KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Large Group Traditional Copayment Plan Evidence of Coverage

Group Name: Clackamas County

Group Number: 1183-001, 013, 024, 028, 029, 031, 032, 040

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Membership Services

Monday through Friday (except holidays)

8 a.m. to 6 p.m.

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

All other areas 1-800-813-2000

TTY

All areas 1-800-735-2900

Language interpretation services

All areas 1-800-324-8010

kp.org

EOLGTRAD0114

TRADITIONAL COPAYMENT PLAN BENEFIT SUMMARY

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

Out-of-Pocket Maximum	
For one Member	$600 per Calendar Year
For an entire Family	$1,200 per Calendar Year
Preventive Care Services	**You Pay**
Routine preventive physical exam (includes adult, well baby, and well child)	$0
Scheduled prenatal care and first postpartum visit	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	**You Pay**
Primary care visit (includes routine OB/GYN visits and medical office visits, routine hearing exams, health education Services, and diabetic outpatient self-management training and education, including medical nutrition therapy)	$10
Specialty care visit (includes diabetic outpatient self-management training and education, including medical nutrition therapy, and health education Services)	$10
TMJ therapy visit	$10
Routine eye exam for Members 18 and younger	$10
Routine eye exam for Members 19 and older	$10
Injection visit provided in the Nurse Treatment Area	$0
Administered medications (all outpatient settings)	$0
Urgent Care visit	$10
Emergency department visit	$75 (Waived if admitted)
Outpatient surgery visit	$10
Chemotherapy/radiation therapy visit	$10
Respiratory/cardiac rehabilitative therapy visit	$10
Physician-referred acupuncture (limited to 12 visits per Calendar Year)	$10
Inpatient Hospital Services	**You Pay**
Room and board, surgery, anesthesia, X-ray, imaging, laboratory, and drugs	$0
Ambulance Services	**You Pay**
Per transport	$75
Bariatric Surgery Services	**You Pay**
Inpatient hospital Services	$0

Chemical Dependency Services	**You Pay**
Outpatient Services	$10
Inpatient hospital Services	$0
Residential Services	$0
Day treatment Services	$10 per day
Dialysis Services	**You Pay**
Outpatient dialysis visit	$10
Home dialysis	$0
External Prosthetic Devices and Orthotic Devices	**You Pay**
External Prosthetic Devices and Orthotic Devices	$0
Hearing Services	**You Pay**
Hearing exams and testing (audiology Services)	$10
Hearing aid per Member age 18 or younger, or enrollees ages 19 to 25 and enrolled in an accredited educational institution (limited to one hearing aid per ear every four years).	$0
Home Health Services	**You Pay**
Home health (up to 130 visits per Calendar Year)	$0
Hospice Services	**You Pay**
Palliative and comfort care	$0
Infertility Services	**You Pay**
Diagnosis office visit	50% Coinsurance
Diagnosis laboratory procedures	50% Coinsurance
Treatment	50% Coinsurance
Limited Outpatient Prescription Drugs, Supplies, and Supplements	**You Pay**
Certain self-administered IV drugs, fluids, additives, and nutrients including the supplies and equipment required for their administration	$0
Medical foods and formulas	$0
Oral chemotherapy medications used for the treatment of cancer	$0
Post-surgical immunosuppressive drugs after covered transplant Services	$0
Mental Health Services	**You Pay**
Outpatient Services	$10
Intensive outpatient Services	$10 per day
Inpatient hospital Services	$0
Residential Services	$0
Outpatient Durable Medical Equipment (DME)	**You Pay**
Outpatient Durable Medical Equipment (DME)	$0
Enteral pump, formulas, and supplies; CADD (continuous ambulatory drug delivery) pumps; osteogenic bone stimulators; osteogenic spine stimulators; and ventilators	$0
Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures	**You Pay**
Laboratory, X-ray, imaging, and special diagnostic procedures	$0
CT, MRI, PET scans	$0
Reconstructive Surgery Services	**You Pay**
Inpatient hospital Services	$0

Outpatient surgery visit	$10
Rehabilitative Therapy Services	**You Pay**
Outpatient Physical, Speech, and Occupational therapies (up to 20 visits per therapy per Calendar Year)	$10
Multidisciplinary rehabilitation (up to a combined total of 60 days per condition per Calendar Year for inpatient and outpatient rehabilitation)	
Inpatient multidisciplinary rehabilitation	$0
Outpatient multidisciplinary rehabilitation	$10 per day
Skilled Nursing Facility Services	**You Pay**
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	$0
Student Out-of-Area Coverage (Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.)	**You Pay**
Routine, continuing, and follow-up Services (up to $1,200 per Calendar Year)	20% of the actual fee the provider, facility, or vendor charged for the Service
Transplant Services	**You Pay**
Inpatient hospital Services	$0
Please see the following pages for additional benefit riders purchased:	
Benefit Riders	**You Pay**
Alternative Care (self-referred) (Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.)	$10 per visit for acupuncture, chiropractic, and naturopathic visits. $25 per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.
Hearing Aids (for Members 19 and older who are not enrolled in an accredited educational institution) (Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.)	Balance after $1,500 allowance is applied for each hearing aid per ear every three years
Outpatient Prescription Drugs, Supplies, and Supplements (Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.)	$10 generic/$20 brand. $0 for formulary contraceptives. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two Copayments. Kaiser Permanente formulary applies. We cover nonformulary drugs only when you meet exception criteria.
Vision Hardware and Optical Services for Members 18 and younger	Refer to the Pediatric Vision Hardware and Optical Services Rider Benefit Summary.
Vision Hardware and Optical Services for Members 19 and older (Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.)	Refer to the Adult Vision Hardware and Optical Services Rider Benefit Summary.

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INTRODUCTION

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

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

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

Term of this *EOC*

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

About Kaiser Permanente

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

We provide covered Services to you using Participating Providers and Participating Facilities located in our Service Area except as described under the following sections:

- "Referrals to Non-Participating Providers and Non-Participating Facilities" in the "How to Obtain Services" section.
- "Emergency, Post-Stabilization, and Urgent Care" section.
- Limited coverage for students outside our Service Area as described under "Student Out-of-Area Coverage" in the "How to Obtain Services" section.
- "Ambulance Services" in the "Benefits" section.

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

DEFINITIONS

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

Allied Plan. Group Health Cooperative located in Washington and northern Idaho.

Alternative Care. Services provided by an acupuncturist, chiropractor, naturopath, or massage therapist.

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

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

Charges. Charges means the following:

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

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

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

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

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

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

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

Dependent Limiting Age. The "Premium, Eligibility, and Enrollment" section requires that most types of Dependents (other than Spouses) be under the Dependent Limiting Age in order to be eligible for membership. The "Benefit Summary" shows the Dependent Limiting Age (the "Student" one is for students, and the "General" one is for non-students).

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

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

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

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

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

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

***Evidence of Coverage* (*EOC*).** This *Evidence of Coverage* document provided to the Subscriber that specifies and describes benefits and conditions of coverage. This document, on its own, is not designed to meet the requirements of a summary plan description (SPD) under ERISA.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Out-of-Pocket Maximum. The total amount of Copayments and Coinsurance you will be responsible to pay in a Calendar 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 Directory* for our Service Area. Participating Facilities are subject to change.

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

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

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

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

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

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

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

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

Premium. Monthly membership charges paid by Group.

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

Services. Health care services, supplies, or items.

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

Spouse. Your legal husband or wife. For the purposes of this *EOC,* the term "Spouse" includes a person legally recognized as your domestic partner in a valid Declaration of Oregon Registered Domestic Partnership issued by the state of Oregon or who is otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your Group.

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

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

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.

Usual and Customary Fee. The lower of (1) the actual fee the provider, facility, or vendor charged for the Service, or (2) the 80th percentile of fees for the same or similar Service in the geographic area where the Service was received according to the most current survey data published by FAIR Health Inc. or another national service designated by Company.

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.

PREMIUM, ELIGIBILITY, AND ENROLLMENT

Premium

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

Who Is Eligible

General

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

- You must meet your Group's eligibility requirements that we have approved. (Your Group is required to inform Subscribers of its eligibility requirements.)

- You must meet the Subscriber or Dependent eligibility requirements described below unless your Group has different eligibility requirements that we have approved.
- You must live or physically work inside our Service Area at least 50 percent of the time. For assistance about the Service Area or eligibility, please contact Membership Services. The Subscriber's or the Subscriber's Spouse's otherwise eligible children are not ineligible solely because they live outside our Service Area or in another Kaiser Foundation Health Plan or Allied Plan service area if: (i) they are attending an accredited college or accredited vocational school; or (ii) otherwise required by law.

Subscribers

To be eligible to enroll as a Subscriber, you must be one of the following:

- An employee of your Group.
- Otherwise entitled to coverage through your Group under a trust agreement, retirement benefit program, employment contract, or the rules of a professional, trade, or bona fide association.

Dependents

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

- Your Spouse.
- A person who is under the general or student Dependent Limiting Age shown in the "Benefit Summary" and who is any of the following:
  - Your or your Spouse's child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed a legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian.
- A person who is under the student Dependent Limiting Age shown in the "Benefit Summary" and who is a full-time registered student at an accredited college or accredited vocational school and is any of the following:
  - Your or your Spouse's child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed a legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian.

You may be asked to provide proof of dependency annually until the Dependent reaches the student Dependent Limiting Age shown in the "Benefit Summary" and his or her coverage ends.

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

- A person of any age who is chiefly dependent upon you or your Spouse for support and maintenance if the person is incapable of self-sustaining employment by reason of developmental disability or physical handicap which occurred prior to his or her reaching the general Dependent Limiting Age shown in the "Benefit Summary," if the person is any of the following:
  - Your or your Spouse's child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian and was a court-appointed guardian prior to the person reaching the Dependent Limiting Age shown in the "Benefit Summary."

  We may request proof of incapacity and dependency annually.

Children born to a Dependent other than your Spouse (for example, your grandchildren) are not eligible for coverage beyond the first 31 days of life, including the date of birth, unless: (a) you or your Spouse adopts them or assumes a legal obligation in anticipation of adoption; (b) they are primarily supported by you or your Spouse and you or your Spouse is their court-appointed guardian; or, (c) your Group has different eligibility requirements that we have approved.

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

When You Can Enroll and When Coverage Begins

Your Group is required to inform you about when you are eligible to enroll and your effective date of coverage. Your effective date of coverage will depend upon how and when you enroll. If you are eligible to enroll, enrollment is permitted as described below.

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

New Employees and Their Dependents

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Company-approved enrollment application to your Group within 31 days of eligibility for enrollment.

Adding New Dependents to an Existing Account

To enroll a Dependent who first becomes eligible to enroll after you became a Subscriber, you must submit a Company-approved enrollment application to your Group as follows:

- **Newborn child.** Newborns are covered from the moment of birth for the first 31 days of life. In order for coverage to continue beyond this 31-day period, you must submit an enrollment application to your Group within 31 days after the child's birth if additional Premium is required to add the Dependent. If additional Premium is not required, the application requirement is waived; however, please notify Membership Services of the birth so that we may update our records for more efficient provision of covered Services.

- **Newly Adopted child.** Newly adopted children or children for whom you or your Spouse have newly assumed a legal obligation for total or partial support in anticipation of adoption are covered for 31 days following the date of adoption or the date you or your Spouse assume legal obligation. In order for coverage to continue beyond this 31-day period, you must submit an enrollment application to your Group within 31 days after the date of adoption or the date you or your Spouse assumed legal obligation if additional Premium is required. If additional Premium is not required, the application requirement is waived and Company will add the child to your Plan upon notification of the adoption. Assumption of legal obligation means when the adopting parent assumes and retains the legal obligation for total or partial support of the child in anticipation of the adoption of the child. Placement terminates upon termination of the legal obligations.

