GROUP AGREEMENT

kp.org

Willamette University

KAISER PERMANENTE®

All Plans offered and underwritten by
Kaiser Foundation Health Plan of the Northwest

April 2, 2020

Danita Phr Chapin
Willamette University
900 State Street

Salem, OR 97301

Group number: 2014-019-022

Dear Danita Phr,

Choosing a health plan for your group is an important decision. Thank you for selecting Kaiser Permanente for your employees' health care needs.

Enclosed is the Deductible Added Choice Plan Group Agreement effective 4/1/2020 through 3/31/2021 for Willamette University. The Group Agreement includes group contract provisions, such as monthly Premium amounts, and incorporates the Evidence of Coverage (EOC) which is the member portion of the contract. The EOC contains benefit descriptions and cost sharing amounts, limitations, exclusions, and information to assist the member in obtaining care.

Also enclosed is a Summary of Changes and Clarifications. Please review this to learn about changes to the Group Agreement for this year.

We know you have a choice of health plans and we appreciate your business. If you have any questions about this Group Agreement or your health plan, please contact Otoniel Rosales at (503) 813-3391.

Sincerely,

Kaiser Permanente Sales & Account Management Team
Enclosures

/kjm

Kaiser Permanente Building
500 N.E. Multnomah Street, Suite 100
Portland, OR 97232-2099

LOWLG0120

KAISER PERMANENTE®

2020 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups

This is a summary of changes and clarifications that we have made to your *Group Agreement*. The *Group Agreement* includes the *Evidence of Coverage* (*EOC*), "Benefit Summary," and any applicable rider and endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement*. These changes and clarifications do not include changes that may occur throughout the remainder of the year as a result of federal or state mandates.

Other Group-specific or product-specific plan design changes (including changes to Copayment or Coinsurance amounts) may apply, such as moving to standard benefits. Refer to the Rate Proposal and/or the Summary of Plan Changes document for information about these types of changes.

To the extent that this summary of changes and clarifications conflicts with, modifies, or supplements the information contained in your *Group Agreement*, the information contained in the *Group Agreement* shall supersede what is set forth below. Unless another date is listed, the changes in this document are effective when your Group renews in 2020. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Changes and clarifications that apply to Traditional, Deductible, High Deductible, Added Choice®, and PPO Plus medical plans

Changes to Senior Advantage plans are explained at the end of this summary.

Benefit changes

- The "Referrals to Participating Providers and Participating Facilities" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified. Ophthalmology has been removed from the list of departments that do not require a referral for outpatient Services. A referral will now be required to schedule an appointment for ophthalmology Services.

Benefit clarifications

- The "What You Pay" section of the *EOC* has been modified to align with changes made to the "Benefit Summary" describing all Deductible accumulation types in terms of a self-only Deductible, an individual Family Member Deductible, and a Family Deductible. The edits provide clarification to Members by distinguishing the difference between self-only and an individual in a Family. Aggregate and embedded accumulation types are now discerned by the amounts listed on the "Benefit Summary" for each of the categories.
- The "What You Pay" section of the *EOC* has been modified to align with changes made to the "Benefit Summary" describing all Out-of-Pocket accumulation types in terms of a self-only Out-of-Pocket Maximum, an individual Family Member Out-of-Pocket Maximum, and a Family Out-of-Pocket Maximum to provide clarification to Members by distinguishing the difference between self-only and an individual in a Family. Aggregate and embedded accumulation types are now discerned by the amounts listed on the "Benefit Summary" for each of these categories.
- The "Emergency, Post-Stabilization and Urgent Care" in the *EOC* has been modified to reflect a change in terminology on the "Benefit Summary." Emergency Services has been changed to emergency

department visit to more accurately describe when the emergency department visit Copayment or Coinsurance applies.

- The "Emergency Services" section of the *EOC* has been modified to specify that Emergency Services may be received anywhere in the world as long as the Services would have been covered under the "Benefits" section if received by a Participating Provider or at a Participating Facility.
- The "Preventive Care Services" section of the *EOC* has been modified to clarify that Services to diagnose current or ongoing signs or symptoms are not considered preventive and may be subject to applicable cost shares.
- The "Hearing Aid Services for Dependents" section of the *EOC* has been modified to clarify coverage requirements per the amendment of ORS 743A.141 in the 2018 Oregon House Bill (HB) 4104. A new "Hearing Aid Services for Dependents Limitations" section has been added to describe the limited coverage of replacement ear molds and hearing aid batteries as stated in HB 4104. These benefits were covered in 2019, language has been added to the 2020 contract documents for Member clarity. An exclusion has also been removed from the "Hearing Aid Services for Dependents Exclusions."
- The "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC* has been modified for better alignment with the "Outpatient Prescription Drug Rider" and to provide clarity regarding how to get covered drugs and supplies.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC* has been modified to clarify that lancets and injection aids are covered under the "Outpatient Durable Medical Equipment (DME)" section.
- The "Outpatient Durable Medical Equipment (DME)" section of the *EOC* has been modified to reflect that lancets and injection aids are covered under the DME benefit.
- The "Reconstructive Surgery Services" section of the Traditional, Deductible and High Deductible Health Plan *EOCs* has been modified to specify that Services are covered when prescribed by a Participating Physician and are subject to Utilization Review. The word significant has been removed in this section for consistency across products. Services are covered based upon Utilization Review.
- The "Custodial Services" exclusion in the "Exclusions and Limitations" section of the *EOC* has been changed to "Custodial Care." The exclusion has also been modified to align across lines of business for Member clarity.
- The phrase "not subject to Deductible" has been removed from several rows of the "Benefit Summary" for contract integrity and continuity. Our contract convention is to specify when benefits are subject to the Deductible and to not reference the Deductible when it does not apply. The "What You Pay" section of the *EOC* notes that the "Benefit Summary" indicates which Services are subject to the Deductible.
- The "Deductible" section of the "Benefit Summary" has been modified to describe all accumulation types in terms of a self-only Deductible, an individual Family Member Deductible, and a Family Deductible. Aggregate accumulation is represented when the individual Family Member Deductible amount equals the Family Deductible amount. Embedded accumulation is represented when the self-only Deductible amount equals the individual Family Member Deductible amount.
- The "Out-of-Pocket Maximum" section of the "Benefit Summary" has been modified to describe all accumulation types in terms of a self-only Out-of-Pocket Maximum, an individual Family Member Out-of-Pocket Maximum, and a Family Out-of-Pocket Maximum. Aggregate accumulation is represented when the individual Family Member Out-of-Pocket Maximum amount equals the Family Out-of-Pocket

Maximum amount. Embedded accumulation is represented when the self-only Out-of-Pocket Maximum amount equals the individual Family Member Out-of-Pocket Maximum amount.

- The Emergency Services row of the "Benefit Summary" has been changed to emergency department visit to more accurately reflect when the emergency department visit Copayment or Coinsurance applies.
- The "Hearing Aid Services for Dependents" section of the "Benefit Summary" has been modified to clarify coverage requirements per the amendment of ORS 743A.141 in the 2018 Oregon House Bill (HB) 4104. Language has been added to clarify that hearing aids are limited to one per ear every 36 months.
- A "Maternal diabetes management" row has been added to the "Maternity and Newborn Care" section of all HSA-qualified plan "Benefit Summaries" to reflect that these benefits are covered at $0 after Deductible.
- The "Palliative and comfort care" row in the "Benefit Summary" has been removed to avoid confusion. These Services are included under hospice Services without a separate cost share.
- A row for tobacco use cessation drugs has been added to the "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" to align with covered Services listed in the *EOC*.
- The "Lancets and injection aids" row in the "Benefit Summary has been moved from the "Limited Outpatient Prescription Drugs and Supplies" section to the "Outpatient Durable Medical Equipment" section for accuracy as the DME cost share applies to these items.

Administrative changes or clarifications

- The "Definitions" section of the *EOC* has been modified. The definition of Dependent Limiting Age has been modified for consistency of terminology with the "Benefit Summary."
- The defined term "Medical Directory" has been changed throughout the Traditional, Deductible, and High Deductible Health Plan *EOCs* to "Medical Facility Directory" to accurately reflect the directory name as it appears on **kp.org**. The definition has also been modified for accuracy.
- The "Definitions" section of the *EOC* has been modified. Language indicating that a Member may contact Member Services has been removed from definitions where present, as it is not a defining characteristic and to reduce redundancy.
- The definition of "Dependent Limiting Age" has been modified for clarity.
- The "Dependents" section in the "Who is Eligible" section has been updated for clarity regarding the eligibility of a person who is under the student Dependent Limiting Age. This applies to Groups that choose to cover Dependents over the age 26 if they are full-time registered students.
- The Advice Nurses section has been modified for accuracy to reflect that an Advice Nurse may be reached by contacting the Member Services number during normal business hours, as well as, evenings, weekends, and holidays rather than contacting a specific medical office. The list of Member Services numbers has been removed to ensure accuracy and consistency. It is listed on the *EOC* cover, as well as, in the "Getting Assistance" section.
- The "Your Primary Care Participating Provider" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified for accuracy, to reflect that changes to a primary care Participating Provider take effect immediately.
- Language in the "Appointments for Routine Services" section has been re-ordered for accuracy and alignment across products.

- The Member Services phone number has been removed from the body of the *EOC* (except in the "Grievances, Claims, Appeals, and External Review" section) to ensure accuracy and consistency. It is listed on the *EOC* cover, as well as, in the "Getting Assistance" section.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC* has been modified. Language has been added to explain that while a Member may obtain a first fill of a prescription drug at any participating pharmacy, all refills must be obtained at a pharmacy owned and operated by Kaiser Permanente (including our mail-order pharmacy), or at another participating pharmacy we designate for covered refills.
- The "Help with Your Claim and/or Appeal" section of the *EOC* has been modified. The name of the Consumer Advocacy Unit has been updated to the Consumer Advocacy Section, a fax number has been added, the email address has been revised, and the URL has been updated for accuracy.
- In the "Grievances, Claims, Appeals, and External Review" section of the *EOC*, the Member Relations fax number has changed to accommodate a new digital fax process.
- Language in the "Termination Due to Loss of Eligibility" section of the *EOC* has been revised for clarity.
- The "Nondiscrimination" section of the *EOC* has been modified to confirm that we do not discriminate based on a Member's marital status.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the Traditional, Deductible, and High Deductible Health Plan "Benefit Summary" has been modified for consistency within the contract. The word "formulary" has been removed from the row for contraceptive drugs, as all prescription drugs received from a Participating Pharmacy are formulary.
- A "Grandfathered Health Plan Coverage" section has been added to the "Miscellaneous Provisions" section of the *Group Agreement*, indicating that a Group must inform Company if coverage identified as a "grandfathered health plan" in the *EOC* does not meet (or no longer meets) the requirements for grandfathered status.

Additional changes and clarifications that apply to Added Choice® medical plans only

Benefit changes

- The "Referrals to Select Providers and Select Facilities" section of *EOC* has been modified. Ophthalmology has been removed from the list of departments that do not require a referral for outpatient Services. A referral will now be required to schedule an appointment for ophthalmology Services.

Benefit clarifications

- The "Reconstructive Surgery Services" section of the *EOC* has been modified to align with other sections within the *EOC*. Language indicating that Services are covered when prescribed by a Select, PPO, or Non-Participating Provider has been moved to the beginning of the section. Additionally, language has been added to specify that Services are subject to Utilization Review. The word significant has been removed in this section for consistency across products. Services are covered based upon Utilization Review.

- The Chiropractic Services Received Without a Referral" exclusion in the "Exclusions and Limitations" section of the *EOC* has been retitled "Chiropractic Services" for alignment with other products and other exclusions within the section.
- The "Custodial Care" exclusion in the "Exclusions and Limitations" section of the *EOC* has been modified to align across lines of business and for Member clarity.
- The "Optometric Vision Therapy and Orthoptics (Eye Exercises)" exclusion in the "Exclusions and Limitations" section of the *EOC* has been modified for clarity and moved so that it appears in alphabetical order. Language has been added explaining that Services related to optometric vision therapy and orthoptics (eye exercises) are excluded.
- A "Hospitalization on Your Effective Date" section has been added to the *EOC* for alignment across products.
- A sentence has been added to the second paragraph of the "Benefit Summary" to clarify that all applicable visit limits are combined across all tiers, unless otherwise indicated in the *EOC*. Language has been removed from the left column of the "Benefit Summary" table indicating "all tiers combined."
- A row for "certain preventive medications" has been added to the "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" to align with covered Services listed in the *EOC*.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for better alignment with the "Outpatient Prescription Drug Rider" to more accurately reflect that these drugs may be obtained from Select Pharmacies or Medimpact Pharmacies.

Administrative changes or clarifications

- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for accuracy. The word "formulary" has been removed from the row for contraceptive drugs. In addition to Select Pharmacies and Facilities, this section represents limited prescription drugs and supplies received from MedImpact Pharmacies, which are not subject to the formulary.
- The defined term "Added Choice Medical Directory" has been changed throughout the *EOC* to "Medical Facilities Directory" to accurately reflect the directory name as it appears on **kp.org**. The definition has also been modified for accuracy.
- The "Your Primary Care Select Provider" section of the *EOC* has been modified for accuracy to reflect that changes to a primary care Select Provider take effect immediately.

Additional changes and clarifications that apply to PPO Plus medical plans only

Benefit clarifications

- The "Reconstructive Surgery Services" section of the *EOC* has been modified to align with other sections within the *EOC*. Language has been moved and modified to specify that Services are subject to Utilization Review by Company. The word significant has been removed in this section for consistency across products. Services are covered based upon Utilization Review.
- The "Custodial Care" exclusion in the "Exclusions and Limitations" section of the *EOC* has been modified to align across lines of business and for Member clarity.

- A sentence has been added to the "Benefit Summary" to clarify that all applicable visit limits are combined across both tiers, unless otherwise indicated in the *EOC*. Language has been removed from the left column of the "Benefit Summary" table indicating "both tiers combined."
- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for better alignment with the "Outpatient Prescription Drug Rider" to more accurately reflect that these drugs may be obtained from Medimpact or Kaiser Permanente Pharmacies.

Administrative changes or clarifications

- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified for accuracy. The word "formulary" has been removed from the row for contraceptive drugs. In addition to Kaiser Permanente Pharmacies, this section represents limited prescription drugs and supplies received from MedImpact Pharmacies, which are not subject to the formulary.

Changes and clarifications that apply to medical benefit riders

Benefit clarifications

- The "Alternative Care Services Rider" has been modified for better clarity around coverage for specific treatment modalities. References to the *EOC* "Exclusions and Limitations" have been moved to the subsections for each modality. Additionally, the modality references in the provider definitions have been removed.
- The "Outpatient Prescription Drug Rider" has been modified. All references to the medical directory have been updated to "Medical Facility Directory" to reflect the revised definition in the *EOC*.
- The "Outpatient Prescription Drug Rider" used for Traditional, Deductible, and High Deductible Health Plans has been modified. A sentence has been added to the "Copayments and Coinsurance for Covered Drugs and Supplies" section to clarify that prescription drugs and supplies received are subject to the Deductible, Copayment, or Coinsurance until the medical Out-of-Pocket Maximum is met.
- The "Outpatient Prescription Drug Rider" used for PPO Plus plans has been modified. A sentence has been added to the "Copayments and Coinsurance for Covered Drugs and Supplies" section to clarify that prescription drugs and supplies received at MedImpact Pharmacies are subject to the Deductible, Copayment, or Coinsurance until the Tier 1 medical Out-of-Pocket Maximum is met.
- The "Outpatient Prescription Drug Rider" has been modified. A "Prior Authorization Exception Process" subsection has been added to the "About Our Drug Formulary" section to align across lines of business and ensure consistency of administration.
- The rows for tobacco use cessation drugs and contraceptives have been removed from the "Outpatient Prescription Drug Rider Benefit Summary" to reduce redundancy. These items are included in the "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC*.
- References to the Deductible and Prescription Drug Deductible have been removed from the "Copayments and Coinsurance for Covered Drugs and Supplies" and "Day Supply Limit" sections of the "Outpatient Prescription Drug Rider" contract integrity and administrative consistency. The "Deductible" section of the *EOC* describes how the Deductible is applied. The "Outpatient Prescription Drug Rider Benefit Summary" indicates which Services are subject to the Deductible.
- The "About Our Drug Formulary" section in the "Outpatient Prescription Drug Rider" has been modified for accuracy and Member clarity.

- The phrase "not subject to Deductible" has been removed from several rows of the "Outpatient Prescription Drug Rider Benefit Summary" for contract integrity and continuity. Our contract convention is to specify when benefits are subject to the Deductible and to not reference the Deductible when it does not apply.
- The "Pediatric Vision Hardware and Optical Services Rider Benefit Summary" (including the rider for the enhanced benefit) has been modified for clarity. The "You Pay" cells for comprehensive eye exams and low vision evaluations have been updated to show the Member cost share rather than pointing to the primary care visit cost share in the *EOC* "Benefit Summary."

Administrative changes or clarifications

- The "Covered Drugs and Supplies" section of the "Outpatient Prescription Drug Rider" has been modified. Language has been added to explain that while a Member may obtain a first fill of a prescription drug at any participating pharmacy, all refills must be obtained at a pharmacy owned and operated by Kaiser Permanente (including our mail-order pharmacy), or at another participating pharmacy we designate for covered refills.

Changes and clarifications that apply to dental plans

Benefit clarifications

- To align with current administration, language regarding diagnosis and evaluation was removed from the Oral Surgery Services, Periodontic Services, and Endodontic Services sections and added to the Oral Exam row in the benefit summary to clarify that all exams, including diagnosis and evaluation, are subject to the Preventive and Diagnostic Services cost share.
- Benefits within the *EOC* and Benefit Summary have been alphabetized when appropriate to do so.
- The "Exclusions and Limitations" section has been modified to align across lines of business, where appropriate, ensure consistency of administration, and aid in Member clarity. This synchronization did not result in any benefit changes.
- To better align with state regulations, several limitations in the "Limitations" section have been modified by changing the language from "covered" to "limited to."

Administrative changes or clarifications

- The definition of *Dental Provider Directory* has been modified for accuracy and a new definition for *Dental Facility Directory* has been added. References throughout the *EOC* have been updated with the corresponding directory name.
- In the "Definitions" section and throughout the *EOC*, the dental PPO Third Party Administrator (TPA) name has changed from Scion Dental, Inc. to SKYGEN USA, LLC, ("SKYGEN").
- The definition of "Dependent Limiting Age" in the "Definitions" section of the *EOC* has been modified for clarity.
- The "Dependents" section under "Who is Eligible" in the *EOC* has been updated to clarify the bullet regarding the eligibility of a person who is under the student Dependent Limiting Age. This section applies to Groups that choose to cover Dependents over the age 26 if they are full-time registered students.

