KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

A nonprofit health maintenance organization

INDIVIDUAL & FAMILY MEDICAL EVIDENCE OF COVERAGE

Flex Bronze American Indian / Alaska Native Limited Cost Share

Nonacceptance of Evidence of Coverage.
If for any reason the Contract Holder is not satisfied with this Evidence of Coverage, it may be terminated by its return to Kaiser Foundation Health Plan of Washington (KFHPWA) or the producer within 10 days of delivery. It is assumed that delivery will have occurred within 3 days of the date mailed by KFHPWA. In the event that the Evidence of Coverage is returned within 10 days, KFHPWA shall promptly refund all premium received in connection with the issuance and the Evidence of Coverage shall be void from the beginning. If KFHPWA does not refund payments within 30 days of its timely receipt of the returned Evidence of Coverage, it must pay a penalty of 10% of such premium. The refund will be reduced based on payment made for received services.

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Kaiser Foundation Health Plan of Washington ("KFHPWA") is a nonprofit health maintenance organization, duly registered under the laws of the State of Washington, furnishing health care coverage on a prepayment basis. This Evidence of Coverage ("EOC") sets forth the terms under which that coverage will be provided, including the rights and responsibilities of the contracting party; requirements for enrollment and eligibility; and benefits to which those enrolled under this EOC are entitled.

This EOC is made between Kaiser Foundation Health Plan of Washington and the individual designated herein as the "Contract Holder". The EOC between KFHPWA and the Contract Holder consists of the following:

- Evidence of Coverage
- Premium schedule

This Evidence of Coverage is in force beginning [Eff Date**]**.

Important Notice Under Federal Health Care Reform

Kaiser Foundation Health Plan of Washington ("KFHPWA") recommends each Member choose a Network Personal Physician. This decision is important since the designated Network Personal Physician provides or arranges for most of the Member's health care. The Member has the right to designate any Network Personal Physician who participates in KFHPWA's Core Network and who is available to accept the Member or the Member's family members. For information on how to select a Network Personal Physician, and for a list of the participating Network Personal Physicians, please call Kaiser Permanente Member Services at (206) 630-4640 in the Seattle area, or toll-free in Washington, 1-800-290-8900.

For children, the Member may designate a pediatrician as the primary care provider.

The Member does not need Preauthorization from KFHPWA or from any other person (including a Network Personal Physician) to access obstetrical or gynecological care from a health care professional in the KFHPWA network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Preauthorization for certain services, following a pre-approved treatment plan, or procedures for obtaining Preauthorization. For a list of participating health care professionals who specialize in obstetrics or gynecology, please call Kaiser Permanente Member Services at (206) 630-4640 in the Seattle area, or toll-free in Washington, 1-800-290-8900.

Women's health and cancer rights
If the Member is receiving benefits for a covered mastectomy and elects breast reconstruction in connection with the mastectomy, the Member will also receive coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

These services will be provided in consultation with the Member and the attending physician and will be subject to the same Cost Shares otherwise applicable under the EOC.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act
Carriers offering group health coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, carriers may not, under federal law, require that a provider obtain authorization from the carrier for prescribing a length of stay not in excess of 48 hours (or 96 hours). Also, under federal law, a carrier may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

For More Information

KFHPWA will provide the information regarding the types of plans offered by KFHPWA to members on request. Please call Kaiser Permanente Member Services at (206) 630-4640 in the Seattle area, or toll-free in Washington, 1-800-290-8900.

Standard Provisions

1. KFHPWA agrees to provide benefits as set forth in the Evidence of Coverage to the Contract Holder.

2. Monthly Premium Payments.
Premium payments are due in advance of the month covered. Monthly premium payments must be made to KFHPWA in compliance with KFHPWA's terms and guidelines:

a. Off-Exchange (Direct)

- Initial payment will be billed once enrollment has been completed
- Correct premium amount must be received on or before the first of the month. If KFHPWA does not receive your premium payment on or before the due date, then KFHPWA will send a notice of nonpayment to you about the failure to make a timely premium payment in full and will describe any grace period to the extent available under current applicable law. This notice will also contain information about the date on which your coverage will terminate if all premium payments owed are not paid. During any grace period, coverage will continue in force if, and for the period, required by applicable law. If KFHPWA does not receive the full amount of your premium payment by the end of any applicable grace period, then KFHPWA will send a notice of termination. If your coverage is terminated for non-payment, you will not be entitled to a special enrollment period and may not reenroll until the next annual open enrollment period. You will be responsible for paying KFHPWA, Network Facilities, and/or Network Providers, as applicable, for any services received after the effective date of the termination of your coverage.
- Payments are accepted via: (i) online at www.kp.org/payonline; (ii) phone at 1-844-340-2468; or, (iii) mail at PO Box 7172, Pasadena, CA 91109-7172

To the extent permissible by law, a third-party paying premiums on behalf of an applicant is required to either (1) set up an individual online account for payment at www.kp.org/payonline or (2) submit one check per subscriber policy if receiving a paper bill.

b. On-Exchange

- Initial payment must be paid within 30 days of the effective date; enrollment will not be completed until premium has been received
- Correct premium amount must be received on or before the last day of the month. If KFHPWA does not receive your premium payment on or before the due date, then KFHPWA will send a notice of nonpayment to you about the failure to make a timely premium payment in full and will describe any grace period to the extent available under current applicable law. This notice will also contain information about the date on which your coverage will terminate if all premium payments owed are not paid. During any grace period, coverage will continue in force if, and for the period, required by applicable law. If KFHPWA does not receive the full amount of your premium payment by the end of any applicable grace period, then KFHPWA will send a notice of termination. If your coverage is terminated for non-payment, you will not be entitled to a special enrollment period and may have to remit overdue premium payments if you try to reenroll during the next annual open enrollment period if permitted by applicable law. You will be responsible for paying KFHPWA, Network Facilities, and/or Network Providers, as applicable, for any services received after the effective date of the termination of your coverage.
- Payments are accepted via: (i) online at www.kp.org/wa/paymenttransition; (ii) phone at 1-844-340-2468; or, (iii) mail at PO Box 7172, Pasadena, CA 91109-7172

To the extent permissible by law, a third-party paying premiums on behalf of an applicant is required to either (1) set up an individual online account for payment at www.kp.org/wa/paymenttransition or (2) submit one check per subscriber policy if receiving a paper bill.

3. Identification Cards.
KFHPWA will furnish cards, for identification purposes only, to all Members enrolled under this EOC.

4. Administration of Evidence of Coverage.

KFHPWA may adopt reasonable policies and procedures to help in the administration of this EOC. This may include, but is not limited to, policies or procedures pertaining to benefit entitlement and coverage determinations.

5. Modification of Evidence of Coverage.
This EOC, including premium, may be modified by KFHPWA upon 30 days written notice mailed to each Contract Holder's address, as it appears in KFHPWA's records. Failure to receive such notice shall not affect the modification or effective date thereof. Call Kaiser Permanente Member Services at (206) 630-4640 in the Seattle area, or toll-free in Washington, 1-800-290-8900 to provide a change of address.

No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this EOC, convey or void any coverage, increase or reduce any benefits under this EOC or be used in the prosecution or defense of a claim under this EOC.

6. Notices.
The Contract Holder shall notify either the Washington Health Benefit Exchange in compliance with their guidelines or KFHPWA in writing of any changes in residence within 30 days of such change. Notices provided for in this EOC shall be mailed to KFHPWA at its principal address and to the Contract Holder's address as it appears in KFHPWA's records.

7. Compliance With Law.
KFHPWA and the Contract Holder shall comply with all applicable state and federal laws and regulations in performance of this EOC. This EOC is entered into and governed by the laws of Washington State, except as otherwise pre-empted by federal laws.

8. Governmental Approval.
If KFHPWA has not received any necessary government approval by the date when notice is required under this EOC, KFHPWA will notify the Contract Holder of any changes once governmental approval has been received. KFHPWA may amend this EOC by giving notice to the Contract Holder upon receipt of government approved rates, benefits, limitations, exclusions or other provisions, in which case such rates, benefits, limitations, exclusions or provisions will go into effect as required by the governmental agency. All amendments are deemed accepted by the Contract Holder unless the Contract Holder gives KFHPWA written notice of non-acceptance within 10 days after receipt of amendment, in which event this EOC and all rights to services and other benefits terminate on the said date.