Open Enrollment

Your Group will inform you of your annual open enrollment period and effective date of coverage. You may enroll as a Subscriber along with any eligible Dependents if you or your Dependents were not previously enrolled. If you are an existing Subscriber, you may add eligible Dependents not previously enrolled by submitting a Company-approved enrollment application to your Group during the open enrollment period. If you do not enroll when you are first eligible or during open enrollment and later want to enroll, you must wait until the next open enrollment unless one of the sections described below applies.

Special Enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible as described in this "Special Enrollment" section.
- You did not enroll when you were first eligible and your Group provided to us a written statement that verifies you signed a document that explained restrictions about enrolling in the future, but only if your Group required you to sign such a document. The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Company–approved enrollment or change of enrollment application from the Subscriber.

Special Enrollment due to New Dependents

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Company-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

The effective date of an enrollment resulting from marriage is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption.

Special Enrollment due to Loss of Other Coverage

You may enroll as a Subscriber (along with any eligible Dependents) if you or your Dependents were not previously enrolled and existing Subscribers, may add eligible Dependents not previously enrolled if all of the following are true:

- You did not enroll when you were first eligible and your Group provided to us a written statement that verifies you signed a document that explained restrictions about enrolling in the future, but only if your Group required you to sign such a document.
- You or at least one of your eligible Dependents had other coverage when you or the eligible Dependent previously declined Company coverage (some groups require the reason you are declining coverage be submitted in writing).

- The loss of the other coverage is due to one of the following:
  - Exhaustion of COBRA coverage.
  - Termination of employer contributions for non-COBRA coverage.
  - Loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, reaching the age limit for dependent children, or the Subscriber's death, termination of employment, or reduction in hours of employment, or as a result of moving out of the Service Area.
  - Loss of eligibility for Medicaid coverage or Child Health Insurance Program coverage, but not termination for cause.

Note: If you are enrolling as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Company-approved enrollment or change of enrollment application to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for Medicaid or Child Health Insurance Program (CHIP) coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives the enrollment or change of enrollment application from the Subscriber.

Special Enrollment due to Eligibility for Premium Assistance under Medicaid or CHIP

You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, if the Subscriber or at least one of the enrolling Dependents becomes eligible to receive Premium assistance under Medicaid or CHIP. To request enrollment, the Subscriber must submit a Company-approved enrollment or change of enrollment application to your Group within 60 days after the Subscriber or Dependent is determined eligible for premium assistance. The effective date of an enrollment resulting from eligibility for the premium assistance under Medicaid or CHIP is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Note: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

Special Enrollment due to Court or Administrative Order

A court or administrative agency may require a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements to be added as a Dependent. You may add the Spouse or child as a Dependent by submitting to your Group a Company-approved enrollment application within 31 days of the court or administrative order. Your Group will let us know who to enroll under the order and the effective date of the enrollment. The effective date cannot be earlier than the date of the order and cannot be later than the first day of the month following the date of the order.

Special Enrollment due to Re-employment after Military Service

If you terminated your health care coverage because you were called to active duty in the military service, you may be able to be re-enrolled in your Group's health plan if required by state or federal law. Ask your Group for more information.

HOW TO OBTAIN SERVICES

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

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulated employee benefits, including the claim and appeal procedures for benefit Plans offered by certain employers. If an

employer's benefit Plan is subject to ERISA, each time you request Services that must be approved before the Service is provided, you are filing a "pre-Service claim" for benefits. You are filing a "post-Service claim" when you ask us to pay for or cover Services that have already been received. You must follow our procedure for filing claims, and we must follow certain rules established by ERISA for responding to claims.

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

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

Using Your Identification Card

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

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

Getting Assistance

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

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

Portland area 503-813-2000

All other areas 1-800-813-2000

TTY for the hearing and speech impaired 1-800-735-2900

Language interpretation services 1-800-324-8010

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

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

Our Advice Nurses

If you are unsure whether you need to be seen by a physician or where to go for Services, or if you would like to discuss a medical concern, call one of our advice nurses. Each Participating Medical Office owned and operated by Kaiser Permanente has an advice nurse telephone number. During regular office hours, call the advice number at the medical office near you. Telephone numbers and office hours are listed by facility in the *Medical Directory* and online at **kp.org**.

On evenings, weekends, and holidays, call one of the following numbers:

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

Vancouver area..... 1-800-813-2000

All other areas..... 1-800-813-2000
(You may call at any time to discuss urgent concerns.)

TTY for the hearing and speech impaired 1-800-735-2900

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

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

Your Primary Care Participating Provider

Your primary care Participating Provider plays an important role in coordinating your health care needs, including Participating Hospital stays and referrals to Specialists. We encourage you and your Dependents to each choose a primary care Participating Provider.

You may select a primary care Participating Provider from family medicine, internal medicine, or pediatrics. Female Members also have the option of choosing a women's health care Participating Provider as their primary care Participating Provider, as long as the women's health care Participating Provider accepts designation as primary care Participating Provider. A women's health care Participating Provider must be an obstetrician or gynecologist, a physician assistant specializing in women's health, an advanced registered nurse practitioner of women's health, or a certified nurse midwife, practicing within his or her applicable scope of practice.

To learn how to choose your primary care Participating Provider, please call Membership Services or visit **kp.org**. You may change your primary care Participating Provider by calling Membership Services. The change will be effective the first day of the following month.

Appointments for Routine Services

If you need to make a routine care appointment, please refer to the *Medical Directory* for appointment telephone numbers, or go to **kp.org** to request an appointment online. Routine appointments are for medical needs that are not urgent, such as checkups and follow-up visits that can wait more than a day or two. Try to make your routine care appointments as far in advance as possible. For information about getting other types of care, refer to the "Emergency, Post-Stabilization, and Urgent Care" section.

Women's Health Services

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

Medically appropriate maternity care, covered reproductive health Services, preventive Services, general examinations, gynecological Services, and follow-up visits are provided to female Members directly from a Participating Provider, without a referral from their primary care Participating Provider. Annual

mammograms for women 40 years of age or older are covered with or without a referral from a Participating Physician. Mammograms are provided more frequently to women who are at high risk for breast cancer or disease with a Participating Provider referral. We also cover breast examinations, pelvic examinations, and cervical cancer screenings annually for women 18 or older, and at any time with a referral from your women's health care Services Participating Provider. Women's health care Services also include any appropriate Service for other health problems discovered and treated during the course of a visit to a women's health care Participating Provider for a women's Service.

Prior and Concurrent Authorization and Utilization Review

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

If you request Services that must be approved through Utilization Review and the Participating Provider believes they are Medically Necessary, the Participating Provider may submit the request for Utilization Review on your behalf. If the request is denied, we will send a letter to you within two business days of the Participating Provider's request. If you choose to submit a request for services directly to Member Relations, we will notify you within 15 days of the decision. The decision letter will explain the reason for the determination along with instructions for filing an appeal. You may request a copy of the complete Medically Necessary criteria used to make the determination. Please contact Member Relations at 503-813-4480.

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

- Bariatric surgery Services.
- Breast reduction surgery.
- Dental and orthodontic Services for the treatment of craniofacial anomalies.
- Drug formulary exceptions.
- Durable Medical Equipment.
- General anesthesia and associated hospital or ambulatory surgical facility Services provided in conjunction with covered dental Services.
- Hospice and home health Services.
- Inpatient hospital Services.
- Inpatient and residential Chemical Dependency Services.
- Inpatient and residential mental health Services.
- Non-emergency medical transportation.
- Open MRI.
- Plastic surgery.
- Referrals for any Non-Participating Facility Services or Non-Participating Provider Services.
- Referrals to Specialists who are not employees of Medical Group.
- Rehabilitative therapy Services.
- Routine foot Services.

- Skilled Nursing Facility Services.
- Transplant Services.

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. Membership Services can connect you with the correct manager, who will listen to your issues and discuss your options.

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

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

Referrals

Referrals to Participating Providers and Participating Facilities

Primary care Participating Providers provide primary medical care, including pediatric care and obstetrics/gynecology care. Specialists provide specialty medical care in areas such as surgery, orthopedics, cardiology, oncology, urology, dermatology, and allergy/immunology. Your primary care Participating Provider will refer you to a Specialist when appropriate. In most cases, you will need a referral to see a Specialist the first time. If the Specialist is not an employee of Medical Group, your referral will need prior authorization approval in order for the Services to be covered. See the *Medical Directory* for information about specialty Services that require a referral or discuss your concerns with your primary care Participating Provider. In some cases, a standing referral may be allowed to a Specialist for a time period that is in accord with your individual medical needs as determined by the Participating Provider and Company.

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

- Cancer Counseling.
- Chemical Dependency Services.
- Mental Health Services.
- Obstetrics/Gynecology.
- Occupational Health.
- Ophthalmology.
- Optometry (routine eye exams).
- Social Services.

Referrals to Non-Participating Providers and Non-Participating Facilities

If your Participating Physician decides that you require Services not available from Participating Providers or Participating Facilities, he or she will recommend to Medical Group and Company that you be referred to a Non-Participating Provider or Non-Participating Facility inside or outside our Service Area. If the Medical

Group's assigned Participating Provider determines that the Services are Medically Necessary and are not available from a Participating Provider or Participating Facility and Company determines that the Services are covered Services, Company will authorize your referral to a Non-Participating Provider or Non-Participating Facility for the covered Services. The Copayment or Coinsurance for these approved referral Services are the same as those required for Services provided by a Participating Provider or Participating Facility. You will need written authorization in advance in order for the Services to be covered. If Company authorizes the Services, you will receive a written "Authorization for Outside Medical Care" approved referral to the Non-Participating Provider or Non-Participating Facility, and only the Services and number of visits that are listed on the written referral will be covered, subject to any benefit limitations and exclusions applicable to these Services.

Participating Providers and Participating Facilities Contracts

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

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

Provider Whose Contract Terminates

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

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

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

If you satisfy all of the following requirements, you may qualify for this continuity of care:

- You are a Member on the date you receive the Services.
- You are undergoing an active course of treatment that is Medically Necessary and you and the Participating Provider agree that it is desirable to maintain continuity of care.
- We would have covered the Services if you had received them from a Participating Provider.
- The provider agrees to adhere to the conditions of the terminated contract between the provider and Company or its designee.

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

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

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

- The 45th day after the birth; or
- As long as you continue under an active course of treatment, but not later than the 120th day from the date we notify you about the contract termination.

Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas

Visiting Member Services ensure that you can receive Services when you are temporarily visiting another Kaiser Foundation Health Plan region or Allied Plan service area. You can get visiting Member Services when you are temporarily visiting a Kaiser Foundation Health Plan region or Allied Plan service area. Visiting Member Services are generally limited to 90 days. This 90-day limit does not apply if you are a Member registered as a college student attending an accredited college or accredited vocational school.

If you permanently move to another Kaiser Foundation Health Plan region or Allied Plan service area or visit for more than 90 days, you may not be eligible to continue your Kaiser Foundation Health Plan of the Northwest membership. You will not be able to receive visiting Member Services when you permanently reside in another Kaiser Foundation Health Plan region or Allied Plan service area.

You can receive visiting Member Services in any Kaiser Foundation Health Plan region or Allied Plan service area if a Participating Physician provides or arranges for them. For information about regions, service areas, and facility locations, please call Membership Services in the Northwest. You may also contact Member Services in the region or service area you will be visiting.

Visiting Member Services and your out-of-pocket costs may be different from the Services and Copayments and Coinsurance that apply inside our Service Area.

If you would like to receive one of our *When You are Away from Home* brochures, please call Membership Services and a brochure will be sent to your home. The brochure includes telephone numbers for Member Services in other service areas.