- The "Adding New Dependents to an Existing Account" section of the *EOC* has been modified. Language has been added to clarify that an enrollment application is required to add new dependents if additional premium is required to add the dependent and that the application requirement is waived if additional premium is not required.
- A "Referrals" section has been added to all nonPPO plans for clarity and transparency.
- The "Prior Authorization" section in PPO plans has been modified to reflect that providers can now request Prior Authorization on a Member's behalf electronically. The language about requesting prior authorization by fax has also been removed, since there is no longer a fax number on the back of Members' ID cards.
- The address in the "Post-Service Claims - Services Already Received" section has been updated to reflect that nonPPO dental claim forms should be sent to our local dental claims' office in Portland, Oregon.
- The Member Services phone number has been removed throughout the *EOC* when referring Members to contact Member Services (except in the "Grievances, Claims, and Appeals" section) to ensure accuracy and consistency. It is listed on the *EOC* cover, as well as, in the "Getting Assistance" section.
- The "Help with Your Claim and/or Appeal" section has been modified. The name of the Consumer Advocacy Unit has been updated to the Consumer Advocacy Section, a fax number has been added, the email address has been revised, and the URL has been updated for accuracy.
- In the "Grievances, Claims, and Appeals" section, the Member Relations fax number has changed to accommodate a new digital fax process.
- Language in the "Termination Due to Loss of Eligibility" section has been revised for clarity.
- The language in the "Termination for Cause" section has been revised to reflect that Members may only be terminated for fraud and misrepresentation. It has also been updated for consistency.
- The "Nondiscrimination" section has been modified to confirm that we do not discriminate based on a Member's marital status.

Changes and clarifications that apply to dental benefit riders

Benefit clarifications

- The "Dental Implant Services Rider" has been modified for clarity.
    - The first bullet in the "Dental Implant Benefit" section has been moved out of alphabetical order to the end of the list since it is a secondary alternative to the other benefits listed.
    - The "Repair of a Dental Implant" limitation has been modified to include a clarifying sentence that provides for repairs when postoperative complications or failure of a Dental Implant happens through no fault of the Member.

Changes and clarifications that apply to all Senior Advantage plans

Benefit changes and clarifications

- The following changes have been made to the Medical Benefits Chart:

- Opioid treatment program services have been added to the Chart. Covered services include FDA-approved opioid treatment medications, substance use counseling, individual and group therapy, and toxicology testing.
- Outpatient hospital observation services are now in a separate row of the Chart. Previously, these services were addressed under the "Emergency care" and "Outpatient hospital services" rows. Language has been added to explain to members what observation services are and the conditions for coverage.
- The Member cost-sharing for health and wellness education programs has changed from various amounts per class of session to no charge.
- More detailed information about covered telehealth services has been added to the "Physician/practitioner services, including doctor's office visits" section of the Chart. This section now describes numerous services available through telehealth when clinically appropriate.

- In Chapter 3, Section 2.2 of the *EOC*, the list of services that do not require referral has changed. Members will need a PCP referral for services from obstetrics/gynecology, occupational health and social services.
- Information has been added to Chapter 3, Section 3.2 of the *EOC* to clarify the circumstances under which we cover worldwide urgent care services outside the United States.
- For Medicare Part D plans, Chapter 5, Section 5.2 of the *EOC* has been modified to explain that we will offer a temporary supply of a non-formulary drug if the member experiences a level of care change. We will cover up to a one-month supply of the Part D drug during level of care transitions even if the drug is not on our Drug List (formulary).
- For Medicare Part D plans, Chapter 5, Section 6.2 of the *EOC* has been edited to clarify what happens when there are changes to the Drug List (formulary); if and when coverage changes for a drug the member is taking; and how the member is notified. The Senior Advantage 2020 Annual Notice of Change (*ANOC*) that is sent to Senior Advantage members provides additional detail explaining what happens if a drug the member is taking is changed or removed from the 2020 Drug List, and what a member can do, such as working with their provider to find a different drug that we cover or to ask for a formulary exception.

Administrative changes and clarifications

- The eligibility requirements list in Chapter 1, Section 2.1 of the *EOC*, has been modified to remove a restriction. We allow enrollment in our group Senior Advantage plan when a person's Medicare coverage is either primary or secondary to the group plan.
- Information about coverage decisions, appeals and complaints in Chapter 9 of the *EOC* for plans with Medicare Part D, and Chapter 7 of the *EOC* for plans without Medicare Part D, has been updated to explain when we or the IRO must respond if the request for benefits determination is for a Medicare Part B drug.

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation

Portland, Oregon

Large Group Plan
Group Agreement

Group Name: Willamette University

Group Number: 2014-019-022

Term of *Agreement*

4/1/2020 through 3/31/2021

Anniversary date

April 1

Ruth W. Brinkley

_____

Ruth Williams Brinkley, FACHE
President, Northwest Region
Kaiser Foundation Health Plan & Hospitals

TABLE OF CONTENTS

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

A Nonprofit Corporation

Group Agreement

INTRODUCTION

This *Group Agreement* (*Agreement*), including the attached *Evidence of Coverage* (*EOC)* incorporated herein by reference, and any amendments, constitutes the contract between Kaiser Foundation Health Plan of the Northwest (Company) and **Willamette University** (Group). In this *Agreement,* some capitalized terms have special meaning; please see the "Definitions" section in the *EOC* document for terms you should know.

To be eligible under this *Agreement*, the Group must meet the underwriting requirements set forth in Company's Rate Assumptions and Requirements document.

PREMIUM

Group will pay to Company, for each Subscriber and his or her Dependents, the Premium amount(s) specified for each month on or before the date on the monthly invoice or, if Group is self-pay, then the date to which Company and Group agree in writing, but in no event later than the last day of the month preceding the month of coverage (the "Premium Due Date"). If Group fails to make payments on or before the Premium Due Date, then upon renewal and at Company's option (and in lieu of any other remedy), the new Premium may include an additional charge.

When this *Agreement* terminates, if Group does not have another agreement with Company, then the due date for all Premium amounts will be the earlier of: (1) the last Premium Due Date, or (2) the termination date of this *Agreement*.

Monthly Premium Amounts

Group will pay Company the following Premium amount(s) each month for each Subscriber and his or her Dependents. Only Members for whom Company has received the appropriate Premium payment listed below are entitled to coverage under this *Agreement*, and then only for the period for which Company has received appropriate payment.

Subscriber only: $891.55

Subscriber with one Family Dependent: $1783.09

Subscriber with two or more Family Dependents: $2478.51

Medicare as Secondary Payer

Members who are eligible and enrolled in Medicare Part A or B and for whom Medicare is secondary payer are subject to the same Premium amounts (shown above) and receive the same benefits as Members who are not eligible for Medicare. Members who are eligible and enrolled in Medicare Parts A and B as secondary payer and who meet applicable eligibility requirements may also enroll in a Kaiser Permanente Senior Advantage Plan. These Members receive the coverages described in both the non-Medicare Plan and the Senior Advantage Plan, and the Premium amounts for these Members are the Premium amounts for the non-Medicare Plan (shown above).

Medicare as Primary Payer

Premium amounts are based on the assumption that Company or its designee will receive Medicare payments for Medicare-covered Services provided to certain types of Members. For each Member to whom this "Medicare as Primary Payer" section applies, Group must pay the applicable Premium listed in this "Monthly

Premium Amounts" section if the Member is for any reason not enrolled through Group in Kaiser Permanente Senior Advantage (including inability to enroll because he or she does not meet the Senior Advantage Plan's eligibility requirements or Group does not offer a Senior Advantage Plan).

Those Members eligible for Medicare based on disability, end stage renal disease (ESRD), domestic partner status, or who are Medicare eligible and enrolled in COBRA will continue to be charged the Premium amount for the non-Medicare Plan (shown above).

Members to whom this "Medicare as Primary Payer" section applies. This "Medicare as Primary Payer" section applies to Members who meet all of the following requirements:

- They are age 65 or over.
- They are eligible for Medicare Parts A and B as primary payer (i.e., retirees).

TERM OF *AGREEMENT*, ACCEPTANCE OF *AGREEMENT*, AND RENEWAL

Term of *Agreement*

Unless terminated as set forth in the "Termination of *Agreement*" section, this *Agreement* is effective for the term shown on the cover page.

Acceptance of *Agreement*

Group will be deemed as having accepted this *Agreement* and any amendments issued during the term of this *Agreement*, if Group pays Company any amount toward Premium.

Group may **not** change this *Agreement* by adding or deleting words, and any such addition or deletion is void. If Group wishes to change anything in this *Agreement*, Group must contact its Company account manager. Company might not respond to any changes or comments that Group may submit. Group may not construe Company's lack of response to any submitted changes or comments to imply acceptance. Company will issue a new *agreement* or amendment if Company and Group agree on any changes.

Renewal

This *Agreement* is guaranteed renewable, but does not automatically renew. If Group complies with all of the terms of this *Agreement,* Company will offer to renew this *Agreement,* upon not less than 30 days prior written notice to Group, either by sending Group a new group *agreement* to become effective immediately after termination of this *Agreement,* or by extending the term of this *Agreement* pursuant to "Amendments Effective on Anniversary Date" in the "Amendment of *Agreement*" section. The new or extended group *agreement* will include a new term of *agreement* and other changes. If Group does not renew this *Agreement*, Group must give Company written notice as described under "Termination on Notice" in the "Termination of *Agreement*" section.

AMENDMENT OF *AGREEMENT*

Amendments Effective on Anniversary Date

Upon not less than 30 days prior written notice to Group, Company may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective on the anniversary date of any year (see cover page for anniversary date).

Amendment due to Tax or Other Charges

If during the term of this *Agreement* a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Company, Medical Group, or Kaiser Foundation Hospitals or upon any activity of any of them, then upon 31 days prior written notice, Company may increase Group's Premium to include Group's share of the new or increased tax or charge.

Other Amendments

Company may amend this *Agreement* at any time by giving written notice to Group, in order to: (a) address any law or regulatory requirement; (b) reduce or expand the Company Service Area; or (c) increase any benefits of any Medicare product approved by the Centers for Medicare and Medicaid Services (CMS), if applicable to this *Agreement*.

TERMINATION OF *AGREEMENT*

This *Agreement* will terminate under any of the conditions listed in this "Termination of *Agreement*" section. All rights to benefits under this *Agreement* end at 11:59 p.m. on the termination date, except as expressly provided in the "Termination of Membership" or "Continuation of Membership" sections of *the EOC*.

If this *Agreement* terminates and Group does not replace this coverage with another Plan, Company will give Group written notice of termination not later than 10 working days after the termination date and will explain the rights of Members regarding continuation of coverage as provided by federal and state law.

If Company fails to give notice as required, this *Agreement* shall continue in effect from the date notice should have been given until the date the Group receives the notice. Company will waive the Premium for the period for which coverage is continued and the time period within which Member may exercise any right to continuation shall commence on the date that Group receives the notice. Company will properly notify Members of their right to continuation of coverage under federal and state law.

Termination on Notice

Group may terminate this *Agreement* by giving prior written notice to Company not less than 30 days prior to the termination date and remitting all amounts payable relating to this *Agreement*, including Premium, for the period through the termination date.

Termination due to Nonacceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Company written notice of nonacceptance at least 15 days before the effective date of the amendment in which case this *Agreement* will terminate the day before the effective date of the amendment.

Termination for Nonpayment

When Group fails to pay Premium on or before the Premium Due Date, Group shall have a period of at least 31 days to pay all Premiums owed ("Grace Period"). The Grace Period shall begin the day after the Premium Due Date. If Group fails to pay all Premiums owed (including those owed for the Grace Period) on or before the last day of the Grace Period, then Company may, at its option and in lieu of any other remedy, terminate this Agreement without further extension or consideration.

Company will notify Group of the past-due amount and the effective date of termination. Such notice shall be sent at least 10 days prior to the effective date of termination. Group shall continue to be liable for all Premiums due through the date of termination.

This Agreement will remain in full force and effect throughout the Grace Period and Group will remain responsible for payment of Premiums. If Company receives full payment of Premiums on or before the last day of the Grace Period, this Agreement will remain in effect according to its terms and conditions.

If Premiums are paid after the Grace Period ends, Company may charge interest on the overdue Premiums. Interest shall not accrue during the Grace Period, and the (simple) interest rate shall be 6 percent per year or the maximum amount permitted by applicable law, whichever is less.

Termination for Fraud

Company may terminate this *Agreement* by giving at least 30 days prior written notice to Group, if Group commits fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. For example, an intentional misrepresentation of material fact occurs if Group intentionally furnishes incorrect or incomplete material information to Company or is aware that incorrect or incomplete material information has been provided to Company on enrollment or other Company forms.

Termination for Violation of Contribution or Participation Requirements

Company may terminate this *Agreement* upon 31 days prior written notice to Group, if Group fails to comply with Company's contribution or participation requirements (including those listed in the "Contribution and Participation Requirements" section).

Termination for Discontinuance of a Product or all Products within a Market

Company may terminate a particular product or all products offered in the group market as permitted by law.

Company may terminate this *Agreement* if it ceases to write new business in the group market in Oregon or in a specific service area within Oregon, or elects not to renew all of its group Plans in Oregon or in a specific service area within Oregon, or both cease offering and cease renewing all products in Oregon or a specific service area in Oregon, if Company fails to reach an agreement with health care providers. To discontinue all products, Company must: (a) notify the Director of the Department of Consumer and Business Services and all Groups; and (b) not cancel coverage for 180 days after the date of notice to the Director and Groups.

Company may terminate this *Agreement* if it elects not to offer or renew, or offer and renew, this type of Plan in Oregon or within a specific service area within Oregon. Except as provided below regarding failure to reach agreement with providers, in order to discontinue a product, Company must: (a) cease to offer and/or cease to renew this Plan for all groups; (b) offer (in writing) to each group covered by this Plan, enrollment in any other Plan offered by Company in the group market, not less than 90 days prior to discontinuance; and (c) act uniformly without regard to claims experience of affected groups or the health status of any current or prospective Member.

Company may terminate this *Agreement* if the Director of the Department of Consumer and Business Services orders Company to discontinue coverage upon finding that continuation of coverage (a) would not be in the best interests of the Members; or (b) would impair Company's ability to meet its contractual obligations.

Company may terminate this *Agreement* by providing not less than 90 days prior written notice if there are no Members covered under this *Agreement* who reside or work in the Service Area.

Company may terminate this *Agreement* if it is unable to reach an agreement with the health care providers to provide Services within a specific service area. Company must: (a) cease to offer and cease to renew this Plan for all groups within the service area; and (b) not less than 90 days prior to discontinuance, notify the Director of the Department of Consumer and Business Services and each group in that service area of the decision to discontinue offering the Plan(s) and offer all other group Plans available in that service area.

CONTRIBUTION AND PARTICIPATION REQUIREMENTS

No change in Group's contribution or participation requirements is effective for purposes of this *Agreement* unless Company consents in writing.

Group must:

- Meet all underwriting requirements set forth in Company's Rate Assumptions and Requirements document.
- With respect to all persons entitled to coverage under Group's Plan(s), offer enrollment in Company's Plan to all such persons on conditions no less favorable than those for any other Plan available through Group.
- Permit Company to examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*.

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

Company may adopt policies, procedures, rules, and interpretations to promote efficient administration of this *Agreement*.

Assignment

Company may assign this *Agreement*. Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Company's prior written consent. This *Agreement* shall be binding on the successors and permitted assignees of Company and Group.

Attorney Fees and Costs

If Company or Group institutes legal action against the other to collect any sums owed under this *Agreement*, the party that substantially prevails will be reimbursed for its reasonable costs of collection, including attorneys' fees, by the other party.

Governing Law

Except as preempted by federal law, this *Agreement* will be governed in accord with Oregon law and any provision that is required to be in this *Agreement* by state or federal law shall bind Group and Company regardless of whether that provision is set forth in this *Agreement*.

Grandfathered Health Plan Coverage

For any coverage identified in an *EOC* as a "grandfathered health plan" under the Patient Protection and Affordable Care Act and regulations, Group must immediately inform Company if this coverage does not meet (or no longer meets) the requirements for grandfathered status. This includes, but is not limited to, any change in its contribution rate to the cost of any grandfathered health plan(s) during the contract year. Group represents that, for any coverage identified as a grandfathered health plan in the applicable *EOC*, Group has not decreased its contribution rate more than five percent for any rate tier in that plan when compared to the contribution rate in effect on March 23, 2010 for the same plan. Company will rely on Group's representation when issuing and/or continuing grandfathered health plan coverage.

No Waiver

Company's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision, or impair Company's right thereafter to require Group's strict performance of any provision.

Notices

Notices must be sent to the addresses listed below, except that Company or Group may change its address for notices by giving written notice to the other. Notices are deemed given when delivered in person, sent via email, or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

Notices from Company to Group will be sent to:

Group Contact	Danita PHR Chapin
Group Name	Willamette University
Group Address	900 State Street
Group Address	
Group Address	Salem, OR 97301
Producer Contact	Frederick Fischer
Producer Name	Montgomery & Graham, Inc.
Producer Address	625 Hawthorne Ave. SE #100
Producer Address	
Producer Address	Salem, OR 97301

Note: When Company sends Group a new (or renewed) group *agreement*, Company will enclose a summary that discusses the changes Company has made to this *Agreement*. Groups that want information about changes before receiving the new group *agreement* may request advance information from Group's Company account manager. Also, if Group designates in writing a third party such as a "Producer of Record," Company may send the advance information to the third party rather than to Group (unless Group requests a copy also).

Notices from Group to Company regarding billing and enrollment must be sent to:

Kaiser Foundation Health Plan of the Northwest
P.O. Box 203012
Denver, CO 80220-9012
Or emailed to: **csc-den-roc-group@kp.org**

Notices from Group to Company regarding Premium payments must be sent to:

Kaiser Foundation Health Plan of the Northwest
PO Box 34178
Seattle, WA 98124

Notices from Group to Company regarding termination of this *Agreement* must be sent to the Group's account manager at:

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah Street, Suite 100
Portland, OR 97232

Other Group Coverages that Cover Essential Health Benefits (EHBs)

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

For each non-grandfathered non-Medicare health plan coverage, except for any retiree-only coverage, Group must do all of the following if Group provides Company Members with other medical or dental coverage (for example, separate pharmacy coverage) that covers any Essential Health Benefits that Company coverage does not cover:

- Notify Company of the Out-of-Pocket Maximum (OOPM) that applies to those Essential Health Benefits in each of the other medical or dental coverages.
- Ensure that the sum of the OOPM in Company's coverage plus the OOPMs that apply to those Essential Health Benefits in all of the other medical and dental coverages does not exceed the annual limitation on cost sharing described in 45 CFR 156.130.

Premium Rebates

If state or federal law requires Company to rebate premiums from this or any earlier contract year and Company rebates premiums to Group, Group represents that Group will use that rebate for the benefit of Members, in a manner consistent with the requirements of the Public Health Service Act, the Affordable Care Act, and the obligations of a fiduciary under the Employee Retirement Income Security Act (ERISA).

Reporting Membership Changes and Retroactivity

Company's billing statement to Group explains how to report membership changes. Group's Kaiser Permanente account manager can also provide Group with this information. Group must report membership changes (including sending Company-approved membership forms) within the time limit for retroactive changes and in accord with any applicable "rescission" provisions of the Patient Protection and Affordable Care Act and regulations. The time limit for retroactive membership changes is the calendar month when Company's Denver Service Center receives Group's notification of the change plus the previous two months unless Company agrees otherwise in writing.

Representation Regarding Waiting Periods

Pursuant to section 2708 of the Public Health Service Act (PHSA) and 45 CFR 116(b), Group hereby represents that Group does not impose a waiting period exceeding 90 days on its employees who meet Group's substantive eligibility requirements. (A waiting period is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective, including completion of Group's reasonable and bona fide employment-based orientation period that does not exceed one month, if any.)