9. Confidentiality.
KFHPWA is required by federal and state law to maintain the privacy of Member personal and health information. KFHPWA is required to provide notice of how KFHPWA may use and disclose personal and health information held by KFHPWA. The Notice of Privacy Practices is distributed to Members and is available in Kaiser Permanente medical centers, at www.kp.org/wa, or upon request from Member Services.

10. Nondiscrimination.
KFHPWA does not discriminate on the basis of physical or mental disabilities in its employment practices and services. KFHPWA will not refuse to enroll or terminate a Member's coverage and will not deny care on the basis of age, sex, race, religion, national origin, citizenship or immigration status veteran or military status, occupation or health status.

11. Termination of Entire Evidence of Coverage.
This is a guaranteed renewable EOC and cannot be terminated except as provided in compliance with the KFHPWA or Washington Health Benefit Exchange terms and guidelines.

12. Withdrawal or Cessation of Services.

a. KFHPWA may determine to withdraw from a Service Area or from a segment of its Service Area after KFHPWA has demonstrated to the Washington State Office of the Insurance Commissioner that

KFHPWA's clinical, financial or administrative capacity to service the covered Members would be exceeded.

b. KFHPWA may determine to cease to offer the plan and replace the plan with another plan offered to all covered Members within that line of business that includes all of the health care services covered under the replaced plan and does not significantly limit access to the services covered under the replaced plan. KFHPWA may also allow unrestricted conversion to a fully comparable KFHPWA product.

KFHPWA will provide written notice to each covered Member of the discontinuation or non-renewal of the plan at least 90 days prior to discontinuation.

Table of Contents

I. Introduction

This Evidence of Coverage (EOC) is a statement of the terms of enrollment, payment and coverage under which the Contract Holder may secure health benefits. Kaiser Foundation Health Plan of Washington endeavors to provide and arrange for a wide range of medical and hospital care.

The provisions of the EOC must be considered together to fully understand the benefits available under the EOC. Words with special meaning are capitalized and are defined in Section XII. If the Member is eligible for Medicare, the Member should read Section IV. Drugs – Outpatient Prescription as it may affect their prescription drug coverage.

Contact Kaiser Permanente Member Services at 206-630-4640 or toll-free 1-800-290-8900 for benefits questions.

II. How Covered Services Work

A. Accessing Care.

1. **Your Provider Network is KFHPWA's Core Network (Network).** Members are entitled to Covered Services only at Network Facilities and from Network Providers, except for Emergency services and care pursuant to a Preauthorization.

   Benefits under this EOC will not be denied for any health care service performed by a registered nurse licensed to practice under chapter 18.88 RCW, if first, the service performed was within the lawful scope of such nurse's license, and second, this EOC would have provided benefit if such service had been performed by a Doctor of Medicine licensed to practice under chapter 18.71 RCW.

   A listing of Network Personal Physicians, specialists, women's health care providers and KFHPWA-designated Specialists is available by contacting Member Services or accessing the KFHPWA website at www.kp.org/wa. Information available online includes each physician's location, education, and specialties. KFHPWA also utilizes Health Care Benefit Managers for certain services. To see a current list of Health Care Benefit Managers, go to https://healthy.kaiserpermanente.org/washington/support/forms and choose the "Evidence of Coverage" link.

   Receiving Care in another Kaiser Foundation Health Plan Service Area
   If you are visiting in the service area of another Kaiser Permanente region, visiting member services may be available from designated providers in that region if the services would have been covered under this EOC. Visiting member services are subject to the provisions set forth in this EOC including, but not limited to, Preauthorization and cost sharing. For more information about receiving visiting member services in other Kaiser Permanente regional health plan service areas, including provider and facility locations, please call Kaiser Permanente Member Services at (206) 630-4640 in the Seattle area, or toll-free in Washington, 1-800-290-8900. Information is also available online at www.wa.kaiserpermanente.org/html/public/services/traveling.

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

2. **Primary Care Provider Services.**
   KFHPWA recommends that Members select a Network Personal Physician when enrolling. One Network personal physician may be selected for an entire family, or a different Network personal physician may be selected for each family member. For information on how to select or change Network Personal Physicians, and for a list of participating Network Personal Physicians, call Kaiser Permanente Member Services at (206) 630-4640 in the Seattle area, or toll-free in Washington at 1-800-290-8900 or by accessing the

KFHPWA website at www.kp.org/wa. The change will be made within 24 hours of the receipt of the request if the selected physician's caseload permits. If a Network personal physician accepting new Members is not available in your area, contact Kaiser Permanente Member Services, who will ensure you have access to a Network personal physician by contacting a physician's office to request they accept new Members.

To find a personal physician, contact Member Services or access the KFHPWA website at www.kp.org/wa to view physician profiles. Information available online includes physician's location, education, credentials, and specialties.

For your personal physician, choose from these specialties:

- Family medicine
- Adult medicine/internal medicine
- Pediatrics/adolescent medicine (for children up to 18)

Be sure to check that the physician you are considering is accepting new patients.

If your choice does not feel right after a few visits, you can change personal physician at any time, for any reason. If you don't choose a physician when you first become a KFHPWA Member, we will match you with a physician to make sure you have one assigned to you if you get sick or injured.

In the case that the Member's Network personal physician no longer participates in KFHPWA's network, the Member will be provided access to the Network personal physician for up to 60 days following a written notice offering the Member a selection of new Network personal physicians from which to choose.

3. Specialty Care Provider Services.

Unless otherwise indicated in Section II. or Section IV., Preauthorization is required for specialty care and specialists that are not KFHPWA-designated Specialists and are not providing care at facilities owned and operated by Kaiser Permanente.

Specialty Care Provider Copayment.

The following providers are subject to the specialty Copayment level: allergy and immunology, anesthesiology, audiology, cardiology (pediatric and cardiovascular disease), critical care medicine, dentistry, dermatology, endocrinology, enterostomal therapy, gastroenterology, genetics, hepatology, infectious disease, massage therapy, neonatal-perinatal medicine, nephrology, neurology, nutrition, oncology pharmacist, pain management, hematology/oncology, occupational medicine, occupational therapy, ophthalmology, orthopedics, ENT/otolaryngology, pathology, physiatry (physical medicine), physical therapy, podiatry, pulmonary medicine/disease, radiology (nuclear medicine, radiation therapy), respiratory therapy, rheumatology, speech therapy, sports medicine, general surgery and urology.

KFHPWA-designated Specialist.

Preauthorization is not required for services with KFHPWA-designated Specialists at facilities owned and operated by KFHPWA. To access a KFHPWA-designated Specialist, consult your Network Personal Physician. For a list of KFHPWA designated Specialists, contact Member Services or view the Provider Directory located at www.kp.org/wa. The following specialty care areas are available from KFHPWA-designated Specialists: allergy, audiology, cardiology, chiropractic/ manipulative therapy, dermatology, gastroenterology, general surgery, hospice, mental health and wellness, nephrology, neurology, obstetrics and gynecology, occupational medicine, oncology/hematology, ophthalmology, optometry, orthopedics, otolaryngology (ear, nose and throat), physical therapy, smoking cessation, speech/language and learning services, substance use disorder and urology.

4. Hospital Services.

Non-Emergency inpatient hospital services require Preauthorization. Refer to Section IV. for more information about hospital services.

5. **Emergency Services.**
Emergency services at a Network Facility or non-Network Facility are covered. Members must notify KFHPWA by way of the Hospital notification line (1-888-457-9516 as noted on your Member identification card) within 24 hours of any admission, or as soon thereafter as medically possible. Coverage for Emergency services at a non-Network Facility is limited to the Allowed Amount. Refer to Section IV. for more information about Emergency services.

