA for the above reasons, PEBB insurance coverage for all of the retiree's eligible Dependents is also terminated.

Appeal Rights

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

Learn more at hca.wa.gov/pebb-appeals.

Fax: 360-763-4709

Mail: Health Care Authority
Attn: PEBB Appeals Unit
PO Box 45504
Olympia, WA 98504-5504

Hand deliver: Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

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

Relationship to Law and Regulations

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

PEBB Customer Service

For questions about PEBB retiree eligibility and enrollment, please call the PEBB Program at 1-800-200-1004 (TRS: 711) or visit hca.wa.gov/pebb-retirees. For questions about Medicare, please call the Centers for Medicare and Medicaid Services (CMS) at 1-800-MEDICARE or visit medicare.gov.

HOW TO OBTAIN SERVICES

The provider network for this High Deductible Health Plan is the Classic network.

The Classic network includes Participating Providers who are either employed by us or contract directly or indirectly with us to provide covered Services for Members enrolled in this High Deductible Health Plan. You pay the Cost Share amount shown on your “Benefit Summary” when you receive covered Services from Participating Providers and Participating Facilities.

To receive covered benefits, you must obtain Services from Participating Providers and Participating Facilities except as described under the following sections in this *EOC*:

- “Referrals to Non-Participating Providers and Non-Participating Facilities.”
- “Emergency, Post-Stabilization, and Urgent Care.”
- “Receiving Care in Another Kaiser Foundation Health Plan Service Area.”
- “Out-of-Area Coverage for Dependents.”
- “Ambulance Services.”

To locate a Participating Provider or Participating Facility, contact Member Services or visit kp.org/doctors to see all Kaiser Permanente locations near you, search for Participating Providers, and read online provider profiles.

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

Primary Care Providers

We encourage you to choose a primary care provider(PCP) for each covered Family Member. This decision is important as your primary care provider provides or arranges most of your health care needs.

You may select a Participating Provider from family practice, internal medicine, or pediatrics as your primary care provider. Members also have the option of choosing a women’s health care Participating Provider as their primary care provider. A women’s health care provider includes an obstetrician or gynecologist, a physician assistant specializing in women’s health, an advanced registered nurse practitioner specializing in

women's health, or a certified nurse midwife. Not all Participating Providers in these specialties are designated primary care providers.

If you do not select a primary care provider, we will assign you to an individual primary care provider or primary care team. We will send you a letter that includes information to help you learn more about your provider or care team, how to find information about other primary care providers near you, and how to change your primary care provider. You may select a different primary care provider at any time. The change will take effect immediately.

For more information, visit kp.org/doctors to search for Participating Providers and Kaiser Permanente locations near you and read online provider profiles. For help with selecting or changing your primary care provider, contact Member Services.

Referrals

Referrals to Participating Providers and Participating Facilities

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

In most cases, Members 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 provider.

Any PCP can make a referral to a Specialist when needed. Once a Member has been referred to a Specialist, they will not need a referral for return visits for the same condition.

In some cases, a standing referral may be allowed to a Specialist for a time period that is in accord with your individual medical needs, as determined by the PCP and Kaiser.

Some outpatient specialty Services are available in Participating Medical Offices without a referral. 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.
- Mental health Services.
- Obstetrics/Gynecology.
- Occupational Health.
-).
- Social Services.
- Substance Use Disorder Services.

Referrals to Non-Participating Providers and Non-Participating Facilities

If your PCP decides that you require Services not available from Participating Providers or Participating Facilities, they will recommend to Medical Group and Kaiser 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 determines that the Services are covered Services, Kaiser will authorize your referral to a Non-

Participating Provider or Non-Participating Facility for the covered Services. 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 Kaiser authorizes the Services, you will receive a written “Authorization for Outside Medical Care” approved referral to the Non-Participating Provider or Non-Participating Facility, and only the Services and number of visits that are listed on the written referral will be covered, subject to any benefit limitations and exclusions applicable to these Services.

Prior 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 Kaiser. If you seek a specific Service, you should talk with your Participating Provider. Your Participating Provider will discuss your needs and recommend an appropriate course of treatment.

If you request Services that must be approved through Utilization Review and the Participating Provider believes they are Medically Necessary, the Participating Provider may submit the request for Utilization Review on your behalf. If the request was received electronically and is denied, we will send a letter to you within three calendar days after we receive the request. If the request was received orally or in writing and is denied, we will send a letter to you within five calendar days after we receive the request. The decision letter will explain the reason for the determination along with instructions for filing an appeal. You may request a copy of the complete Utilization Review criteria used to make the determination by calling Member Services.

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

- Acupuncture Services (physician referred). The initial evaluation and management visit and up to six treatment visits in a New Episode of Care do not require authorization.
- Bariatric surgery Services.
- Breast reduction surgery.
- Drug Formulary exceptions.
- Durable Medical Equipment.
- External Prosthetic 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, including birthing centers.
- Inpatient and residential Substance Use Disorder 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. The initial evaluation and management visit and up to six treatment visits in a New Episode of Care for physical, massage (soft tissue mobilization), occupational, and speech therapies do not require authorization.
- Routine foot care.
- Skilled nursing facility Services.
- Spinal and Extremity Manipulation Therapy Services (physician-referred). The initial evaluation and management visit and up to six treatment visits in a New Episode of Care do not require authorization.
- Organ transplant Services.
- Transgender Surgical Services.
- Travel and lodging expenses.

If you ask for Services that the Participating Provider believes are not Medically Necessary and does not submit a request on your behalf, you may ask for a second opinion from another Participating Provider. You should contact the manager in the area where the Participating Provider is located. Member Services can connect you with the correct manager, who will listen to your issues and discuss your options.

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

Except in the case of misrepresentation, prior authorization review decisions will not be retrospectively denied. Prior authorization determinations shall expire no sooner than forty-five days from the date of approval. We may revoke or amend an authorization for Services you have not yet received if your membership terminates or your coverage changes or you lose your eligibility, or if we receive information that is materially different from that which was reasonably available at the time of the original determination.

Individual Case Management

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

Home Health Care Alternative to Hospitalization

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

Participating Providers and Participating Facilities Contracts

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

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

Provider Whose Contract Terminates

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

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

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

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

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

Receiving Care in Another Kaiser Foundation Health Plan Service Area

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

POST SERVICE CLAIMS – SERVICES ALREADY RECEIVED

In general, if you have a medical or pharmacy bill from a Non-Participating Provider, Non-Participating Facility, or non-participating pharmacy 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.

If you receive Services from a Non-Participating Provider or Non-Participating Facility without an authorized referral, or from a pharmacy that is not a Participating Pharmacy, and you believe Kaiser 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.

Kaiser accepts CMS 1500 claim forms for professional Services and UB-04 forms for hospital claims. Even if the provider bills Kaiser 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 Kaiser, 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

Emergency Services

If a Member has an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department, Independent Freestanding Emergency Department, or Behavioral Health Emergency Services Provider. A Member does not need prior authorization for Emergency Services. When a Member has an Emergency Medical Condition, we cover Emergency Services they 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 “Benefit Details” section (subject to the “Benefit Exclusions and Limitations” section) if the Member had received them from Participating Providers or Participating Facilities. You pay the emergency department visit Cost Share shown in the “Benefit Summary”

under “Emergency Services” for all Services received in the emergency department or from the Behavioral Health Emergency Services Provider.

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 or from the Behavioral Health Emergency Services Provider.

If you have an Emergency Medical Condition, we cover licensed ambulance Services when:

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

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

Post-Stabilization Care

Post-Stabilization Services relate to medical, mental health or Substance Use Disorder treatment necessary in the short term to avoid placing the health of the individual, or with respect to a pregnant person, the health of them or their unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

We cover Post-Stabilization Care 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.
- Services are provided after you are Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and Stabilization Services have been furnished.

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

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

When you receive Emergency Services from Non-Participating Providers, Post Stabilization Care may qualify as Emergency Services pursuant to federal law. We will not require prior authorization for such Post-Stabilization Care when your attending Non-Participating Provider determines that, after you are Stabilized, and taking into account your medical or behavioral health condition, you are not able to travel to an available Participating Provider located within a reasonable travel distance, using non-medical transportation or non-emergency transportation.