Student Out-of-Area Coverage

This limited Student Out-of-Area benefit is available to Members who are temporarily away at school outside our Service Area if the Subscriber gives us written certification that the Member is a registered full-time student at an accredited college or accredited vocational school.

We make limited payments for Medically Necessary routine, continuing, and follow-up Services that a qualifying student Member receives from Non-Participating Providers outside our Service Area but inside the United States (which for the purpose of this benefit means the 50 states, the District of Columbia, and United States territories). These "Student Out-of-Area Coverage" benefits are subject to special limits and Member Copayments or Coinsurance as shown in the "Benefit Summary."

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

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

- "Transplant Services."
- Visiting Member Services as described under "Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas" of this *EOC*.

POST-SERVICE CLAIMS – SERVICES ALREADY RECEIVED

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

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

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

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

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

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

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

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

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

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

EMERGENCY, POST-STABILIZATION, AND URGENT CARE

Coverage, Copayments or Coinsurance, and Reimbursement

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

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

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

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

The Copayments or Coinsurance for covered Emergency Services, Post-Stabilization Care, and Urgent Care are the same ones you would pay if the Services were not Emergency Services, Post-Stabilization Care, or Urgent Care. For example, if you receive covered inpatient hospital Services, you pay the Copayment or Coinsurance shown in the "Benefit Summary" under "Inpatient Hospital Services," regardless of whether the Services also constitute Emergency Services, Post-Stabilization Care, or Urgent Care. If you visit an emergency department and are not admitted directly as an inpatient, you pay the emergency department visit Copayment or Coinsurance shown in the "Benefit Summary" under "Outpatient Services."

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

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Participating Providers, Participating Facilities, Non-Participating Providers, and Non-Participating Facilities anywhere in the world.

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

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

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

Post-Stabilization Care

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

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

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

Urgent Care

Inside our Service Area

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

Outside our Service Area

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

WHAT YOU PAY

Copayments and Coinsurance

The Copayment or Coinsurance for each covered Service is shown in the "Benefit Summary." Copayments or Coinsurance are due when you receive the Service. If we must bill you, an accounting fee may be added to offset handling costs.

Out-of-Pocket Maximum

There is a maximum to the total dollar amount of Copayments and Coinsurance that you must pay for certain covered Services that you receive within the same Calendar Year under this or any other evidence of coverage with the same group number printed on this *EOC*. This Out-of-Pocket Maximum shown in the "Benefit Summary" is per Calendar Year for a Member or for an entire Family. After you reach the Out-of-Pocket Maximum, you are not required to pay Copayments and Coinsurance for these Services for the remainder of the year. Membership Services can provide you with the amount you have paid toward your Out-of-Pocket Maximum.

The applicable Copayments and Coinsurance you pay for the following covered Services count toward the Out-of-Pocket Maximum:

- Ambulance Services.
- Chemical Dependency Services.
- Emergency Services.
- Infertility Services.
- Inpatient hospital Services.
- Laboratory, X-ray, imaging and special diagnostic procedures.

- Maternity and interrupted pregnancy Services.
- Office visits (including professional Services such as mental health, dialysis treatment, and physical, occupational, respiratory and speech therapy).
- Outpatient Durable Medical Equipment (DME), External Prosthetic Devices, and Orthotic Devices.
- Outpatient surgery Services.
- Skilled nursing facility Services.

BENEFITS

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

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

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

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

Preventive Care Services

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

Preventive care Services include:

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

We cover these preventive care Services at the Copayment or Coinsurance shown in your "Benefit Summary." Services received for an existing illness, injury, or condition during a preventive care examination may be subject to the applicable Copayment or Coinsurance.

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

- Bone densitometry.

- Cervical cancer screening.
- Chlamydia test.
- Cholesterol tests (all types).
- Colorectal cancer screening.
- Contraceptive services and supplies, including, but not limited to, tubal ligation, and insertion/removal of IUD, or implanted birth control drugs and devices.
- Fasting glucose test.
- Fecal occult test.
- Flexible sigmoidoscopy.
- Immunizations.
- Mammography.
- Prenatal visits and first postpartum visit.
- Routine preventive physical exam (adult, well-child, and well-baby).
- Screening prostate-specific antigen (PSA) test (not including monitoring or ultrasensitive tests).

If you would like additional information about covered preventive care Services, call Membership Services at 503-813-2000 in Portland, and all other areas 1-800-813-2000. Information is also available online at **kp.org**.

Benefits for Outpatient Services

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

- Primary care visits for internal medicine, gynecology, family medicine, and pediatrics.
- Cardiac rehabilitative therapy visits.
- Chemotherapy and radiation therapy Services.
- Specialty care visits.
- Allergy testing and treatment materials.
- Treatment for temporomandibular joint disorder (TMJ).
- Routine eye exams.
- Routine hearing exams.
- Nurse treatment room visits to receive injections, including allergy injections.
- Urgent Care visits.
- Emergency department Services.
- Outpatient surgery and other outpatient procedures (including interrupted pregnancy surgery performed in an outpatient setting).
- Internally implanted devices except for internally implanted insulin pumps, artificial hearts, and artificial larynx.
- 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, Supplies, and Supplements" section.

- Rehabilitative therapy Services such as physical, occupational and speech therapy, subject to the benefit limitations shown in the "Rehabilitative Therapy Services" section of the "Benefit Summary."
- Respiratory therapy.
- Multidisciplinary rehabilitation therapy in an outpatient multidisciplinary rehabilitation facility or program. This benefit is subject to the benefit limitations shown in the "Rehabilitative Therapy Services" section of the "Benefit Summary."

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

- "Ambulance Services."
- "Chemical Dependency Services."
- "Dialysis Services."
- "External Prosthetic Devices and Orthotic Devices."
- "Health Education Services."
- "Hearing Services."
- "Home Health Services."
- "Hospice Services."
- "Infertility Services."
- "Limited Dental Services."
- "Limited Outpatient Prescription Drugs, Supplies, and Supplements."
- "Mental Health Services."
- "Outpatient Durable Medical Equipment (DME)."
- "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures."
- "Preventive Care Services."
- "Reconstructive Surgery Services."
- "Rehabilitative Therapy Services."
- "Services Provided in Connection with Clinical Trials."
- "Telemedical Services."
- "Transplant Services."

Benefits for Inpatient Hospital Services

We cover the following Services when you are admitted as an inpatient in a Participating Hospital, but only to the extent that the Services are generally and customarily provided by acute care general hospitals in our Service Area, or are required by law:

- Anesthesia.
- Blood, blood products, and their administration.
- Chemotherapy and radiation therapy Services.

- Dialysis Services (this benefit is subject to the benefit limitations described under "Dialysis Services" in this "Benefits" section).
- Drugs and radioactive materials used for therapeutic purposes, except for the types of drugs excluded under the "Limited Outpatient Prescription Drugs, Supplies, and Supplements" section.
- Durable Medical Equipment and medical supplies.
- Emergency detoxification.
- General and special nursing care.
- Internally implanted devices except for internally implanted insulin pumps, artificial hearts, and artificial larynx.
- Interrupted pregnancy surgery when performed in an inpatient setting.
- Laboratory, X-rays and other imaging, and special diagnostic procedures.
- Maternity hospital care for mother and baby. We will not limit the length of a maternity hospital stay for a mother and baby to less than 48 hours for vaginal delivery and 96 hours for a cesarean section delivery. The length of inpatient stay is determined by an attending Participating Provider, in consultation with the mother. Our policy complies with the federal Newborns' and Mothers' Health Protection Act of 1996 (NMHPA).
- Medical foods and formulas if Medically Necessary.
- Medical social Services and discharge planning.
- Obstetrical care and delivery (including cesarean section).
- Operating and recovery rooms.
- Orthognathic surgery for treatment of cleft palate diagnosed at birth or cleft lip diagnosed at birth.
- Participating Physician's Services, including consultation and treatment by Specialists.
- Prescription drugs, including injections.
- Rehabilitative therapy Services such as physical, occupational, and speech therapy and multidisciplinary rehabilitation Services, subject to the benefit limitations described under the "Rehabilitative Therapy Services" section.
- Respiratory therapy.
- Room and board, including a private room if Medically Necessary.
- Specialized care and critical care units.
- Temporomandibular joint (TMJ) surgery for the treatment of TMJ disorders subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

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

- "Bariatric Surgery Services."
- "Chemical Dependency Services."
- "Dialysis Services."
- "Health Education Services."
- "Hospice Services."
- "Infertility Services."

- "Limited Dental Services."
- "Mental Health Services."
- "Reconstructive Surgery Services."
- "Rehabilitative Therapy Services."
- "Skilled Nursing Facility Services."
- "Telemedical Services."
- "Transplant Services."

Ambulance Services

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

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

Ambulance Services Exclusions

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

Bariatric Surgery Services

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

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

Chemical Dependency Services

We cover Chemical Dependency Services subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request these criteria by calling Membership Services. Coverage includes medical treatment for withdrawal symptoms (including methadone maintenance by referral). Emergency detoxification for medical conditions associated with acute alcohol, drug, or other substance abuse is covered without prior authorization.

Outpatient Services for Chemical Dependency

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

Inpatient Hospital Services for Chemical Dependency

We cover inpatient hospital Services for Chemical Dependency.

Residential Services

We cover residential Services in a residential program.

Day Treatment Services

We cover day treatment Services in a day treatment program.

Dialysis Services

We cover two types of dialysis: hemodialysis and peritoneal dialysis. You pay Copayment or Coinsurance shown in the "Benefit Summary" under "Dialysis Services." We cover dialysis Services for acute renal failure and end-stage renal disease if:

- The Services are provided inside our Service Area.
- You satisfy all Utilization Review criteria developed by Medical Group and approved by Company.

We cover treatment at outpatient dialysis facilities.

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

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

External Prosthetic Devices and Orthotic Devices

We cover External Prosthetic Devices and Orthotic Devices when the following are true:

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

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

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

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

- 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.
- Maxillofacial prosthetic devices: coverage is limited to the least costly clinically appropriate treatment as determined by a Participating Physician. We cover maxillofacial prosthetic devices if they are necessary for restoration and management of head and facial structures that cannot be replaced with living tissue and are defective because of disease, trauma, or birth and developmental deformities when this restoration and management are performed for the purpose of:
    - Controlling or eliminating infection;
    - Controlling or eliminating pain; or
    - Restoring facial configuration or functions such as speech, swallowing, or chewing, but not including cosmetic procedures rendered to improve the normal range of conditions.

- Ocular prosthesis.
- Prosthetic devices for treatment of temporomandibular joint (TMJ) conditions.
- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity. This includes but is not limited to ostomy and urological supplies.
- Repair or replacement (unless due to loss or misuse).
- Rigid and semi-rigid Orthotic Devices required to support or correct a defective body part.
- Therapeutic shoes and inserts to prevent and treat diabetes-related complications.
- Tracheotomy equipment.

DME Formulary

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

Our formulary guidelines allow you to obtain non-formulary items (those not listed on our DME formulary for your condition) if Medical Group's designated DME review physician determines that it is Medically Necessary and that there is no formulary alternative that will meet your medical needs.

External Prosthetic Devices and Orthotic Devices Exclusions

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

Health Education Services

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

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

You pay the applicable primary care or specialty care Copayment or Coinsurance shown in the "Benefit Summary" for most individual and group visits. There are fees for some health education classes. For more information about our health education programs, see our *Healthy Living* catalog, call Membership Services, or go to **kp.org**. To use the free phone-based "Talk with a Health Consultant" service call 503-286-6816 or 1-866-301-3866 (toll free) and select option 2.

Health Education Services Exclusions

- Educational and clinical programs for weight control.