Members are covered for Emergency care and Medically Necessary urgent care anywhere in the world. If you think you are experiencing an emergency, go immediately to the nearest emergency care facility or call 911. Go to the closest urgent care center for an illness or injury that requires prompt medical attention but is not an emergency. Examples include, but are not limited to minor injuries, wounds, and cuts needing stiches; minor breathing issues; minor stomach pain. If you are unsure whether urgent care is your best option, call the consulting nurse helpline for advice at 1-800-297-6877 or 206-630-2244.

If you need Emergency care while traveling and are admitted to a non-network hospital, you or a family member must notify us within 24 hours after care begins, or as soon as is reasonably possible. Call the notification line listed on the back of your KFHPWA Member ID card to help make sure your claim is accepted. Keep receipts and other paperwork from non-network care. You'll need to submit them with any claims for reimbursement after returning from travel.

Access to non-Emergency care across the Core Network service area: your Plan provides access to all providers in the Core Network, including many physicians and services at Kaiser Permanente medical facilities and Core Network Facilities across the state. Find links to providers at www.kp.org/wa/directory or contact Member Services at 1-800-290-8900for assistance.

6. **Urgent Care.**
Inside the KFHPWA Service Area, urgent care is covered at a Kaiser Permanente medical center, Kaiser Permanente urgent care center or Network Provider's office. Outside the KFHPWA Service Area, urgent care is covered at any medical facility. Refer to Section IV. for more information about urgent care.

For urgent care during office hours, you can call your personal physician's office first to see if you can get a same-day appointment. If a physician is not available or it is after office hours, you may speak with a licensed care provider anytime at 1-800-297-6877 or 206-630-2244. You may also check www.kp.org/wa/directory or call Member Services to find the nearest urgent care facility in your Network.

7. **Women's Health Care Direct Access Providers.**
Female Members may see a general and family practitioner, physician's assistant, gynecologist, certified nurse midwife, licensed midwife, doctor of osteopathy, pediatrician, obstetrician or advance registered nurse practitioner who is unrestricted in your KFHPWA Network to provide women's health care services directly, without Preauthorization, for Medically Necessary maternity care, covered reproductive health services, preventive services (well care) and general examinations, gynecological care and follow-up visits for the above services. Women's health care services are covered as if the Member's Network Personal Physician had been consulted, subject to any applicable Cost Shares. If the Member's women's health care provider diagnoses a condition that requires other specialists or hospitalization, the Member or the chosen provider must obtain Preauthorization in accordance with applicable KFHPWA requirements. For a list of KFHPWA providers, contact Member Services or view the Provider Directory located at www.kp.org/wa.

8. **Travel Advisory Services.**
Our Travel Advisory Service offers recommendations tailored to your travel outside the United States. Nurses certified in travel health will advise you on any vaccines or medications you need based on your destination, activities, and medical history. The consultation is not a covered benefit and there is a fee for a KFHPWA Member using the service for the first time. Travel-related vaccinations and medications are usually not covered. Visit www.kp.org/wa/travel-service for more details.

9. Process for Medical Necessity Determination.

Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Members will be notified in writing when a determination has been made.

First Level Review:

First level reviews are performed or overseen by appropriate clinical staff using KFHPWA approved clinical review criteria. Data sources for the review include, but are not limited to, referral forms, admission request forms, the Member's medical record, and consultation with qualified health professionals and multidisciplinary health care team members. The clinical information used in the review may include treatment summaries, problem lists, specialty evaluations, laboratory and x-ray results, and rehabilitation service documentation. The Member or legal surrogate may be contacted for information. Coordination of care interventions are initiated as they are identified. The reviewer consults with the health care team when more clarity is needed to make an informed medical necessity decision. The reviewer may consult with a board-certified consultative specialist and such consultations will be documented in the review text. If the requested service appears to be inappropriate based on application of the review criteria, the first level reviewer requests second level review by a physician or designated health care professional.

Second Level (Practitioner) Review:

The practitioner reviews the treatment plan and discusses, when appropriate, case circumstances and management options with the attending (or referring) physician. The reviewer consults with the health care team when more clarity is needed to make an informed coverage decision. The reviewer may consult with board certified physicians from appropriate specialty areas to assist in making determinations of coverage and/or appropriateness. All such consultations will be documented in the review text. If the reviewer determines that the admission, continued stay or service requested is not a covered service, a notice of non-coverage is issued. Only a physician, behavioral health practitioner (such as a psychiatrist, doctoral-level clinical psychologist, certified addiction medicine specialist), dentist or pharmacist who has the clinical expertise appropriate to the request under review with an unrestricted license may deny coverage based on medical necessity.

B. Assignment

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

C. Preauthorization.

Refer to Section IV. or call Member Services for more information regarding which services, equipment, and facility types KFHPWA requires Preauthorization. Failure to obtain Preauthorization when required may result in denial of coverage for those services, and the Member may be responsible for the cost of these non-Covered services. Members may contact Member Services to request Preauthorization.

Preauthorization requests, including prescription requests, are reviewed and approved based on Medical Necessity, eligibility and benefits. KFHPWA will generally process Preauthorization requests and provide notification for benefits within the following timeframes:

- For electronic standard requests – within three calendar days, excluding holidays
    - If insufficient information has been provided, a request for additional information will be made within one calendar day.
- For electronic expedited prior authorization requests – within one calendar day
    - If insufficient information has been provided, a request for additional information will be made within one calendar day.
- For nonelectronic standard requests – within five calendar days
    - If insufficient information has been provided, a request for additional information will be made within five calendar days.
- For nonelectronic expedited requests - within two calendar days

- If insufficient information has been provided, a request for additional information will be made within one calendar day.

D. Recommended Treatment.

KFHPWA's medical director will determine the necessity, nature and extent of treatment to be covered in each individual case and the judgment, will be made in good faith. Members have the right to appeal coverage decisions (see Section VIII.). Members have the right to participate in decisions regarding their health care. A Member may refuse any recommended services to the extent permitted by law. Members who obtain care not recommended by KFHPWA's medical director do so with the full understanding that KFHPWA has no obligation for the cost, or liability for the outcome, of such care.

New and emerging medical technologies are evaluated on an ongoing basis by the following committees – the Interregional New Technologies Committee, Medical Technology Assessment Committee, Medical Policy Committee, and Pharmacy and Therapeutics Committee. These physician evaluators consider the new technology's benefits, whether it has been proven safe and effective, and under what conditions its use would be appropriate. The recommendations of these committees inform what is covered on KFHPWA health plans.

E. Second Opinions.

The Member may access a second opinion from a Network Provider regarding a medical diagnosis or treatment plan. The Member may request Preauthorization or may visit a KFHPWA-designated Specialist for a second opinion. When requested or indicated, second opinions are provided by Network Providers and are covered with Preauthorization, or when obtained from a KFHPWA-designated Specialist. Coverage is determined by the Member's EOC; therefore, coverage for the second opinion does not imply that the services or treatments recommended will be covered. Preauthorization for a second opinion does not imply that KFHPWA will authorize the Member to return to the physician providing the second opinion for any additional treatment. Services, drugs and devices prescribed or recommended as a result of the consultation are not covered unless included as covered under the EOC.

F. Unusual Circumstances.

In the event of unusual circumstances such as a major disaster, epidemic, military action, civil disorder, labor disputes or similar causes, KFHPWA will not be liable for administering coverage beyond the limitations of available personnel and facilities.

In the event of unusual circumstances such as those described above, KFHPWA will make a good faith effort to arrange for Covered Services through available Network Facilities and personnel. KFHPWA shall have no other liability or obligation if Covered Services are delayed or unavailable due to unusual circumstances.

G. Utilization Management.

"Case Management" means a care management plan developed for a Member whose diagnosis requires timely coordination. All benefits, including travel and lodging, are limited to Covered Services that are Medically Necessary and set forth in the EOC. KFHPWA may review a Member's medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent or retrospective review, KFHPWA may deny coverage if, in its determination, such services are not Medically Necessary. Such determination shall be based on established clinical criteria and may require Preauthorization.

KFHPWA will not deny coverage retroactively for services with Preauthorization and which have already been provided to the Member except in the case of an intentional misrepresentation of a material fact by the patient, Member, or provider of services, or if coverage was obtained based on inaccurate, false, or misleading information provided on the enrollment application; or for nonpayment of premiums.