Urgent Care

Inside our Service Area

You may receive covered Urgent Care Services from Participating Providers, including Kaiser Permanente Urgent Care. Visit kp.org/getcare or call Member Services to find the Kaiser Permanente Urgent Care locations nearest you.

Outside our Service Area

You may receive covered Urgent Care Services from Participating Providers or Participating Facilities. Visit kp.org/getcare or call Member Services to find Urgent Care locations nearest you.

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

WHAT YOU PAY

Deductible

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

For Services that are subject to the Deductible, you must pay Charges for the Services when you receive them, until you meet your Deductible.

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

After you meet the Deductible, you pay the applicable Copayments and Coinsurance for covered Services for the remainder of the Year until you meet your Out-of-Pocket Maximum (see “Out-of-Pocket Maximum” section).

Increasing the Deductible

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

Changes to Your Family

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

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

Copayments and Coinsurance

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

Out-of-Pocket Maximum

There is a maximum to the total dollar amount of Deductible, Copayment and Coinsurance that you must pay for covered Services that you receive within the same Year under this or any other evidence of coverage with the same Group number printed on this *EOC*.

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 Deductibles, Copayments and Coinsurance amounts 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 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 you exhausted (used up) your benefit allowance, or because we already covered the benefit maximum amount or the maximum number of days or visits for a Service.
- Payments for vision hardware for Members age 19 and older.
- Payments for hearing aid Services.
- Amounts recovered from a liability claim against another party subject to reimbursement under the “Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-fault Insurance” section.

BENEFIT DETAILS

The Services described in this “Benefit Details” section are covered only if all the following conditions are satisfied, and will not be retrospectively denied:

- You are a Member on the date you receive the Services.
- 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 the coverage requirements described in this “Benefit Details” section. Some Services are subject to benefit-specific exclusions and/or limitations and eligibility provisions, which are listed, when applicable, in each benefit section. A broader list of exclusions and limitations that apply to all benefits is provided under the “Benefit Exclusions and Limitations” section.

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.

1. Accidental Injury to Teeth

The Services of a licensed dentist will be covered for repair of accidental injury to sound, healthy, natural teeth. Evaluation of the injury and development of a written treatment plan must be completed within 30 days from the date of injury. Treatment must be completed within the period established in the treatment plan unless delay is medically indicated and the written treatment plan is modified.

Accidental Injury to Teeth Exclusions

- Conditions not directly resulting from the accident; and treatment not completed within the time period established in the written treatment plan.
- Dental appliances and dentures.
- Dental implants.
- Dental Services for injuries to teeth caused by biting or chewing.
- Hospital Services for dental care.
- Orthodontic treatment.
- Routine or preventive dental Services.
- Services to correct malocclusion resulting from an accidental injury, except for emergency stabilization.

2. Administered Medications

Administered Medications such as drugs, injectables, and radioactive materials used for therapeutic or diagnostic purposes, are covered if they are administered to you in a Participating Hospital, Participating Medical Office or during home visits.

3. Acupuncture Services

Acupuncture Services are provided by a Participating Provider in the Participating Provider's office. East Asian medicine practitioners use acupuncture to influence the health of the body by the insertion of very fine needles. Acupuncture treatment is primarily used to relieve pain, reduce inflammation, and promote healing. Covered Services include:

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

To locate a Participating Provider, visit www.chpgroup.com. The CHP Group is a Participating Provider we contract with to provide acupuncture Services. 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.

Self-referred Acupuncture Services

We cover self-referred outpatient visits for acupuncture Services, up to the visit limit shown on your "Benefit Summary." You do not need a referral or prior authorization.

Physician-referred Acupuncture Services

We cover physician-referred outpatient visits for acupuncture Services when provided by a Participating Provider when you receive a referral from a Participating Provider, and only when the Services are provided as outpatient Services in the Participating Provider's office. These Services are subject to Utilization Review by Kaiser using criteria developed by Medical Group and approved by Kaiser. However, you do not need authorization for an initial evaluation and management visit and up to six treatment visits for a New Episode of Care.

Acupuncture Services 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.

4. Ambulance Services

Emergency ground ambulance Services are covered to a Participating Facility, or the nearest facility where care is available. If ground ambulance Services are not appropriate for transporting the Member to the nearest facility, the Plan covers emergency air ambulance.

Ambulance Services are covered only when all of the following are true:

- A Participating Provider determines that your condition requires the use of medical Services that only a licensed ambulance can provide.

- A Participating Provider determines that the use of all other means of transportation, whether or not available, would endanger your health.
- The ambulance transports you to or from a location where you receive covered Services, such as between a hospital and a Behavioral Health Emergency Services Provider.

Ambulance Services Exclusions

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

5. Bariatric Surgery and Weight Control and Obesity Treatment

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

The Member 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:

- The Member fully complies with the Kaiser Permanente Severe Obesity Evaluation and Management Program's contract for participation approved by Kaiser.
- The Member receives the Service at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).

6. Services Provided in Connection with Clinical Trials

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

- We would have covered the Services if they were not related to a clinical trial.
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
 - A Participating Provider makes this determination.
 - You provide us with medical and scientific information establishing this determination.
 - If any Participating Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Participating Provider unless the clinical trial is outside the state where you live.
- The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
 - The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (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.

- o The Agency for Health Care Research and Quality.
- o The Centers for Medicare & Medicaid Services.
- o A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
- o A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- o 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 “Hospital Services” in the “Benefit Summary” for the Cost Share that applies to hospital inpatient care.

7. Diabetic Education

Medically Necessary diabetic education, including diabetic counseling and diabetic self-management training is covered. The Member’s PCP or Participating Provider must prescribe the Services.

8. Diagnostic Testing, Laboratory, Mammograms and X-ray

Laboratory or special diagnostic procedures such as CT scans, MRI, mammograms, including tomosynthesis (3-D mammography), imaging, including X-ray, ultrasound imaging, cardiovascular testing, nuclear medicine, and allergy testing, prescribed by the Member’s PCP or Participating Provider, and provided at a Participating Facility are covered. Screening and special diagnostic procedures during pregnancy and related genetic counseling when Medically Necessary for prenatal diagnosis of congenital disorders are included.

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

Some Services, such as preventive screenings and routine mammograms, are not covered under this “Diagnostic Testing, Laboratory, Mammograms and X-ray” benefit but may be covered under the “Preventive Care Services” section. We cover preventive care Services without charge.

Diagnostic Testing, Laboratory, Mammograms and X-ray Limitations

Covered genetic testing 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. These Services are subject to Utilization Review by Kaiser using criteria developed by Medical Group and approved by Kaiser.

9. Dialysis—Outpatient

Outpatient professional and facility Services necessary for dialysis when referred by the Member’s PCP or Participating Provider are covered. Dialysis is covered while you are temporarily absent from our Service Area. A temporary absence is an absence lasting less than twenty-one (21) days. Services must be preauthorized prior to departure from our Service Area.

10. Durable Medical Equipment (DME) and External Prosthetic Devices and Orthotic Devices

This Plan covers the rental or purchase of Durable Medical Equipment (DME) and related medical supplies, External Prosthetic Devices, and Orthotic Devices.

Outpatient Durable Medical Equipment (DME)

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

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

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

Covered DME includes but is not limited to the following:

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

Outpatient Durable Medical Equipment (DME) Exclusions

- Comfort, convenience, or luxury equipment or features.
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies) unless specifically listed as covered in this “Durable Medical Equipment (DME) and External Prosthetic Devices and Orthotic Devices” section.
- Exercise or hygiene equipment.
- Modifications to your home or car.
- More than one corrective appliance or artificial aid or item of DME, serving the same function or the same part of the body, except for necessary repairs, adjustments and replacements as specified in this “Durable Medical Equipment (DME) and External Prosthetic Devices and Orthotic Devices” 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.

External Prosthetic Devices and Orthotic Devices

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

- The device is Medically Necessary to restore or maintain your ability to complete activities of daily living or essential job-related activities and is 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 patient instruction in the use of the device.