Hearing Services

We cover Services in this section for Members 18 years of age or younger, and for Dependent children 19 years of age and older who are under the Dependent Limiting Age shown in the "Benefit Summary" and enrolled in an accredited educational institution. You may have additional coverage if your Group has purchased a "Hearing Aid Rider."

Hearing Exam

We cover exams to determine the need for hearing correction. In addition, we cover visits to determine the appropriate hearing aid model, visits to verify that the hearing aid conforms to the prescription and visits for fitting, counseling, adjustment, cleaning, and inspection.

Hearing Aids

We cover hearing aids, when prescribed by a Participating Provider, limited to one hearing aid per ear every four years. The date we cover a hearing aid is the date on which you are fitted for the hearing aid. Therefore, if you are fitted for a hearing aid while you are covered under this *EOC*, and if we would otherwise cover the hearing aid, we will provide the hearing aid even if you do not receive the device until after you are no longer covered under this *EOC*.

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

Bone-anchored hearing aids, cochlear implants, and osseointegrated hearing devices are not covered under this "Hearing Services" benefit because they are internally implanted during a surgical procedure. Please refer to internally implanted devices in the "Benefits for Outpatient Services" and "Benefits for Inpatient Hospital Services" sections.

Hearing Services Exclusions

- Hearing aids that were fitted before you were covered under this *EOC*.
- Internally implanted hearing aids.
- Repair of hearing aids beyond the warranty period.
- Replacement of lost or broken hearing aids, if you have exhausted (used up) your allowance.
- Replacement parts and batteries.

Home Health Services

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

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

The "Benefit Summary" shows a visit maximum for home health Services. That visit maximum will be exhausted (used up) for a Calendar Year when the number of visits that we covered during the Calendar Year under this *EOC*, plus any visits we covered during the Calendar 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 Calendar Year.

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

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

Home Health Services Exclusions

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

Hospice Services

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

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

- A Medical Group physician has diagnosed you with a terminal illness and determines that your life expectancy is six months or less.

- The Services are provided in your home (or a place of temporary or permanent residence used as your home).
- The Services are provided by a licensed hospice agency approved by Kaiser Foundation Hospitals.
- The Services are necessary for the palliation and management of your terminal illness and related conditions.
- The Services meet Utilization Review by Company using criteria developed by Medical Group and approved by Company.

We cover the following hospice Services:

- Counseling and bereavement Services for up to one year.
- Durable Medical Equipment (DME).
- Home health aide and Homemaker Services.
- Medical social Services.
- Medical supplies and appliances.
- Participating Physician Services.
- Rehabilitative therapy Services for purposes of symptom control or to enable you to maintain activities of daily living.
- Services of volunteers.
- Short-term inpatient Services including respite care and care for pain control and acute and chronic symptom management. Inpatient respite care is limited to no more than five consecutive days in a 30-day period.
- Skilled nursing Services, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers.

Infertility Services

The following inpatient and outpatient infertility Services are covered:

- Diagnosis and treatment of involuntary infertility.
- Artificial insemination.

Infertility Services Exclusions

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

Limited Dental Services

We do not cover dental Services except as described below. Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request these criteria by calling Membership Services.

Covered Dental Services

We cover dental Services only as described below:

- Dental and orthodontic Services for the treatment of craniofacial anomalies if the Services are Medically Necessary to improve or restore function.
- Dental Services necessary for or resulting from medical treatment such as surgery on the jawbone and radiation treatment, limited to (a) emergency dental Services, or (b) extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.
- General anesthesia and associated hospital or ambulatory surgical facility Services in conjunction with covered dental Services when Medically Necessary if (a) you are physically or developmentally disabled, or (b) you have a medical condition that your Participating Physician determines would place you at undue risk if the dental procedure were performed in a dental office.

Covered Services provided, prescribed, authorized, or directed by a licensed Dentist or denturist may also be performed by a dental hygienist under the supervision of a licensed Dentist. You pay the Copayment or Coinsurance you would pay if the Services were not related to a covered dental Service.

Limited Dental Services Exclusions

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

- Dental appliances and dentures.
- Dental implants.
- Dental Services following accidental injury to teeth, unless your Group has purchased the "Dental Accidental Injury Rider."
- Extraction of teeth, except as described above in the "Covered Dental Services" section.
- Hospital Services for dental care, except as described above in the "Covered Dental Services" section.
- Injuries to teeth resulting from biting or chewing.
- Orthodontics, except as described above in the "Covered Dental Services" section.
- Routine or preventive dental care and dental x-rays.
- Services to correct malocclusion.

Limited Outpatient Prescription Drugs, Supplies, and Supplements

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

Covered Drugs, Supplies, and Supplements

We cover the following outpatient drugs, supplies, and supplements from a Participating Pharmacy when prescribed by a Participating Provider in accordance with drug formulary guidelines.

- Certain preventive medications (including, but not limited to, aspirin, fluoride, and iron) 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.
- Contraceptives including injectable contraceptives.
- Drugs, injectables, and radioactive materials used for therapeutic or diagnostic purposes, if they are administered to you in a Participating Medical Office or during home visits. We cover these items upon payment of the administered medications Copayment or Coinsurance shown under "Outpatient Services" in the "Benefit Summary."
- Medical foods and formulas necessary for the treatment of phenylketonuria (PKU), severe intestinal malabsorption, specified inborn errors of metabolism, or other metabolic disorders.
- Oral chemotherapy medications used for the treatment of cancer.
- Post-surgical immunosuppressive drugs after covered transplant Services.

About Our Drug Formulary

Our drug formulary includes the list of drugs that our Regional Formulary and Therapeutics Committee has approved for our Members. The Regional Formulary and Therapeutics Committee meets monthly and is made up of Participating Physicians, other Participating Providers, pharmacists, and administrative staff. The Regional Formulary and Therapeutics Committee chooses drugs for the formulary based on a number of factors, including safety and effectiveness as determined from a review of the scientific literature. To see if a drug, supply or supplement is on our drug formulary, call our Formulary Application Services Team (FAST) at 503-261-7900. If you would like a copy of our drug formulary or additional information about the formulary process, please call Membership Services. The drug formulary is also available online at **kp.org**. The presence of a drug on our drug formulary does not necessarily mean that your Participating Provider will prescribe it for a particular medical condition.

Drug Formulary Exception Process

Our drug formulary guidelines include an exception process that is available when a Participating Provider prescribes a drug, supply, or supplement 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, supplies, and supplements that the law does not require to bear this legend, or for any drug, supply, or supplement prescribed by someone other than a Participating Provider.

A Participating Provider may request an exception if he or she determines that the non-formulary drug, supply, or supplement is Medically Necessary. We will approve the exception if all of the following requirements are met:

- We determine that the drug, supply, or supplement 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, supply, or supplement is Medically Necessary because you are allergic to, or intolerant of, or have experienced treatment failure with, any alternative drugs, supplies, or supplements 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, supply, or supplement. For this drug, supply, or supplement, 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, supply, or supplement.

Limited Outpatient Prescription Drugs, Supplies, and Supplements Exclusions

- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.
- Drugs prescribed for an indication if the U.S. Food and Drug Administration (FDA) determined that use of that drug for that indication is contraindicated.
- Drugs prescribed for an indication if the FDA has not approved the drug for that indication, except that this exclusion does not apply if the Oregon Health Evidence Review Commission or our Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health and Human Services.
- Drugs, supplies, and supplements 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 drugs, supplies, or supplements that our drug formulary lists for your condition.
- Drugs that the FDA has not approved.
- Drugs used in weight management.
- Drugs used to enhance athletic performance.
- Extemporaneously compounded drugs, unless the formulation is approved by our Regional Formulary and Therapeutics Committee.
- Injectable drugs that are self-administered.
- Mail-order drugs for anyone who is not a resident of Oregon or Washington.
- Replacement of drugs, supplies, and supplements due to loss, damage, or carelessness.
- The following are excluded, but you may have coverage for them if your Group purchased an "Outpatient Prescription Drug Rider":
    - Prescription drugs, supplies, and supplements that are dispensed on an outpatient basis, except those listed under "Covered Drugs, Supplies, and Supplements" of this "Limited Outpatient Prescription Drugs, Supplies, and Supplements" section.
    - Drugs for treatment of infertility.
    - Drugs used for the treatment or prevention of sexual dysfunction disorders.

Mental Health Services

We cover the following mental health Services when they are necessary for:

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

We cover mental health Services subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request the criteria by calling Membership Services. We cover Participating Provider Services under this "Mental Health Services" section only if they are provided by a licensed psychiatrist, licensed psychologist, licensed clinical social worker, licensed mental health counselor, licensed professional counselor, licensed marriage and family therapist, or advanced practice psychiatric nurse. The benefits described in this "Mental Health Services" section comply with the Mental Health Parity and Addiction Equity Act.

Outpatient Services

We cover individual office visits, group therapy visits, and intensive outpatient visits for mental health.

Inpatient Hospital Services

We cover inpatient hospital Services for mental health. Prior authorization is not required for Members who are involuntarily committed and subsequently treated in a state hospital.

Residential Services

We cover residential Services in a residential facility.

Psychological Testing

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

Mental Health Services Exclusions and Limitations

- Mental health Services, including evaluations and psychological testing, on court order or as a condition of parole or probation, unless Medically Necessary. Court-ordered sex offender treatment programs are excluded regardless of whether they are Medically Necessary.
- Psychological testing for ability, aptitude, intelligence, or interest.
- Mental health Services for the following disorders listed by their diagnostic codes as set out in the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition), published by the American Psychiatric Association:
  - (Mental retardation) codes 317, 318.0, 318.1, 318.2, and 319.
  - (Learning disorders) codes 315.00, 315.1, 315.2, and 315.9.
  - (Paraphilias) codes 302.2, 302.4, 302.81, 302.82, 302.83, 302.84, and 302.89.
  - (Life transition problems referred to as "V" codes) codes V15.81 through V62.81 and V62.83 through V71.09. This exclusion does not apply to anyone 5 years of age or younger for code V61.20 (parent-child relational problems) or code V61.21 (neglect, physical abuse, or sexual abuse of child).
- Mental health Services for substance related disorders, except as covered under "Chemical Dependency Services" in this "Benefits" section.
- In home mental health Services, unless all of the following are true:
  - You are substantially confined to your home (or a friend's or relative's home), or the care is provided in lieu of Medically Necessary hospitalization.
  - Your Participating Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home.
  - You receive prior authorization from Company in accordance with Utilization Review criteria developed by Medical Group and approved by Company.

Outpatient Durable Medical Equipment (DME)

We cover outpatient Durable Medical Equipment (DME according to the DME formulary guidelines. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. DME must be for use in your primary residence (or another location used as your

primary residence). Coverage is limited to the standard supply or equipment that adequately meets your medical needs. We decide whether to rent or purchase the DME, and we select the vendor. We also decide whether to repair, adjust, or replace the DME when necessary.

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

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

Covered DME includes the following:

- Bilirubin lights.
- CADD (continuous ambulatory drug delivery) pumps.
- Compression garments for burns.
- Diabetic equipment and supplies including external insulin pumps, infusion devices, glucose monitors, diabetic foot care appliances, injection aids, and lancets.
- Enteral pump and supplies.
- Enteral supplements and formula.
- Lymphedema wraps and garments.
- Osteogenic bone stimulators.
- Osteogenic spine stimulators.
- Oxygen and oxygen supplies.
- Ventilators.
- Wheelchairs.

DME Formulary

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

Our formulary guidelines allow you to obtain non-formulary DME items (those not listed on our DME formulary for your condition) if Medical Group's designated DME review physician determines that it is Medically Necessary and that there is no formulary alternative that will meet your medical needs.