III. Financial Responsibilities

A. Premium.

The Contract Holder is liable for payment of premium.

B. Financial Responsibilities for Covered Services.

The Contract Holder is liable for payment of the following Cost Shares for Covered Services provided to the Contract Holder and their Dependents. Payment of an amount billed must be received within 30 days of the billing date. Charges will be for the lesser of the Cost Shares for the Covered Service or the actual charge for that service. Cost Shares will not exceed the actual charge for that service.

1. Annual Deductible.

Covered Services may be subject to an annual Deductible. Charges subject to the annual Deductible shall be borne by the Contract Holder during each year until the annual Deductible is met. Covered Services must be received from a Network Provider at a Network Facility, unless the Member has received Preauthorization or has received Emergency services.

There is an individual annual Deductible amount for each Member and a maximum annual Deductible amount for each Family Unit. Once the annual Deductible amount is reached for a Family Unit in a calendar year, the individual annual Deductibles are also deemed reached for each Member during that same calendar year.

2. Plan Coinsurance.

After the applicable annual Deductible is satisfied, Members may be required to pay Plan Coinsurance for Covered Services.

3. Copayments.

Members shall be required to pay applicable Copayments at the time of service. Payment of a Copayment does not exclude the possibility of an additional billing if the service is determined to be a non-Covered Service or if other Cost Shares apply.

4. Out-of-pocket Limit.

Out-of-pocket Expenses which apply toward the Out-of-pocket Limit are set forth in Section IV. Total Out-of-pocket Expenses incurred during the same calendar year shall not exceed the Out-of-pocket Limit.

C. Financial Responsibilities for Non-Covered Services.

The cost of non-Covered Services and supplies is the responsibility of the Member. The Contract Holder is liable for payment of any fees charged for non-Covered Services provided to the Contract Holder and their Dependents at the time of service. Payment of an amount billed must be received within 30 days of the billing date.

IV. Benefits Details

Benefits are subject to all provisions of the EOC. Members are entitled only to receive benefits and services that are Medically Necessary and clinically appropriate for the treatment of a Medical Condition as determined by KFHPWA's medical director and as described herein. All Covered Services are subject to case management and utilization management. Benefits available will not duplicate benefits provided under any other KFHPWA medical coverage EOC.

There is no cost-sharing for items and services received or referred through Indian Health Services (HIS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (ACA Sec. 1402(d)(2)).

Annual Deductible	Member pays $6,000 per Member per calendar year or $12,000 per Family Unit per calendar year
Coinsurance	**Plan Coinsurance:** Member pays 20%
Lifetime Maximum	No lifetime maximum on covered Essential Health Benefits
Out-of-pocket Limit	Limited to a maximum of $9,200 per Member or $18,400 per Family Unit per calendar year
	The following Out-of-pocket Expenses apply to the Out-of-pocket Limit: All Cost Shares for Covered Services **The following expenses do not apply to the Out-of-pocket Limit:** Premiums, charges for services in excess of a benefit, charges in excess of Allowed Amount, charges for non-Covered Services
Pre-existing Condition Waiting Period	No pre-existing condition waiting period

Acupuncture	
Acupuncture needle treatment limited to 12 visits per calendar year. Preauthorization is not required. No visit limit for treatment for Substance Use Disorders.	After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Herbal supplements; any services not within the scope of the practitioner's licensure	

Advanced Care at Home	
Advanced Care at Home is a personalized, patient-centered program that provides care for patients with certain clinical conditions in their homes, or at another appropriate care location such as a family member's home or temporary residence. Advanced Care at Home services must be associated with an acute episode in which the member is treated for a brief but severe episode of illness, for conditions that are the result of disease such as, but not exclusive to, congestive heart failure, pneumonia, upper urinary tract infection or cellulitis. The treatment plan may include restorative care associated with the acute episode. The duration of an episode of care (which includes acute and restorative phases) is limited to a total of 30 days. To receive advanced care in the home: • The member must be referred into the advanced care program by the managing provider at an emergency room, urgent care or inpatient setting, • Advanced Care at Home requires Preauthorization based on the Member's health status, treatment plan, and home setting or another appropriate care location within the Service Area, • The clinical condition must meet inpatient Medical Necessity criteria, • The Member must consent to receiving advanced care described in the treatment plan, • The care location, such as the member's residence, must be within 30 minutes ground travel time of an emergency department, and • The care location, such as the member's residence, must, have cell service. Advanced Care at Home is provided through Medically Home, our Network provider, and they will provide the	No charge; Member pays nothing

following services in the Member's home or appropriate care location: • Home visits by RNs, physical therapists, occupational therapists, speech therapists, respiratory therapists, nutritionist, health aides, and other healthcare professionals in accordance with the Advanced Care at Home treatment plan and the provider's scope of practice and licensure. • Communication devices to allow the Member to contact the medical command center 24 hours a day, 7 days a week. This includes needed communication technology to support reliable connection for communication, and a personal emergency response system alert device to contact the medical command center if the Member is unable to get to a phone. Additional services covered under this benefit include: • The following equipment necessary to ensure that you are monitored appropriately in your home: blood pressure cuff/monitor, pulse oximeter, scale, and thermometer. • Mobile imaging and tests such as X-rays, ultrasounds, and EKGs. • Safety items when Medically Necessary, such as shower stools, raised toilet seats, grabbers, long handled shoehorn, and sock aids. • Meals when Medically Necessary while you are receiving advanced care at home will be provided through our network provider, Medically Home. In addition, cost sharing is waived for the following covered services and items when the services and items are prescribed as part of your Advanced Care at Home treatment plan: • Durable Medical Equipment. • Medical Supplies. • Member transportation to and from Network facilities when Member transport is Medically Necessary will be arranged by Medically Home based on the most appropriate mode of transportation which could be ambulance, cabulance, or otherwise. • Physician Assistant and Nurse Practitioner house calls. • Emergency Department visits associated with this benefit. The cost share is not waived and will apply to any services that are not part of your Advanced Care at Home treatment plan (for example, DME not specified in your Advanced Care at Home treatment plan). For outpatient prescription drug cost shares, see Drugs - Outpatient Prescription.	

Exclusions: Private Duty Nursing; housekeeping or meal services not part of your Advanced Care at Home treatment plan; any care provided by or for a family member; any other services rendered in the home which are not specified in your Advanced Care at Home treatment plan

Allergy Services	
Allergy testing.	After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Allergy serum and injections.	After Deductible, Member pays 20% Plan Coinsurance

Cancer Screening and Diagnostic Services	
Routine cancer screening covered as Preventive Services in accordance with the well care schedule established by KFHPWA and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in Kaiser Permanente medical centers, at www.kp.org/wa, or upon request from Member Services. See Preventive Services for additional information.	No charge; Member pays nothing
Diagnostic laboratory, diagnostic procedures (including colonoscopies, cardiovascular testing, pulmonary function studies, and neurology/neuromuscular procedures) and diagnostic services for cancer. See Laboratory and Radiology for additional information. Preventive laboratory/radiology services are covered as Preventive Services.	After Deductible, Member pays 20% Plan Coinsurance

Circumcision	
Circumcision. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year,

	Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance Within 60 days of birth: No charge, Member pays nothing

Clinical Trials	
Notwithstanding any other provision of this document, the Plan provides benefits for Routine Patient Costs of qualified individuals in approved clinical trials, to the extent benefits for these costs are required by federal or state law. Routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. Clinical Trials are a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. "Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. Clinical trials require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Routine patient costs do not include: (i) the investigational item, device, or service, itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.	