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

- A wig or hairpiece to replace lost hair due to radiation therapy or chemotherapy for a covered condition, up to a lifetime benefit maximum payment of \$100 per Member.

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

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

External Prosthetic Devices and Orthotic Devices Exclusions

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

11. Emergency Services

Emergency department visits at an emergency room facility are covered. If the Member is transferred from the emergency room to an observation bed, there is no additional Cost Share. If the Member is admitted as an inpatient directly from the emergency room or from an observation bed, the inpatient hospital Cost Share will be applied. Use of a hospital emergency room for a non-medical emergency is not covered.

12. Habilitative Services

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

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

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

The following habilitative Services are covered as described under the “Durable Medical Equipment (DME) and External Prosthetic Devices and Orthotic Devices” section:

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

Habilitative Services Exclusions

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

13. Hearing Instruments

We cover Medically Necessary Services for the treatment of hearing loss as described in this “Hearing Instruments” section. Hearing instruments means any wearable prosthetic instrument or device designed for aiding, improving, compensating for, or correcting defective human hearing, and any parts, attachments, or accessories necessary for the device to function, excluding batteries, cords, and assistive listening devices. Hearing instruments include bone conduction hearing devices, as an alternative to conventional hearing aids, when Medically Necessary.

Coverage includes the initial assessment, fitting, adjustment, auditory training, and ear molds as necessary to maintain optimal fit. We will cover these Services for Members who intend to obtain or have already obtained any hearing instrument, including an over-the-counter hearing instrument; however, we will not cover the over-the-counter hearing instrument itself.

For minors under 18 years of age, the benefits described in this “Hearing Instruments” section are available only after the Member has received medical clearance within the preceding six months from:

- An otolaryngologist for an initial evaluation of hearing loss; or
- A licensed physician, which indicates there has not been a substantial change in clinical status since the initial evaluation by an otolaryngologist.

We provide an allowance toward the price of a hearing instrument for each ear with hearing loss. The allowance amount is shown in the “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 instrument for that ear within the same benefit period.

Hearing Instruments Exclusions

- 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).

- Batteries, cords, cleaners, and moisture guards.
- Over-the-counter (non-prescription) hearing instruments.
- Repair of hearing instruments beyond the warranty period.
- Replacement of lost or broken hearing aids if you have exhausted (used up) your allowance.
- Replacement parts.

14. Home Health Services

Home health Services are Services provided in the home by nurses, medical social workers, mental health and Substance Use Disorder professionals, home health aides, and physical, occupational, speech and respiratory therapists.

We cover home health Services only if all of the following are true:

- You are substantially confined to your home (or to a place of temporary or permanent residence used as your home) or the care is provided in lieu of Medically Necessary hospitalization.
- A Medical Group physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home.
- You receive prior authorization from Kaiser in accordance with Utilization Review criteria developed by Medical Group and approved by Kaiser.
- Services are provided through a licensed Home Health Agency.

Home Health Services Exclusions

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

15. 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.

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 Kaiser Utilization Review criteria.

The following hospice Services are covered (Deductible may apply):

- 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.

16. Hospital Services

Inpatient Hospital Services

We cover Services when you are admitted as an inpatient in a Participating Hospital. Additional types of inpatient Services are covered as described under other headings in this section.

Some inpatient Services may be subject to prior authorization from Company in accordance with Utilization Review criteria developed by Medical Group and approved by Company. For more information about Services that require Utilization Review, or to request a copy of the criteria for a specific condition or Service, please contact Member Services.

Covered inpatient Services include but are not limited to:

- 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.
- Drugs and radioactive materials used for therapeutic purposes, except for the types of drugs excluded under the “Prescription drugs, insulin, and diabetic supplies” section.

- Durable Medical Equipment and medical supplies.
- Emergency detoxification.
- Gender Affirming Treatment.
- General and special nursing care Services.
- Internally implanted devices, including cochlear implants, except for internally implanted insulin pumps.
- Interrupted pregnancy surgery when performed in an inpatient setting.
- Laboratory, X-rays and other imaging, and special diagnostic procedures.
- Medical foods and formulas if Medically Necessary.
- Medical social Services and discharge planning.
- Operating and recovery rooms.
- Orthognathic surgery and supplies for treatment of temporomandibular joint (TMJ) disorder or injury, sleep apnea or congenital anomaly.
- Palliative care.
- Participating Provider's Services, including consultation and treatment by Specialists.
- Prescription drugs, including injections.
- 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 Kaiser using criteria developed by Medical Group and approved by Kaiser.
- Vasectomy.

Outpatient Hospital Services

We cover 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. Additional types of outpatient Services are covered as described under other headings in this "Benefits" section.

Some outpatient Services may be subject to prior authorization from Company in accordance with Utilization Review criteria developed by Medical Group and approved by Company. For more information about Services that require Utilization Review, or to request a copy of the criteria for a specific condition or Service, please contact Member Services.

Covered outpatient Services include but are not limited to:

- Allergy testing and treatment materials.
- Cardiac rehabilitative therapy visits.
- Chemotherapy and radiation therapy Services.
- Diagnostic Services and scope insertion procedures, such as colonoscopy, endoscopy, and laparoscopy.
- Drugs, injectables, and radioactive materials used for therapeutic or diagnostic purposes, if they are administered to you in a Participating Medical Office or during home visits, subject to the drug formulary and exclusions described under the "Limited Outpatient Prescription Drugs and Supplies" section.
- Emergency department visits.

- Gender Affirming Treatment.
- Internally implanted devices, including cochlear implants, except for internally implanted insulin pumps.
- Nurse treatment room visits to receive injections, including allergy injections.
- Outpatient surgery and other outpatient procedures, including interrupted pregnancy surgery performed in an outpatient setting.
- Primary care visits for internal medicine, gynecology, family medicine, and pediatrics.
- Respiratory therapy.
- Routine hearing exams.
- Specialty care visits (includes home birth).
- Treatment for temporomandibular joint (TMJ) disorder.
- Urgent Care visits.
- Vasectomy.

Dental Anesthesia—Inpatient/Outpatient

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

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

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

17. Interrupted Pregnancy Surgery

We cover interrupted pregnancy surgery in an inpatient or outpatient setting.

18. Massage Therapy

We cover outpatient visits for therapeutic massage Services without prior authorization, when the Services are received from a Participating Provider and provided as outpatient Services in the provider’s office, up to the visit limit shown on your “Benefit Summary.”

Therapeutic massage involves the manipulation of soft tissue structures of the body to help alleviate pain, muscle discomfort, and stress by helping to promote health and wellness.

To locate a Participating Provider, visit www.chpgroup.com. The CHP Group is a Participating Provider we contract with to provide therapeutic massage Services. If you need assistance searching for a 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.

Massage Therapy Exclusions

- Dermal friction technique.

- East Asian massage and tui na.
- Qi gong.
- Services designed to maintain optimal health in the absence of symptoms.

19. Medical Foods and Formula

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

- 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.

20. Mental Health Services

We cover mental health Services as found in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by the American Psychiatric Association, including Services for treatment of eating disorders when associated with a diagnosis of a DSM categorized mental health condition.

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

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

Outpatient Services

Services for diagnosis and treatment of mental illness are covered for intensive outpatient visit, partial hospitalization, and without charge for Assertive Community Treatment (ACT) Services for mental health. ACT Services are designed to provide comprehensive outpatient treatment and support to Members who are diagnosed with a severe mental illness and whose symptoms of mental illness lead to serious dysfunction in daily living.

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

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

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

- You are substantially confined to your home (or a friend’s or relative’s home), or the care is provided in lieu of Medically Necessary hospitalization.
- Your Participating Provider determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home.
- You receive prior authorization from Kaiser in accordance with Utilization Review criteria developed by Medical Group and approved by Kaiser.

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.

21. 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. The CHP Group is a Participating Provider we contract with to provide naturopathic medicine Services. 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.