In addition, Group represents that eligibility data provided by the Group to Company will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in 45 CFR 116.

Social Security and Tax Identification Numbers

Within 60 days after Company sends Group a written request, Group will send Company a list of all Members covered under this *Agreement,* along with the following:

- The Member's Social Security number.
- The tax identification number of the employer of the Subscriber in the Member's Family.
- Any other information that Company is required by law to collect.

Summaries of Benefits and Coverage

Group will provide electronic or paper summaries of benefits and coverage (SBCs) to participants and beneficiaries to the extent required by law, except that Company will provide SBCs to Members who make a request to Company.

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Large Group
Deductible Added Choice® Plan
Evidence of Coverage

Group Name: Willamette University

Group Number: 2014-019-022

This *Evidence of Coverage* is effective 4/1/2020 through 3/31/2021

Printed: April 2, 2020

Member Services

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

All areas.....1-866-616-0047

TTY

All areas..... 711

Language interpretation services

All areas.....1-800-324-8010

kp.org

DEDUCTIBLE ADDED CHOICE® 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. For a list of defined terms, refer to the "Definitions" section of this *EOC*.

Services that are subject to the Deductible are indicated below. After you meet your Deductible, you pay the amount listed in this summary. In Tier 1 and Tier 2, Coinsurance is a percentage of Charges. In Tier 3, Coinsurance is a percentage of the Allowed Amount. In Tier 3, you will also be responsible for paying any provider or facility fees in excess of the Allowed Amount. All applicable visit limits are combined across all tiers, unless otherwise indicated in this *EOC*.

Some Services require prior authorization, as described in this EOC. Under Tier 3, if you fail to get prior authorization for a covered Service that requires prior authorization, you will have to pay the Copayment or Coinsurance shown in this summary plus an additional 50 percent of the Allowed Amount (except that this additional amount will not exceed $500) and any amounts over the Allowed Amount. Refer to "Services Subject to Prior Authorization Review under Tier 2 and Tier 3" and "Failure to Satisfy Prior Authorization Review Requirements under Tier 3" in the "How to Obtain Services under Tier 2 and Tier 3" section for more information.

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

	Tier 1	**Tier 2**	**Tier 3**
	Select Providers	**PPO Providers**	**Non-Participating Providers**
Deductible The amounts you pay for covered Services subject to the Deductible in Tier 1 and Tier 2 cross accumulate. This means that the amounts you pay for covered Services in Tier 1 also count toward the Deductible in Tier 2, and do not count toward the Deductible in Tier 3. The amounts you pay for covered Services subject to the Deductible in Tier 3 only count toward the Deductible in Tier 3.			
Self-only Deductible per Year (for a Family of one Member)	$1,000	$2,000	$3,000
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$1,000	$2,000	$3,000
Family Deductible per Year (for an entire Family)	$3,000	$6,000	$9,000
Out-of-Pocket Maximum All Deductible, Copayment, and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise indicated in this *EOC*. The amounts you pay for covered Services that count toward the Out-of-Pocket Maximum in Tier 1 and Tier 2 cross accumulate. This means that the amounts you pay for covered Services in Tier 1 also count toward the Out-of-Pocket Maximum in Tier 2, and do not count toward the Out-of-Pocket Maximum in Tier 3. The amounts you pay for covered Services that count toward the Out-of-Pocket Maximum in Tier 3 only count toward the Out-of-Pocket Maximum in Tier 3.			
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$4,000	$6,000	$7,500
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$4,000	$6,000	$7,500

	Tier 1	Tier 2	Tier 3
	Select Providers	**PPO Providers**	**Non-Participating Providers**
Family Out-of-Pocket Maximum per Year (for an entire Family)	$8,000	$12,000	$15,000
Preventive Care Services	**You Pay**		
Routine preventive physical exam (includes adult, well baby, and well child)	$0	$0	40% Coinsurance after Deductible
Immunizations	$0	$0	$0
Preventive tests	$0	$0	40% Coinsurance after Deductible
Outpatient Services	**You Pay**		
Primary care visit (includes routine OB/GYN visits and medical office visits, health education Services, and diabetic outpatient self-management training and education, including medical nutrition therapy)	$25	$35	40% Coinsurance after Deductible
Specialty care visit (includes routine hearing exams, health education Services, and diabetic outpatient self-management training and education, including medical nutrition therapy)	$35	$45	40% Coinsurance after Deductible
TMJ therapy visit	$35 after Deductible	$45	40% Coinsurance after Deductible
Routine eye exam (covered until the end of the month in which Member turns 19 years of age)	$0	$0	40% Coinsurance after Deductible
Routine eye exam for Members age 19 years and older	$25	$35	40% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Administered medications, including injections (all outpatient settings)	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care visit	$45	$55	40% Coinsurance after Deductible
Emergency department visit	$200 after Deductible (Waived if admitted)		
Outpatient surgery visit	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Vasectomy	$0	$0	Refer to the applicable Tier 3 Copayment or Coinsurance
Interrupted pregnancy surgery	$0	$0	Refer to the applicable Tier 3 Copayment or Coinsurance
Chemotherapy/radiation therapy visit	$35 after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Respiratory therapy visit	$35 after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Cardiac rehabilitative therapy visit	$35 after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible

	Tier 1	Tier 2	Tier 3
	Select Providers	**PPO Providers**	**Non-Participating Providers**
Physician-referred acupuncture (limited to 12 visits per Year)	$35	Not covered	Not covered
Inpatient Hospital Services	**You Pay**		
Room and board, surgery, anesthesia, X-ray, imaging, laboratory, and drugs	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Vasectomy	$0	$0	40% Coinsurance after Deductible
Interrupted pregnancy surgery	$0	$0	40% Coinsurance after Deductible
Ambulance Services	**You Pay**		
Per emergency transport	20% Coinsurance after Deductible		
Per non-emergency transport	20% Coinsurance after Deductible	Not applicable	40% Coinsurance after Deductible. Maximum benefit is $2,000 per Year.
Bariatric Surgery Services	**You Pay**		
Inpatient hospital Services	20% Coinsurance after Deductible	Not Covered	Not covered
Chemical Dependency Services	**You Pay**		
Outpatient Services	$25 per visit	$35 per visit	40% Coinsurance after Deductible
Inpatient hospital Services	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Residential Services	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Day treatment Services	$25 per day	$35 per day	40% Coinsurance after Deductible
Dialysis Services	**You Pay**		
Outpatient dialysis visit	$35 after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Home dialysis	$0	$0	$0
External Prosthetic Devices and Orthotic Devices	**You Pay**		
External Prosthetic Devices	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Orthotic Devices	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Habilitative Services (Visit maximums do not apply to habilitative Services for treatment of mental health conditions.)	**You Pay**		
Outpatient physical, speech, and occupational therapies (20 visits per Year)	$35	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Services	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible

	Tier 1	Tier 2	Tier 3
	Select Providers	**PPO Providers**	**Non-Participating Providers**
Hearing Aid Services for Dependents	**You Pay**		
Hearing exams, testing, and visits for hearing aid Services	$35	$45	40% Coinsurance after Deductible
	Select Vendors	**PPO Vendors**	**Non-Participating Vendors**
Hearing aids (for Members who are under the Dependent Limiting Age), limited to one hearing aid per ear every 36 months.	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Health Services	**You Pay**		
Home health (up to 130 visits per Year)	$0 after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospice Services	**You Pay**		
Hospice Services (Respite care is limited to no more than five consecutive days in a 30-day period.)	$0	$0	$0
Infertility Services	**You Pay**		
Diagnosis office visit	50% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Diagnosis laboratory procedures	50% Coinsurance after Deductible	50% Coinsurance after Deductible	50% Coinsurance after Deductible

Limited Outpatient Prescription Drugs and Supplies	**Select Pharmacies, Select Facilities or MedImpact Pharmacies You Pay**
Certain preventive medications (including, but not limited to, aspirin, fluoride, and liquid iron for infants)	$0
Certain self-administered IV drugs, fluids, additives, and nutrients including the supplies and equipment required for their administration	$0
Contraceptive drugs or devices	$0
Self-administered chemotherapy medications used for the treatment of cancer	Refer to your Outpatient Prescription Drug Rider
Tobacco use cessation drugs	$0

	Tier 1	Tier 2	Tier 3
	Select Providers	**PPO Providers**	**Non-Participating Providers**
Maternity and Newborn Care	**You Pay**		
Scheduled prenatal care visits and postpartum visits	$0	$0	40% Coinsurance after Deductible
Maternal diabetes management (Medically Necessary Services beginning with conception and ending through six weeks postpartum)	$0	$0	40% Coinsurance after Deductible

	Tier 1	Tier 2	Tier 3
	Select Providers	**PPO Providers**	**Non-Participating Providers**
Inpatient hospital Services	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Medical Foods and Formula	**You Pay**		
Medical foods and formula	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health Services	**You Pay**		
Outpatient Services	$25 per visit	$35 per visit	40% Coinsurance after Deductible
Intensive outpatient Services	$25 per day	$35 per day	40% Coinsurance after Deductible
Assertive Community Treatment (ACT) Services	$0	Not covered	Not covered
Inpatient hospital Services	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Residential Services	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Durable Medical Equipment (DME)	**You Pay**		
Outpatient Durable Medical Equipment (DME)	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Lancets and injection aids	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures	**You Pay**		
Laboratory	$25 per department visit	$35 per department visit	40% Coinsurance after Deductible
Genetic testing	$25 per department visit	$35 per department visit	40% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	$25 per department visit	$35 per department visit	40% Coinsurance after Deductible
CT, MRI, PET scans	$100 per department visit	30% Coinsurance after Deductible	40% Coinsurance after Deductible

	Tier 1	Tier 2	Tier 3
	Select Providers	**PPO Providers**	**Non-Participating Providers**
Reconstructive Surgery Services	**You Pay**		
Inpatient hospital Services	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient surgery visit	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible

	Tier 1	Tier 2	Tier 3
	Select Providers	**PPO Providers**	**Non-Participating Providers**
Rehabilitative Therapy Services (Visit maximums do not apply to rehabilitative therapy Services for treatment of mental health conditions.)	**You Pay**		
Outpatient physical, speech, and occupational therapies (20 visits per Year)	$35	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Services	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Skilled Nursing Facility Services	**You Pay**		
Inpatient skilled nursing Services (up to 100 days per Year)	20% Coinsurance after Deductible	30% Coinsurance after Deductible	40% Coinsurance after Deductible
Transplant Services	**You Pay**		
Inpatient hospital Services	20% Coinsurance after Deductible	Not covered	Not covered
Dependent Limiting Age	**Limiting Age**		
General	26		
Student	26		

TABLE OF CONTENTS

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 Deductible Added Choice® 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.

General Overview

This "General Overview" section is a brief summary of some key features of this Deductible Added Choice® Plan. You should read this entire *EOC* for details and additional coverage requirements.

Benefit Tiers

This Deductible Added Choice® Plan lets you choose among three levels of benefit "tiers" when you receive covered Services. The Services we cover, and the amounts you pay for covered Services, differ among the three tiers. The "Benefits" section explains what Services we cover under each tier. In most cases, the type of provider (Select Provider, PPO Provider, or Non-Participating Provider) or type of facility (Select Facility, PPO Facility, or Non-Participating Facility) that provides the Service will determine which tier applies for that Service. You may choose different tiers for different covered Services. Services must be Medically Necessary to be covered. If you choose to receive non-covered Services, you will be responsible for the full price of the Services. Company is not responsible for any amounts you are billed for non-covered Services. Any amounts you pay for non-covered Services will not count toward your Deductible or Out-of-Pocket Maximum.

Referrals and Prior Authorization

Some covered Services require a provider referral or prior authorization.

Referral requirements are explained under "Tier 1 Referrals" in the "How to Obtain Services under Tier 1" section and under "When Referrals are Required under Tier 2 and Tier 3" in the "How to Obtain Services under Tier 2 and Tier 3" section.

Prior authorization requirements are explained under "Tier 1 Prior Authorization Review Requirements" in the "How to Obtain Services under Tier 1" section and under "Tier 2 and Tier 3 Prior Authorization Review Requirements," and "Failure to Satisfy Prior Authorization Review Requirements under Tier 3" in the "How to Obtain Services under Tier 2 and Tier 3" section.

Exclusions, Limitations, and Reductions

All Services are subject to exclusions, limitations, and reductions. The "Benefits" section lists exclusions and limitations that apply only to a particular benefit, or only to a particular benefit under certain tiers. The "Exclusions and Limitations" and "Reductions" sections list exclusions, limitations, and reductions that apply for all tiers. Exclusions and limitations that apply to all benefits, but only under Tier 2 and Tier 3, are listed

under "Exclusions and Limitations that Apply Only to Tier 2 and Tier 3" in the "Exclusions and Limitations" section.

Day, Dollar, and Visit Maximums

Some benefits are limited by day, dollar, or visit maximums. Most of these maximums are combined maximums that apply to all three tiers. For those maximums, Services that we cover under any tier count toward the maximum. When you reach the maximum, we will not cover any more of that Service under any tier for the rest of that Year (or other benefit period listed for some maximums). Other maximums are combined maximums that apply only to Tier 1 and Tier 2. The "Benefits" section and the "Benefit Summary" explain all of the day, dollar, and visit maximums.

The maximums include any Services we cover under any other evidence of coverage with the same group number printed on this *EOC*.

What You Pay for Covered Services

The "What You Pay" section and the "Benefit Summary" explain what you pay for covered Services. You generally pay the least under Tier 1 and the most under Tier 3.

In Tier 1 and Tier 2, there are limits to the total amount of Copayments and Coinsurance that a Member or Family must pay for Tier 1 and Tier 2 covered Services received in the same Year. See "Tier 1 and Tier 2 Out-of-Pocket Maximums" in the "What You Pay" section. The amounts of the Member and Family Out-of-Pocket Maximum are listed in the "Benefit Summary."

In Tier 3, there are also limits to the total amount of Coinsurance that a Member or Family must pay for Tier 3 covered Services received in the same Year. See "Tier 3 Out-of-Pocket Maximum" in the "What You Pay" section. The amounts of the Member and Family Out-of-Pocket Maximum are listed in the "Benefit Summary."

DEFINITIONS

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

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

Allowed Amount. The lower of the following amounts:

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

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

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

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

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

Charges. Charges means the following:

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

Chemical Dependency. An 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 or the percentage of the Allowed Amount that you must pay when you receive a covered Service.

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

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

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

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

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

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

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

Emergency Medical Condition. An Emergency Medical Condition means a medical condition:

- That manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:
  - Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
  - Serious impairment to bodily functions.
  - Serious dysfunction of any bodily organ or part.
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.
- That is a Behavioral Health Crisis.

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

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

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

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

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

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

Group. The employer, union trust, or association with which we have an *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 Group. Northwest Permanente, P.C., Physicians and Surgeons, a professional corporation of physicians organized under the laws of the state of Oregon. Medical Group contracts with Company to provide professional medical Services to Members and others primarily on a capitated, prepaid basis in Select Facilities.

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

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

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

Non-Participating Facility. Any of the following licensed institutions that provide Services, but which are not Select Facilities or PPO 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, 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 Select Physician or a PPO Physician.

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

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

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

Out-of-Pocket Maximum. The total amount of Deductibles, Copayments, and Coinsurance you will be responsible to pay in a Year, as described in the "What You Pay" section of this *EOC*.

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.

PPO Facility. A facility (other than a pharmacy) that participates in First Choice Health Network. PPO Facilities are subject to change.

PPO Physician. Any licensed physician who participates in First Choice Health Network. PPO Physicians are subject to change.

PPO Provider. Any person who participates in First Choice Health Network and who is:

- Regulated under state law to practice health or health-related services or otherwise practicing health care services consistent with state law, or
- An employee or agent of any persons previously described in this definition, acting in the course and scope of his or her employment.

PPO Providers are subject to change.

PPO Vendor. Any business, or any provider or facility regulated under state law to practice health or health-related services or otherwise practicing health care services consistent with state law, that sells or leases Durable Medical Equipment (DME), vision hardware (glasses and contact lenses), hearing aids, and other medical supplies and equipment and that participates in First Choice Health Network. PPO Vendors are subject to change.

Premium. Monthly membership charges paid by Group.

Select Facility. A facility that is owned or operated by Kaiser Permanente, or that contracts directly with Kaiser Permanente, and that is listed as a Select Facility in the *Added Choice Medical Facilities Directory*. Select Facilities are subject to change.

Select Pharmacy. A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate, that is listed as a Select Pharmacy in the *Added Choice Medical Facilities Directory*. Select Pharmacies are subject to change.

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

Select Provider. Any person who is either:

- A Select Physician, or
- A person regulated under state law to practice health or health-related services or otherwise practicing health care services consistent with state law and who is an employee of a Select Physician or of Kaiser Permanente.

Select Providers are subject to change.

Select Vendor. Kaiser Permanente, or any business (or any provider or facility regulated under state law to practice health or health-related services or otherwise practicing health care services consistent with state law) that sells or leases Durable Medical Equipment (DME), vision hardware (glasses and contact lenses), hearing aids, and other medical supplies and equipment and that is owned or operated by Kaiser Permanente or that contracts directly with Kaiser Permanente. Select Vendors are subject to change.

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

Services. Health care services, supplies, or items.

Specialist. Any licensed physician, who practices in a specialty care area of medicine (not family medicine, pediatrics, gynecology, obstetrics, general practice, or internal medicine).

Spouse. The person to whom you are legally married under applicable law. For the purposes of this *EOC,* the term "Spouse" includes a person legally recognized as your domestic partner in a valid 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.

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

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

PREMIUM, ELIGIBILITY, AND ENROLLMENT

Premium

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

Who Is Eligible

General

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

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

Subscribers

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

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

Dependents

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

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

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

- A person of any age who is primarily dependent upon you or your Spouse for support and maintenance if the person is incapable of self-sustaining employment by reason of 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 persons, or between children of married or unmarried persons.

When You Can Enroll and When Coverage Begins

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

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

New Employees and Their Dependents

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

Open Enrollment

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

Special Enrollment

If an eligible employee or their eligible Dependents do not enroll when they are first eligible, and later want to enroll, they can enroll only during open enrollment unless they experience a qualifying event as defined in applicable state and federal law. Your Group will administer special enrollment rights under applicable state and federal law.

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

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

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

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

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

Adding New Dependents to an Existing Account

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

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

To add all other newly eligible Dependents (such as a new Spouse), you must submit an enrollment application to your Group within 30 days after the qualifying event.

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

When Coverage Begins

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

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

HOW TO OBTAIN SERVICES—GENERAL INFORMATION

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.

This Deductible Added Choice® Plan lets you choose among three benefit tiers when you receive covered Services. You may choose different tiers for different covered Services. The Services we cover, and the amounts you pay for covered Services, differ among the three tiers. We cover some Services, such as transplants, only under Tier 1.

The "Benefits" section explains what Services we cover under each tier. In most cases, the type of provider or facility that provides the Service will determine which tier applies:

- Except where specifically noted to the contrary in the "Benefits" section, Tier 1 covered Services must meet the following requirements:
  - A Select Provider must provide, prescribe, direct, or make a referral for the Service.
  - You must receive the Service from a Select Provider or Select Facility.

Exceptions to these Tier 1 requirements include covered Emergency Services and covered Urgent Care outside our Service Area.