Dental Services and Dental Anesthesia	
Dental services (i.e., routine care, evaluation and treatment) including accidental injury to natural teeth.	Not covered; Member pays 100% of all charges
Dental services or appliances provided during medical treatment for emergent dental care, dental care which requires the extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, and oral surgery related to trauma. Dental problems such as infections requiring emergency treatment outside of standard business hours are covered as Emergency Services.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance

	For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
General anesthesia services and related facility charges for dental procedures for Members who are under 9 years of age or are physically or developmentally disabled or have a Medical Condition where the Member's health would be put at risk if the dental procedure were performed in a dentist's office. General anesthesia services for dental procedures require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Dentist's or oral surgeon's fees for non-emergent dental care, surgery, services and appliances, including: non-emergent treatment of accidental injury to natural teeth, reconstructive surgery to the jaw in preparation for dental implants, dental implants, orthodontic braces for any condition, periodontal surgery; any other dental service not specifically listed as covered	

Devices, Equipment and Supplies (for home use)	
Durable medical equipment: Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and is used in the Member's home. • Examples of covered durable medical equipment include: hospital beds; wheelchairs; walkers; crutches; canes; braces and splints; blood glucose monitors; external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters); oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks); and therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease. KFHPWA will determine if equipment is made available on a rental or purchase basis. • Orthopedic appliances: Items attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function. • Orthotic devices. • Ostomy supplies: Supplies for the removal of bodily secretions or waste through an artificial opening. • Post-mastectomy bras/forms limited to 2 every 6 months. Replacements within this 6-month period are covered when Medically Necessary due to a change in the Member's condition. • Prosthetic devices: Items which replace all or part of an external body part, or function thereof. • Sales tax for devices, equipment and supplies.	After Deductible, Member pays 20% Plan Coinsurance Annual Deductible does not apply to strip-based blood glucose monitors, test strips, lancets, or control solutions.

When provided in lieu of hospitalization, benefits will be the greater of benefits available for devices, equipment and supplies, home health or hospitalization. See Advanced Care at Home for durable medical provided in an Advanced Care at Home setting. See Hospice for durable medical equipment provided in a hospice setting. Devices, equipment and supplies including repair, adjustment or replacement of appliances and equipment require Preauthorization.	
Exclusions: Over-the-counter arch supports; orthopedic shoes that are not attached to an appliance; wigs/hair prosthesis; take-home dressings and supplies following hospitalization; supplies, dressings, appliances, devices or services not specifically listed as covered above; same as or similar equipment already in the Member's possession; replacement or repair due to loss, theft, breakage from willful damage, neglect or wrongful use, or due to personal preference; structural modifications to a Member's home or personal vehicle	

Diabetic Education, Equipment and Pharmacy Supplies	
Diabetic education and training.	After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Diabetic equipment: Blood glucose monitors and external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters), and therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease. See Devices, Equipment and Supplies for additional information.	After Deductible, Member pays 20% Plan Coinsurance Annual Deductible does not apply to strip-based blood glucose monitors, test strips, lancets, or control solutions.
Diabetic pharmacy supplies: Insulin, lancets, lancet devices, needles, insulin syringes, disposable insulin pens, pen needles, glucagon emergency kits, prescriptive oral agents and blood glucose test strips for a supply of 30 days or less per item. Certain brand name insulin drugs will be covered at the generic level. See Drugs – Outpatient Prescription for additional pharmacy information.	**Preferred generic drugs (Tier 1):** Member pays $25 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** After Deductible, Member pays 40% coinsurance up to a 90-day supply **Non-preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays 50% coinsurance up to a 90-day supply **Specialty drugs (Tier 4):** After Deductible, Member pays 50% coinsurance up to a 30-day supply

	Annual Deductible does not apply to strip-based blood glucose monitors, test strips, lancets, or control solutions. Note: A Member will not pay more than $35, not subject to Deductible, for a 30-day supply of insulin to comply with state law requirements. Any cost-sharing paid will apply toward the annual Deductible.
Diabetic retinal screening.	No charge; Member pays nothing

Dialysis (Home and Outpatient)	
Dialysis in an outpatient or home setting is covered for Members with acute kidney failure or end-stage renal disease (ESRD). Dialysis requires Preauthorization.	After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Injections administered by a Network Provider in a clinical setting during dialysis.	After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Self-administered injectables. See Drugs – Outpatient Prescription for additional pharmacy information.	**Preferred generic drugs (Tier 1):** Member pays $25 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** After Deductible, Member pays 40% coinsurance up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays 50% coinsurance up to a 90-day supply **Specialty drugs (Tier 4):** After Deductible, Member pays 50% coinsurance up to a 30-day supply

Drugs - Outpatient Prescription	
Prescription drugs, supplies and devices for a supply of 30 days or less including diabetic pharmacy supplies (insulin, lancets, lancet devices, needles, insulin syringes, disposable insulin pens, pen needles and blood glucose test strips), mental health and wellness drugs, self-administered injectables, teaching doses of self-administered injections, limited to 3 doses per medication per lifetime, medications for the treatment arising from sexual assault, and routine costs for prescription medications provided in a clinical trial. "Routine costs" means items and services delivered to the Member that are consistent with and typically covered by the plan or coverage for a Member who is not enrolled in a clinical trial. All drugs, supplies and devices must be for Covered Services. All drugs, supplies and devices must be obtained at a KFHPWA-designated pharmacy except for drugs dispensed for Emergency services or for Emergency services obtained outside of the KFHPWA Service Area, including out of the country. Information regarding KFHPWA-designated pharmacies is reflected in the KFHPWA Provider Directory or can be obtained by contacting Kaiser Permanente Member Services. Prescription drug Cost Shares are payable at the time of delivery. Certain brand name insulin drugs are covered at the generic drug Cost Share. A list of these drugs is available at www.kp.org/wa/formulary. Members may be eligible to receive an emergency fill for certain prescription drugs filled outside of KFHPWA's business hours or when KFHPWA cannot reach the prescriber for consultation. For emergency fills, Members pay the prescription drug Cost Share for each 7-day supply or less, or the minimum packaging size available at the time the emergency fill is dispensed. A list of prescription drugs eligible for emergency fills is available on the pharmacy website at www.kp.org/wa/formulary. Members can request an emergency fill by calling 1-855-505-8107. Certain drugs are subject to Preauthorization as shown in the Preferred drug list (formulary) available at www.kp.org/wa/formulary. For outpatient prescription drugs and/or items that are covered under the Drugs – Outpatient Prescription section and obtained at a pharmacy owned and operated by KFHPWA, a Member may be able to use approved manufacturer coupons as payment for the Cost Sharing that a Member owes, as allowed under KFHPWA's coupon program. A Member will owe any additional amount if the coupon does not cover the entire amount of the Cost Sharing for the Member's prescription. When a Member uses an approved coupon for payment of their Cost Sharing, the coupon amount and any	**Preferred generic drugs (Tier 1):** Member pays $25 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** After Deductible, Member pays 40% coinsurance up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays 50% coinsurance up to a 90-day supply **Specialty drugs (Tier 4):** After Deductible, Member pays 50% coinsurance up to a 30-day supply Annual Deductible does not apply to strip-based blood glucose monitors, test strips, lancets, or control solutions. Note: A Member will not pay more than $35, not subject to Deductible, for a 30-day supply of insulin to comply with state law requirements. Any cost-sharing paid will apply to the annual Deductible.

additional payment that they make will accumulate to their Deductible and Out-of-Pocket Limit. More information is available regarding the Kaiser Permanente coupon program rules and limitations at kp.org/rxcoupons.	
Injections administered by a Network Provider in a clinical setting.	After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Over-the-counter drugs not included under Preventive Care or Reproductive Health.	Not covered; Member pays 100% of all charges
Mail order drugs dispensed through the KFHPWA-designated mail order service.	**Preferred generic drugs (Tier 1):** Member pays $20 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** After Deductible, Member pays 35% coinsurance up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays 45% coinsurance up to a 90-day supply **Specialty drugs (Tier 4):** After Deductible, Member pays 50% coinsurance up to a 30-day supply Annual Deductible does not apply to strip-based blood glucose monitors, test strips, lancets, or control solutions. Note: A Member will not pay more than $35, not subject to Deductible, for a 30-day supply of insulin to comply with state law requirements. Any cost-sharing paid will apply toward the annual Deductible.
The KFHPWA Preferred drug list is a list of prescription drugs, supplies, and devices considered to have acceptable efficacy, safety and cost-effectiveness. The Preferred drug list is maintained by a committee consisting of a group of physicians, pharmacists and a consumer representative who review the scientific evidence of these products and determine the Preferred and Non-Preferred status as well as utilization management requirements. Preferred drugs generally have better scientific evidence for safety and effectiveness and are more affordable than Non-Preferred drugs. The preferred drug list is available at www.kp.org/wa/formulary, or upon request from Member Services. A Member, a Member's designee, or a prescribing physician may request a coverage exception to gain access to clinically appropriate drugs if the drug is not otherwise covered by contacting Member Services. Coverage determination reviews may include requests to cover non-preferred drugs, obtain Preauthorization for a specific drug,	

or exceptions to other utilization management requirements, such as quantity limits. KFHPWA will provide a determination and notification of the determination no later than 72 hours of the request after receipt of information sufficient to make a decision. The prescribing physician must submit an oral or written statement regarding the need for the non-Preferred drug, and a list of all of the preferred drugs which have been ineffective for the Member.