22. Obstetrics, Maternity and Newborn Care

This Plan covers obstetrics, maternity and newborn care Services, including Services for pregnancy and pregnancy complications. There is no pre-existing condition waiting period. Services must be determined by the Member’s PCP or women’s health care Participating Provider, in conjunction with the mother, to be Medically Necessary and appropriate based on accepted medical practice.

Services covered include:

- Prenatal care visits and postpartum visits,
- Maternity hospital care for mother and baby, including Services for complications of pregnancy.
- Vaginal or cesarean childbirth delivery, in a hospital or a birth center, including facility fees.
- Home childbirth services when provided by a Participating Provider, including Medically Necessary supplies for a home birth, for low risk pregnancies.
- Newborn medical Services following birth and initial physical exam.
- Newborn PKU test.

- Medically Necessary donor human milk for inpatient use for infants who are medically or physically unable to receive maternal human milk or participate in breastfeeding or whose mother is medically or physically unable to produce maternal human milk.

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

We will not limit the length of a maternity inpatient hospital stay for a mother and baby to less than 48 hours for vaginal delivery and 96 hours for a cesarean section delivery. The length of inpatient hospital stay is determined by the Member’s PCP or Participating Provider, in consultation with the mother. Our policy complies with the federal Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA).

Use of birthing centers for delivery must be preauthorized as described in the “Prior Authorization Review Requirements” section of this *EOC*. Medically Necessary Services furnished in connection with childbirth at your home are covered when provided by a Participating Provider, subject to the specialty care office visit Cost Share.

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

Services related to voluntary and involuntary termination of pregnancy on an outpatient basis are covered. Inpatient hospital Services related to voluntary and involuntary termination of pregnancy are covered, subject to the inpatient hospital Cost Share.

Obstetrics, Maternity and Newborn Care Exclusions

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

23. Office Visits

Services provided by the Member’s PCP are covered at your Primary care visit cost share shown in the “Benefit Summary”. Visits to a Specialist, when referred by the Member’s PCP, are covered at the Specialty care visit Cost Share shown in the “Benefit Summary”.

A Urgent Care visit Cost Share applies to qualifying Urgent Care received during certain hours at designated Urgent Care facilities and Participating Medical Offices within the Service Area and from Non-Participating Providers outside the Service Area.

Injections, including allergy injections, are covered when received in a nurse treatment room.

Family Planning Services are covered when provided by the Member’s PCP or women’s health care Participating Provider.

24. Organ Transplants

Transplant Services for bone marrow, cornea, heart, heart-lung, kidney, liver, lung, pancreas, pancreas after kidney, simultaneous kidney-pancreas, small bowel, small bowel/liver, and stem cell, including professional and Participating Facility fees for inpatient accommodation, diagnostic tests and exams, surgery and follow-up care, are covered subject to inpatient hospital Cost Share or office visit Cost Share and preauthorization requirements as described in the “Prior Authorization Review Requirements” section of this *EOC*.

See other benefits of this Plan for related Services, such as prescription drugs and outpatient laboratory and X-ray.

Organ transplants are covered when preauthorized as described in the “Prior Authorization Review Requirements” section of this *EOC*, and performed in a National Transplant Network facility.

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

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

Organ transplant donor. Kaiser provides (or pays for) certain donation-related Services for a living transplant 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 a Member. Kaiser’s criteria for donor Services are available by calling Member Services.

Organ Transplants Limitations

- 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.
- Kaiser, 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 may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. Your transplant coordinator can provide information about covered expenses.

Organ Transplants Exclusions

- Non-human organs and their implantation.

25. Out-of-Area Coverage for Dependents

This limited out-of-area benefit is available to Dependent children 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 outside any Kaiser Foundation Health Plan service area but inside the United States (which for the

purpose of this benefit means the 50 states, the District of Columbia, and United States territories). These out-of-area benefits are limited to the following Services as otherwise covered under this *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 Substance Use Disorder Services, naturopathic medicine 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, such as:

- Services covered under the “Emergency, Post-Stabilization, and Urgent Care” section; or under “Primary Care Provider” in the “How to Obtain Services” section.
- “Organ transplants” under “Benefit Details.”
- “Receiving Care in Another Kaiser Foundation Health Plan Service Area.”

26. Outpatient Surgery Visit

Services at an ambulatory surgical center (discharged within 24 hours of admission) are covered. Services must be provided at a Participating Facility and are subject to Utilization Review by Kaiser using criteria developed by Medical Group and approved by Kaiser.

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

- is a child under age seven, or is physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
- has a medical condition that the Member’s PCP determines would place the Member at undue risk if the dental procedure were performed in a dental office.

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

27. Prescription Drugs, Insulin, and Diabetic Supplies

We cover outpatient prescription drugs and supplies as described in this section.

Covered drugs and supplies must be prescribed by a Participating Provider or any licensed dentist in accordance with our drug Formulary guidelines. Over-the-counter contraceptive drugs, device, and products, approved by the U.S. Food and Drug Administration (FDA), do not require a prescription in order to be covered.

You must obtain drugs and supplies at a Participating Pharmacy (including our Mail-Order Pharmacy). 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 “Prescription drugs, insulin, and diabetic supplies” benefit include:

- Certain preventive medications (including, but not limited to, aspirin, fluoride, liquid iron for children ages 6 to 12 months at risk for anemia, and tobacco cessation drugs) according to, and as recommended by, the USPSTF, when obtained with a prescription order.
- Certain self-administered IV drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as IV or intraspinal-infusion) for up to a 30-day supply, including the supplies and equipment required for their administration.
- Drugs, injectables, and radioactive materials used for therapeutic or diagnostic purposes, if they are administered to you in a Participating Medical Office or during home visits. We cover these items upon payment of the Administered Medications Cost Share shown in the “Benefit Summary.”
- Drugs prescribed for an indication if the FDA has not approved the drug for that indication (off-label drugs) are covered only if our Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health and Human Services.
- FDA approved prescription and over-the-counter contraceptive drugs and devices including injectable contraceptives and internally implanted time-release contraceptive drugs, emergency contraceptives, spermicide, and contraceptive devices such as condoms, intrauterine devices, diaphragms, and cervical caps.
- Glucagon emergency kits, insulin, ketone test strips for urine-testing, blood glucose test strips, and disposable needles and syringes when prescribed for the treatment of diabetes. We cover additional diabetic equipment and supplies, including lancets and injection aids, under the “Durable Medical Equipment (DME) and External Prosthetic Devices and Orthotic Devices” section.
- Self-administered chemotherapy medications used for the treatment of cancer.
- Post-surgical immunosuppressive drugs after covered transplant Services.
- Prescription medications purchased in a foreign country when associated with an Emergency Medical Condition.

Cost Share for Covered Drugs and Supplies

When you get a prescription from a Participating Pharmacy, or order a prescription from our Mail-Order Pharmacy, you pay the Cost Share as shown in the “Benefit Summary.” This applies for each prescription consisting of up to the day supply shown in the “Benefit Summary.”

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

If Charges for the drug or supply are less than your Cost Share, 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 an approved drug manufacturer coupon as payment for your prescription Copayment or Coinsurance, after you satisfy your Plan’s Deductible. Drug manufacturer coupons cannot be used toward payment of the Deductible in this HSA-compatible high deductible health Plan.

If the coupon does not cover the entire amount of your Copayment or Coinsurance, you are responsible for the additional amount up to the applicable Copayment or Coinsurance as shown in the “Benefit Summary.” When you use an approved coupon for payment of your Copayment or Coinsurance, the coupon amount will count 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 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 for any prescribed quantity that exceeds the day supply limit, unless due to medication synchronization, in which case we will adjust the applicable Cost Share for the quantity that exceeds the day supply limit.

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

Medication Synchronization

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

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

How to Get Covered Drugs or Supplies

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

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

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

Definitions

- **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 ingredient(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 Kaiser’s Regional Formulary and Therapeutics Committee and requires prior authorization for coverage.

- **Preferred Brand-Name Drug.** A Brand-Name drug or supply that Kaiser’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.
- **Preventive Drug.** A drug on our preventive items list when prescribed to prevent the onset of disease or illness. If you would like a copy of the current list of eligible Preventive Drugs, please call Member Services.
- **Specialty Drug.** A drug or supply, including many self-injectables as well as other medications, often used to treat complex chronic health conditions, is generally high cost, and is approved by the U.S. Food and Drug Administration (FDA). Specialty drug treatments often require specialized delivery, handling, monitoring, and administration.