Outpatient Durable Medical Equipment (DME) Exclusions

- Comfort, convenience, or luxury equipment or features.
- Continuous glucose monitoring (CGM) devices, systems, and supplies.
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies).
- Electronic monitors of bodily functions.
- Exercise or hygiene equipment.

- Modifications to your home or car.
- More than one corrective appliance or artificial aid or item of Durable Medical Equipment, serving the same function or the same part of the body, except for necessary repairs, adjustments and replacements as specified under this "Outpatient Durable Medical Equipment (DME)" section.
- Non-medical items, such as sauna baths or elevators.
- Repair or replacement of DME items due to loss or misuse.
- Spare or duplicate use DME.

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

We cover outpatient Services for laboratory, X-ray, imaging, and special diagnostic procedures. Special diagnostic procedures may or may not involve radiology or imaging technology. Examples include, but are not limited to, MRI, CT scans, mammograms, pulmonary function studies, sleep studies, and nerve conduction studies. Some special diagnostic Services may be subject to a higher Copayment or Coinsurance, as shown in the "Benefit Summary."

The special diagnostic procedure Copayment or Coinsurance does not apply to procedures that are usually for treatment purposes, even if that procedure might also be performed for diagnostic reasons, such as colonoscopy, endoscopy, and laparoscopy. For these Services, the outpatient surgery visit Copayment or Coinsurance applies.

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

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

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

If you have questions about your Copayment or Coinsurance, call Membership Services, or ask one of the Membership Services representatives in your Participating Medical Office.

Reconstructive Surgery Services

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

- To correct significant disfigurement resulting from an injury or from Medically Necessary surgery.
- To correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function.
- To treat congenital hemangioma known as port wine stains on the face for Members age 18 or younger.

With respect to maxillofacial prosthetic services, coverage is limited to the least costly clinically appropriate treatment as determined by a Participating Provider. We cover maxillofacial prosthetic Services if they are necessary for restoration and management of head and facial structures that cannot be replaced with living tissue and are defective because of disease, trauma, or birth and developmental deformities when this restoration and management are performed for the purpose of any of the following:

- Controlling or eliminating infection.

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

We also cover:

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

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

Rehabilitative Therapy Services

We cover inpatient hospital and outpatient physical, occupational, speech and multidisciplinary rehabilitation and multidisciplinary day treatment program rehabilitative therapy Services, when prescribed by a Participating Physician, subject to the benefit descriptions and limitations contained in this "Rehabilitative Therapy Services" section. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

Physical, Occupational, and Speech Therapy Services

Therapy Services (physical, occupational, and speech) are covered for the treatment of acute conditions or acute exacerbations of chronic conditions which, in the judgment of the Participating Physician, will show sustainable, objective, measurable improvement as a result of the prescribed therapy. Prescribed outpatient therapy Services must receive prior authorization as described under "Prior and Concurrent Authorization and Utilization Review" in the "How to Obtain Services" section.

Physical, Occupational, and Speech Therapy Services Limitations

- Physical therapy Services and occupational therapy Services are limited to those 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 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.
- The "Benefit Summary" shows a visit maximum for each rehabilitative therapy Service. That visit maximum will be exhausted (used up) for the Calendar Year when the number of visits that we covered during the Calendar Year under this *EOC* plus any visits we covered during the Calendar 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 Calendar Year. This limitation does not apply to hospital inpatient Services.

Multidisciplinary Inpatient Rehabilitation and Multidisciplinary Day Treatment Program Services

We cover multidisciplinary rehabilitation Services in the inpatient hospital or outpatient day treatment program setting.

Multidisciplinary rehabilitation Services are covered for the treatment of conditions which, in the judgment of a Participating Physician will show sustainable, objective measurable improvement as a result of the

prescribed therapy and must receive prior authorization as described under the "Prior and Concurrent Authorization and Utilization Review" in the "How to Obtain Services" section.

Multidisciplinary rehabilitation Services provided in a Participating Skilled Nursing Facility will not reduce the covered days of Service under this "Multidisciplinary Inpatient Rehabilitation and Multidisciplinary Day Treatment Program Services" section.

Multidisciplinary Rehabilitation and Multidisciplinary Day Treatment Program Services Limitations

The "Benefit Summary" shows a combined day maximum for inpatient hospital and outpatient day treatment program Services. That combined day maximum will be exhausted (used up) for the Calendar Year when the number of days that we covered during the Calendar Year under this *EOC* plus any days we covered during the Calendar Year under any other evidence of coverage with the same group number printed on this *EOC* add up to the combined day maximum. After you reach the combined day maximum, we will not cover any more days for the remainder of the Calendar Year.

Rehabilitative Therapy Services Exclusions

- Cognitive rehabilitation programs.
- Long-term rehabilitation.
- Services designed to maintain optimal health in the absence of symptoms.

Services Provided in Connection with Clinical Trials

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

- We would have covered the Services if they were not related to a clinical trial.
- You are eligible to participate in the clinical trial according to the trial protocol, as determined in one of the following ways:
  - A Participating Provider makes this determination.
  - You provide us with medical and scientific information establishing this determination.
  - If any Participating Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Participating Provider unless the clinical trial is outside the state where you live.
- The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial and it meets one of the following requirements:
  - The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
  - The study or investigation is a drug trial that is exempt from having an investigational new drug application.
  - The study or investigation is approved or funded by at least one of the following:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.

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

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

Services Provided in Connection With Clinical Trials Exclusions

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

Skilled Nursing Facility Services

We cover skilled inpatient Services in a licensed Participating Skilled Nursing Facility. The skilled inpatient Services must be those customarily provided by Participating Skilled Nursing Facilities. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

The "Benefit Summary" shows a day maximum for skilled nursing facility Services under "Skilled Nursing Facility Services." That day maximum will be exhausted (used up) for a Calendar Year when the number of days that we covered during the Calendar Year under this *EOC* plus any days we covered during the Calendar 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 Calendar Year.

We cover the following:

- Room and board.
- Nursing Services.
- Medical social Services.
- Medical and biological supplies.
- Blood, blood products, and their administration.

- Dialysis Services.
- Rehabilitative therapy Services (this benefit is subject to the benefit limitations shown in the "Benefit Summary" under "Rehabilitative Therapy Services").
- Drugs prescribed by a Participating Physician as part of your plan of care in the Participating Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Participating Skilled Nursing Facility by medical personnel.

Telemedical Services

General Telemedical Services

This "General Telemedical Services" section describes covered telemedical Services except for those provided in the treatment of diabetes. For information about covered telemedical Services related to diabetes care, see the "Telemedical Services for the Treatment of Diabetes" section below. General telemedical Services are Services delivered via a two-way video communication format that allow a Member who is at an originating site (a location where Services are received) to interact with a Participating Provider who is not physically at the same location. Telephone calls and communication by facsimile machine, electronic mail, or other electronic messaging systems that do not include remote visual contact between the provider and Member are not considered general telemedical Services.

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

- The Service is otherwise covered under this *EOC*.
- The Service is determined by a Participating Provider to be Medically Necessary.
- The Service is not otherwise available to you in person.

Telemedical Services for the Treatment of Diabetes

Telemedical Services for the treatment of diabetes are Services delivered via a two-way electronic communication format, including but not limited to video, audio, Voice over Internet Protocol, or transmission of telemetry. Telemedical Services allow a Member, or person acting on the Member's behalf, who is at an originating site (a location where Services are received) to interact with a Participating Provider who is not physically at the same location.

We cover telemedical Services for the treatment of diabetes at no Charge when all of the following are true:

- The Service is otherwise covered under this *EOC*.
- The Service is determined by a Participating Provider to be Medically Necessary.

Transplant Services

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

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

- It is licensed in the state where it operates.
- It is certified by Medicare as a transplant facility for the specific organ transplant.
- It is designated by Company as a transplant facility for the specific organ transplant.

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

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

- Bone marrow.
- Cornea.
- Heart.
- Heart-lung.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Pancreas after kidney.
- Simultaneous kidney-pancreas.
- Small bowel.
- Small bowel/liver.
- Stem cell.

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

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

Transplant Services Exclusions

- Non-human and artificial organs and their implantation.

EXCLUSIONS AND LIMITATIONS

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

Acupuncture. Services for acupuncture are limited to the following: (a) when a Participating Physician makes a referral for Services in accord with Medical Group criteria, and are subject to benefit limitations (if any) as

shown in the "Benefit Summary"; or (b) or your employer Group has purchased the "Alternative Care Services Rider" (for self-referred acupuncture Services).

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

Chiropractic Services Received Without a Referral by Kaiser Permanente. Chiropractic and related Services are limited to the following: (a) when a Participating Physician makes a referral for Services in accord with Medical Group criteria; or (b) your employer Group has purchased the "Alternative Care Services Rider" or the "Chiropractic Services Rider" (for self-referred chiropractic care).

Cosmetic Services. Cosmetic Services, which means those Services that are intended primarily to change or maintain your appearance and will not result in significant improvement in physical function. This exclusion does not apply to Services that are covered under "Reconstructive Surgery Services" in the "Benefits" section.

Custodial Services. Nonskilled, personal services such as help with activities of daily living (like bathing, dressing, getting in and out of a bed or chair, moving around and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare does not pay for custodial services.

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

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

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

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

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

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

- The prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that:
  - Use of the Services should be substantially confined to research settings, or
  - Further research is necessary to determine the safety, toxicity, or efficacy of the Services.

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

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

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

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

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

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

Genetic Testing. Genetic testing and related Services are limited to genetic counseling and medically appropriate genetic testing for the purpose of diagnostic testing to determine disease and/or predisposition of disease and to develop treatment plans. Covered Services are limited to preconception and prenatal testing for detection of congenital and heritable disorders, and testing for the prediction of high-risk occurrence or reoccurrence of disease when Medically Necessary as determined by a Participating Physician, in accordance with applicable law. However, testing for family members who are not Members is always excluded.

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

Hearing Aids. Hearing aids, tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid are excluded, unless your Group has purchased the "Hearing Aid Rider." This exclusion does not apply to Services that are covered under "Hearing Services" in the "Benefits" section.

Hypnotherapy. All Services related to hypnotherapy.

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

Low-Vision Aids.

Massage Therapy Services. Massage therapy and related Services are limited to when: (a) Participating Physician makes a referral for Services in accord with Medical Group criteria; or (b) your employer Group has purchased the Alternative Care (Massage Therapy) Rider.

Naturopathy Services. Naturopathy and related Services are limited to when; (a) a Participating Physician makes a referral for Services in accord with Medical Group criteria; or (b) your employer Group has purchased the Alternative Care (Naturopathy Services) Rider.

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

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

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

Services Performed by Unlicensed People. Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care Services and where the Member's condition does not require that the Services be provided by a licensed health care provider.

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

Services That are Not Health Care Services, Supplies, or Items. For example, we do not cover:

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

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

Travel and Lodging. Transportation or living expenses for any person, including the patient, are limited to: (a) Medically Necessary ambulance Service covered under "Ambulance Services" in this *EOC*, and (b) certain

expenses that we preauthorize in accord with our travel and lodging guidelines under "Transplant Services" in this *EOC*. Your transplant coordinator can provide information about covered travel and lodging expenses.

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

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

Vision Therapy and Orthoptics or Eye Exercises. Services related to vision therapy and orthoptics and eye exercises are excluded.

REDUCTIONS

Coordination of Benefits

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

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable expense.

Definitions

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

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

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

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

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

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

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

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

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

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.

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

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

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

Order of Benefit Determination Rules

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

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

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

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are

major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

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

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

(2) Dependent child covered under more than one Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

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

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

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

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

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

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The Plan covering the Custodial parent;

The Plan covering the spouse of the Custodial parent;

The Plan covering the non-custodial parent; and then

The Plan covering the spouse of the non-custodial parent.