Expedited or Urgent Reviews: A Member, a Member's designee, or a prescribing physician may request an expedited review for coverage for non-covered drugs when a delay caused by using the standard review process will seriously jeopardize the Member's life, health or ability to regain maximum function or will subject to the Member to severe pain that cannot be managed adequately without the requested drug. KFHPWA or the IRO will provide a determination and notification of the determination no later than 24 hours from the receipt of the request after receipt of information sufficient to make a decision.

Notification of Determination: If coverage is approved, KFHPWA will notify the prescribing physician of the determination. If coverage is denied, KFHPWA will provide notification of the adverse determination to the prescribing physician and the Member.

Prescription drugs are drugs which have been approved by the Food and Drug Administration (FDA) and which can, under federal or state law, be dispensed only pursuant to a prescription order. These drugs, including off-label use of FDA-approved drugs (provided that such use is documented to be effective in one of the standard reference compendia; a majority of well-designed clinical trials published in peer-reviewed medical literature document improved efficacy or safety of the agent over standard therapies, or over placebo if no standard therapies exist; or by the federal secretary of Health and Human Services) are covered. "Standard reference compendia" means the American Hospital Formulary Service – Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia – Drug Information, or other authoritative compendia as identified from time to time by the federal secretary of Health and Human Services. "Peer-reviewed medical literature" means scientific studies printed in health care journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

Generic drugs are dispensed whenever available. A generic drug is a drug that is therapeutically equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. Brand name drugs are dispensed if there is not a generic equivalent. In the event the Member elects to purchase a brand-name drug instead of the generic equivalent (if available), the Member is responsible for paying the difference in cost in addition to the prescription drug Cost Share, which does not apply to the Out-of-pocket Limit.

Drug coverage is subject to utilization management that includes Preauthorization, step therapy (when a Member tries a certain medication before receiving coverage for a similar, but non-Preferred medication), limits on drug quantity or days supply and prevention of overutilization, underutilization, therapeutic duplication, drug-drug interactions, incorrect drug dosage, drug-allergy contraindications and clinical abuse/misuse of drugs. If a Member has a new prescription for a chronic condition, the member may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity. Please contact Member Services for more information

Specialty drugs are high-cost drugs prescribed by a physician that requires close supervision and monitoring for serious and/or complex conditions, such as rheumatoid arthritis, hepatitis, or multiple sclerosis. Specialty drugs must be obtained through KFHPWA's preferred specialty pharmacy vendor and/or network of specialty pharmacies and are covered at the appropriate cost share above. For a list of specialty drugs or more information about KFHPWA's specialty pharmacy network, please go to the KFHPWA website at www.kp.org/wa/formulary or contact Member Services at 206-630-4640 or toll-free at 1-800-290-8900.

The Member's Right to Safe and Effective Pharmacy Services: State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee Members' right to know what drugs are covered and the coverage limitations. Members who would like more information about the drug coverage policies or have a question or concern about their pharmacy benefit, may contact KFHPWA at 206-630-4640 or toll-free 1-800-290-8900 or by accessing the KFHPWA website at www.kp.org/wa. Members who would like to know more about their rights under the law, or think any services received while enrolled may not conform to the terms of the EOC, may contact the Washington State Office of Insurance Commissioner at toll-free 1-800-562-6900. Members who have a concern about the pharmacists or pharmacies serving them may call the Washington State Department of Health at toll-free 1-800-525-0127.
Prescription Drug Coverage and Medicare: This benefit, for purposes of Creditable Coverage, is not actuarially equal to or greater than the Medicare Part D prescription drug benefit; therefore, the Member could be subject to payment of higher Part D premiums if the Member has a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan. Members who are eligible for Medicare Part D can choose to purchase such coverage privately; however, purchase of Medicare Part D through another plan may affect the Member's eligibility under the EOC. A Member who discontinues coverage must meet eligibility requirements in order to re-enroll.
Exclusions: Over-the-counter drugs, supplies and devices not requiring a prescription under state law or regulations, including most prescription vitamins, except as recommended by the U.S. Preventive Services Task Force (USPSTF); drugs and injections for anticipated illness while traveling; drugs and injections for cosmetic purposes; replacement of lost, stolen or damaged drugs or devices; administration of excluded drugs and injectables; drugs used in the treatment of sexual dysfunction disorders; compounds which include a non-FDA approved drug; growth hormones for idiopathic short stature without growth hormone deficiency; prescription drugs/products available over-the-counter or have an over-the-counter alternative that is determined to be therapeutically interchangeable

Emergency Services	
Emergency services at a Network Facility or non-Network Facility. See Section XII. for a definition of Emergency. Emergency services include professional services, treatment and supplies, facility costs, outpatient charges for patient observation, medical screening exams required to stabilize a patient, and post stabilization treatment. Members must notify KFHPWA by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. If a Member is hospitalized in a non-Network Facility, KFHPWA reserves the right to require transfer of the Member to a Network Facility upon consultation between a Network Provider and the attending physician. If the Member refuses to transfer to a Network Facility or does not notify KFHPWA within 24 hours following admission, all further costs incurred during the hospitalization are the responsibility of the Member. Follow-up care which is a direct result of the Emergency must be received from a Network Provider, unless Preauthorization is obtained for such follow-up care from a non-Network Provider.	**Network Facility:** After Deductible, Member pays 20% Plan Coinsurance **Non-Network Facility:** After Deductible, Member pays 20% Plan Coinsurance

Emergency ambulance service is covered when: • Transport is to the nearest facility that can treat your condition • Any other type of transport would put your health or safety at risk • The Service is from a licensed ambulance • The ambulance transports you to a location where you receive covered services Emergency air or sea medical transportation is covered only when: • The above requirements for ambulance service are met, and • Geographic restraints prevent ground Emergency transportation to the nearest facility that can treat your condition, or ground Emergency transportation would put your health or safety at risk.	After Deductible, Member pays 20% Plan Coinsurance
Non-Emergency ground or air interfacility transfer to or from a Network Facility where you received covered services when Preauthorized by KFHPWA. Contact Member Services for Preauthorization.	After Deductible, Member pays 20% Plan Coinsurance **Hospital to hospital ground transfers:** No charge; Member pays nothing

Gender Health Services	
Medically Necessary medical and surgical services for gender affirmation. Consultations and treatment require Preauthorization. Certain procedures are subject to age limits, please see our clinical criteria https://wa-provider.kaiserpermanente.org/static/pdf/hosting/clinical/criteria/pdf/gender_reassignment_surgery.pdf for details. Prescription drugs are covered the same as for any other condition (see Drugs – Outpatient Prescription for coverage). Counseling services are covered the same as for any other condition (see Mental Health and Wellness for coverage). Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Cosmetic services and surgery not related to gender affirming treatment (i.e., face lift or calf implants); complications of non-Covered Services; travel	

Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation are covered only when provided at KFHPWA-approved facilities.	**Hospital – Inpatient:** After Deductible, Member pays 20% Plan Coinsurance