About Our Drug Formulary

Our drug Formulary is a list of drugs that our Regional Formulary and Therapeutics Committee has reviewed and approved for our Members and includes drugs covered under this section “Prescription drugs, insulin, and diabetic supplies.” Drugs on the Formulary have been approved by the FDA.

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

The Regional Formulary and Therapeutics Committee meets to review new drugs and reconsider drugs currently on the market. After this review, they may add drugs to the Formulary or remove drugs from it. If a drug is removed from the Formulary, you will need to switch to another comparable drug that is on the drug Formulary, unless your old drug meets exception criteria. Refer to the “Drug Formulary exception process.”

We will not require the substitution of a non-preferred drug with a preferred drug in a given therapeutic class or increase the Cost Share within the Year, if the prescription is for the refill of a drug prescribed to treat a serious mental illness, the Member is medically stable on the drug, and a Participating Provider continues to prescribe the drug.

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

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

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

Prior Authorization and Step Therapy Prescribing Criteria

Prior authorization is required when you are prescribed certain drugs or supplies before they can be covered. A Participating Provider may request prior authorization if they determine that the drug or supply is Medically Necessary. Prescribing Participating Providers must supply to Kaiser the medical information necessary for

Kaiser to make the prior authorization determination. Coverage for a prescribed drug or supply that is approved for prior authorization begins on the date Kaiser approves the request.

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 Kaiser, 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. A request may be expedited if you are experiencing a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a nonformulary drug.

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

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

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

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. A request may be expedited if you are experiencing a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a nonformulary drug.

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

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

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

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

If we approve an exception through this exception process, then we will cover the drug or supply at the applicable Cost Share shown in the “Prescription drugs, insulin, and diabetic supplies” section 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.

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 Kaiser’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 “Benefit Summary.” An emergency fill is limited to no more than a seven-day supply or the minimum packaging size available.

Your Prescription Drug Rights

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

If you would like to know more about your rights, or if you have concerns about your Plan you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900 or www.insurance.wa.gov. If

you have a concern about the pharmacists or pharmacies serving you, please contact the Washington State Department of Health at 360-236-4700, www.doh.wa.gov, or hsqa.csc@doh.wa.gov.

Medication Management Program

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

Outpatient Prescription Drugs and Supplies 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 70 percent of the quantity. Prescriptions for controlled substances cannot be refilled early refill. Please ask your pharmacy if you have questions about when you can get a covered refill.
- The Participating Pharmacy may reduce the day supply dispensed at the applicable Cost Share to a 30-day supply in any 30-day period if it determines that the drug or supply is in limited supply in the market or for certain other items. Your Participating Pharmacy can tell you if a drug or supply you use is one of these items.
- For certain drugs or supplies we may limit the amount of a drug or supply that is covered for a specified time frame. Quantity limits are in place to ensure safe and appropriate use of a drug or supply. Drugs and supplies subject to quantity limits are indicated on our drug Formulary, available at kp.org/formulary. You may also contact Member Services for more information.
- 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 Drugs and Supplies Exclusions

- Any packaging, such as blister or bubble repackaging, 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 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 Kaiser's 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 non-prescription drugs or supplies described in the "Covered Drugs and Supplies" section.
- Drugs, biological products, and devices that the FDA has not approved.
- Drugs prescribed for fertility treatment.

- Drugs used for the treatment or prevention of sexual dysfunction disorders.
- Drugs used in weight management.
- Drugs used to enhance athletic performance.
- Extemporaneously compounded drugs, unless the formulation is approved by our Regional Formulary and Therapeutics Committee.
- Internally implanted time-release drugs, except that internally implanted time-release contraceptive drugs are covered.
- Nutritional supplements.
- Replacement of drugs and supplies due to loss, damage, or carelessness.

28. 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.

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/uspstf/recommendation-topics/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 supported by HRSA. You can access the list of preventive care Services at www.hrsa.gov/womensguidelines/.

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

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

- Bone densitometry.
- Cervical cancer screening.
- Chlamydia test.
- Cholesterol test (all types).
- Colorectal cancer screening for Members age 45 or older, or for younger Members who are at high risk, including:
 - Fecal occult blood test yearly plus one flexible sigmoidoscopy every four years, or more frequently as recommended by your provider.
 - Colonoscopy every ten years, or double contrast barium enema every five years, or more frequently as recommended by your provider.
 - Follow-up colonoscopy for screening to be achieved following abnormal findings identified by flexible sigmoidoscopy or CT colonography screening.
 - Required specialist consultation prior to the screening procedure.

- Bowel preparation medications prescribed for the screening procedure.
- Anesthesia Services performed in connection with the screening procedure.
- Polyp removal performed during the screening procedure.
- Any pathology exam on a polyp biopsy performed as part of the screening procedure.
- Contraceptive Services and supplies, including, but not limited to, transabdominal and transcervical sterilization procedures, and insertion/removal of IUD, or implanted birth control drugs and devices.
- Depression screening for Members 12 years of age and older, including pregnant and postpartum members.
- Diabetic retinopathy screening.
- Fasting glucose tests.
- Healthy diet counseling and counseling for obesity and weight management.
- Immunizations.
- Mammography, including tomosynthesis (3-D mammography).
- Pre-exposure prophylaxis (PrEP) therapies for Members who are at high risk for HIV infection.
- 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 provider recommends it because you are at high risk for prostate cancer or disease.
- Routine preventive physical exam (adult, well-baby, and well-child).
- Screening for physical, mental, sexual, and reproductive health care needs that arise from a sexual assault.
- Screening Prostate-Specific Antigen (PSA) tests (not including monitoring or ultrasensitive tests).

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

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

29. Radiation and Chemotherapy Services

Prescribed radiation and chemotherapy Services are covered when provided by a Participating Provider.

30. 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 Kaiser using criteria developed by Medical Group and approved by Kaiser.

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

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

31. Rehabilitative Therapy Services

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

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

Outpatient Rehabilitative Therapy Services

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

Outpatient Rehabilitative Therapy Services Limitations

- Physical therapy, massage therapy (soft tissue mobilization), 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.
- Therapy Services do not include maintenance therapy for chronic conditions except for neurodevelopmental conditions.

Inpatient Rehabilitative Therapy Services

Inpatient rehabilitative therapy Services are covered, subject to the inpatient hospital Cost Share, 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.

32. 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 Kaiser using criteria developed by Medical Group and approved by Kaiser.

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

We cover the following:

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

33. Spinal and Extremity Manipulation Therapy Services

We cover outpatient visits for Spinal and Extremity Manipulation therapy Services when provided by a Participating Provider in the Participating Provider’s office. Covered Services include:

- Evaluation and management.
- Diagnostic radiology.
- Musculoskeletal treatments.
- Hot and cold packs,
- Treatment for the onset of an illness or injury, aggravation of an illness or injury, and the exacerbation of an illness or injury.

To locate a Participating Provider, visit www.chpgroup.com. The CHP Group is a Participating Provider we contract with to provide Spinal and Extremity Manipulation therapy Services. 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.

Self-referred Spinal and Extremity Manipulation Therapy Services

We cover self-referred outpatient visits for Spinal and Extremity Manipulation therapy Services. The visit maximum shown in the “Benefit Summary” 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. You do not need a referral or prior authorization.

Physician-referred Spinal and Extremity Manipulation Therapy Services

We cover physician-referred outpatient visits for Spinal and Extremity Manipulation therapy Services when you receive a referral from a Participating Provider. These Services are subject to Utilization Review by Kaiser using criteria developed by Medical Group and approved by Kaiser. However, you do not need authorization for an initial evaluation and management visit and up to six treatment visits for a New Episode of Care.

Spinal and Extremity Manipulation Therapy Services Exclusions

- Dermal friction technique.
- East Asian massage and tui na.
- Nambudripad allergy elimination technique (NAET).
- Qi gong.
- Services designed to maintain optimal health in the absence of symptoms.
- Sonopuncture.