- Tier 2 is for covered Services you receive from a PPO Provider or a PPO Facility.
- Tier 3 is for covered Services you receive inside the United States from a Non-Participating Provider or a Non-Participating Facility.

We will not directly or indirectly prohibit you from freely contracting at any time to obtain non-covered Services. However, if you choose to receive non-covered Services, you will be responsible for the full price of the Services. Company is not responsible for any amounts you are billed for non-covered Services. Any amounts you pay for non-covered Services will not count toward your Deductible or Out-of-Pocket Maximum.

Using Your Identification Card

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

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

To verify your eligibility or benefits, your PPO Provider or Non-Participating Provider may call the Member Services number listed on the ID card. The claims billing address and prior authorization numbers are also on the ID card.

Advice Nurses

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

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

Your PPO Provider's or Non-Participating Provider's office may have advice personnel to assist you. To learn more, check with his or her office.

Your Primary Care Select Provider

Your primary care Select Provider plays an important role in coordinating your Tier 1 Services, including hospital stays and referrals to Specialists. We encourage you and your Dependents to each choose a primary care Select Provider. For information about choosing your primary care Select Provider, please call Member Services or visit **kp.org**.

You may select a primary care Select Provider from family medicine, internal medicine, or pediatrics. Female Members also have the option of choosing a women's health care Select Provider as their primary care Select Provider, as long as the women's health care Select Provider accepts designation as primary care Select Provider. A women's health care Select Provider must be an obstetrician or gynecologist, a physician assistant

specializing in women's health, an advanced registered nurse practitioner of women's health, or a certified nurse midwife, practicing within his or her applicable scope of practice.

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

Women's Health Care Services

Female Members may receive certain women's health care Services directly, without a referral, including at least one annual preventive women's health examination, Medically Necessary follow-up visits resulting from a preventive women's health examination, and pregnancy care (including labor and delivery). In order to be covered without a referral, these Services must be provided by an obstetrician or gynecologist, physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health, naturopathic physician specializing in women's health, or a certified nurse midwife, practicing within the lawful scope of his or her practice.

We cover annual mammograms for women 40 years of age or older, with or without a referral from your Select Physician, and more frequently if your Select Physician recommends it because you are at high risk for breast cancer or disease. We also cover breast examinations, pelvic examinations, and cervical cancer screenings annually for women 18 or older, and any time with a referral from your Select Physician. We cover Medically Necessary Services furnished in connection with childbirth in a Select Facility, a PPO Facility, or a Non-Participating Facility, or at your home, when provided by a Select Provider (for Tier 1), a PPO Provider (for Tier 2), or a Non-Participating Provider (for Tier 3).

Appointments for Routine Services

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

If you need to make an appointment for routine Services with a Select Provider, go to **kp.org** to schedule an appointment online or call Member Services.

You can learn more about locating PPO Providers by contacting Member Services or going to **kp.org/addedchoice/nw**. Please contact the PPO Provider's or the Non-Participating Provider's office directly to make your appointment.

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 Select Providers or Select Facilities, please discuss them with your primary care Select Provider or with other Select Providers who are treating you. If you have any questions or concerns about Services you received from a PPO Provider or a Non-Participating Provider, please discuss them with that provider or the provider's office.

Most Select Facilities have an administrative office staffed with representatives who can provide assistance if you need help obtaining Services. Member Services representatives are also available to assist you Monday through Friday (except holidays), from 8 a.m. to 6 p.m.

Portland area 1-866-616-0047

All other areas 1-866-616-0047

TTY for the hearing and speech impaired 711

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

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

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

Receiving Care in Another Kaiser Foundation Health Plan Service Area

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

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

HOW TO OBTAIN SERVICES UNDER TIER 1

About Kaiser Permanente

You must receive all Tier 1 covered Services from Select Providers and Select Facilities, except as otherwise specifically permitted in this *EOC*.

Deductibles, Copayments, and Coinsurance apply when you use Select Providers and Select Facilities (for Tier 1).

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

Kaiser Permanente either provides or makes the necessary arrangements for Tier 1 Services needed by our Members, through an integrated medical care program. Our medical care program gives you access to all Tier 1 covered Services, such as routine Services from your own personal physician, hospital Services, laboratory Services, and pharmacy Services when your Group purchases pharmacy coverage.

We cover Tier 1 Services if you use Select Providers and Select Facilities except as otherwise provided in this *EOC*. For more information, see the "How to Obtain Services—General Information" section or contact Member Services. If you would like additional information about your benefits, other products, or services, please call Member Services.

You may also e-mail us when you sign on to **kp.org**. The first time you visit our website, you will need to register in order to use certain features. You can do many things on the website. For example, you may e-mail your Select Provider's office, make appointments, or order prescription refills.

Tier 1 Referrals

Referrals to Select Providers and Select Facilities

Primary care Select 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 Select Provider will refer you to a Specialist when appropriate.

In most cases, you will need a referral from a Select Provider to see a Specialist. If the Specialist is not an employee of Medical Group, your referral will need prior authorization in order for the Services to be

covered. Please call Member Services for information about specialty Services that require a referral or discuss this issue with your primary care Select Provider. In some cases, a standing referral is allowed to a Specialist for a time period that is in accord with your individual medical needs as determined by the Select Provider and Company.

A PPO Provider or Non-Participating Provider may also refer you to see a Specialist who is a Select Provider. Your referral will need prior authorization in order for the Services to be covered. See the "Tier 1 Prior Authorization Review Requirements" section.

Some outpatient specialty care is available in Select Facilities without a referral. Please call Member Services to schedule routine appointments in the following departments that do not require a referral for outpatient Services:

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

Referrals to PPO Providers, Non-Participating Providers, PPO Facilities, and Non-Participating Facilities

If your Select Provider decides that you require Services not available from Select Providers or Select Facilities, he or she will recommend to Medical Group and Company that you be referred to a PPO Provider, a Non-Participating Provider, a PPO Facility, or a Non-Participating Facility.

If Medical Group determines that the Services are Medically Necessary and are not available from a Select Provider or Select Facility, and Company determines that the Services are covered Services, Company will authorize your referral for the covered Services.

In order for the Services to be covered, you will need written authorization in advance. If Company authorizes the Services, you will receive a written "Authorization for Outside Medical Care" referral.

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. You pay the same Copayments and Coinsurance for authorized referral Services that you would pay if you received the Services from a Select Provider or at a Select Facility.

Tier 1 Prior Authorization Review Requirements

When you need Services, and you are using your Tier 1 benefits, you should talk with your Select Provider about your medical needs or your request for Services. Your Select Provider provides covered Services that are Medically Necessary. Select 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 Medical Group and approved by Company. If you seek a specific Service, you should talk with your Select Provider. Your Select 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 Select Provider believes they are Medically Necessary, the Select 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 Select 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 Utilization Review criteria used to make the determination. Please contact Member Relations at 503-813-4480.

If you are using your Tier 2 or Tier 3 benefits, your PPO Provider or Non-Participating Provider may refer you to see a Specialist who is a Select Provider (Tier 1). This referral is subject to approval through Utilization Review, based on Utilization Review criteria developed by Medical Group or another organization utilized by Medical Group and approved by Company. If the request is denied, we will send a letter to you within two business days of the provider's request. The decision letter will explain the reason for the determination along with instructions for filing an appeal. You may request a copy of the complete Utilization Review criteria used to make the determination. Please contact Member Relations at 503-813-4480.

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.
- External Prosthetic Devices and Orthotic Devices.
- Gender Affirming Treatment.
- General anesthesia and associated hospital or ambulatory surgical facility Services provided in conjunction with non-covered dental Services.
- Habilitative Services.
- Hospice and home health Services.
- Inpatient hospital Services.
- Inpatient and residential Chemical Dependency Services.
- Inpatient, residential, and Assertive Community Treatment (ACT) mental health Services.
- Non-emergency medical transportation.
- Open MRI.
- Plastic surgery.
- PPO Provider or Non-Participating Provider referrals to a Specialist who is a Select Provider.
- Reconstructive surgery Services.
- Rehabilitative therapy Services.
- Routine foot Services.
- Select Provider referrals to a PPO Provider, a Non-Participating Provider, a PPO Facility, or a Non-Participating Facility.
- Skilled nursing facility Services.
- Transplant Services.
- Travel and lodging expenses.

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

If you ask for Tier 1 Services that the Select Provider believes are not Medically Necessary and does not submit a request on your behalf, you may ask for a second opinion from another Select Provider. You should contact the manager in the area where the Select Provider is located. Member Services can connect you with the correct manager, who will listen to your issues and discuss your options.

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 this 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, if your coverage changes, or you lose your eligibility.

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

Select Provider Whose Contract Terminates

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

This continuity of Services provision applies when our contract with a Select Provider terminates, or when a physician's employment with Medical Group terminates, except when the termination is for cause (including quality of care issues) or because the Select 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 Select Provider agree that it is desirable to maintain continuity of care.
- We would have covered the Services if you had received them from a Select 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.

HOW TO OBTAIN SERVICES UNDER TIER 2 AND TIER 3

You must receive all Tier 2 covered Services from PPO Providers and PPO Facilities. You can learn more about locating PPO Providers and PPO Facilities by contacting Member Services or you may go directly to the list of the First Choice Health providers at **kp.org/addedchoice/nw**. All First Choice Health providers are PPO Providers.

You must obtain Tier 3 covered Services in the United States from licensed Non-Participating Providers and Non-Participating Facilities.

When Referrals are Required under Tier 2 and Tier 3

Generally, you may see any PPO Provider or Non-Participating Provider without a referral. However, you will need a PPO Provider or a Non-Participating Provider referral for:

- Habilitative Services.
- Occupational therapy.
- Physical therapy.
- Respiratory therapy.
- Speech therapy.

Although you need a provider referral, your Tier 2 or Tier 3 benefit applies based on who provides the therapy, not on who makes the referral. If a PPO Provider provides the therapy, your Tier 2 benefit applies. If a Non-Participating Provider provides the therapy, your Tier 3 benefit applies.

Tier 2 and Tier 3 Prior Authorization Review Requirements

Some Services covered under Tier 2 or Tier 3 require prior authorization by Company at least 72 hours in advance. The Tier 2 and Tier 3 Services that require prior authorization are described under "Services Subject to Prior Authorization Review under Tier 2 and Tier 3" in this "How to Obtain Services under Tier 2 and Tier 3" section. PPO Providers are responsible for requesting prior authorization from Company. If a Non-Participating Provider recommends Services that require prior authorization, we suggest that you ask him or her to request prior authorization by calling us at 1-855-281-1840.

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 this Plan are binding on us if obtained no more than 30 days before you receive the Service. We may revoke or amend a prior authorization for Services you have not yet received if your membership terminates, if your coverage changes, or you lose your eligibility.

After you or your PPO Provider or Non-Participating Provider calls us, we will review your proposed course of treatment to verify that it is medically appropriate, and will either:

- Give prior authorization for treatment, and send a confirmation of prior authorization and approved length of stay to your PPO Provider or Non-Participating Provider, and the hospital, surgical center, or other facility, or

- Contact your PPO Provider or Non-Participating Provider to discuss alternative forms of treatment. We will send you and your PPO Provider or Non-Participating Provider a denial letter if we do not agree that the proposed treatment or setting is appropriate.

Following a prior authorization by Company, your treatment may begin. If your hospital stay is longer than the approved length of stay, we will consult with you, your PPO Provider or Non-Participating Provider, and the hospital about a possible extension of your stay.

If you disagree with our prior authorization review decision, you may appeal the decision. Follow the instructions for appeals as outlined in the "Grievances, Claims, Appeals, and External Review" section.

Services Subject to Prior Authorization Review under Tier 2 and Tier 3

All Tier 2 and Tier 3 covered Services require prior authorization by Company, except for the following:

- Ambulance Services.
- Any single DME item with Charges (for Tier 2) or Allowed Amount (for Tier 3) less than $500.
- Emergency Services.
- Health Education.
- Limited outpatient drugs and supplies.
- Maternity Services.
- Outpatient laboratory.
- Outpatient radiology, except MRI, CT scans, PET scans, and bone density/DXA scans. (For MRI, CT scan, PET scan, and bone density/DXA scan prior authorization requirements, see the "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" section.)
- PPO Provider (for Tier 2) and Non-Participating Provider (for Tier 3) office visits that do not include a procedure.
- Services that PPO Providers and PPO Facilities (for Tier 2) and Non-Participating Providers and Non-Participating Facilities (for Tier 3), bill as preventive Services.

Failure to Satisfy Prior Authorization Review Requirements under Tier 3

Under Tier 3, if you fail to get prior authorization for a covered Service that requires prior authorization, you will have to pay the Copayment or Coinsurance shown in the "Benefit Summary" plus an additional 50 percent of the Allowed Amount (except that this additional amount will not exceed $500) and any amounts over the Allowed Amount.

POST-SERVICE CLAIMS – SERVICES ALREADY RECEIVED

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

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

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

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

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

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

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

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

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

EMERGENCY, POST-STABILIZATION, AND URGENT CARE

Coverage, Deductible, Copayments, Coinsurance, and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Urgent Care from a Select Provider or Select 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 PPO Provider, PPO Facility, Non-Participating Provider, or Non-Participating Facility, we cover those Services under Tier 1 only if they meet both of the following requirements:

- This "Emergency, Post-Stabilization, and Urgent Care" section says that we cover the Services under Tier 1 if you receive them from a PPO Provider, PPO Facility, Non-Participating Provider, or Non-Participating Facility.
- The Services would be covered under Tier 1 under the "Benefits" section (subject to the "Exclusions and Limitations" section) if you received them from a Select Provider or Select Facility.

If you receive covered inpatient hospital Services under Tier 1, you pay the Deductible, Copayment, or Coinsurance shown in the "Benefit Summary" for Tier 1 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 for covered Services under Tier 1 and are not admitted directly as an inpatient, you

pay the emergency department visit Copayment or Coinsurance shown in the "Benefit Summary" under "Outpatient Services" for all Services received in the emergency department.

You do not need to file a claim for Services that you receive from a Select Provider, Select Facility, PPO Provider, or PPO 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 should send the bill to Company directly. If you paid for the Services when you received them, you may request reimbursement for covered Services as described in the "Post-service Claims – Services Already Received" section.

Emergency Services

Tier 1 Emergency Services

All covered Emergency Services provided by Select Providers, Select Facilities, PPO Providers, PPO Facilities, Non-Participating Providers, or Non-Participating Facilities are covered under Tier 1.

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 Select Providers, Select Facilities, PPO Providers, PPO Facilities, Non-Participating Providers, and Non-Participating Facilities anywhere in the world, as long as the Services would have been covered under the "Benefits" section (subject to the "Exclusions and Limitations" section) if you had received them from Select Providers or Select Facilities. You pay the emergency department visit Copayment or Coinsurance shown in the "Benefit Summary" under "Outpatient Services" for all Services received in the emergency department.

If you have an Emergency Medical Condition, we cover licensed ambulance Services that are not ordered by a Select Physician 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 Select Facility emergency departments 24 hours a day, seven days a week. Contact Member Services or see our *Added Choice Medical Facilities Directory* for locations of these emergency departments.

Tier 2 and Tier 3 Emergency Services

All covered Emergency Services provided by Select Providers, Select Facilities, PPO Providers, PPO Facilities, Non-Participating Providers, or Non-Participating Facilities are covered under Tier 1.

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 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 under Tier 1 only if one of the following is true:

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

Coverage for Post-Stabilization Care at a Non-Participating Provider or Non-Participating Facility is limited to the Allowed Amount. You are responsible for paying any amount over the Allowed Amount, in addition to

applicable Copayments and Coinsurance, and any such payments do not count toward the Deductible or the Out-of-Pocket Maximum. You are not responsible for paying any amount over the Allowed Amount for Post-Stabilization Care received from a Non-Participating Provider at a Select Facility or a PPO Facility.

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

We understand that extraordinary circumstances can delay your ability to call us, for example if you are unconscious, or if there is no parent or guardian with a young child. In these cases, you or someone on your behalf must call us as soon as reasonably possible.

After we are notified, we will discuss your condition with the PPO Provider or Non-Participating Provider. If we decide that the Post-Stabilization Care is Medically Necessary and would be covered if you received it from a Select Provider or Select Facility, we will either authorize your receiving the Services from the PPO Provider, PPO Facility, Non-Participating Provider, or Non-Participating Facility, or arrange to have a Select Provider or Select Facility (or other designated provider or facility) provide the Services. If we decide to arrange to have a Select Provider or Select Facility (or other designated provider or facility) provide the Services, 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. If your PPO Provider or Non-Participating Provider determines you are clinically stable and you decline special transportation to a Select Provider or Select Facility (or other designated provider or facility that we authorize), Post-Stabilization Care will be covered under Tier 2 (for Services provided by a PPO Facility or a PPO Provider) or Tier 3 (for Services provided by a Non-Participating Facility or a Non-Participating Provider).

If you receive Post-Stabilization Care from a provider or facility other than a Select Provider or Select Facility (or other provider or facility that we have designated or authorized), those Services will not be covered under Tier 1 unless you obtain an authorized referral as described in the "Referrals to PPO Providers, Non-Participating Providers, PPO Facilities, and Non-Participating Facilities" section of this *EOC*. Absent an authorized referral, these Services will be covered under Tier 2 (for Services provided by a PPO Facility or a PPO Provider) or Tier 3 (for Services provided by a Non-Participating Facility or a Non-Participating Provider), but only if they would be covered under that tier if they were not Post-Stabilization Care.

Urgent Care

Tier 1 Urgent Care

We cover Urgent Care during certain hours at designated medical offices that are Select Facilities. Please contact Member Services or see our *Added Choice Medical Facilities Directory* for the locations and the hours of medical offices that are Select Facilities for covered Urgent Care Services.

Tier 2 and Tier 3 Urgent Care

If you receive Urgent Care that is not covered under Tier 1, we will cover it under Tier 2 (for Services provided by a PPO Facility or a PPO Provider) or Tier 3 (for Services provided by a Non-Participating Facility or a Non-Participating Provider), but only if it would be covered under that tier if it were not Urgent Care.

WHAT YOU PAY

What You Pay under Tier 1 and Tier 2

Tier 1 and Tier 2 Deductible

For each Year, most covered Services under Tier 1 and Tier 2 are subject to the Deductible amounts shown in the "Benefit Summary." The "Benefit Summary" indicates which Services are subject to the Deductible.

Your Deductible amounts cross accumulate. This means that the amounts you pay for covered Services subject to the Deductible in Tier 1 also count toward your Tier 2 Deductible.

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

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

After you meet the Deductible, you pay the applicable Copayments and Coinsurance under Tier 1 and Tier 2 for these covered Services for the remainder of the Year, until you meet your Out-of-Pocket Maximum (see "Tier 1 and Tier 2 Out-of-Pocket Maximums" in this "What You Pay" section).

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

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

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

Tier 1 and Tier 2 Copayments and Coinsurance

When you receive Tier 1 and Tier 2 covered Services, you will be required to pay Copayments and Coinsurance, as shown in the "Benefit Summary." Any applicable Copayments or Coinsurance are due when you receive the Service. If we must bill you, an accounting fee will be added to offset handling costs.

For Tier 2 covered Services, we have financial arrangements for rates that we pay to PPO Providers and PPO Facilities. Coinsurance for Tier 2 Services is based on those rates. PPO Providers and PPO Facilities are not permitted to bill you for Tier 2 covered Services, except for your Deductible, Coinsurance, and Copayments.