Cochlear implants or Bone Anchored Hearing System (BAHS) when in accordance with KFHPWA clinical criteria. Covered services for initial cochlear implants and BAHS include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries). Replacement devices and associated supplies – see Devices, Equipment and Supplies section.	**Hospital – Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Hearing aids including hearing aid examinations.	Not covered; Member pays 100% of all charges
Exclusions: Hearing care, routine hearing examinations, programs or treatments for hearing loss including, but not limited to, externally worn hearing or surgically implanted hearing aids, and the surgery and services necessary to implant them except as described above, and hearing screening tests required under Preventive Services	

Home Health Care	
Home health care when the following criteria are met, limited to 130 visits per calendar year: • Except for patients receiving palliative care services, the Member must be unable to leave home due to a health problem or illness. Unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home. • The Member requires intermittent skilled home health care, as described below. • KFHPWA's medical director determines that such services are Medically Necessary and are most appropriately rendered in the Member's home. Covered Services for home health care may include the following when rendered pursuant to a KFHPWA-approved home health care plan of treatment: nursing care; restorative physical, occupational, respiratory and speech therapy; durable medical equipment, medical social worker and limited home health aide services. Home health services are covered on an intermittent basis in the Member's home. "Intermittent" means care that is to be rendered because of a medically predictable recurring need for skilled home health care. "Skilled home health care" means reasonable and necessary care for the treatment of an illness or injury which requires the skill of a nurse or therapist, based on the complexity of the service and the condition of the patient and which is performed directly by an appropriately licensed professional provider. Home health care requires Preauthorization.	After Deductible, Member pays 20% Plan Coinsurance

Exclusions: Private Duty Nursing; housekeeping or meal services; any care provided by or for a family member; any other services rendered in the home which do not meet the definition of skilled home health care above

Hospice	
Hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a Member and any family members who are caring for the Member, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of the Member and their family during the final stages of illness. In order to qualify for hospice care, the Member's provider must certify that the Member is terminally ill and is eligible for hospice services. **Inpatient Hospice Services.** For short-term care, inpatient hospice services are covered with Preauthorization. Respite care is covered to provide continuous care of the Member and allow temporary relief to family members from the duties of caring for the Member on an inpatient or outpatient basis for a maximum of 14 days per lifetime). **Other covered hospice services, when billed by a licensed hospice program, may include the following:** • Inpatient and outpatient services and supplies for injury and illness. • Semi-private room and board, except when a private room is determined to be necessary. • Durable medical equipment, when billed by a licensed hospice program. Hospice care requires Preauthorization.	No charge; Member pays nothing
Exclusions: Private Duty Nursing; financial or legal counseling services; meal services; any services provided by family members	

Hospital - Inpatient and Outpatient	
The following inpatient medical and surgical services are covered: • Room and board, including private room when prescribed, and general nursing services. • Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy services). • Drugs and medications administered during confinement. • Medical implants.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance

• Withdrawal management services. Outpatient hospital includes ambulatory surgical centers. See the Outpatient Services section for provider office visits. Outpatient services include: • Outpatient medical and surgical care • Anesthesia and anesthesia services • Surgical dressings and supplies • Facility costs Alternative care arrangements may be covered as a cost-effective alternative in lieu of otherwise covered Medically Necessary hospitalization or other Medically Necessary institutional care with the consent of the Member and recommendation from the attending physician or licensed health care provider. Alternative care arrangements in lieu of covered hospital or other institutional care must be determined to be appropriate and Medically Necessary based upon the Member's Medical Condition. Such care is covered to the same extent the replaced Hospital Care is covered. Alternative care arrangements require Preauthorization. Members receiving the following nonscheduled services are required to notify KFHPWA by way of the Hospital notification line within 24 hours following any admission, or as soon thereafter as medically possible: acute withdrawal management (detoxification) services, Emergency psychiatric services, Emergency services, labor and delivery and inpatient admissions needed for treatment of Urgent Conditions that cannot reasonably be delayed until Preauthorization can be obtained. Coverage for Emergency services in a non-Network Facility and subsequent transfer to a Network Facility is set forth in Emergency Services. Non-Emergency hospital services require Preauthorization.	
Exclusions: Take home drugs, dressings and supplies following hospitalization; internally implanted insulin pumps and any other implantable device that have not been approved by KFHPWA's medical director	

Infertility (including sterility)	
General counseling and services to diagnose infertility conditions in accordance with KFHPWA clinical criteria.	After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply

	Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Treatment and prescription drugs.	Not covered; Member pays 100% of all charges
Exclusions: Medical treatment of sterility and infertility regardless of origin or cause; all charges and related services for donor materials; all forms of artificial intervention for any reason including artificial insemination and in-vitro fertilization; genetic testing for the detection of congenital and heritable disorders; surrogacy; and any devices, equipment and supplies related to the treatment of infertility	

Infusion Therapy	
Administration of Medically Necessary infusion therapy in an outpatient setting. Infusion therapy requires Preauthorization.	After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Administration of Medically Necessary infusion therapy in the home setting. Infusion therapy requires Preauthorization. To receive benefits for the administration of select infusion medications in the home setting, the drug must be obtained through KFHPWA's preferred specialty pharmacy and administered by a provider we identify. For a list of these specialty drugs or for more information about KFHPWA's specialty pharmacy network, please go to the KFHPWA website at www.kp.org/wa/formulary or contact Member Services.	No charge; Member pays nothing
Associated infused medications include, but are not limited to: • Antibiotics. • Hydration. • Chemotherapy. • Pain management. Preauthorization required.	After Deductible, Member pays 20% Plan Coinsurance

Laboratory and Radiology	
Nuclear medicine, radiology, ultrasound and laboratory services, including high end radiology imaging services such as CAT scan, MRI and PET which are subject to	After Deductible, Member pays 20% Plan Coinsurance

Preauthorization except when associated with Emergency services or inpatient services. Please contact Member Services for any questions regarding these services. Services received as part of an emergency visit are covered as Emergency Services. Preventive laboratory and radiology services are covered in accordance with the well care schedule established by KFHPWA and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in Kaiser Permanente medical centers, at www.kp.org/wa, or upon request from Member Services.	**Breast exams:** No charge, Member pays nothing **Urine Drug Screening:** No charge; Member pays nothing. Limited to 2 tests per calendar year. Benefits are applied in the order claims are received and processed. After allowance: after Deductible, Member pays 20% Plan Coinsurance

Manipulative Therapy	
Manipulative therapy of the spine and extremities when in accordance with KFHPWA clinical criteria, limited to a total of 10 visits per calendar year. Preauthorization is not required. Rehabilitation services, such as massage or physical therapy, provided with manipulations is covered under the Rehabilitation and Habilitative Care (massage, occupational, physical and speech therapy, pulmonary and cardiac rehabilitation) and Neurodevelopmental Therapy section.	After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Supportive care rendered primarily to maintain the level of correction already achieved; care rendered primarily for the convenience of the Member; care rendered on a non-acute, asymptomatic basis; charges for any other services that do not meet KFHPWA clinical criteria as Medically Necessary	

Maternity and Pregnancy	
Pregnancy care and services, including care for complications of pregnancy, in utero treatment for the fetus, prenatal testing for the detection of congenital and heritable disorders when Medically Necessary and prenatal and postpartum care are covered for all Members including eligible Dependents. Preventive services related to preconception, prenatal and postpartum care are covered as Preventive Services including breastfeeding support, supplies and counseling for each birth when Medically Necessary as determined by KFHPWA's medical director and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy. Delivery, care for complications of pregnancy and associated Hospital Care, including home births and Medically Necessary supplies for the home birth, and birthing centers. Home births are considered outpatient services.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance

Members must notify KFHPWA by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. The Member's provider, in consultation with the Member, will determine the Member's length of inpatient stay following delivery.	
Termination of pregnancy. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** No charge; Member pays nothing **Hospital - Outpatient:** No charge; Member pays nothing **Outpatient Services:** No charge; Member pays nothing
Exclusions: Birthing tubs; genetic testing of non-Members; fetal ultrasound not considered Medically Necessary	