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

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid-off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

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

Effect on the Benefits of This Plan

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

Questions About Coordination of Benefits?
Contact Your State Insurance Department

Hospitalization on Your Effective Date

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

Injuries or Illnesses Alleged to be Caused by Third Parties

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

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

If you obtain a settlement or judgment from or on behalf of a third party, you must pay us Charges for covered Services that you receive for the injury or illness, except that you do not have to pay us more than the amount you receive from or on behalf of the third party. This "Injuries or Illnesses Alleged to be Caused by Third Parties" section does not affect your obligation to make any applicable Copayment or Coinsurance payments for these covered Services, but we will credit any such payments toward the amount you must pay us under this paragraph.

If you do not recover anything from or on behalf of the third party, then you are responsible only for any applicable Copayment or Coinsurance payments.

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

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

You must make all reasonable efforts to pursue any claim you may have against a third party. Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to us at:

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

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

You must place and hold in trust a portion of the proceeds of your recovery that is sufficient to satisfy our claims under this "Injuries or Illnesses Alleged to be Caused by Third Parties" section pending final resolution of the claims. You must provide us with written notice before you settle a claim or obtain a judgment against any third party based on your injury or illness.

In addition to the rights set forth above, we shall also be entitled to all of the remedies, benefits, and other rights of sections 742.520 – 742.542, Oregon Revised Statutes.

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

Workers' Compensation or Employer's Liability

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

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

GRIEVANCES, CLAIMS, APPEALS, AND EXTERNAL REVIEW

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

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

A claim is a request for us to:

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

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

- Denial or termination of enrollment of an individual in a health benefit plan;
- Rescission or cancellation of a policy;
- Imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered Services;
- Determination that a Service is experimental or investigational or not Medically Necessary or appropriate; or

- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

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

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

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

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

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

Language and Translation Assistance

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

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

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

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

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

Appointing a Representative

If you would like someone to act on your behalf regarding your claim, you may appoint an authorized representative, an individual who by law or by your consent may act on your behalf. You must make this appointment in writing. Please contact Membership Services at 503-813-2000 for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal

While you are encouraged to use our appeal procedures, you have the right to seek assistance from the Consumer Protection Unit at the Oregon Insurance Division. Contact them by mail, telephone, or online at:

Oregon Division of Insurance
Consumer Advocacy Unit
P.O. Box 14480
Salem, OR 97309-0405
503-947-7984 or 1-888-877-4894
www.insurance.oregon.gov/consumer/consumer.html

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 Membership Services at 1-800-813-2000.

Providing Additional Information Regarding Your Claim

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

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

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

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

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

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

Sharing Additional Information That We Collect

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

Internal Claims and Appeals Procedures

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

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

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision

regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

Pre-Service Claims and Appeals

Pre-Service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive authorization before receiving a Service that must be authorized or pre-certified in order to be a covered benefit may be the basis for our denial of your pre-Service claim or a post-Service claim for payment. If you receive any of the Services you are requesting before we make our decision, your pre-Service claim or appeal will become a post-Service claim or appeal with respect to those Services. If you have any general questions about pre-Service claims or appeals, please call Membership Services at 1-800-813-2000.

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

Pre-Service Claim

- You may request a pre-Service benefit determination on your own behalf. Tell us in writing that you want to make a claim for us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to us at:

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

  - If you want us to consider your pre-Service claim on an urgent basis, your request should tell us that. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life or health (or the life or health of a fetus), or ability to regain maximum function; (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting; or (c) your attending provider requests that your claim be treated as urgent.
  - We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time, but not later than 15 days after we receive your claim.

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

    If we tell you we need more information, we will ask you for the information within the initial 15-day decision period, and we will give you 45 days to send the information.

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

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

    If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.
  - We will send written notice of our decision to you and, if applicable, to your provider.

    If your pre-Service claim was considered on an urgent basis, we will notify you of our decision orally or in writing within a timeframe appropriate to your clinical condition, but not later than 72

hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three days after that.

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

Non-Urgent Pre-Service Appeal

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

  (1) Your name and health record number;

  (2) Your medical condition or relevant symptoms;

  (3) The specific Service that you are requesting;

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

  (5) All supporting documents.

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

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

- We will acknowledge your appeal in writing within seven days after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision within 30 days after we receive your appeal.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, which may be available to you.

Urgent Pre-Service Appeal

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

  (1) Your name and health record number;

  (2) Your medical condition or relevant symptoms;

  (3) The specific Service that you are requesting;

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

  (5) All supporting documents.

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

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

- When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-Service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Grievances, Claims, Appeals, and External Review" section), if our internal appeal decision is not in your favor.
- We will decide whether your appeal is urgent or non-urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life or health (or the life or health of a fetus), or ability to regain maximum function; (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting; or (c) your attending provider requests that your claim be treated as urgent.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three days after that.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, which may be available to you.

Concurrent Care Claims and Appeals

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

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

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

Concurrent Care Claim

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

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

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

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

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

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

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

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

  If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the timeframe we gave you for sending the additional information.
- We will send written notice of our decision to you and, if applicable, to your provider.
- If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three days after receiving your claim.

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

Non-Urgent Concurrent Care Appeal

- Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following:

  (1) Your name and health record number;

  (2) Your medical condition or relevant symptoms;

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

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

  (5) All supporting documents.

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

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

- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision as soon as possible if your care has not ended but not later than 30 days after we receive your appeal.
- If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, which may be available to you.

Urgent Concurrent Care Appeal

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

  (1) Your name and health record number;

  (2) Your medical condition or relevant symptoms;

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

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

  (5) All supporting documents.

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

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

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

Post-Service Claims and Appeals

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

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

Post-Service Claim

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

  (1) The date you received the Services;

  (2) Where you received them;

  (3) Who provided them;

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

  (5) A copy of the bill and any supporting documents.

  Your letter and the related documents constitute your claim. You may contact Membership Services to obtain a claim form. You must either mail or fax your claim to the Claims Department at:

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

- We will not accept or pay for claims received from you after 180 days from the date of Services, except in the absence of legal capacity.

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

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

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

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

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

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

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

Post-Service Appeal

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

  (1) Your name and health record number;

  (2) Your medical condition or relevant symptoms;

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

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

  (5) All supporting documents.

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

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

- We will acknowledge your appeal in writing within seven days after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision within 30 days after we receive your appeal.
- If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

External Review

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

- Whether a course or plan of treatment is Medically Necessary, experimental, or investigational.
- Whether a course or plan of treatment is an active course of treatment for purposes of continuity of care when a Participating Provider's contract with us is terminated.
- Whether a course or plan of treatment is delivered in an appropriate health care setting and with the appropriate level of care.

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

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

Member Relations will forward your request to the director of the Oregon Department of Consumer and Business Services (DCBS) within two business days after receiving your request. Your request for external review will be assigned to one of the nationally accredited independent review organizations (IROs) contracted by DCBS along with any necessary authorizations no later than the next business day after the director receives your request for external review from us. DCBS will send you a written description of the IRO they selected along with more information about the process. They will also notify us of the IRO they selected so we can send documents and information we considered in making our adverse benefit determination. You or your provider may also forward additional information directly to the IRO. The IRO will have one business day after receiving this information to forward that information to us. We may also forward additional information directly to the IRO. The IRO will have one business day after receiving the additional information to forward that information to you.

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.

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

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

Expedited External Review

We shall expedite the external review:

- If the adverse benefit determination concerns an admission, the availability of care, a continued stay or a health care Service for a medical condition for which the enrollee received Emergency Services and has not been discharged from a health care facility; or
- If a provider you have an established relationship with certifies in writing and provides supporting documentation that the ordinary time period for external review would (a) seriously jeopardize your life, health, (or the life or health of a fetus), or ability to regain maximum function; (b) in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting; or (c) your attending provider requests that your claim be treated as urgent.

Additional Review

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

Member Satisfaction Procedure

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

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

- Contact the administrative office in the Participating Facility where you are having the problem.
- Calling Membership Services at 503-813-2000; or
- Sending your written complaint to Member Relations at:

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

All complaints are handled in a confidential manner.

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

- A representative reviews the complaint and conducts an investigation, verifying all the relevant facts.
- The representative or a Participating Provider evaluates the facts and makes a recommendation for corrective action, if any.

- When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
- When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

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

TERMINATION OF MEMBERSHIP

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

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

Termination during Confinement in a Hospital

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

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

Your coverage under this provision continues until the earlier of:

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

Termination Due to Loss of Eligibility

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

Termination for Cause

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

- You knowingly commit fraud in connection with membership, Company, or a Participating Provider. Some examples of fraud include:
  - Misrepresenting eligibility information about you or a Dependent.
  - Presenting an invalid prescription or physician order for Services.
  - Intentionally misusing a Company ID card (or letting someone else use your ID card to obtain Services pretending to be you).
  - Giving us incorrect or incomplete material information.

- Failing to notify us of changes in Family status or Medicare coverage that may affect your eligibility or benefits.

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

If we terminate your membership for cause we will:

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

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

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

Termination of Your Group's *Agreement* With Us

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

Termination of Certain Types of Health Benefit Plans by Us

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

Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act (HIPAA) requires employers or health insurance companies to issue "Certificates of Creditable Coverage" to terminated group members. The certificate documents health Plan membership and is used to prove prior Creditable Coverage when a terminated member seeks new coverage. When your membership terminates, we will mail the certificate to the Subscriber unless your Group has an agreement with us to mail the certificates. If you have any questions, please contact your Group's benefits administrator.

CONTINUATION OF MEMBERSHIP

Strike, Lock-Out, or Other Labor Disputes

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

Illness, Temporary Plant Shut Down, or Leave of Absence

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

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

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

Federal or State-Mandated Continuation of Coverage

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

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

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

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

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

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

- You fail to pay your Premium.
- The Group's *Agreement* with us terminates.
- You are covered under another group health coverage.
- You become eligible for Medicare.

State Continuation Coverage for Non-COBRA Groups

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

- Your Group is not subject to COBRA law.
- The Subscriber in your Family was covered continuously under this *EOC* during the three-month period ending on the date of the qualifying event.
- You were covered under this *EOC* on the day before the qualifying event, or you are a child born to or adopted by the Subscriber while the Subscriber has continuation coverage under this "State Continuation Coverage for Non-COBRA Groups" section and you would have been covered under this *EOC* if you had been born or adopted on the day before the qualifying event. For the purposes of this "State

Continuation Coverage for Non-COBRA Groups" section, "qualifying event" means the loss of membership under this *EOC* caused by one of the following:

- Voluntary or involuntary termination of the employment of the Subscriber.
- A reduction in hours worked by the Subscriber.
- The Subscriber's becoming eligible for Medicare.
- A Dependent's losing Dependent child status under this *EOC*.
- Termination of membership in your Group resulting in loss of eligibility under the Group's evidence of coverage.
- The death of the Subscriber.

- You are not eligible for Medicare, and you are not eligible for coverage under any other hospital or medical coverage or program that was not covering you on the day before the qualifying event.
- To request continuation coverage under this "State Continuation Coverage for Non-COBRA Groups" section, you must send us a written request for this continuation coverage no later than 10 days after the later of the following:
- The date of your qualifying event.
- The date on which we sent you notice of your right to continue coverage under this *EOC*.

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

Consolidated Service Center (CSC)
7901 E Lowry 4th Fl
Denver CO 80230
Fax: 866-311-5974

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

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

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

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

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

If your Group coverage was under another evidence of coverage on the date of your qualifying event and you later became covered under this *EOC*, you may be able to continue coverage under this *EOC* if you otherwise

meet the eligibility requirements in this "State Continuation Coverage for Non-COBRA Groups" section. The period of state continuation coverage includes the number of months you were covered under the previous evidence of coverage plus the number of months of coverage under this *EOC*, not to exceed nine months.