Tier 1 and Tier 2 Out-of-Pocket Maximums

There is a maximum to the total dollar amount of Deductible, Copayments, and Coinsurance that you must pay for covered Services that you receive within the same Year.

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

All Tier 1 and Tier 2 Deductibles, Copayments, and Coinsurance count toward the Tier 1 and Tier 2 Out-of-Pocket Maximum, unless otherwise indicated. After you reach the Out-of-Pocket Maximum, you are not required to pay Copayments and Coinsurance for these Services for the remainder of the Year. Member Services can provide you with the amount you have paid toward your Out-of-Pocket Maximum.

Note: Your Tier 1 and Tier 2 Out-of-Pocket Maximums cross accumulate. This means that the amounts you pay for covered Services that count toward the Out-of-Pocket Maximum in Tier 1 also count toward the Out-of-Pocket Maximum in Tier 2.

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

- Payments for Services that are not covered under this *EOC*.
- Payments that you make because we already covered the benefit maximum amount or the maximum number of days or visits for a Service.
- Payments for Services under the "Infertility Services" section.
- Payments for Services under the "Adult Vision Hardware and Optical Services Rider," if purchased by your Group.
- Payments for Services under the "Alternative Care Services Rider," if purchased by your Group.
- Payments for Services under the "Hearing Aid Rider," if purchased by your Group.
- Payments for Services under the "Infertility Treatment Services Rider," if purchased by your Group.
- Payments for enhanced benefit Services under the "Pediatric Vision Hardware and Optical Services Enhanced Benefit Rider," if purchased by your Group.

What You Pay under Tier 3

Tier 3 Deductible

For each Year, most covered Services under Tier 3 are subject to the Tier 3 Deductible shown in the "Benefit Summary." The "Benefit Summary" indicates which Services are subject to the Deductible.

For Services subject to the Deductible, you must pay providers' or facilities' fees for the Services when you receive them, until you meet the Deductible.

If you are the only Member in your Family, then you must meet the self-only Deductible. If there is at least one other Member in your Family, then you must each meet the individual Family Member Deductible, or your Family must meet the Family Deductible, whichever occurs first. Each individual Family Member

Deductible amount counts toward the Family Deductible amount. Once the Family Deductible is satisfied, no further individual Family Member Deductible will be due for the remainder of the Year. The Deductible amounts for each Tier are shown in the "Benefit Summary."

After you meet the Deductible, you pay the applicable Copayments and Coinsurance under Tier 3 for these covered Services for the remainder of the Year, until you meet your Out-of-Pocket Maximum (see "Tier 3 Out-of-Pocket Maximum" in this "What You Pay under Tier 3" section). For Tier 3, you will also be responsible for paying any provider or facility fees in excess of the Allowed Amount. You are not responsible for paying any amount over the Allowed Amount for Services received from a Non-Participating Provider at a Select Facility or a PPO Facility.

For each Year, only the following payments count toward your Deductible:

- Charges you pay for Tier 3 covered Services that you receive in that Year and that are subject to the Deductible.
- The Allowed Amount you pay for Tier 3 covered Services that you receive in that Year and that are subject to the Deductible. Payments you make for amounts in excess of the Allowed Amount do not count toward the Deductible.
- **Deductible take-over.** Payments that were counted toward your deductible under your prior group health coverage if all of the following requirements are met:
  - This group health coverage with Company replaces the Group's prior group health coverage.
  - Your prior group health coverage was not with Company or with any Kaiser Foundation Health Plan.
  - You were covered under Group's prior group health coverage on the day before the effective date of this *EOC*.
  - The payments were for Services you received during the period of 12 months or less that occurred between the plan year effective date under Group's prior group health coverage and your effective date of coverage under this *EOC*.
  - The payments were for Services that we would have covered under this *EOC* if you had received them as a Member during the term of this *EOC*.
  - We would have counted the payments toward your Deductible under this *EOC* if you had received the Services as a Member during the term of this *EOC*.
  - The payments did not exceed the Allowed Amount.

Tier 3 Copayments and Coinsurance

When you receive Tier 3 covered Services, you will be required to pay Copayments and Coinsurance, as shown in the "Benefit Summary."

For Tier 3 covered Services, Coinsurance is based on the Allowed Amount. In addition, Non-Participating Providers and Non-Participating Facilities may bill you for amounts in excess of the Allowed Amount, but those amounts are not Copayments or Coinsurance.

Tier 3 Out-of-Pocket Maximum

There is a maximum to the total dollar amount of Deductible, Copayments, and Coinsurance you must pay for covered Services that you receive within the same Year. There is a separate Out-of-Pocket Maximum amount in Tier 3 as shown in the "Benefit Summary."

If you are the only Member in your Family, then you must meet the self-only Out-of-Pocket Maximum. If there is at least one other Member in your Family, then you must each meet the individual Family Member Out-of-Pocket Maximum, or your Family must meet the Family Out-of-Pocket Maximum, whichever occurs

first. Each individual Family Member Out-of-Pocket Maximum amount counts toward the Family Out-of-Pocket Maximum amount. The Out-of-Pocket Maximum amounts for each Tier are shown in the "Benefit Summary."

All Tier 3 Deductible, Copayments, and Coinsurance count toward the Tier 3 Out-of-Pocket Maximum, unless otherwise indicated. After you reach the Out-of-Pocket Maximum, you are not required to pay Copayments and Coinsurance for these Services for the remainder of the Year. Member Services can provide you with the amount you have paid toward your Out-of-Pocket Maximum.

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

- Additional amounts you pay for Tier 3 covered Services that require prior authorization but for which you did not get prior authorization (see "Failure to Satisfy Prior Authorization Review Requirements under Tier 3" in the "How to Obtain Services under Tier 2 and Tier 3" section and the "Benefit Summary").
- Amounts you pay for Tier 3 Services that are in excess of the Allowed Amount.
- Payments for Services that are not covered under this *EOC*.
- Payments that you make because we already covered the benefit maximum amount or the maximum number of days or visits for a Service.
- Payments for Services under the "Infertility Services" section.
- Payments for Services under the "Adult Vision Hardware and Optical Services Rider," if purchased by your Group.
- Payments for Services under the "Alternative Care Services Rider," if purchased by your Group.
- Payments for Services under the "Hearing Aid Rider," if purchased by your Group.
- Payments for Services under the "Infertility Treatment Services Rider," if purchased by your Group.
- Payments for enhanced benefit Services under the "Pediatric Vision Hardware and Optical Services Enhanced Benefit Rider," if purchased by your Group.

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.
- The Services are Medically Necessary.
- You receive a referral for the Services if required under the "How to Obtain Services under Tier 1" section or the "How to Obtain Services under Tier 2 and Tier 3" section, or this "Benefits" section.
- For Tier 1:
  - The Services are provided, prescribed, authorized, or directed by a Select Provider except where specifically noted to the contrary in this *EOC*.
  - You receive the Services from a Select Provider or a Select Facility, except where specifically noted to the contrary in this *EOC*.
  - You receive prior authorization for the Services, if required under the "How to Obtain Services under Tier 1" section.
- For Tier 2:
  - A PPO Provider or a PPO Facility provides the Services.

- You receive prior authorization for the Services, if required under the "How to Obtain Services under Tier 2 and Tier 3" section.

- For Tier 3:
  - A Non-Participating Provider or a Non-Participating Facility provides the Services inside the United States.
  - For Services subject to prior authorization, either you get prior authorization for the Services, or Company reviews the Services and determines that they are Medically Necessary. See the "How to Obtain Services under Tier 2 and Tier 3" section for details.

All Services are subject to exclusions, limitations, and reductions. This "Benefits" section lists exclusions and limitations that apply only to a particular benefit, or only to a particular benefit under certain tiers. The "Exclusions and Limitations" and "Reductions" sections list exclusions, limitations and reductions that apply for all tiers. Exclusions and limitations that apply to all benefits, but only under Tier 2 and Tier 3, are listed under "Exclusions and Limitations that Apply Only to Tier 2 and Tier 3" in the "Exclusions and Limitations" section. Exclusions and limitations that apply to all benefits, but only under Tier 3, are listed under "Exclusions and Limitations that Apply Only to Tier 3" in the "Exclusions and Limitations" section.

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

How to Find Information about Specific Benefits

The "Benefits" section has separate headings for each benefit (for example, "Ambulance Services"). Under each of these headings is a general benefit description of the Services covered under that benefit, in most cases followed by tier-specific benefit information. The tier-specific benefit information may include additional Services that are covered under one or more tiers, and it may include tier-specific limitations or exclusions on Services that the general benefit description says are covered.

In the case of some benefits, due to the extent of the differences between the Services covered under Tier 1 and those covered under Tier 2 and Tier 3, the Tier 1 benefit is described separately from the Tier 2 and Tier 3 benefit.

Preventive Care Services

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

Preventive care Services include:

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

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

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

- Bone densitometry.
- Cervical cancer screening.
- Chlamydia test.
- Cholesterol tests (all types).
- Colorectal cancer screening, including exam, bowel preparation medications, colonoscopy, sigmoidoscopy, and fecal occult test.
- Contraceptive services and supplies, including insertion/removal of IUD or implanted birth control drugs and devices.
- Fasting glucose test.
- Healthy diet counseling and counseling for obesity and weight management.
- Immunizations.
- Mammography.
- Routine preventive physical exam (adult, well-child, and well-baby).
- Screening prostate-specific antigen (PSA) test (not including monitoring or ultrasensitive tests).
- Transabdominal and transcervical sterilization procedures.

When a Select Provider (for Tier 1), a PPO Provider (for Tier 2), or a Non-Participating Provider (for Tier 3) determines that a recommended Service is medically appropriate for an individual and the individual satisfies the criteria for the Service or treatment, we will provide coverage for the recommended Service regardless of sex assigned at birth, gender identity, or gender of the individual otherwise recorded by us.

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

Benefits for Outpatient Services

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

- Allergy testing and treatment materials.
- Cardiac rehabilitative therapy visits.
- Chemotherapy and radiation therapy Services.
- Diagnostic Services and scope insertion procedures, such as colonoscopy, endoscopy, and laparoscopy.
- Drugs, injectables, and radioactive materials used for therapeutic or diagnostic purposes, if they are administered to you at a Select Facility (for Tier 1), PPO Facility (for Tier 2), Non-Participating Facility (for Tier 3), or during home visits, subject to the drug formulary and exclusions described under the "Limited Outpatient Prescription Drugs and Supplies" section.
- Emergency department visits.
- Gender Affirming Treatment.
- Internally implanted devices, including bilateral cochlear implants and bone-anchored hearing aids, except for internally implanted insulin pumps, artificial hearts, and artificial larynx.
- Interrupted pregnancy surgery performed in an outpatient setting.
- Nurse treatment room visits to receive injections, including allergy injections.

- Outpatient surgery and other outpatient procedures.
- Primary care visits for internal medicine, gynecology, family medicine, and pediatrics.
- Rehabilitative therapy Services such as physical, occupational, and speech therapy Services, subject to the benefit limitations described under the "Rehabilitative Therapy Services" section.
- Respiratory therapy.
- Routine eye exams.
- Routine hearing exams.
- Specialty care visits.
- Treatment for temporomandibular joint (TMJ) disorder, including splint therapy for TMJ.
- Urgent Care visits.
- Vasectomy.

Additional Information about Certain Outpatient Services

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

- "Ambulance Services."
- "Chemical Dependency Services."
- "Dialysis Services."
- "External Prosthetic Devices and Orthotic Devices."
- "Habilitative Services."
- "Health Education Services."
- "Hearing Aid Services for Dependents."
- "Home Health Services."
- "Hospice Services."
- "Infertility Services."
- "Limited Dental Services."
- "Limited Outpatient Prescription Drugs and Supplies."
- "Mental Health Services."
- "Outpatient Durable Medical Equipment (DME)."
- "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures."
- "Preventive Care Services."
- "Reconstructive Surgery Services."
- "Rehabilitative Therapy Services."
- "Services Provided in Connection with Clinical Trials."
- "Telehealth Services."
- "Transplant Services." Note*:* These Services are available only under Tier 1.

Benefits for Inpatient Hospital Services

We cover the following inpatient hospital Services to the extent that they are generally and customarily provided by acute care general hospitals:

- Anesthesia.
- Blood, blood products, blood storage, and their administration, including the Services and supplies of a blood bank.
- Chemotherapy and radiation therapy Services.
- Dialysis Services.
- Drugs and radioactive materials used for therapeutic purposes, except for the types of drugs excluded under the "Limited Outpatient Prescription Drugs and Supplies" section.
- Durable Medical Equipment and medical supplies.
- Emergency detoxification.
- Gender Affirming Treatment.
- General and special nursing Services.
- Internally implanted devices, including bilateral cochlear implants and bone-anchored hearing aids, except for internally implanted insulin pumps, artificial hearts, and artificial larynx.
- Interrupted pregnancy surgery when performed in an inpatient setting.
- Laboratory, X-ray and other imaging, and special diagnostic procedures.
- Medical foods and formulas if Medically Necessary.
- Medical social Services and discharge planning.
- Operating and recovery rooms.
- Orthognathic surgery and supplies for treatment of temporomandibular joint (TMJ) disorder or injury, sleep apnea or congenital anomaly.
- Palliative care.
- Rehabilitative therapy Services such as physical, occupational, and speech therapy Services.
- Respiratory therapy.
- Select Physician's (for Tier 1), PPO Physician's (for Tier 2), or Non-Participating Physician's (for Tier 3) Services, including consultation and treatment by Specialists.
- Room and board, including a private room if Medically Necessary.
- Specialized care and critical care units.
- Temporomandibular joint (TMJ) disorder surgery for the treatment of TMJ disorders, subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.
- Vasectomy.

Additional Information about Certain Inpatient Services

When you are receiving covered inpatient Services in a Select Facility, a PPO Facility, or a Non-Participating Facility, we will cover inpatient physician Services you receive from radiologists, anesthesiologists, and pathologists under the same tier under which we are covering the facility Services, regardless of whether the physician is a Select Physician, a PPO Physician, or a Non-Participating Physician. For example, if you are receiving Tier 2 covered inpatient Services from a hospital that is a PPO Facility, we will cover the

radiologist's inpatient Services under Tier 2, even if that radiologist is a Non-Participating Physician. We will determine coverage for inpatient Services you receive from physicians other than radiologists, anesthesiologists, and pathologists based on whether the physician is a Select Physician, a PPO Physician, or a Non-Participating Physician. For example, if you receive inpatient physician Services in a PPO Facility from a surgeon who is a Non-Participating Physician, we will cover the PPO Facility Services under Tier 2 and the Non-Participating Physician Services under Tier 3.

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

- "Bariatric Surgery Services."
- "Chemical Dependency Services."
- "Dialysis Services."
- "Health Education Services."
- "Hospice Services."
- "Infertility Services."
- "Limited Dental Services."
- "Maternity and Newborn Care."
- "Mental Health Services."
- "Reconstructive Surgery Services."
- "Rehabilitative Therapy Services."
- "Skilled Nursing Facility Services."
- "Telehealth Services."
- "Transplant Services." Note*:* These Services are available only under Tier 1**.**

Ambulance Services

We cover licensed ambulance Services, subject to the additional provisions listed under "Tier 1" and Tier 3," only when all of the following are true:

- Your condition requires the use of medical Services that only a licensed ambulance can provide.
- A Select Physician, a PPO Physician, or a Non-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 provider or facility.

Tier 1

There are no additional changes to the benefit description in this "Ambulance Services" section.

Tier 3

We cover non-emergency ambulance Services under Tier 3 up to the benefit maximum shown in the "Benefit Summary" per Year. Your benefit maximum will be exhausted (used up) when the Allowed Amount for Services that we have covered under Tier 3 under this *EOC,* plus any non-emergency ambulance Services we

covered during the same Year under Tier 3 under any other evidence of coverage with the same group number printed on this *EOC,* less any Copayments or Coinsurance you paid for those Services, add up to the benefit maximum shown in the "Benefit Summary."

Bariatric Surgery Services

We cover bariatric surgery Services for clinically severe obesity under Tier 1 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.

Tier 1

There are no additional changes to the benefit description in this "Bariatric Surgery Services" section.

Tier 2 and Tier 3

We do not cover bariatric surgery Services under Tier 2 and Tier 3.

Chemical Dependency Services

We cover Chemical Dependency Services, subject to the additional provisions listed under "Tier 1" and "Tier 2 and Tier 3."

We cover these Services subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request Utilization Review criteria by calling Member Services. Inpatient and residential Services require prior authorization by Company. See the "Tier 1 Prior Authorization Review Requirements" and "Tier 2 and Tier 3 Prior Authorization Review Requirements" sections.

Coverage includes medical treatment for withdrawal symptoms. 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, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the inpatient facility.

Residential Services

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

Day Treatment Services

We cover day treatment Services in a day treatment program.

Tier 1

Coverage under Tier 1 for medical treatment for withdrawal symptoms includes methadone maintenance by referral.

Tier 2 and Tier 3

Coverage under Tier 2 and Tier 3 includes medical treatment for withdrawal symptoms, but it does not include methadone maintenance treatment.

Dialysis Services

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

We cover treatment at outpatient dialysis facilities. Outpatient dialysis treatment is considered a specialty office visit.

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 skilled nursing facility that is a Select Facility, the Services will be covered according to your inpatient hospital or skilled nursing facility benefit.

External Prosthetic Devices and Orthotic Devices

We cover External Prosthetic Devices and Orthotic Devices, subject to the additional provisions listed under "Tier 1" and "Tier 2 and Tier 3," 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:

- Compression garments for burns.
- Diabetic foot care appliances and therapeutic shoes and inserts to prevent and treat diabetes-related complications.
- External prostheses after a Medically Necessary mastectomy, including prostheses when Medically Necessary, and up to four brassieres required to hold a prosthesis every 12 months.
- Fitting and adjustments.
- Halo vests.
- Lymphedema wraps and garments.
- Maxillofacial prosthetic devices: coverage is limited to the least costly clinically appropriate treatment as determined by a Select Physician (for Tier 1) or a PPO Physician or a Non-Participating Physician (for Tier 2 and Tier 3). We cover maxillofacial prosthetic devices if they are necessary for restoration and management of head and facial structures that cannot be replaced with living tissue and are defective

because of disease, trauma, or birth and developmental deformities when this restoration and management are performed for the purpose of:

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

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

External Prosthetic Devices and Orthotic Devices Exclusions

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

Tier 1

We cover outpatient External Prosthetic Devices and Orthotic Devices under Tier 1 according to our DME formulary guidelines. We cover these Services subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

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

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

Tier 2 and Tier 3

Our DME formulary does not apply to Tier 2 and Tier 3.

Any single DME item with Charges (for Tier 2) or Allowed Amount (for Tier 3) over $500 requires prior authorization by Company.

Habilitative Services

We cover inpatient and outpatient habilitative Services subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request Utilization Review criteria by calling Member Services. See the "Tier 1 Prior Authorization Review Requirements" and "Tier 2 and Tier 3 Prior Authorization Review Requirements" sections.