34. Substance Use Disorder Services

We cover Substance Use Disorder Services as found in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, including medical treatment for withdrawal symptoms (including methadone maintenance) and acupuncture treatment for Substance Use Disorder. Acupuncture visit limits do not apply to acupuncture treatment for Substance Use Disorder.

Services are 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.

The benefits described in this “Substance Use Disorder Services” section comply with the Mental Health Parity and Addiction Equity Act.

You do not need to obtain prior authorization for the following Substance Use Disorder Services:

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

Additional Services require prior authorization as described under “Prior Authorization Review Requirements” in the “How to Obtain Services” section.

Outpatient Services for Substance Use Disorder

We cover individual office visits and group therapy visits for Substance Use Disorder.

We cover in-home Substance Use Disorder Services, when all of the following are true:

- You are substantially confined to your home (or a friend’s or relative’s home), or the care is provided in lieu of Medically Necessary hospitalization.
- Your Participating Provider determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home.
- You receive prior authorization from Kaiser in accordance with Utilization Review criteria developed by Medical Group and approved by Kaiser.

Inpatient Hospital Services for Substance Use Disorder

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

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

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.

35. Telehealth Services

Telemedicine

Telemedicine is the delivery of health care services through use of real-time interactive audio and video communication, or store and forward technology, allowing a Member, or person acting on the Member's behalf, to interact with a Participating Provider who is not physically at the same location, for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include fax, email, voicemail, or text messages.

Store and forward technology means sending a Member's medical information from an originating site to the health care provider at a distant site for later review. The provider follows up with a medical diagnosis for the Member and helps manage their care. Store and forward technology does not include use of audio-only telephone, fax, or email.

Audio-only telemedicine is the delivery of health care services through the use of audio-only technology, allowing a Member, or person acting on the Member's behalf, to interact real-time with a Participating Provider who is not physically at the same location, for the purpose of diagnosis, consultation, or treatment. Audio-only telemedicine does not include fax or email, or health care Services that are customarily delivered by audio-only technology such as sharing of laboratory results.

We cover telemedicine Services at the applicable telemedicine 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.
- The technology used to provide the Service meets the standards required by state and federal laws governing the privacy and security of protected health information; and
- For audio-only telemedicine, the Member has an established relationship with the provider.

For purposes of this section, "established relationship" means:

- The Member must have had at least one in-person appointment or at least one real-time interactive appointment using both audio and video technology in the past 3 years with the provider providing audio-only telemedicine, or with a provider employed by the same medical group, at the same facility, or by the same integrated delivery system operated by Company as the provider providing the audio-only telemedicine; or
- The Member was referred to the provider providing audio-only telemedicine by a provider with whom they had an in-person appointment within the past 3 years.

Telephone and E-Visits

We cover scheduled telephone visits with a Participating Provider. To schedule a telephone visit, sign on to kp.org or the Kaiser Permanente app, then select “Appointments” or call Member Services.

We also cover e-visits. 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 interactive audio and video communications, telephone visits and e-visits, including a short instructional video and troubleshooting tips, visit kp.org/telehealth/northwest.

36. Temporomandibular Joint Dysfunction (TMJ)

Medical Services for Medically Necessary treatment of temporomandibular joint dysfunction (TMJ) are covered subject to Utilization Review by Kaiser using criteria developed by Medical Group and approved by Kaiser. Non-surgical outpatient Services are subject to the Cost Share shown in the “Benefit Summary”. Surgical Services, such as orthognathic surgery, are subject to the hospital Services Cost Share and outpatient surgery Cost Share.

37. Tobacco Use Cessation

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

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

These health education classes are offered through Kaiser. Members do not pay a fee to participate. For more information or to register, see Kaiser’s Healthy Living catalog, call Member Services, or go to kp.org. To use the free phone-based program, “Talk with a Health Consultant,” call 503-286-6816 or 1-866-301-3866 (toll free) and select option 2.

38. Vasectomy Services

Male sterilization procedures such as vasectomy are covered.

BENEFIT EXCLUSIONS AND LIMITATIONS

In addition to any exclusions listed in “Benefit Details,” this Plan does not cover the following:

- Services not provided by a Participating Provider or obtained in accordance with Kaiser’s standard referral and authorization requirements, except for Emergency Services and Urgent Care or as covered under coordination of benefits provisions.
- Services provided by Non-Participating Providers are not covered inside or outside of the Service Area except for: Emergency Services and Urgent Care; as specifically provided in the Out-of-Area coverage section; or when otherwise specifically provided.
- **Experimental or investigational Services, supplies, and drugs.** This exclusion does not apply to Services that are covered under “Services Provided in Connection with Clinical Trials” in the “Benefit Details” section of this *EOC*.
- **Certain Exams and Services.** Physical examinations and other Services are excluded when: (a) required for obtaining or maintaining employment or participation in employee programs, (b) required for

insurance or governmental licensing, (c) court ordered or required for parole or probation, or (d) received while incarcerated.

- Services for which no charge is made, or for which a charge would not have been made if the Member had no health care coverage or for which the Member is not liable; Services provided by a family member.
- Drugs and medicines not prescribed by a PCP, Participating Provider, or any licensed dentist, except for Emergency Services and Urgent Care.
- **Cosmetic Services.** Services that are intended primarily to change or maintain your appearance and will not result in significant improvement in physical function. This exclusion does not apply to Services that are covered under “Reconstructive surgery Services” and “Transgender surgical Services” in the “Benefit Details” section or Medically Necessary Gender Affirming Treatment.
- **Custodial Care.** Assistance with activities of daily living (for example, 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.
- Conditions caused by or arising from acts of war.
- **Dental Services.** This exclusion does not apply to Services that are covered under “Accidental injury to teeth,” “Hospital Services” or “Outpatient surgery visits.”
- **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.
- **Reversal of voluntary sterilization.**
- Testing and treatment of infertility and sterility, including but not limited to artificial insemination, and in-vitro fertilization.
- Services provided solely for the comfort of the Member, except palliative care provided under the “Hospice Services” benefit.
- **Weight Control and Obesity Treatment.**
 - **Non-surgical:** Any weight loss or weight control programs, treatments, services, or supplies, even when prescribed by a physician, including, but not limited to, prescription and over-the-counter drugs, exercise programs (formal or informal) and exercise equipment. Travel expenses associated with non-surgical or surgical weight control or obesity services are not covered.
 - **Surgical:** Surgery for dietary or weight control, and any direct or non-direct complications arising from such non-covered surgeries, whether prescribed or recommended by a physician, including surgeries such as:
 - Gastric banding (including adjustable gastric/lap banding and vertical banded gastroplasty).
 - Mini-gastric banding (gastric bypass using a Billroth II type of anastomosis).
 - Distal gastric bypass (long limb gastric bypass).
 - Biliopancreatic bypass and biliopancreatic with duodenal switch.
 - Jejunioileal bypass.

- o Gastric stapling or liposuction.
- o Removal of excess skin.
- The surgical exclusion for weight control and obesity treatment will not apply to pre-authorized, Medically Necessary bariatric surgery for adult morbid obesity as specifically set forth in this *EOC* and the Kaiser Permanente Severe Obesity Evaluation and Management Program criteria. More than one bariatric surgery for you or your enrolled Dependents will not be covered under the PEBB Program.
- Evaluation and treatment of learning disabilities, including dyslexia, except as provided for neurodevelopmental therapies.
- **Eye Surgery.** Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures.
- Orthotics, except foot care appliances for prevention of complications associated with diabetes which are covered.
- Services for which a Member has contractual right to recover cost under homeowner's or other no-fault coverage, to the extent that it can be determined that the Member received double recovery for such services.
- **Non-Medically Necessary Services.** Services that are not Medically Necessary.
- **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.
- When Medicare coverage is primary, charges for Services provided to Members through a "private contract" agreement with a physician or practitioner who does not provide Services through the Medicare program.
- **Travel Immunizations.** Travel-related immunizations for yellow fever, typhoid, and Japanese encephalitis.
- **Travel and Lodging.** Transportation or living expenses for any person, including the patient, are limited to travel and lodging expenses needed for the Member to receive covered Services at Non-Participating Facilities, subject to Utilization Review by Kaiser using criteria developed by Medical Group and approved by Kaiser.
- **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.
 - Recreation therapy.
 - Aquatic therapy and other water therapy.
- **Designated Blood Donations.** Collection, processing, and storage of blood donated by donors whom you designate, and procurement and storage of cord blood is covered only when Medically Necessary for the imminent use at the time of collection for a designated recipient.
 - **Detained or Confined Members.** Services provided or arranged by criminal justice officials or institutions for detained or confined Members are limited to Services which meet the requirements of Emergency Services under this *EOC*.
 - **Employer Responsibility.** We do not reimburse the employer for any Services that the law requires an employer to provide. When we cover any of these Services we may recover the Charges for the Services from the employer.
 - **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.
 - **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.
 - **Low-Vision Aids.** Low-vision aids 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.**
 - **Vision Hardware and Optical Services.** Corrective lenses, eyeglasses, and contact lenses are excluded.