State Continuation Coverage after Workers' Compensation Claim

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

Conversion to an Individual Plan

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

Moving to another Kaiser Foundation Health Plan or Allied Plan Service Area

If you move to another Kaiser Foundation Health Plan or Allied Plan service area, you should contact your Group's benefits administrator to learn about your Group health care options. You may be able to transfer your Group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premium, deductible, and copayments and coinsurance may not be the same in the other service area.

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

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

Agreement Binding on Members

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

Amendment of *Agreement*

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

Annual Summaries and Additional Information

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

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

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

DCBS Insurance Division
Consumer Protection Unit
PO Box 14480
Salem, OR 97309-0405
503-947-7984 (in Salem)
1-888-877-4894 (all other areas)
E-mail: DCBS.insmail@state.or.us
www.oregoninsurance.org

Applications and Statements

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

Assignment

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

Attorney Fees and Expenses

In any dispute between a Member and Company or Medical Group or Kaiser Foundation Hospitals, each party will bear its own attorneys' fees and other expenses in any dispute.

Exercise of Conscience

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

Governing Law

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

Group and Members not Company Agents

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

No Waiver

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

Nondiscrimination

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

Notices

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

Overpayment Recovery

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

Privacy Practices

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

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

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 Membership Services. You can also find the notice at your local Participating Facility or on our website at **kp.org**.

Unusual Circumstances

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

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST ALTERNATIVE CARE SERVICES RIDER

This rider is part of the *Evidence of Coverage (EOC)* to which it is attached. All provisions of this rider become part of the *EOC* "Benefits" section, except for the "Alternative Care Services Benefit Summary," which becomes part of the *EOC* "Benefit Summary." This entire benefit rider is therefore subject to all the terms and provisions of the *EOC*. The "Acupuncture," "Chiropractic Services Received Without a Referral from Kaiser Permanente," "Massage Therapy Services," and "Naturopathy Services" exclusions in the *EOC* "Exclusions and Limitations" section do not apply to Services we cover under this rider.

Alternative Care Services

We cover self-referred acupuncture, chiropractic, massage therapy, and naturopathy Services described in this "Alternative Care Services Rider" at the Copayment or Coinsurance shown in the "Alternative Care Services Benefit Summary."

1. Acupuncture Services

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

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

2. Chiropractic Services

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

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

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

3. Massage Therapy (up to 12 visits per Calendar Year)

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. We cover up to 12 visits per Calendar Year. Covered Services include evaluation and management.

4. Naturopathic Medicine

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.

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

Definitions

The following terms, when capitalized and used in this "Alternative Care Services Rider," mean:

- **The CHP Group.** A network of alternative care and chiropractic providers who provide Participating Provider Services and which provides utilization management and prior authorization services for Company. You can contact The CHP Group by calling 1-800-449-9479, 8 a.m. to 5 p.m. (PT), Monday through Friday.
- **Covered Services.** Care provided by a Participating Provider that is within scope of license and determined to be Medically Necessary, and is not specifically limited or excluded by this rider.
- **Non-Participating Provider.** A chiropractor, acupuncturist, naturopathic physician, or massage therapist who is not under contract with The CHP Group to treat Members.
- **Participating Provider.** An individual who is duly licensed to practice as a chiropractor, acupuncturist, naturopathic physician, or massage therapist in Oregon or Washington who is under contract with Company, Medical Group or The CHP Group to provide chiropractic, acupuncture, naturopathic or massage therapy Services to Members. A list of Participating Providers can be obtained by contacting Membership Services or by visiting **www.chpgroup.com**.

General Benefit Requirements

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

- Services are received from Participating Providers and provided as outpatient Services in the Participating Provider's office.
- You are required to pay the Copayment or Coinsurance amount to the Participating Provider at the time of service. You are not responsible for any fees in excess of Charges.
- You are responsible for paying the full amount for Services after you reach your benefit maximum as shown in the "Alternative Care Services Benefit Summary."

Alternative Care Services Exclusions

- Acupressure.
- Behavioral training and modification, biofeedback, hypnotherapy, play therapy, and sleep therapy.
- Chiropractic Services in excess of those necessary for maximum chiropractic improvement. This includes supportive care when physician dependence, somatization, illness behavior, or secondary gain exists.
- Cosmetics, dietary supplements, recreation, health or beauty classes, aids, or equipment.
- Costs or charges incurred for which the Member is not legally required to pay, or for professional Services rendered by a person who resides in the Member's home, or who is related

to the Member by marriage or blood (including parents, children, sisters, brothers, or foster children).

- Cupping.
- Dental Services, including temporomandibular (TMJ) Services.
- Dermal friction technique.
- Disorders connected to military service, any treatment or service to which the Member is legally entitled through the United States Government or for which facilities are available.
- Durable Medical Equipment, devices, appliances, orthotics, or prosthetics.
- Expenses incurred for any Services provided before coverage begins or after coverage ends.
- Expenses incurred as a result of treatment or service for pre-employment, school entrance, or athletic physical examinations.
- Experimental treatment including laboratory tests, X-rays, and Services that are provided primarily for medical research purposes.
- Fertility Services, including reversal of sterilizations.
- Gynecological Services.
- Health or exercise classes, aids, or equipment.
- Hearing exams.
- Infertility Services.
- The following laboratory Services:
  - Comprehensive digestive stool analysis.
  - Cytotoxic food allergy test.
  - Darkfield examination for toxicity or parasites.
  - EAV and electronic tests for diagnosis or allergy.
  - Fecal transient and retention time.
  - Henshaw test.
  - Intestinal permeability.
  - Loomis 24 hour urine nutrient/enzyme analysis.
  - Melatonin biorhythm challenge.
  - Salivary caffeine clearance.
  - Sulfate/creatine ratio.
  - Thermography, hair analysis, heavy metal screening, and mineral studies.
  - Tryptophan load test.
  - Urinary sodium benzoate.
  - Urine saliva pH.
  - Zinc tolerancy test.

- Laserpuncture.
- Mental health Services of any kind.
- Moxibustion.
- MRIs, diagnostic ultrasounds, CT scans, bone scans, and other special imaging studies.
- Nambudripad allergy eliminated technique (NAET).
- Nerve conduction studies, electromyography, computerized muscle testing or range of motion testing.
- Obesity or weight control.
- Obstetrical Services.
- Over-the-counter drugs, medications (prescription or non-prescription) including vitamins, minerals, nutritional or dietary supplements, or any other supply or product, whether or not prescribed.
- Personal or comfort items, environmental enhancements, modifications to dwellings, property or motor vehicles, adaptive equipment, and training in the use of the equipment, personal lodging, travel expenses, or meals.
- Physical examinations for evaluations and reports for licensing, school, sports, premarital, or those required for court proceedings.
- Point injection therapy (aquapuncture).
- Preventive Services.
- Proctology Services.
- Public facility care in which Services or care is required by federal, state, or local law.
- Radiological procedures performed on equipment not certified, registered, or licensed by the State of Oregon or Washington, and/or radiological procedures that, when reviewed by The CHP Group are determined to be of such poor quality that they cannot safely be utilized in diagnosis or treatment.
- Services considered experimental or investigational.
- Services designed to maintain optimal health in the absence of symptoms.
- Smoking cessation.
- Sonopuncture.
- Surgery.
- Thermography, hair analysis, heavy metal screening, and mineral studies.
- Transportation Services, including ambulances and care cars.
- Treatment for purposes of obesity or weight control, to include any weight control supplies or products.
- Treatment of alcohol, drug, or chemical dependency in a specialized inpatient or residential facility.
- Treatment of workers' compensation illnesses or injuries.

- Vocational rehabilitation.
- X-ray documentation and/or interpretation when prescribed by an acupuncturist or naturopath.

Alternative Care Services Benefit Summary

	You Pay
Alternative Care (self-referred)	$10 per visit for acupuncture, chiropractic, and naturopathic visits. $25 per massage therapy visit (up to 12 visits per Calendar Year). $1,500 benefit maximum for all Services combined.

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST OUTPATIENT PRESCRIPTION DRUG RIDER

This rider is part of the *Evidence of Coverage* (*EOC*) to which it is attached. This rider becomes part of the *EOC* "Benefits" section. The provisions of the *EOC* apply to this entire rider.

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

Covered Drugs, Supplies, and Supplements

When all of the following requirements are met, we cover outpatient drugs, supplies, and supplements up to the day supply limits shown in the "Benefit Summary":

- A Participating Provider or any licensed dentist must prescribe the drug, supply, or supplement in accord with our drug formulary guidelines.
- You get the drug, supply, or supplement from a Participating Pharmacy.
- In addition, one of the following must be true:
  - The law requires the drug, supply, or supplement to bear the legend "Rx only." This includes glucagon emergency kits when prescribed for treatment of diabetes and contraceptive drugs and devices such as intrauterine devices, diaphragms, and cervical caps.
  - The drug, supply, or supplement is a nonprescription item that our drug formulary lists for your condition. These items include the following when prescribed for treatment of diabetes: insulin, ketone test strips for urine-testing, blood glucose test strips, and disposable needles and syringes. We cover additional diabetic equipment and supplies under the "Outpatient Durable Medical Equipment (DME)" section of the EOC.

Copayments and Coinsurance for Covered Drugs, Supplies, and Supplements

When you pick up a prescription at a Participating Pharmacy or order a prescription from our Mail-Delivery Pharmacy, you pay the Copayment or Coinsurance as shown in the "Benefit Summary." This applies for each prescription consisting of up to the day supply limit shown in the "Benefit Summary."

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

Day Supply Limit

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

How to Get Covered Drugs, Supplies, or Supplements

You must get covered drugs, supplies, and supplements from a Participating Pharmacy. These pharmacies are located in many Participating Facilities. To find a Participating Pharmacy, please see your *Medical Directory*, visit **kp.org**, or contact Membership Services.

Participating Pharmacies include our Mail-Delivery Pharmacy. This pharmacy offers postage-paid delivery to residents of Oregon and Washington. Some drugs, supplies, and supplements are not available through our

Mail-Delivery Pharmacy, for example drugs that require special handling or refrigeration, or are high cost. Drugs, supplies, and supplements available through our Mail-Delivery Pharmacy are subject to change at any time without notice.

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

Definitions

The following terms, when capitalized and used in this "Benefit Summary", mean:

- **Brand-Name Drug.** The first approved version of a drug. Marketed and sold under a proprietary, trademark-protected name by the pharmaceutical company that holds the original patent.
- **Generic Drug.** A drug that contains the same active ingredient as a Brand-Name Drug and is approved by the U.S. Food and Drug Administration (FDA) as being therapeutically equivalent and having the same active ingredients(s) as the Brand-Name Drug. Generally, Generic Drugs cost less than Brand-Name Drugs, and must be identical in strength, safety, purity, and effectiveness.
- **Maintenance Drug.** A maintenance drug, supply, or supplement is an item that meets both of the following requirements: Our Regional Formulary and Therapeutics Committee determines that there is evidence that the drug is safe and effective to use for at least six months; and the drug, supply, or supplement is prescribed for regular or scheduled use rather than on an as-needed basis.

About Our Drug Formulary

Our drug formulary includes a list of drugs that our Regional Formulary and Therapeutics Committee has approved for our Members. The Regional Formulary and Therapeutics Committee meets monthly and is made up of Participating Physicians, other Participating Providers, pharmacists, and administrative staff. The Regional Formulary and Therapeutics Committee chooses drugs for the formulary based on a number of factors, including safety and effectiveness as determined from a review of the scientific literature. To see if a drug, supply, or supplement is on our drug formulary, 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 Membership Services. The drug formulary is also available online at **kp.org**. The presence of a drug on our drug formulary does not necessarily mean that your 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, supplies, or supplements before they can be covered. A Participating Provider may request prior authorization if he or she determines that the drug, supply, or supplement is Medically Necessary. Prescribing Participating Providers must supply to Company the medical information necessary for Company to make the prior authorization determination. Coverage for a prescribed drug, supply, or supplement that is approved for prior authorization begins on the date Company approves the request.