Coverage includes the range of Medically Necessary Services or health care devices designed to help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical, occupational, and speech therapy, and other Services for people with disabilities, and that:

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

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

Habilitative Services Exclusions

- Daycare.
- Exercise programs for healthy individuals (unless Medically Necessary within an applied behavior analysis (ABA) treatment plan).
- Housing.
- Recreational activities (unless Medically Necessary within an applied behavior analysis (ABA) treatment plan).
- Respite care.
- Services and devices delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEA) requirements.
- Services solely for palliative purposes.
- Social services.
- Specialized job testing.

Health Education Services

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

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

- Tobacco use cessation. For the purposes of this *EOC*, tobacco use is defined as the use of tobacco on average four or more times per week within no longer than the past six months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco.

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

Hearing Aid Services for Dependents

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

Hearing Exam

We cover exams to determine the need for hearing correction. 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, including hearing assistive technology systems, when prescribed by a licensed provider and dispensed by a licensed hearing aid vendor, as shown in the "Benefit Summary" in accordance with state and federal law. For more information about hearing aid coverage, please contact Member Services.

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*.

Covered hearing aids are any non-disposable, 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 selection 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 Aid Services for Dependents" 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 Aid Services for Dependents Limitations

- Replacement ear molds are limited to four times per Year for Members seven years of age or younger and limited to once per Year for Members eight years of age or older.
- Replacement batteries are limited to one box per Year for each hearing aid.

Hearing Aid Services for Dependents Exclusions

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

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 Services are provided in lieu of Medically Necessary hospitalization.
- A 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 as described under "Tier 1 Prior Authorization Review Requirements" in the "How to Obtain Services under Tier 1" section and under "Tier 2 and Tier 3 Prior Authorization Review Requirements" in the "How to Obtain Services under Tier 2 and Tier 3" section.
- Services are provided through a licensed Home Health Agency.

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

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

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

Home Health Services Exclusions

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

Hospice Services

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

receive care to try to cure the terminal illness. You may change your decision to receive hospice Services at any time. You pay the Deductible, Copayment, or Coinsurance shown in the "Benefit Summary" under "Hospice Services."

We cover hospice Services, subject to the additional provisions listed under "Tier 1" and "Tier 2 and Tier 3," if all of the following requirements are met:

- A 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 and/or certified hospice agency.
- The Services are necessary for the palliation and management of your terminal illness and related conditions.

We cover the following hospice Services:

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

Tier 1

Under Tier 1, the hospice Services must be provided by a licensed hospice agency approved by Company.

Tier 2 and Tier 3

Under Tier 2 and Tier 3, the hospice Services must be provided by a state licensed and/or certified hospice agency, but there is no requirement that Company approve the agency that provides the Services.

Under Tier 2 and Tier 3, you must receive prior authorization by Company for hospice Services. (See "Tier 2 and Tier 3 Prior Authorization Review Requirements" section in the "How to Obtain Services under Tier 2 and Tier 3" section.)

Infertility Services

We cover the diagnosis of involuntary infertility. Infertility Services include diagnostic imaging and laboratory tests, limited to tests to rule out sexually transmitted diseases, hormone level tests, semen analysis, and diagnostic laparoscopy or hysteroscopy. This benefit includes diagnosis of both male and female infertility,

however Services are covered only for the person who is the Member. You may have additional coverage if your Group has purchased an "Infertility Treatment Services Rider."

Infertility Services Exclusions

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

Limited Dental Services

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

Covered Dental Services

We cover dental Services only as described below:

- Dental and orthodontic Services for the treatment of craniofacial anomalies if the Services are Medically Necessary to improve or restore function.
- Dental Services necessary for or resulting from medical treatment such as surgery on the jawbone and radiation treatment, limited to (a) emergency dental Services, or (b) extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.
- General anesthesia and associated hospital or ambulatory surgical facility Services in conjunction with non-covered dental Services when Medically Necessary if:
    - You have a medical condition that your Select Physician (for Tier 1), PPO Physician (for Tier 2), or Non-Participating Physician (for Tier 3) determines would place you at undue risk if the dental procedure were performed in a dental office; or
    - You are physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated 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 Deductible, Copayment, or Coinsurance you would pay if the Services were not related to a covered dental Service.

Limited Dental Services Exclusions

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

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

- Services to correct malocclusion.

Limited Outpatient Prescription Drugs and Supplies

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

Covered Drugs and Supplies

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

At Select Pharmacies and Select Facilities:

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

At MedImpact Pharmacies:

- The drug or supply is prescribed by a Select Provider or any other licensed provider (including a dentist). Over-the-counter contraceptive drugs, devices, and products approved by the FDA do not require a prescription in order to be covered.
- The law requires the drug or supply to bear the legend "Rx only," or the drug or supply is a covered non-prescription item, such as certain preventive medications or drugs or supplies prescribed for treatment of diabetes.
- You obtain the drug or supply at a MedImpact Pharmacy (including MedImpact Mail-Order).

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

- Certain preventive medications (including, but not limited to, aspirin, fluoride, liquid iron for infants, and tobacco use cessation drugs) according to, and as recommended by, the USPSTF, when obtained with a prescription order.
- Certain self-administered IV drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as IV or intraspinal-infusion) for up to a 30-day supply, including the supplies and equipment required for their administration.
- Drugs, injectables, and radioactive materials used for therapeutic or diagnostic purposes, if they are administered to you in a Select Facility (for Tier 1), a PPO Facility (for Tier 2), or a Non-Participating Facility (for Tier 3), or by a Select Provider (for Tier 1), a PPO Provider (for Tier 2), or a Non-Participating Provider (for Tier 3) during home visits. We cover these items upon payment of the administered medications Copayment or Coinsurance shown under "Outpatient Services" in the "Benefit Summary."

- FDA approved contraceptive drugs and devices including injectable contraceptives and internally implanted time-release contraceptive drugs, emergency contraceptives, and contraceptive devices such as intrauterine devices, diaphragms, and cervical caps. You may receive a three-month supply for a first dispensing of a contraceptive drug and a 12-month supply of a subsequent dispensing of the same contraceptive drug, unless you request a smaller supply. Over-the-counter contraceptive drugs, devices, and products, approved by the FDA, do not require a prescription in order to be covered.
- Glucagon emergency kits, insulin, ketone test strips for urine-testing, blood glucose test strips, and disposable needles and syringes when prescribed for the treatment of diabetes. We cover additional diabetic equipment and supplies, including lancets and injection aids, under the "Outpatient Durable Medical Equipment (DME)" section and the "External Prosthetic Devices and Orthotic Devices" section.
- Self-administered chemotherapy medications used for the treatment of cancer.

You may fill your prescriptions at a Select Pharmacy or a MedImpact Pharmacy. These limited drugs and supplies are available to you even if your Group has not purchased additional drug coverage. If your Group has purchased additional drug coverage, the limited drugs and supplies listed in this "Limited Outpatient Prescription Drugs and Supplies" section are not covered under it.

Day Supply Limit

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

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

How to Get Covered Drugs or Supplies

You may fill your prescriptions at a Select Pharmacy or a MedImpact Pharmacy, though our coverage (including limitations, exclusions, and Copayments or Coinsurance) will differ depending on which type of pharmacy you choose. A MedImpact Pharmacy is a pharmacy that contracts directly with MedImpact. You may contact Member Services for information on finding a MedImpact Pharmacy.

At Select Pharmacies

Select Pharmacies are located in many Select Facilities. To find a Select Pharmacy, please see your *Added Choice Medical Facilities Directory*, visit **kp.org/addedchoice/nw**, or contact Member Services.

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

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

At MedImpact Pharmacies

MedImpact Pharmacies are located across the United States. To find a location, or for information on the MedImpact Mail-Order, please contact Member Services.

About Our Drug Formulary (Select Pharmacies only)

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

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

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

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

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

If a provider other than a Select Provider prescribes a drug or supply that our drug formulary does not list for your condition, your options include:

- Asking a Select Pharmacy to contact your prescribing provider to see if your prescription can be changed to a drug or supply that our drug formulary lists for your condition.
- Making an appointment for a Select Provider to evaluate your medical condition. The Select Provider may prescribe a drug or supply that our drug formulary lists for your condition. If the Select Provider prescribes a drug or supply that our drug formulary does not list for your condition, he or she may request a formulary exception (see the "Drug Formulary Exception Process" section).
- Getting the drug or supply from a MedImpact Pharmacy.

Drug Formulary Exception Process

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

A Select Provider or any licensed dentist may request an exception if he or she determines that the non-formulary drug or supply is Medically Necessary. We will make a coverage determination within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests. We will approve the exception if all of the following requirements are met:

- We determine that the drug or supply meets all other coverage requirements except for the fact that our drug formulary does not list it for your condition.
- Medical Group or a designated physician makes the following determinations:

- The drug or supply is Medically Necessary because you are allergic to, or intolerant of, or have experienced treatment failure with, any alternative drugs or supplies that our formulary lists for your condition.
- Your condition meets any additional requirements that the Regional Formulary and Therapeutics Committee has approved for the drug or supply. For these drugs or supplies, the pharmacy can provide a copy of the additional criteria upon request. In some cases, there may be a short delay in filling your prescription while your information is being reviewed.

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

Limited Outpatient Prescription Drugs and Supplies Exclusions

- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.
- Drugs and supplies from the Mail-Order Pharmacy to addresses outside of Oregon or Washington.
- Drugs prescribed for an indication if the FDA has determined that use of that drug for that indication is contraindicated.
- Drugs prescribed for an indication if the FDA has not approved the drug for that indication, except that this exclusion does not apply if the Oregon Health Evidence Review Commission or our Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health and Human Services.
- Drugs and supplies that are available without a prescription, even if the non-prescription item is in a different form or different strength (or both), except that this exclusion does not apply to drugs or supplies that our drug formulary lists for your condition.
- Drugs, biological products, and devices that the U.S. Food and Drug Administration (FDA) has not approved.
- Drugs used to enhance athletic performance.
- Extemporaneously compounded drugs, unless the formulation is approved by our Regional Formulary and Therapeutics Committee.
- Injectable drugs that are self-administered (except insulin).
- Nutritional supplements.
- Replacement of drugs and supplies due to loss, damage, or carelessness.
- The following are excluded, but you may have coverage for them if your Group purchased an "Outpatient Prescription Drug Rider":
  - Prescription drugs and supplies that are dispensed on an outpatient basis, except those listed under "Covered Drugs and Supplies" of this "Limited Outpatient Prescription Drugs and Supplies" section.
  - Drugs for treatment of infertility.
  - Drugs and supplies to treat sexual dysfunction are excluded except for drugs that are FDA-approved to treat mental health symptoms of sexual dysfunction.
  - Drugs used in weight management.

Maternity and Newborn Care

We cover the following maternity and newborn care Services:

- Prenatal care visits and postpartum visits.
- Maternal diabetes management (Medically Necessary Services beginning with conception and ending through six weeks postpartum).
- Maternity hospital care for mother and baby, including Services for complications of pregnancy.
- Obstetrical care and delivery (including cesarean section).
- Newborn medical Services following birth and initial physical exam.
- Newborn PKU test.

We will not limit the length of a maternity hospital stay for a mother and baby to less than 48 hours for vaginal delivery and 96 hours for a cesarean section delivery. The length of inpatient stay is determined by an attending Select Physician (for Tier 1), PPO Physician (for Tier 2), or Non-Participating Physician (for Tier 3), in consultation with the mother. Our policy complies with the federal Newborns' and Mothers' Health Protection Act of 1996 (NMHPA).

Newborns are covered from the moment of birth for the first 31 days of life and are subject to their own Deductible, Copayment, and Coinsurance. In order for coverage to continue beyond this 31-day period, you must follow the rules for adding Dependents as described under "Adding New Dependents to an Existing Account" in the "When You Can Enroll and When Coverage Begins" section.

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

Medical Foods and Formula

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

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

Mental Health Services

We cover mental health Services as found in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by the American Psychiatric Association, including Medically Necessary applied behavior analysis (ABA) for autism spectrum disorder, and Medically Necessary treatment for pervasive developmental disorder (PDD), when they are necessary for:

- Crisis intervention.
- Evaluation.
- Treatment of mental disorders or chronic conditions that a mental health Select Provider (for Tier 1) or mental health PPO Provider or a mental health Non-Participating Provider (for Tier 2 and Tier 3) expects to result in objective, measurable improvement.

We cover mental health Services, subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request the criteria by calling Member Services. Some mental health Services require prior authorization by Company. See the "Tier 1 Prior Authorization Review Requirements" and "Tier 2 and Tier 3 Prior Authorization Review Requirements" sections.

We cover Select Provider, PPO Provider, or Non-Participating Provider Services under this "Mental Health Services" section only if they are provided by:

- A licensed psychiatrist.
- A licensed psychologist.
- An advanced practice psychiatric nurse.
- A certified nurse practitioner with a specialty in psychiatric mental health.
- A licensed clinical social worker.
- A certified clinical social work associate.
- A licensed mental health counselor.
- A licensed professional counselor.
- A licensed marriage and family therapist.
- A licensed behavioral analyst.
- A licensed assistant behavioral analyst or registered behavioral analyst interventionist.
- An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field.
- Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

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

Outpatient Services

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

Inpatient Hospital Services

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

Residential Services

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

Psychological Testing

If, in the professional judgment of a Select Provider (for Tier 1), or a PPO Provider or Non-Participating Provider (for Tier 2 and Tier 3), you require psychological testing as part of diagnostic evaluation, prescribed tests are covered in accord with this "Mental Health Services" section. We do not cover court-ordered testing or testing for ability, aptitude, intelligence, or interest unless Medically Necessary.

Tier 1

For Tier 1, there are no additional changes to the benefit description in this "Mental Health Services" section.

Tier 2 and Tier 3

We do not cover Assertive Community Treatment (ACT) Services under Tier 2 or Tier 3.

Outpatient Durable Medical Equipment (DME)

We cover outpatient Durable Medical Equipment (DME), subject to the additional provisions listed under "Tier 1" and "Tier 2 and Tier 3." 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 cover DME obtained from a Select Vendor (for Tier 1), a PPO Vendor (for Tier 2), or a Non-Participating Vendor (for Tier 3). Under Tier 2 and Tier 3, your PPO Provider or Non-Participating Provider must order your DME. Even if a PPO Provider or a Non-Participating Provider orders your DME, you may obtain covered DME from a Select Vendor and obtain a Tier 1 benefit, if the DME item ordered is in our formulary. If you want help, the Kaiser Permanente DME department will assist you in securing covered DME from a Select Vendor.

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

Covered DME includes the following:

- Bilirubin lights.
- CADD (continuous ambulatory drug delivery) pumps.
- Diabetic equipment and supplies including external insulin pumps, infusion devices, glucose monitors, lancets, and injection aids.
- Enteral pump and supplies.
- Osteogenic bone stimulators.
- Osteogenic spine stimulators.
- Oxygen and oxygen supplies.
- Ventilators.
- Wheelchairs.
- Wigs following chemotherapy or radiation therapy, limited to one synthetic wig per Year.

Outpatient Durable Medical Equipment (DME) Exclusions

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

Tier 1

We cover outpatient DME under Tier 1 according to our DME formulary guidelines. We cover these Services subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. 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 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 Member 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.

Our DME formulary guidelines allow certain DME (such as crutches and canes) for use in your home to be picked up from Select Providers.

Tier 2 and Tier 3

Our DME formulary does not apply to Tier 2 and Tier 3.

Any single DME item with Charges (for Tier 2) or Allowed Amount (for Tier 3) over $500 requires prior authorization by Company.

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

We cover outpatient Services for laboratory, X-ray, imaging, and special diagnostic procedures, subject to the additional provisions listed under "Tier 1" and "Tier 2 and Tier 3." Some Services, such as preventive screenings and routine mammograms, are not covered under this "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" benefit but may be covered under the "Preventive Care Services" section.

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 Select 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 Select Provider recommends it because you are at high risk for prostate cancer or disease.

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

Laboratory, X-ray, and Imaging

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

- Bone densitometry.

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

Special Diagnostic Procedures

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

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

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

Tier 1

If you choose to bring a PPO Provider's or a Non-Participating Provider's laboratory, X-ray, imaging, or special diagnostic procedure order to a Select Facility, the Services will be covered under the Tier 1 benefit and the Tier 1 Copayment or Coinsurance will apply.

Under Tier 1, women 40 years or older, who are seeking annual routine mammograms, may contact the Radiology Department directly to set up appointments.

Tier 2 and Tier 3

Under Tier 2 and Tier 3, you must receive prior authorization by Company for MRI, CT scans, PET scans, and bone density/DXA scans. (See "Tier 2 and Tier 3 Prior Authorization Review Requirements" section in the "How to Obtain Services under Tier 2 and Tier 3" section.)

Reconstructive Surgery Services

We cover inpatient and outpatient reconstructive surgery Services as indicated below, when prescribed by a Select Provider (for Tier 1) or a PPO Provider or a Non-Participating Provider (for Tier 2 and Tier 3). Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

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

With respect to maxillofacial prosthetic services, coverage is limited to the least costly clinically appropriate treatment as determined by a Select Provider (for Tier 1) or a PPO Provider or a Non-Participating Provider (for Tier 2 and Tier 3). We cover maxillofacial prosthetic Services if they are necessary for restoration and management of head and facial structures that cannot be replaced with living tissue and are defective because of disease, trauma, or birth and developmental deformities when this restoration and management are performed for the purpose of any of the following:

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

We also cover:

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

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

Rehabilitative Therapy Services

We cover inpatient and outpatient physical, occupational, and speech therapy Services when prescribed by a Select Provider (for Tier 1), a PPO Provider (for Tier 2), or a Non-Participating Provider (for Tier 3), subject to the benefit descriptions and limitations contained in this "Rehabilitative Therapy Services" section. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

Outpatient Rehabilitative Therapy Services

We cover outpatient rehabilitative therapy Services for the treatment of conditions which, in the judgment of a Select Provider (for Tier 1), a PPO Provider (for Tier 2), or a Non-Participating Provider (for Tier 3), will show sustainable, objective, measurable improvement as a result of the prescribed therapy. Prescribed outpatient therapy Services must receive prior authorization as described in the "Tier 1 Prior Authorization Review Requirements" and "Tier 2 and Tier 3 Prior Authorization Review Requirements" sections.

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

Outpatient Rehabilitative Therapy Services Limitations

- Physical therapy Services and occupational therapy Services are covered as Medically Necessary to restore or improve functional abilities when physical and/or sensory perceptual impairment exists due to injury, illness, stroke, or surgery.

- Speech therapy Services are covered as Medically Necessary for speech impairments of specific organic origin such as cleft palate, or when speech, language, or the swallowing function is lost due to injury, illness, stroke, or surgery.

Inpatient Rehabilitative Therapy Services

We cover inpatient rehabilitative therapy Services in an inpatient setting.

Inpatient rehabilitative therapy Services are covered for the treatment of conditions which, in the judgment of a Select Provider (for Tier 1), a PPO Provider (for Tier 2), or a Non-Participating Provider (for Tier 3) will show sustainable, objective, measurable improvement as a result of the prescribed therapy, and must receive prior authorization as described in the "Tier 1 Prior Authorization Review Requirements" and "Tier 2 and Tier 3 Prior Authorization Review Requirements" sections.