REDUCTIONS

When the Member has Other Medical Coverage

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

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

The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable Expense. If the Secondary Plan receives a claim without the Primary Plan’s payment details, the Secondary Plan will notify the submitting provider and/or you as soon as possible and within 30 days of receipt of the claim that the claim is

incomplete. After receiving the missing information, the Secondary Plan will promptly process the claim. If the Primary Plan has not processed the claim within 60 days and is not waiting for additional information, the provider and/or you may submit the claim to the Secondary Plan with a notice that the Primary Plan has failed to pay the claim. The Secondary Plan must pay the claim as the Primary Plan within 30 calendar days. After payment information is received from the Primary Plan, the Secondary Plan may recover any excess amount paid under the “Right of Recovery” provision.

Notice to Covered Persons

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

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

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

Definitions for this “When the Member has Other Medical Coverage” section:

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

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

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

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

Primary Plan/Secondary Plan. The order of benefit determination rules 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, Kaiser determines payment for the benefits first before those of any other Plan without considering any other Plan's benefits. Kaiser will not reduce the Member's benefits under This Plan.

When This Plan is secondary, Kaiser determines the benefits after those of another Plan and must make payment in an amount so that when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim equal 100 percent of the total Allowable Expense for that claim. This means that when This Plan is secondary, Kaiser must pay the amount which, when combined with what the Primary Plan paid, cannot be less than the same Allowable Expense the Secondary Plan would have paid if it had been the Primary Plan. In addition, if This Plan is secondary, Kaiser must calculate the savings (the amount paid subtracted from the amount Kaiser would have paid had Kaiser been the Primary Plan) and record these savings as a medical benefit reserve for the covered person. This reserve must be used to pay any medical expenses during that Year, whether or not they are an Allowable Expense under This Plan. If This Plan is Secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

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

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

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

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

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

Order of Benefit Determination Rules

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

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

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

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

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

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

Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a

Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the “Order of Benefit Determination Rules” section can determine the order of benefits.

COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, Member, Subscriber or retiree or covering the person as a dependent of an employee, Member, Subscriber or retiree is the Primary Plan and the COBRA or state or other federal Continuation Coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the “Order of Benefit Determination Rules” section can determine the order of benefits.

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

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

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

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

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

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

Questions about coordination of benefits?

Contact your state insurance department.

Hospitalization on Your Effective Date

If you are an inpatient in a hospital on your membership effective date but had other Group coverage on the day before your membership effective date, coverage will commence on your effective date; however, you may be transferred to a Participating Hospital when a Participating Provider, in consultation with the

attending physician, determines that you are medically stable. If you refuse to transfer to a Participating Hospital, all further costs incurred during the hospitalization are your responsibility.

When Another Party is Responsible for Injury or Illness (Subrogation)

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

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

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

For purposes of this section, “no-fault insurance” means a type of insurance policy that covers your medical expenses for injury or illness due to an accident, regardless of who caused the accident.

Subject to applicable law, if you obtain a settlement, award, or judgment from or on behalf of another party or insurer, or a payment under a no-fault insurance provision, you must ensure we are reimbursed for covered Services that you receive for the injury or illness, except that we will not collect to the extent that the payment would leave you less than fully compensated for your injury or illness. This “Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-fault Insurance” section does not affect your obligation to pay any applicable Cost Share for these covered Services. The amount of reimbursement due to the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

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

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

To secure our rights, we will have a lien on the proceeds of any judgment, award, or settlement you or we (when we subrogate) obtain against another party or any other insurer, regardless of how those proceeds may be characterized or designated. The proceeds that are subject to our lien include any judgment, award, or settlement that you obtain.

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

The Phia Group, LLC
40 Pequot Way
Canton, MA 02021
Fax: 781-848-1154

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 other insurer based on your injury or illness, you must pay us after you are reimbursed the total

amount of the actual losses and damages you incurred. Sufficient funds to satisfy our claims must be held in a specifically identifiable account until our claims are resolved. Pending final resolution of our claims, you must retain control over the recovered amounts to which we may assert a right.

If reasonable collections costs have been incurred by your attorney in connection with obtaining recovery, we will reduce the amount of our claim by the amount of an equitable apportionment of the collection costs between us and you. This reduction will be made only if:

- We receive a list of the fees and associated costs before settlement, and
- Your attorney's actions were directly related to securing a recovery for you.

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

Surrogacy Arrangements – Traditional and Gestational Carriers

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 section applies to 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 – Traditional and Gestational Carriers” 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, Kentucky 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 – Traditional and Gestational Carriers” section and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this “Surrogacy Arrangements – Traditional and Gestational Carriers” section without our prior, written consent.

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

Workers’ Compensation or Employer’s Liability

If you suffer from an injury or illness that is compensable under a workers’ compensation or employer’s liability law, we will provide Services even if it is unclear whether you are entitled to a payment or settlement under the law. You have an obligation to reimburse us to the extent of a payment or any other benefit, including any amount you receive as a settlement under the law.

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

GRIEVANCES, CLAIMS, APPEALS, AND EXTERNAL REVIEW

Terms We Use in this Section

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

A claim is a request for us to:

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

An adverse benefit determination includes:

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

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

Grievance Procedure

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

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

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

- Call Member Services; 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 physician evaluates the facts and makes a recommendation for corrective action, if any.
- When you file a complaint, we will respond within 30 calendar days.

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

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

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

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

Language and Translation Assistance

If we send you 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 1-324-8010. 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 seek assistance from the Office of the Insurance Commissioner. Contact them by mail, telephone, or online at:

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

Reviewing Information Regarding Your Claim

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

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 mail 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 Services.

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

Kaiser 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.

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 procedures described below before initiating an external review.

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 contact Member Services.

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

Non-urgent Pre-Service Claim

- You may request a pre-service benefit determination on your own behalf. Tell us in writing or orally that you want to make a claim for us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You may email your request to us at <https://healthy.kaiserpermanente.org/oregon-washington/support>, call us, or mail your claim to us at:

Kaiser Foundation Health Plan of the Northwest
Attn: Utilization Management 500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 1-877-899-4972

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; or (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 three calendar days if your request was received electronically and within five calendar days if your request was received orally or in writing.

If more information is needed to make a decision, we will ask you for the information within one calendar day after we receive your claim, and we will give you 45 calendar days to send the information.

We will make a decision and send notification within 15 calendar days after we receive the first piece of information (including documents) we requested or by the deadline for receiving the information, whichever is sooner.

- We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision.
- We will send written notice of our decision to you, and if applicable, to your provider.

Urgent Pre-service Claim

- If your pre-service claim was considered on an urgent basis, we will make a decision within one calendar day if your request was received electronically and within two calendar days if your request was received orally or in writing.
- If more information is needed to make a decision, we will ask you for the information within one calendar day after we receive your claim, and we will give you seven calendar days to send the information.

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 notify you of our decision orally, we will send you, and, if applicable, your provider, written confirmation within three calendar 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 or orally that you want to appeal our denial of your pre-Service claim. Please include the following:
 - (1) Your name and health record number;
 - (2) Your medical condition or relevant symptoms;

- (3) The specific Service that you are requesting;
- (4) All of the reasons why you disagree with our adverse benefit determination; and
- (5) All supporting documents.