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

We apply step therapy prescribing criteria, developed by Medical Group and approved by Company, to certain drugs, supplies, and supplements. 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, supplies, and supplements subject to step therapy prescribing criteria, and the requirements for moving to the next step drug, is available online at **kp.org** or you may contact Membership Services at 1-800-813-2000.

Drug Formulary Exception Process

Our drug formulary guidelines include an exception process that is available when a Participating Provider prescribes a drug, supply, or supplement 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, supplies, and supplements that the law does not require to bear this legend.

A Participating Provider may request an exception if he or she determines that the non-formulary drug, supply, or supplement is Medically Necessary. We will approve the exception if all of the following requirements are met:

- We determine that the drug, supply, or supplement 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, supply, or supplement is Medically Necessary because you are allergic to, or intolerant of, or have experienced treatment failure with, any alternative drugs, supplies, or supplements 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, supply, or supplement. For this drug, supply, or supplement, the pharmacy can provide a copy of the additional criteria upon request. In some cases, there may be a short delay in filling your prescription while your information is being reviewed.

If we approve an exception through this exception process, then we will cover the drug, supply, or supplement.

Outpatient Prescription Drug Rider Limitations

- If your prescription allows refills, there are limits to how early you can receive a refill. We will refill your prescription when you have used at least 75 percent of the quantity, unless the law or your prescribing provider prohibits an early refill. Please ask your pharmacy if you have questions about when you can get a covered refill.
- The Participating Pharmacy may reduce the day supply dispensed at the Copayment or Coinsurance to a 30-day supply in any 30-day period if it determines that the drug, supply, or supplement is in limited supply in the market or for certain other items. Your Participating Pharmacy can tell you if a drug, supply, or supplement you use is one of these items.
- We cover tobacco cessation drugs for up to 8 to 12 weeks of treatment per attempt at quitting tobacco use, but only if you receive them in conjunction with a tobacco cessation program that we have approved and that uses nicotine replacement therapy. Covered drugs include prescribed nicotine gum and patches.

Outpatient Prescription Drug Rider Exclusions

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

- Drugs, supplies, and supplements 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 drugs, supplies, or supplements that our drug formulary lists for your condition.
- Drugs that the FDA has not approved.
- Drugs used for the treatment of infertility.
- Drugs used for the treatment or prevention of sexual dysfunction disorders.
- Drugs used in weight management.
- Drugs used to enhance athletic performance.
- Extemporaneously compounded drugs, unless the formulation is approved by our Regional Formulary and Therapeutics Committee.
- Internally implanted time-release drugs, except for internally implanted time-release contraceptive drugs.
- Mail-order drugs for anyone who is not a resident of Oregon or Washington.
- Outpatient drugs that require special handling, refrigeration, or high cost drugs are not provided through Mail-Delivery Pharmacy.
- Outpatient drugs that require administration by medical personnel or observation by medical personnel during self-administration, except for internally implanted time-release contraceptive drugs (refer instead to the "Limited Outpatient Prescription Drugs, Supplies, and Supplements" section).
- Replacement of drugs, supplies, and supplements due to loss, damage, or carelessness.

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST HEARING AID RIDER

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

Hearing Aids

We cover hearing aids only for Members 19 or older. Hearing aids for Members 18 or younger, or for Dependent children 19 years of age or older who are under the Dependent Limiting Age and enrolled in an accredited education institute are not covered under this "Hearing Aid Rider," but are covered instead under "Hearing Aid Services" in the "Benefits" section of the *EOC*. Every three years, we provide an allowance for each ear toward the price of a hearing aid prescribed by a Participating Provider. The allowance is shown in the "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 covered a hearing aid for that ear within the previous three years under this or any other evidence of coverage (including riders) with the same group number printed on this *EOC*. The date we cover a hearing aid is the date on which you are fitted for the hearing aid. Therefore, if you are fitted for a hearing aid while you are covered under this *EOC*, and if we would otherwise cover the hearing aid, we will provide the allowance even if you do not receive the hearing aid until after you are no longer covered under this *EOC*.

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

Note: Hearing exams to determine the need for hearing correction and to provide a prescription for hearing aids are not covered under this "Hearing Aid Rider" (see the "Benefits" section of the *EOC*).

Hearing Aid Exclusions

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

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST ADULT VISION HARDWARE AND OPTICAL SERVICES RIDER

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

Vision Services covered under this "Adult Vision Hardware and Optical Services Rider" are only for Members age 19 and older. Vision Services for Members age 18 and younger are not covered under this rider, but are covered if your Group has purchased the "Pediatric Vision Hardware and Optical Services Rider."

We cover the Services listed in this rider at Participating Facility optical centers when prescribed by a Participating Provider or a Non-Participating Provider. The "Vision Hardware and Optical Services" exclusion in the *EOC* "Exclusions and Limitations" section does not apply to Services we cover under this rider.

Eyeglasses and Contact Lenses

We provide an allowance toward the price of eyeglass lenses and a frame, or contact lenses. The allowance is shown in the "Adult Vision Hardware and Optical Services Rider Benefit Summary." We will not provide the allowance if we have covered a lens, frame, or contact lens (but not counting any that we covered under "Eyeglasses and Contact Lenses after Cataract Surgery") within the previous 12 or 24 months as shown in the "Adult Vision Hardware and Optical Services Rider Benefit Summary," under this or any other evidence of coverage (including riders) with the same group number printed on this *EOC*. The date we cover any of these items is the date on which you order the item.

If a Participating Provider determines that one or both of your eyes has had a change in prescription of at least .50 diopters within 12 months after the date of your last exam where the "Adult Vision Hardware and Optical Services Rider" benefit was used, we will provide an allowance toward the price of a replacement eyeglass lens or contact lens for each qualifying eye at the following maximum values:

- $60 for single vision eyeglass lenses
- $60 for single vision cosmetic contact lenses
- $90 for multifocal eyeglass lenses
- $90 for multifocal cosmetic contact lenses

This replacement lens allowance is the same total amount whether you replace one lens or two. The replacement lenses must be the same type as the lenses you are replacing (eyeglass lenses or contact lenses).

Eyeglasses and Contact Lenses after Cataract Surgery

If you have cataract surgery and since that surgery we have never covered eyeglasses or contact lenses under any benefit for eyeglasses and contact lenses after cataract surgery (including any eyeglasses or contact lenses we covered under any other coverage), we cover your choice of one of

the following (except that we will cover both of the following if, in the judgment of a Participating Provider, you must wear eyeglass lenses and contact lenses at the same time to provide a significant improvement in vision not obtainable with regular eyeglass lenses or contact lenses alone) without charge:

- One contact lens determined by your Participating Provider for each eye on which you had cataract surgery, and fitting and follow-up care for the lens.
- One pair of regular eyeglass lenses determined by your Participating Provider and a frame from a specified selection of frames.

Note: Refraction exams to determine the need for vision correction and to provide a prescription for eyeglass lenses are not covered under this "Adult Vision Hardware and Optical Services Rider" (see the "Benefits" section).

Adult Vision Hardware and Optical Services Exclusions

- Low vision aids.
- Non-prescription products (other than eyeglass frames), such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
- Non-prescription sunglasses.
- Plano contact lenses or glasses (non-prescription).
- Professional services for fitting and follow-up care for contact lenses, except that this exclusion does not apply to contact lenses we cover under "Eyeglasses and Contact Lenses after Cataract Surgery" in this "Adult Vision Hardware and Optical Services Rider."
- Replacement of lost, broken, or damaged lenses or frames.
- Vision therapy (orthoptics or eye exercises).

Adult Vision Hardware and Optical Services Rider Benefit Summary

Vision Hardware	You Pay*
Initial allowance of up to $250 for eyeglasses or contact lenses, not more than once every 24 months	Any amount by which price exceeds allowance

*Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST PEDIATRIC VISION HARDWARE AND OPTICAL SERVICES RIDER

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

Vision Services covered under this "Pediatric Vision Hardware and Optical Services Rider" are only for Members age 18 and younger. Vision Services for Members age 19 and older are not covered under this rider, but are covered if your Group has purchased the "Adult Vision Hardware and Optical Services Rider."

We cover the Services listed in this rider at Participating Facility optical centers when prescribed by a Participating Provider or a Non-Participating Provider. The "Vision Hardware and Optical Services" exclusion in the *EOC* "Exclusions and Limitations" section does not apply to Services we cover under this rider.

Eyeglasses and Contact Lenses

We cover one pair of eyeglass lenses (single vision, bifocal, lenticular, or trifocal, including polycarbonate lenses and scratch-resistant coating) determined by your Participating Provider and a standard frame selected from a specified collection of frames, or one set of contact lenses in lieu of eyeglasses. We will not provide the benefit if we have covered a lens, frame, or contact lens (but not counting any that we covered under "Eyeglasses and Contact Lenses after Cataract Surgery") within the previous 12 or 24 months as shown in the "Pediatric Vision Hardware and Optical Services Rider Benefit Summary," under this or any other evidence of coverage (including riders) with the same group number printed on this *EOC*. The date we cover any of these items is the date on which you order the item.

If a Participating Provider determines that one or both of your eyes has had a change in prescription of at least .50 diopters within 12 months after the date of your last exam where the "Pediatric Vision Hardware and Optical Services Rider" benefit was used, we will provide one pair of replacement eyeglass lens or replacement set of contact lens for each qualifying eye. The replacement lenses must be the same type as the lenses you are replacing (eyeglass lenses or contact lenses).

Eyeglasses and Contact Lenses after Cataract Surgery

If you have cataract surgery and since that surgery we have never covered eyeglasses or contact lenses under any benefit for eyeglasses and contact lenses after cataract surgery (including any eyeglasses or contact lenses we covered under any other coverage), we cover your choice of one of the following (except that we will cover both of the following if, in the judgment of a Participating Provider, you must wear eyeglass lenses and contact lenses at the same time to provide a significant improvement in vision not obtainable with regular eyeglass lenses or contact lenses alone) without charge:

- One contact lens determined by your Participating Provider for each eye on which you had cataract surgery, and fitting and follow-up care for the lens.
- One pair of regular eyeglass lenses determined by your Participating Provider and a frame from a specified selection of frames.

Note: Refraction exams to determine the need for vision correction and to provide a prescription for eyeglass lenses are not covered under this "Pediatric Vision Hardware and Optical Services Rider" (see the "Benefits" section).

Pediatric Vision Hardware and Optical Services Exclusions

- Low vision aids.
- Non-prescription products (other than eyeglass frames), such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
- Non-prescription sunglasses.
- Plano contact lenses or glasses (non-prescription).
- Professional services for fitting and follow-up care for contact lenses, except that this exclusion does not apply to contact lenses we cover under "Eyeglasses and Contact Lenses after Cataract Surgery" in this "Pediatric Vision Hardware and Optical Services Rider."
- Replacement of lost, broken, or damaged lenses or frames.
- Vision therapy (orthoptics or eye exercises).

Pediatric Vision Hardware and Optical Services Rider Benefit Summary

Vision Hardware	You Pay
Standard eyeglasses (limited to one pair every 24 months)	No charge
Conventional or disposable contact lenses, in lieu of eyeglasses (not more than once every 24 months)	No charge
Medically necessary contact lenses (limited to one pair every 24 months, prior authorization required)	No charge

NOTES