Rehabilitative Therapy Services Exclusions

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

Services Provided in Connection with Clinical Trials

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

- We would have covered the Services if they were not related to a clinical trial.
- You are eligible to participate in the clinical trial according to the trial protocol, as determined in one of the following ways:
  - A Select Provider (for Tier 1), PPO Provider (for Tier 2) or Non-Participating Provider (for Tier 3) makes this determination.
  - You provide us with medical and scientific information establishing this determination.
  - If any Select Providers (for Tier 1), PPO Providers (for Tier 2), or Non-Participating Providers (for Tier 3) 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 Select Provider (for Tier 1), PPO Provider (for Tier 2), or Non-Participating Provider (for Tier 3) 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 Deductible, Copayment, or Coinsurance you would pay if the Services were not related to a clinical trial. For example, see "Inpatient Hospital Services" in the "Benefit Summary" for the Deductible, Copayment, or Coinsurance that applies to hospital inpatient care.

Services Provided in Connection with Clinical Trials Exclusions

- The investigational Service.
- Services provided solely for data collection and analysis and that are not used in your direct clinical management.
- 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 skilled nursing facility, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the facility. The skilled inpatient Services must be those customarily provided by skilled nursing facilities.

We cover the following:

- Blood, blood products, blood storage, and their administration, including the Services and supplies of a blood bank.
- Dialysis Services.
- DME Services. (This benefit is subject to the benefit limitations described under "Outpatient Durable Medical Equipment (DME)" in this section.)
- Habilitative Services.
- Medical and biological supplies.
- Medical social Services.
- Nursing Services.
- Rehabilitative therapy Services.
- Room and board.

Skilled Nursing Facility Services Limitations

The "Benefit Summary" shows a day maximum for skilled nursing facility Services. That day maximum will be exhausted (used up) for a Year when the number of days that we covered during the Year under this *EOC,* plus any days we covered during the Year under any other evidence of coverage with the same group number

printed on this *EOC,* add up to the day maximum. After you reach the day maximum, we will not cover any more days for the remainder of the Year.

Tier 1

Under Tier 1, we cover drugs prescribed by a Select Provider, a PPO Provider, or a Non-Participating Provider as part of your plan of care in a Select Facility that is a skilled nursing facility, in accord with our drug formulary guidelines if they are administered to you by medical personnel in the Select Facility that is a skilled nursing facility. For information about our drug formulary guidelines, refer to the "Limited Outpatient Prescription Drugs and Supplies" section under "About Our Drug Formulary."

Tier 2 and Tier 3

Our drug formulary does not apply to Tier 2 or Tier 3.

Telehealth Services

Telehealth allows a Member, or person acting on the Member's behalf, to interact with a Select Provider (for Tier 1), PPO Provider (for Tier 2), or Non-Participating Provider (for Tier 3) who is not physically at the same location.

We cover telehealth Services when all of the following are true:

- The Service is otherwise covered under this *EOC.*
- The Service is determined by a Select Provider (for Tier 1), PPO Provider (for Tier 2), or Non-Participating Provider (for Tier 3) to be Medically Necessary.
- Medical Group determines the Service may be safely and effectively provided using telehealth, according to generally accepted health care practices and standards.

Telemedical Services

Telemedical Services are Services provided via synchronous two-way interactive video conferencing by a Select Provider (for Tier 1), PPO Provider (for Tier 2), or Non-Participating Provider (for Tier 3). Telephone calls and communication by facsimile machine, electronic mail, or other electronic messaging systems that do not include remote visual contact between the provider and Member, are not considered telemedical Services.

Telephone Services

We cover scheduled telephone visits with a Select Provider (for Tier 1), PPO Provider (for Tier 2), or Non-Participating Provider (for Tier 3).

Tier 1 and Tier 2

We cover telehealth Services at no Charge under Tier 1 and Tier 2.

Tier 3

We cover telehealth Services at the Tier 3 Deductible, Copayment, or Coinsurance that would apply if the Service had been provided in person.

Transplant Services

We cover the listed transplants in this "Transplant Services" section only under Tier 1, only at National Transplant Network facilities, and only if you meet Utilization Review criteria developed by Medical Group and approved by Company. You pay the Deductible and Copayment or Coinsurance you would pay if the Services were not related to a transplant. For Services we provide (or pay for) for actual or potential donors, there is no Charge.

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

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

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

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

Transplant Services Limitations

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

- If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made.
- Company, Select Facilities, Medical Group, and Select Providers are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor.
- We provide or pay for certain donation-related Services for a donor, or an individual identified by Medical Group as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. Our criteria for coverage of Services for living transplant donors are available by calling Member Services.
- If we refer you for or preauthorize transplant Services at a distant location (farther away than the normal community patterns of care) and you choose to obtain your transplant at this distant location, we cover appropriate travel and lodging expenses for you and a caregiver. Your transplant coordinator can provide information about covered expenses.

Transplant Services Exclusions

- Non-human and artificial organs and tissues, and their implantation.

Tier 1

For Tier 1, there are no additional changes to the benefit description in this "Transplant Services" section.

Tier 2 and Tier 3

We do not cover transplant Services under Tier 2 or Tier 3.

EXCLUSIONS AND LIMITATIONS

Exclusions and Limitations that Apply to All Three Tiers

The Services listed below are either completely excluded from coverage or partially limited under this *EOC* for all three tiers. These exclusions and limitations apply to all Services that would otherwise be covered under this *EOC*. Additional exclusions and limitations that apply only to Tier 2 or Tier 3 are listed under "Exclusions and Limitations that Apply Only to Tier 2 and Tier 3" in the "Exclusions and Limitations" section. Additional exclusions and limitations that apply only to a particular Service are listed in the description of that Service in this *EOC*.

Acupuncture. Services for acupuncture are limited to the following: (a) when a Select Physician makes a referral for the Services in accordance with Medical Group criteria, and are subject to benefit limitations (if any) as shown in the "Benefit Summary;" or (b) your employer Group has purchased an "Alternative Care Services Rider" that includes coverage for self-referred acupuncture Services.

Certain Exams and Services. Physical examinations and other Services are excluded when: (a) required for obtaining or maintaining employment or participation in employee programs, (b) required for insurance or governmental licensing, or (c) on a court order or required for parole or probation. This exclusion does not apply to Medically Necessary court-ordered Services that are covered under "Chemical Dependency Services" or "Mental Health Services" in the "Benefits" section.

Chiropractic Services. Chiropractic and related Services are limited to the following: (a) when a Select Physician makes a referral for Services in accord with Medical Group criteria; or (b) your employer group has purchased an "Alternative Care Services Rider" that includes coverage for self-referred chiropractic Services.

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

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

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

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

Employer Responsibility. For any Services that the law requires an employer to provide, we will not pay the employer, and when we cover any of these Services we may recover the Charges for the Services from the employer.

Experimental or Investigational Services. Services are experimental or investigational if any of the following is true:

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

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

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

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

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

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

Government Agency Responsibility. For any Services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any of these Services we may recover the Charges for the Services from the government agency. This exclusion does not apply to Medicaid.

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

Hypnotherapy. All Services related to hypnotherapy.

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

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

Massage Therapy Services. Massage therapy and related Services are limited to the following: (a) when a Select Physician makes a referral for the Services in accordance with Medical Group criteria; or (b) when your employer group has purchased an "Alternative Care Services Rider" that includes coverage for self-referred massage therapy Services.

Naturopathy Services. Naturopathy and related Services are limited to the following: (a) when a Select Physician makes a referral for the Services in accordance with Medical Group criteria; or (b) when your employer group has purchased an "Alternative Care Services Rider" that includes coverage for self-referred naturopathy Services.

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

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

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

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

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

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

- Academic coaching or tutoring for skills such as grammar, math, and time management.
- Aquatic therapy and other water therapy.
- Educational testing.
- Items and services that increase academic knowledge or skills.
- Professional growth courses.
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning.
- Teaching and support services to increase intelligence.

- Teaching art, dance, horse riding, music, play or swimming.
- Teaching manners and etiquette.
- Teaching skills for employment or vocational purposes.
- Teaching you how to read, whether or not you have dyslexia.
- Training for a specific job or employment counseling.
- Vocational training or teaching vocational skills.

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

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

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

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

Exclusions and Limitations that Apply Only to Tier 2 and Tier 3

The Services listed below are either completely excluded from coverage or partially limited under this *EOC* for Tier 2 and Tier 3. These exclusions and limitations apply to all Services that would otherwise be covered under this *EOC*. Additional exclusions and limitations that apply only to a particular Service are listed in the description of that Service in this *EOC*.

Transplants and transplant Services. (See "Transplant Services" in the "Benefits" section for your Tier 1 benefit.)

Weight Control or Obesity Services. Bariatric surgery, gastric stapling, gastric bypass, gastric bands, switch duodenal, biliopancreatic diversion, weight loss programs, and any other Service for obesity or weight control, even if one of the purposes of the Services are to treat other medical conditions related to, caused by, or complicated by obesity are excluded (see "Bariatric Surgery Services" in the "Benefits" section for your Tier 1 benefit). This exclusion does not apply to Services that are covered under "Preventive Care Services" in the "Benefits" section.

REDUCTIONS

Reductions that Apply to All Three Tiers

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

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

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

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

C. The order of benefit determination rules 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:

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

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

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

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

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

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

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

1. The Plan covering the Custodial parent;
2. The Plan covering the spouse of the Custodial parent;
3. The Plan covering the non-custodial parent; and then
4. The Plan covering the spouse of the non-custodial parent.

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

(d) For a dependent child:

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

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

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

order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

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

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

Effect on the Benefits of This Plan

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we 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 ensure we are reimbursed for covered Services that you receive for the injury or illness, except that we will not collect 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 Deductible, Copayment, or Coinsurance payments for these covered Services.

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

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

To secure our rights, we will have a lien on the proceeds of any judgment or settlement you or we (when we subrogate) obtain against a third party, 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.

Surrogacy Arrangements

If you enter into a Surrogacy Arrangement, you must ensure we are reimbursed for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services"), except that the amount we collect will not exceed the payments or other compensation you and any other payee are entitled to receive under the Surrogacy Arrangement. A "Surrogacy Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Note: This "Surrogacy Arrangements" section does not affect your obligation to pay your Deductible, Copayment, Coinsurance, or other amounts you are required to pay for these Services. After you surrender a baby to the legal parents, you are not obligated to pay Charges for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

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

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

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

You must send this information to:

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

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

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

Workers' Compensation or Employer's Liability

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

In addition, we or Select Providers or PPO Providers may seek reimbursement for the Services directly from the responsible employer or the government agency that administers this 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, we will include a notice of language assistance (oral translation). You may request language assistance with your claim and/or appeal by calling 1-800-813-2000. The notice of language assistance "Help in your Language" is also included in this *EOC*.

Appointing a Representative

If you would like someone to act on your behalf regarding your claim, you may appoint an authorized representative, an individual who by law or by your consent may act on your behalf. You must make this appointment in writing. Please contact Member 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 file a complaint or seek other assistance from the Consumer Advocacy Section of the Division of Financial Regulation. Contact them by mail, e-mail, telephone, fax, or online at:

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

Reviewing Information Regarding Your Claim

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

Providing Additional Information Regarding Your Claim

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

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

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

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

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

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

Sharing Additional Information That We Collect

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

Internal Claims and Appeals Procedures

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

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

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

Pre-service Claims and Appeals

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

post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call Member Services 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 mail or fax your claim to us at:

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

  - If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life or health (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 the oral notification.

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

Non-Urgent Pre-service Appeal

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

  (1) Your name and health record number;

  (2) Your medical condition or relevant symptoms;

  (3) The specific Service that you are requesting;

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

  (5) All supporting documents.

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

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

- We will acknowledge your appeal in writing within 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 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: 1-855-347-7239
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 the oral notification.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, which may be available to you.

Concurrent Care Claims and Appeals

Concurrent care claims are requests that Company continues to provide, or pay for, an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. If you have any general questions about concurrent care claims or appeals, please call Member Services at 1-800-813-2000.

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

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

Concurrent Care Claim

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

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239
  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 care claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your claim. If we notify you of our decision orally, we will send you written confirmation within three days after the oral notification.

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

Non-Urgent Concurrent Care Appeal

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

  (1) Your name and health record number;

  (2) Your medical condition or relevant symptoms;

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

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

  (5) All supporting documents.

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

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

- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision as soon as possible if your care has not ended but 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: 1-855-347-7239
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 the oral notification.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review that may be available to you.

Post-service Claims and Appeals

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

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

Post-service Claim

- Within 12 months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following:

  (1) The date you received the Services;

  (2) Where you received them;

  (3) Who provided them;

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

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

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

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

  We will not accept or pay for claims received from you after 12 months from the date of Services, except in the absence of legal capacity.

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

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

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

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

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

  If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.
- If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Post-service Appeal

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

  (1) Your name and health record number;

  (2) Your medical condition or relevant symptoms;

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

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

  (5) All supporting documents.

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

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239
- We will acknowledge your appeal in writing within 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 Select 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: 1-855-347-7239

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 provider or another member of your health care team. If you are not satisfied with your provider, you may request another. Contact Member Services for assistance. You always have the right to a second opinion from a qualified provider at the applicable 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 facility where you are having the problem.
- Calling Member 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: 1-855-347-7239

All complaints are handled in a confidential manner.

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

- A representative reviews the complaint and conducts an investigation, verifying all the relevant facts.
- The representative or a physician evaluates the facts and makes a recommendation for corrective action, if any.
- When you file a complaint, we will respond within 30 calendar days, unless additional information is required.

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

TERMINATION OF *AGREEMENT*

If the *Agreement* terminates and Group does not replace this coverage with another Plan, Company will give Group written notice of termination not later than 10 working days after the termination date and will explain the rights of Members regarding continuation of coverage as provided by federal and state law.

TERMINATION OF MEMBERSHIP

If your membership terminates, all rights to benefits end at 11:59 p.m. 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, Select Providers, Select Facilities, PPO Providers, and PPO Facilities have no further liability or responsibility under this *EOC* after your membership terminates except as provided under "Termination during Confinement in a Hospital" in this "Termination of Membership" section.

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 Deductibles, 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 loss of eligibility due to divorce or a Dependent child who has reached the Dependent Limiting Age. If you no longer meet the eligibility requirements described in this *EOC*, please confirm with your Group's benefits administrator when your membership will end.

Termination for Cause

If you or any other Member in your Family knowingly commits fraud in connection with membership, Company, or a Select Provider, we may terminate your membership under this employer's *Agreement* by sending written notice, including the specific reason for termination with supporting evidence to the Subscriber at least 31 days before the membership termination date. Some examples of fraud include:

- Misrepresenting eligibility information about yourself or a Dependent.
- Presenting an invalid prescription or physician order for Services.

- Intentionally misusing a Company ID card (or letting someone else use your ID card to obtain Services pretending to be you).
- Giving us incorrect or incomplete material information.
- Failing to notify us of changes in Family status or Medicare coverage that may affect your eligibility or benefits.

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

If we terminate your membership for cause we will:

- Refund any amounts we owe your Group for Premium paid for the period after the termination date.
- Pay you any amounts we have determined that we owe you for claims during your membership.
- We may deduct any amounts you owe Company, Select Providers, or Select Facilities from any payment we make to you.

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

Termination of Your Group's *Agreement* with Us

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

Termination of Certain Types of Health Benefit Plans by Us

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

CONTINUATION OF MEMBERSHIP

Strike, Lock-Out, or Other Labor Disputes

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

Illness, Temporary Plant Shut Down, or Leave of Absence

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

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

You may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. COBRA applies to most employees (and most of their

covered dependents) of most employers with 20 or more employees (however, it does not apply to church plans as defined by federal law). Please contact your Group for details about COBRA continuation coverage, such as how to elect coverage and how much you must pay your Group for the coverage.

Federal or State-Mandated Continuation of Coverage

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

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

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

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

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

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

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

State Continuation Coverage for Non-COBRA Groups

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

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

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

- You are not eligible for Medicare, and you are not eligible for coverage under any other hospital or medical coverage or program that was not covering you on the day before the qualifying event.
- To request continuation coverage under this "State Continuation Coverage for Non-COBRA Groups" section, you must send us a written request for this continuation coverage no later than 15 days after the later of the following:
  - The date of your qualifying event.
  - The date on which we sent you notice of your right to continue coverage under this *EOC*.

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

Consolidated Service Center (CSC)
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 Member Services if you have questions.

Moving to Another Kaiser Foundation Health Plan Service Area

If you move to another Kaiser Foundation Health Plan service area, you should contact your Group's benefits administrator to learn about your Group health care options. You may be 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 Plan

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

Plan 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 Plan

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

Annual Summaries and Additional Information

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

- Our annual summary of grievances and appeals.
- Our annual summary of the utilization management program.
- Our annual summary of quality assurance activities.

- The results of publicly available accreditation surveys of our health plan.
- Our annual summary of health-promotion and disease-prevention activities.
- An annual summary of scope of network and accessibility of Services.

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

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

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *EOC*. In the absence of fraud, all statements made by an applicant, Group, or Subscriber shall be deemed representations and not warranties. No statement made for the purpose of effecting coverage shall void coverage or reduce benefits unless contained in a written instrument signed by the Group or Subscriber, a copy of which has been furnished to the Group or Subscriber.

Assignment

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

Attorney Fees and Expenses

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

Compensation of Providers and Facilities

Select Providers, Select Facilities, PPO Providers, and PPO 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 Select Providers, Select Facilities, PPO Providers, and PPO Facilities only for the professional Services they deliver, and not for Services provided by other physicians, hospitals, or facilities. We pay Non-Participating Providers and Non-Participating Facilities the Allowed Amount for their Services. Please call Member Services if you would like to learn more about the ways providers and facilities are paid to provide or arrange medical and hospital Services for Members.

Our contracts with Select Providers, Select Facilities, PPO Providers, and PPO Facilities provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services that you receive from a Select Provider, Select Facility, PPO Provider, PPO Facility, Non-Participating Provider, or Non-Participating Facility. You will also be liable for the cost of Services that you receive without required authorization.

Exercise of Conscience

We recognize the rights to exercise religious beliefs and conscience. If a provider or facility declines to provide a covered Service for reasons of conscience or religion, contact Member Services and we will direct you to another provider or facility.

Governing Law

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

Group and Members not Company Agents

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

Information about New Technology

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

No Waiver

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

Nondiscrimination

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

Notices

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

Overpayment Recovery

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

Privacy Practices

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

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

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

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

Unusual Circumstances

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 Select Facility or at a PPO Facility, complete or partial destruction of facilities, and labor disputes. However, in these circumstances, neither we nor any Select Provider, Select Facility, PPO Provider, or PPO 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 Kaiser Permanente, we may postpone non-Emergency Services until after resolution of the labor dispute.

NONDISCRIMINATION STATEMENT AND NOTICE OF LANGUAGE ASSISTANCE

Nondiscrimination Notice

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

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

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

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

Member Relations Department
Attention: Kaiser Civil Rights Coordinator

500 NE Multnomah St. Ste 100
Portland, OR 97232-2099
Phone: 1-800-813-2000

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

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

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

Help in Your Language

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-800-813-2000** (TTY: **711**).
Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-813-2000** (TTY: **711**).

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST ALTERNATIVE CARE SERVICES RIDER

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

General Benefit Requirements

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

- Services are received from Select Providers, PPO Providers, or Non-Participating Providers and provided as outpatient Services in the provider's office.
- You are required to pay the Copayment or Coinsurance amount to the provider at the time of service.
- You are responsible for Charges in excess of the Allowed Amount if you receive Services from a Non-Participating Provider.
- You are responsible for paying the full amount for Services after you reach your benefit maximum as shown in the "Alternative Care Services Rider Benefit Summary."