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

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

- We will acknowledge your appeal in writing within 72 hours after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision within 14 calendar days after we receive your appeal, unless you are notified that additional time is needed to complete the review. The extension will not delay the decision beyond 30 calendar days without your consent.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, which may be available to you.

Urgent Pre-Service Appeal

- Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-Service claim. Please include the following:
 - (1) Your name and health record number;
 - (2) Your medical condition or relevant symptoms;
 - (3) The specific Service that you are requesting;
 - (4) All of the reasons why you disagree with our adverse benefit determination; and
 - (5) All supporting documents.

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

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
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 receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within 72 hours after that the decision is made.
- 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, which are all considered urgent, are requests that Kaiser 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 will have to pay for the Services that we decide are not covered.

Here are the procedures for filing a concurrent care claim and a concurrent care appeal:

Concurrent Care Claim

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

Kaiser Foundation Health Plan of the Northwest
 Attn: Utilization Management 500 N.E. Multnomah St., Suite 100
 Portland, OR 97232-2099
 Fax: 1-877-899-4972

- 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 receive your claim.
- If we notify you of our decision orally, we will send you, and, if applicable, your provider, written confirmation within three calendar days after the oral notification.

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

Concurrent Care Appeal

- Within 180 calendar days after you receive our adverse benefit determination notice, you must tell us in writing or orally that you want to appeal our adverse benefit determination. Please include the following:
 - (1) Your name and health record number;
 - (2) Your medical condition or relevant symptoms;
 - (3) The ongoing course of covered treatment that you want to continue or extend;
 - (4) All of the reasons why you disagree with our adverse benefit determination; and
 - (5) All supporting documents.

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

Kaiser Foundation Health Plan of the Northwest
 Member Relations Department
 500 N.E. Multnomah St., Suite 100
 Portland, OR 97232-2099
 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. 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 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 72 hours after that the decision is made.
- 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.

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) 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 Foundation Health Plan of the Northwest
National Claims Administration - Northwest
P.O. Box 370050
Denver, CO 80237-9998

- We will not accept or pay for claims received from you after 12 months from the date of Service, except for 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 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 or orally that you want to appeal our denial of your post-Service claim. Please include the following:
 - (1) Your name and health record number;
 - (2) Your medical condition or relevant symptoms;
 - (3) The specific Services that you want us to pay for;
 - (4) All of the reasons why you disagree with our adverse benefit determination; and
 - (5) All supporting documents.

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

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

- We will acknowledge your appeal in writing within 72 hours after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision within 14 calendar days after we receive your appeal. We may extend the time for making a decision on your appeal for up to an additional 16 calendar days if there is good cause.
- If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

External Review

If you are dissatisfied with our final adverse benefit determination, you have a right to request an external review. An external review is a request for an independent review organization (IRO) to determine whether our internal appeal decision is correct. For example, you have the right to request external review of an adverse decision that is based on any of the following:

- Relies on medical judgment, including but not limited to, medical necessity, appropriateness, health care setting, level of care, or that the requested Service is not efficacious or otherwise unjustified under evidence-based medical criteria.
- Concludes that a treatment is experimental or investigational.
- Concludes that parity exists in the non-quantitative treatment limitations applied to behavioral health care (mental health and/or Substance Use Disorder) benefits.
- Involves consideration of whether we are complying with federal law requirements regarding balance (surprise) billing and/or cost sharing protections pursuant to the No Surprises Act (Public Health Service Act sections 2799A-1 and 2799A-2 and 45 C.F.R. §§149.110 --149.130).
- Involves a decision related to rescission of your coverage.

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

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

Within 180 calendar days after the date of our appeal denial letter you must call Member Services or 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 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 1-855-347-7239

Member Relations will forward your request to the IRO no later than the third business day after the date they receive your request for review. They will include written information received in support of the appeal along with medical records and other documents relevant in making the determination. Within one day of selecting the IRO, we will notify the appellant of the name of the IRO and its contact information.

You will have five business days to submit to the IRO, in writing, additional information that the IRO must consider when conducting the external review. The IRO will forward to us any additional information you submit within one business day of receipt.

Your request for external review will be expedited if the your request concerns an admission, availability of care, continued stay, or health care Service for which you received Emergency Services but have not been discharged from a facility, or ordinary time period for external review would seriously jeopardize your life or health, the life or health of a fetus, or your ability to regain maximum function.

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

You are not responsible for the costs of the external review, and you may name someone else to file the request for external review for you if you give permission in writing and include that with your request for external review.

Kaiser will be bound by and act in accordance with the decision of the IRO notwithstanding the definition of Medically Necessary care. If we do not follow a decision of an IRO, you have the right to sue us.

Experimental or Investigational Determination and Appeal

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

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

MISCELLANEOUS PROVISIONS

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.

Information about New Technology

When a new medical technology or procedure needs review, our Inter-regional New Technology Committee examines and evaluates data from government agencies, medical experts, medical journals, and medical

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

Privacy Practices

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

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

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

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

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

Unusual Circumstances

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.

COORDINATION OF BENEFITS CONSUMER EXPLANATORY BOOKLET

Important Notice

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

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

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

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

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the “primary” or “secondary” benefit payer. The primary plan always pays first when you have a claim. Any plan that does not contain your state’s COB rules will always be primary.

If you are covered by more than one health benefit plan, and you do not know which plan is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within 30 calendar days.

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

When This Plan is Primary

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

- **Your Own Expenses.** The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.
- **Your Spouse’s Expenses.** The claim is for your spouse, who is covered by Medicare, and you are not both retired.
- **Your Child’s Expenses.** The claim is for the health care expenses of your child who is covered by this plan; and
 - You are married, and your birthday is earlier in the year than your spouse’s or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual’s birthday. This is known as the “birthday rule”; or
 - You are separated or divorced, and you have informed us of a court decree that makes you responsible for the child’s health care expenses; or

- There is no court decree, but you have custody of the child.

Other Situations

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

How We Pay Claims When We Are Primary

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

How We Pay Claims When We Are Secondary

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

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

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

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

Questions about coordination of benefits?

Contact your state insurance department.

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:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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., Suite 100
 Portland, OR 97232-2099
 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.

You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at **1-800-562-6900**, or **360-586-0241** (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.

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 ሊያግዙዎት ተዘጋጅተዋል። ወደ ሚክሳሎ ቁጥር ይደውሉ **1-800-813-2000** (TTY: 711)።

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

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

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

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

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

日本語 (Japanese)

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

ខ្មែរ (Khmer) ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ 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. ໂທ 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)**.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS AND BALANCE BILLING IN WASHINGTON STATE

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you take an ambulance rider, have an emergency, or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you, via their websites or on request, which providers, hospitals and facilities are in their networks. Hospitals, surgical facilities, providers, behavioral health emergency service providers, and ground ambulance providers must tell you which provider networks they participate in on their website or on request.

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition, mental health or substance use disorder condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes ground or air ambulance rides and care you receive in a hospital and in facilities that provide crisis services to people experiencing a mental health or substance use disorder emergency. You can’t be balance billed for these emergency services, including services you may get after you’re in a stable condition.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount.

You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

When can you be asked to waive your protections from balance billing:

Health care providers, including hospitals, emergency behavioral health services providers, and air and ground ambulance providers, can **never** require you to give up your protections from balance billing.

If you have coverage through a self-funded group health plan, in some limited situations, a provider can ask you to consent to waive your balance billing protections, but you are **never** required to give your consent. Please contact your employer or health plan for more information.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may file a complaint with the federal government at www.cms.gov/nosurprises/consumers or by calling 1-800-985-3059; and/or file a complaint with the Washington State Office of the Insurance Commissioner at www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by calling 1-800-562-6900.

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

Visit the Office of the Insurance Commissioner Balance Billing Protection Act website at www.insurance.wa.gov/what-consumers-need-know-about-surprise-or-balance-billing for more information about your rights under Washington state law.