Definitions

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

- **The CHP Group.** A network of Alternative Care providers who provide Select 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.** Alternative Care Services provided by a provider that are within scope of license, are determined to be Medically Necessary and are not specifically limited or excluded by this rider.
- **Non-Participating Provider.** An Alternative Care provider who is not a Select Provider or PPO Provider.
- **PPO Provider. Any** person who participates in First Choice Health Network and who is:
  - Regulated under state law, to practice health or health-related services or otherwise practicing health care services consistent with state law, or
  - An employee or agent of any persons previously described in this definition, acting in the course and scope of his or her employment.

  A list of PPO Providers can be obtained by contacting Member Services or by visiting **http://www.kp.org/addedchoice/nw**.
- **Select Provider.** An individual who is under contract with Company, Medical Group, or The CHP Group to provide Covered Alternative Care Services to Members. A list of Select Providers can be obtained by contacting Member Services or by visiting **http://www.chpgroup.com**.

Alternative Care Services

We cover the self-referred Alternative Care Services described in this "Alternative Care Services Rider." These benefits are subject to visit limits and applicable Copayment or Coinsurance shown in the "Alternative Care Services Rider Benefit Summary." Visit limits are combined across all tiers.

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.

The "Acupuncture" exclusion in the *EOC* "Exclusions and Limitations" section does not apply to Services we cover under this rider.

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*.

The "Chiropractic Services" exclusion in the *EOC* "Exclusions and Limitations" section does not apply to Services we cover under this rider.

Massage Therapy

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. Covered Services include evaluation and management.

The "Massage Therapy Services" exclusion in the *EOC* "Exclusions and Limitations" section does not apply to Services we cover under this rider.

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*.

The "Naturopathy Services" exclusion in the *EOC* "Exclusions and Limitations" section does not apply to Services we cover under this rider.

Alternative Care Services Exclusions

- Acupressure.
- Behavioral training and modification, including but not limited to biofeedback, hypnotherapy, play therapy, and sleep therapy.
- Charges incurred as a result of missed appointment or an appointment not canceled.
- 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 joint (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.
- Environmental enhancements, modifications to dwellings, property or motor vehicles, adaptive equipment, personal lodgings, travel expenses, meals.
- Expenses incurred for any Services provided before coverage begins or after coverage ends.
- 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 tolerance 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.
- 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.
- 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.
- Transportation Services, including ambulances and care cars.
- Treatment for purposes of obesity or weight control, to include any weight control supplies or products.
- Vocational rehabilitation.
- X-ray documentation and/or interpretation when prescribed by an acupuncturist or naturopath.

Alternative Care Services Rider Benefit Summary

	Tier 1	Tier 2	Tier 3
	Select Providers	**PPO Providers**	**Non-Participating Providers**
Benefit Maximum per Year all Covered Services combined	$1,500		
	You Pay		
Acupuncture Services	$25 per visit	$25 per visit	$25 per visit
Chiropractic Services	$25 per visit	$25 per visit	$25 per visit
Massage Therapy (up to 12 visits per Year)	$25 per visit	$25 per visit	$25 per visit
Naturopathic Medicine	$25 per visit	$25 per visit	$25 per visit

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST OUTPATIENT PRESCRIPTION DRUG RIDER (Including MedImpact Pharmacies)

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

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

Covered Drugs and Supplies

We cover outpatient prescription drugs and supplies as described in this "Outpatient Prescription Drug Rider," and only if all of the following conditions are met. You may fill your prescriptions at a Select Pharmacy or a MedImpact Pharmacy.

At Select Pharmacies and Select Facilities

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

At MedImpact Pharmacies

- The drug or supply is prescribed by a Select Provider or any other licensed provider (including a dentist).
- The law requires the drug or supply to bear the legend "Rx only," or the drug or supply is a covered non-prescription item, such as certain preventive medications or drugs or supplies prescribed for the treatment of diabetes.
- You obtain the drug or supply at a MedImpact Pharmacy (including MedImpact Mail-Order).

Copayments and Coinsurance for Covered Drugs and Supplies

At Select Pharmacies and Select Facilities

When you get a prescription from a Select Pharmacy or Select Facility, or order a prescription from our Mail-Order Pharmacy, you pay the Copayment or Coinsurance as shown in the "Outpatient Prescription Drug

Rider Benefit Summary." This applies for each prescription consisting of up to the day supply shown in the "Outpatient Prescription Drug Rider Benefit Summary."

Outpatient prescription drugs and supplies are subject to Copayment or Coinsurance until the Tier 1 medical Out-of-Pocket Maximum is met.

At a Select Pharmacy, if Charges for a covered drug or supply are less than your Copayment or Coinsurance, you pay the lesser amount.

At MedImpact Pharmacies

When you get a prescription from a MedImpact Pharmacy or order a prescription from MedImpact Mail-Order, you pay the Copayment or Coinsurance as shown in the "Outpatient Prescription Drug Rider Benefit Summary." This applies for each prescription consisting of up to the day supply shown in the "Outpatient Prescription Drug Rider Benefit Summary."

Outpatient prescription drugs and supplies are subject to Copayment or Coinsurance until the Tier 1 medical Out-of-Pocket Maximum is met.

At a MedImpact Pharmacy, if the retail price or contracted price of a covered drug or supply is less than your Copayment or Coinsurance, you pay the lesser amount. If a generic equivalent is available and you or your prescribing provider choose a Preferred or Non-Preferred Brand-Name Drug or supply, you pay the difference between the pharmacy's retail prices for the Preferred Brand-Name or Non-Preferred Brand-Name Drug or supply and the Generic Drug or supply, in addition to the Preferred Brand-Name or Non-Preferred Brand-Name Drug Copayment or Coinsurance.

Day Supply Limit

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

Medication Synchronization

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

How to Get Covered Drugs or Supplies

You may fill your prescriptions at a Select Pharmacy or a MedImpact Pharmacy, though our coverage (including limitations, exclusions, and Copayments or Coinsurance) will differ depending on which type of pharmacy you choose. A MedImpact Pharmacy is a pharmacy that contracts directly with MedImpact. You may contact Member Services for information on finding a MedImpact Pharmacy.

At Select Pharmacies

Select Pharmacies are located in many Select Facilities. To find a Select Pharmacy, please see your *Added Choice Medical Facilities Directory*, visit **kp.org/addedchoice/nw**, or contact Member Services.

Select Pharmacies include our Mail-Order Pharmacy. This pharmacy offers postage-paid delivery to addresses in Oregon and Washington. Some drugs and supplies are not available through our Mail-Order Pharmacy, for

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

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

At MedImpact Pharmacies

MedImpact Pharmacies are located across the United States. To find a location, or for information on the MedImpact Mail-Order, please contact Member Services.

Definitions

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

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

About Our Drug Formulary (Select Pharmacies only)

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

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

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

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

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

To see if a drug or supply is on our drug formulary, or to find out what drug tier the drug is in, go online to **kp.org/formulary**. You may also call our Formulary Application Services Team (FAST) at 503-261-7900 or toll free at 1-888-572-7231. If you would like a copy of our drug formulary or additional information about

the formulary process, please call Member Services. The presence of a drug on our drug formulary does not necessarily mean that your provider will prescribe it for a particular medical condition.

If a provider other than a Select Provider prescribes a drug or supply that our drug formulary does not list for your condition, your options include:

- Asking a Select Pharmacy to contact your prescribing provider to see if your prescription can be changed to a drug or supply that our drug formulary lists for your condition.
- Making an appointment for a Select Provider to evaluate your medical condition. The Select Provider may prescribe a drug or supply that our drug formulary lists for your condition. If the Select Provider prescribes a drug or supply that our drug formulary does not list for your condition, he or she may request a formulary exception (see the "Drug Formulary Exception Process" section).
- Getting the drug or supply from a MedImpact Pharmacy.

Drug Formulary Exception Process

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

A Select Provider or any licensed dentist may request an exception if he or she determines that the non-formulary drug or supply is Medically Necessary. We will make a coverage determination within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests.

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

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

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

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

Prior Authorization and Step Therapy Prescribing Criteria

Prior authorization is required when you are prescribed certain drugs or supplies before they can be covered. A prescribing provider may request prior authorization if he or she determines that the drug or supply is Medically Necessary. Prescribing providers must supply to Company the medical information necessary for Company to make the prior authorization determination. Coverage for a prescribed drug or supply that is approved for prior authorization begins on the date Company approves the request.

A list of those drugs and supplies that require prior authorization is available online at **kp.org/addedchoice/nw** or you may contact Member Services at 1-866-616-0047.

We apply step therapy prescribing criteria, developed by Medical Group and approved by Company, to certain drugs and supplies. The step therapy prescribing criteria require that you try a therapeutically similar drug (step 1) for a specified length of time before we will cover another drug (step 2) prescribed for the same condition. A list of drugs and supplies subject to step therapy prescribing criteria, and the requirements for moving to the next step drug, is available online at **kp.org/addedchoice/nw** or you may contact Member Services at 1-866-616-0047.

Prior Authorization Exception Process

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

Your prescribing provider may request an exception if he or she determines that the drug or supply is Medically Necessary. Prescribing providers must supply to the Select Pharmacy or the MedImpact Pharmacy the medical information necessary to review the request for exception. A coverage determination will be made within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests.

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

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

Emergency Fill

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

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

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

Your Prescription Drug Rights

You have the right to safe and effective pharmacy Services. You also have the right to know what drugs are covered under this Plan and the limits that apply. If you have a question or a concern about your prescription drug benefits, please contact Member Services at 1-866-616-0047 or visit us online at **kp.org**.

Medication Management Program

We have a Medication Management Program. The program's primary focus is on reducing cardiovascular risk, especially by controlling lipid levels and high blood pressure. Select Providers, including pharmacists, nurse

care managers and other staff work with Members to educate, and monitor and adjust medication doses. There is no extra Copayment or Coinsurance for the Medication Management Program.

Outpatient Prescription Drug Rider Limitations

- If your prescription allows refills, there are limits to how early you can receive a refill. Your prescription will be refilled 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 pharmacy may reduce the day supply dispensed at the Copayment or Coinsurance to a 30-day supply in any 30-day period if it determines that the drug or supply is in limited supply in the market or for certain other items. Your pharmacy can tell you if a drug or supply you use is one of these items.

Outpatient Prescription Drug Rider Limitations (Select Pharmacies only)

- For certain drugs or supplies we may limit the amount of a drug or supply that is covered for a specified time frame. Quantity limits are in place to ensure safe and appropriate use of a drug or supply. Drugs and supplies subject to quantity limits are indicated on our drug formulary, available at **kp.org/formulary**. You may also contact Member Services at 1-866-616-0047 for more information.

Outpatient Prescription Drug Rider Exclusions (Select Pharmacies only)

- Drugs and supplies ordered from the Mail-Order Pharmacy to addresses outside of Oregon or Washington.
- Non-formulary drugs that have not been approved (refer to the "Drug Formulary Exception Process").

Outpatient Prescription Drug Rider Exclusions

- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.
- Brand-Name Drugs for which a Generic Drug is available, unless approved. Refer to the "Prior Authorization and Step Therapy Prescribing Criteria" section.
- Drugs prescribed for an indication if the 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 and supplies that are available without a prescription, even if the nonprescription item is in a different form or different strength (or both), except that this exclusion does not apply to nonprescription drugs or supplies listed under "Covered Drugs and Supplies" in this rider if either of the following requirements is met:
  - You get them from a MedImpact Pharmacy.
  - You get them from a Select Pharmacy, and they are listed for your condition on our drug formulary.
- Drugs, biological products, and devices that the FDA has not approved.
- Drugs used for the treatment of infertility.
- Drugs and supplies to treat sexual dysfunction are excluded except for drugs that are FDA-approved to treat mental health symptoms of sexual dysfunction.

- Drugs used in weight management.
- Drugs used to enhance athletic performance.
- Extemporaneously compounded drugs, unless the formulation is approved by our Regional Formulary and Therapeutics Committee.
- Internally implanted time-release drugs, except that internally implanted time-release contraceptive drugs are covered.
- Nutritional supplements.
- Outpatient drugs that require special handling, refrigeration, or high cost drugs are not provided through the Mail-Order Pharmacy.
- Outpatient drugs that require professional administration by medical personnel or observation by medical personnel during self-administration (refer instead to the "Limited Outpatient Prescription Drugs and Supplies" section).
- Replacement of drugs and supplies due to loss, damage, or carelessness.

Outpatient Prescription Drug Rider Benefit Summary

Outpatient Prescription Drugs and Supplies	**Select Pharmacies You Pay**
Generic Drugs	$20 for up to a 30-day supply
Generic Drugs from our Mail-Order Pharmacy	$20 for up to a 30-day supply $40 for a 31- to 90-day supply
Preferred Brand-Name Drugs or supplies	$40 for up to a 30-day supply
Preferred Brand-Name Drugs or supplies from our Mail-Order Pharmacy	$40 for up to a 30-day supply $80 for a 31- to 90-day supply
Non-Preferred Brand-Name Drugs or supplies	$60 for up to a 30-day supply
Non-Preferred Brand-Name Drugs or supplies from our Mail-Order Pharmacy	$60 for up to a 30-day supply $120 for a 31- to 90-day supply
Self-administered chemotherapy medications used for the treatment of cancer	20% Coinsurance or subject to the applicable prescription drug tier Copayment or Coinsurance, whichever is less

Outpatient Prescription Drugs and Supplies	**MedImpact Pharmacies You Pay**
Generic Drugs from a MedImpact Pharmacy	$20 for up to a 30-day supply
Generic Drugs from MedImpact Mail-Order	$20 for up to a 30-day supply $40 for a 31- to 60-day supply $60 for a 61- to 90-day supply
Preferred Brand-Name Drugs or supplies from a MedImpact Pharmacy	$40 for up to a 30-day supply

Outpatient Prescription Drugs and Supplies	MedImpact Pharmacies You Pay
Preferred Brand-Name Drugs or supplies from MedImpact Mail-Order	$40 for up to a 30-day supply $80 for a 31- to 60-day supply $120 for a 61- to 90-day supply
Non-Preferred Brand-Name Drugs or supplies from a MedImpact Pharmacy	$60 for up to a 30-day supply
Non-Preferred Brand-Name Drugs or supplies from MedImpact Mail-Order	$60 for up to a 30-day supply $120 for a 31- to 60-day supply $180 for a 61- to 90-day supply
Self-administered chemotherapy medications used for the treatment of cancer	20% Coinsurance or subject to the applicable prescription drug tier Copayment or Coinsurance, whichever is less

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 years and older. Vision Services for Members under age 19 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 prescription eyeglass lenses and a frame, or prescription contact lenses, including Medically Necessary 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 previously covered a lens, frame, or contact lens under this rider (but not counting any that we covered under "Eyeglasses and Contact Lenses after Cataract Surgery") within the same benefit period shown in the "Adult Vision Hardware and Optical Services Rider Benefit Summary." The date we cover any of these items is the date on which you order the item.

Medically Necessary Contact Lenses

Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of the following conditions:

- Keratoconus.
- Pathological myopia.
- Aphakia.
- Anisometropia.
- Aniseikonia.
- Aniridia.
- Corneal disorders.
- Post-traumatic disorders.
- Irregular astigmatism.

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

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 without charge. 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:

- One conventional contact lens, or up to a 6-month supply of disposable contact lenses, 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.
- Optometric vision therapy and orthoptics (eye exercises).
- Plano contact lenses or glasses (non-prescription).
- Professional services for evaluation, fitting and follow-up care for contact lenses, except that this exclusion does not apply to contact lenses we cover under "Medically Necessary Contact Lenses" or "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.

Adult Vision Hardware and Optical Services Rider Benefit Summary

Vision Hardware	**You Pay**
Initial allowance of up to $250 for prescription eyeglasses or conventional or disposable prescription contact lenses, including Medically Necessary contact lenses, not more than once every Year.	Any amount by which price exceeds allowance

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 covered until the end of the month in which the Member turns 19 years of age. Vision Services for Members age 19 years 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 when prescribed by any licensed provider and obtained from a Select Vendor (Tier 1), a PPO Vendor (Tier 2), or a Non-Participating Vendor (Tier 3). The "Vision Hardware and Optical Services" exclusion in the *EOC* "Exclusions and Limitations" section does not apply to Services we cover under this rider.

Examinations

We cover a comprehensive eye examination with refraction, including dilation when determined to be Medically Necessary, as shown in the "Pediatric Vision Hardware and Optical Services Rider Benefit Summary."

Standard 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 provider and a standard frame selected from a specified collection of frames, or contact lenses in lieu of eyeglasses. We will not provide benefits under this rider if we have already covered, in part or in full, a lens, frame, or contact lens (but not counting any that we covered under "Standard Eyeglasses and Contact Lenses after Cataract Surgery") within the same Year 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.

Standard 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, without charge, if obtained from a Select Vendor or a PPO Vendor. We will cover both of the following if, in the judgment of a licensed 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:

- One conventional contact lens, or a 6-month supply of disposable contact lenses, determined by your licensed 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 licensed provider and a frame from a specified selection of frames.

Medically Necessary Contact Lenses

Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of the following conditions:

- Keratoconus.
- Pathological myopia.
- Aphakia.
- Anisometropia.
- Aniseikonia.
- Aniridia.
- Corneal disorders.
- Post-traumatic disorders.
- Irregular astigmatism.

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

Low Vision Aids

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

Pediatric Vision Hardware and Optical Services Rider Exclusions

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

Pediatric Vision Hardware and Optical Services Rider Benefit Summary

	Tier 1	**Tier 2**	**Tier 3**
Pediatric Vision Hardware and Optical Services	**You Pay**		
	Select Providers	**PPO Providers**	**Non-Participating Providers**
Comprehensive eye exam (limited to one exam per Year, all tiers combined)	$0	$0	40% Coinsurance after Deductible

Low vision evaluation and/or follow up exams (evaluations limited to once every five years, all tiers combined; follow up exams limited to four exams every five years, all tiers combined)	$0	$0	40% Coinsurance after Deductible
Eyeglasses and Contact Lenses	**Select Vendors**	**PPO Vendors**	**Non-Participating Vendors**
Standard eyeglasses (limited to one pair per Year, all tiers combined)	$0		50% Coinsurance
Conventional or disposable contact lenses, in lieu of eyeglasses (limited to one pair per Year for conventional contact lenses or up to a 12-month supply of disposable contact lenses per Year, all tiers combined)	$0		50% Coinsurance
Medically Necessary Contact Lenses	**Select Vendors**	**PPO Vendors**	**Non-Participating Vendors**
Medically Necessary contact lenses (limited to one pair per Year for conventional contact lenses or up to a 12-month supply of disposable contact lenses per Year, all tiers combined, prior authorization required)	$0		50% Coinsurance
Low Vision Aids	**Select Vendors**	**PPO Vendors**	**Non-Participating Vendors**
Low vision aids (limited to one device per Year, all tiers combined, prior authorization required)	$0		50% Coinsurance

KAISER PERMANENTE
Kaiser Foundation Health Plan
of the Northwest
500 NE Multnomah St., Ste 100
Portland, OR 97232

79 **********SINGLE PIECE

016021227355

DANITA PHR CHAPIN
WILLAMETTE UNIVERSITY
900 STATE ST
SALEM OR 97301-3922