Mental Health and Wellness	
Mental health and wellness services provided at the most clinically appropriate and Medically Necessary level of mental health care intervention as determined by KFHPWA's medical director. Treatment may utilize psychiatric, psychological and/or psychotherapy services to achieve these objectives. Mental health and wellness services including medical management and prescriptions are covered the same as for any other condition, including behavioral treatment for a DSM category diagnosis. Eating disorder treatment provided on an inpatient or outpatient basis must be Medically Necessary, and the treatment program must meet clinical criteria standards. The inpatient mental health and wellness benefit can only be used if a Member with an eating disorder also meets clinical criteria for inpatient psychiatric care. Applied behavioral analysis (ABA) therapy, limited to outpatient treatment of an autism spectrum disorder or, has a developmental disability for which there is evidence that ABA therapy is effective. Documented diagnostic assessments, individualized treatment plans and progress evaluations are required. Partial hospitalization is covered subject to Hospital - Outpatient Cost Shares. Services for any involuntary court-ordered treatment program shall be covered only if determined to be Medically Necessary by KFHPWA's medical director. Services provided under involuntary commitment statutes are covered.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, no charge; Member pays nothing. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance **Group Visits:** No charge, Member pays nothing

Coverage for services incurred at non-Network Facilities shall exclude any charges that would otherwise be excluded for hospitalization within a Network Facility. Members must notify KFHPWA by way of the KFHPWA Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Mental health and wellness services rendered to treat mental disorders are covered. Mental Disorders means mental disorders covered in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except as otherwise excluded under Sections IV. or V. Mental Health and Wellness Services means Medically Necessary outpatient services, Residential Treatment, partial hospitalization program, and inpatient services provided by a licensed facility or licensed providers, including advanced practice psychiatric nurses, mental health and wellness counselors, marriage and family therapists and social workers, except as otherwise excluded under Section IV. or V. Medically Necessary mental health and wellness services provided in an outpatient and home health setting. Mental health and wellness services are covered when Medically Necessary for treatment of parent-child relational problems for children 5 years of age or younger, neglect or abuse of a child for children five years of age or younger, bereavement for children five years of age or younger, and gender dysphoria unless preempted by federal law. Medically Necessary inpatient mental health and wellness services, partial hospitalization programs, and residential treatment must be provided at a hospital or facility that KFHPWA has approved specifically for the treatment of mental disorders. Non-Emergency inpatient hospital services, including Residential Treatment programs, require Preauthorization. Outpatient specialty services, including partial hospitalization, rTMS, ECT, and Esketamine require Preauthorization. Routine outpatient therapy and psychiatry services with Network Providers do not require Preauthorization.	
Exclusions: Specialty treatment programs such as “behavior modification programs” not considered Medically Necessary; parent-child relational problems for children six years of age and older; neglect or abuse counseling for individuals six years of age or older; bereavement counseling for individuals six years of age or older; counseling for relational or phase of life problems for individuals six years of age or older; wilderness therapy; aversion therapy	

Naturopathy	
Naturopathy. Laboratory and radiology services are covered only when obtained through a Network Facility.	After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Herbal supplements; nutritional supplements; any services not within the scope of the practitioner's licensure	

Newborn Services	
Newborn services, including nursery services and supplies, are covered the same as for any other condition. Any Cost Share for newborn services is separate from that of the mother. Preventive services for newborns are covered under Preventive Services. See Section VI.A.3. for information about temporary coverage for newborns. Newborn services care covered for newly adopted children.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance

Nutritional Counseling	
Nutritional counseling. Nutritional counseling is not subject to visit limitations. Services related to a healthy diet to prevent obesity are covered as Preventive Services.	After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Nutritional supplements; weight control self-help programs or memberships, such as Weight Watchers, Jenny Craig, or other such programs	

Nutritional Therapy	
Medical formula necessary for the treatment of phenylketonuria (PKU), specified inborn errors of metabolism, or other metabolic disorders.	After Deductible, Member pays 20% Plan Coinsurance
Enteral therapy is covered when Medical Necessity criteria are met and when given through a PEG, J tube, or orally, or for an eosinophilic gastrointestinal associated disorder. Necessary equipment and supplies for the administration of enteral therapy are covered as Devices, Equipment and Supplies.	After Deductible, Member pays 20% Plan Coinsurance
Parenteral therapy (total parenteral nutrition). Necessary equipment and supplies for the administration of parenteral therapy are covered as Devices, Equipment and Supplies.	After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Any other dietary formulas, medical foods, or oral nutritional supplements that do not meet Medical Necessity criteria or are not related to the treatment of inborn errors of metabolism; special diets and prepared foods/meals	

Obesity Related Services	
Services directly related to obesity, including bariatric surgery. Services related to obesity screening and counseling are covered as Preventive Services.	Not covered; Member pays 100% of all charges
Exclusions: Obesity treatment and treatment for morbid obesity for any reason including any medical services, drugs, supplies or any bariatric surgery (such as gastroplasty, gastric banding or intestinal bypass), regardless of co-morbidities, except as described above; specialty treatment programs such as weight control self-help programs or memberships, such as Weight Watchers, Jenny Craig or other such programs; medications and related physician visits for medication monitoring	

Oncology	
Radiation therapy, chemotherapy, oral chemotherapy. See Infusion Therapy for infused medications.	**Oral Chemotherapy Drugs:** After Deductible, Member pays 20% Plan Coinsurance up to a 90-day supply **Radiation Therapy and Chemotherapy:** After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply

	Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance

Optical (adult vision)	
Members age 19 and over – routine eye examinations and refractions, limited to one per calendar year. Eye and contact lens examinations for eye pathology and to monitor Medical Conditions when Medically Necessary.	**Routine Exams:** Member pays $40 Copayment **Exams for Eye Pathology:** After Deductible, Member pays 20% Plan Coinsurance. For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply. Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Contact lenses or framed lenses for eye pathology when Medically Necessary. One contact lens per diseased eye in lieu of an intraocular lens is covered following cataract surgery provided the Member has been continuously covered by KFHPWA since such surgery. In the event a Member's age or medical condition prevents the Member from having an intraocular lens or contact lens, framed lenses are available. Replacement of lenses for eye pathology, including following cataract surgery, is covered only once within a 12-month period and only when needed due to a change in the Member's prescription.	**Frames and Lenses:** Not covered; Member pays 100% of all charges **Contact Lenses or framed lenses for Eye Pathology:** After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Eyeglasses; contact lenses, contact lens evaluations, fittings and examinations not related to eye pathology; fees related to the lens fitting of non-network issued frames; orthoptic therapy (i.e., eye training); evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures	

Optical (pediatric vision)	
Members to age 19 – one routine screening eye examinations and one comprehensive examination with refractions, coverage is limited to one per calendar year. Eye and contact lens examinations for eye pathology and to monitor Medical Conditions when Medically Necessary.	**Routine Exams:** No charge; Member pays nothing **Exams for Eye Pathology:** After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance

Members to age 19 – eyeglass frames, lenses (any type), lens options such as tinting, or prescription contact lenses, contact lens evaluations and examinations associated with their fitting. The benefit period begins on January 1 and continues through the end of the calendar year. The benefit may be used toward contact lenses (in lieu of eyeglasses) or 1 eyeglass frame and pair of lenses in any of the following combination: • Eyeglass frames • Eyeglass lenses (any type) including tinting and coating • Corrective industrial (safety) lenses • Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation examinations Contact lenses or framed lenses for eye pathology when Medically Necessary. Note: Disposable contact lenses are available up to a 1-year supply as prescribed by the Member's provider. One contact lens per diseased eye in lieu of an intraocular lens is covered following cataract surgery provided the Member has been continuously covered by KFHPWA since such surgery. In the event a Member's age or medical condition prevents the Member from having an intraocular lens or contact lens, framed lenses are available. Replacement of lenses for eye pathology, including following cataract surgery, is covered only once within a 12-month period and only when needed due to a change in the Member's prescription. Replacement for loss or breakage is subject to the frames and lenses benefit.	**Frames and Lenses:** No charge; Member pays nothing for 1 set of frames and lenses (or contact lenses in lieu of eyeglasses) per calendar year **Contact Lenses or framed lenses for Eye Pathology after benefit is exhausted:** After Deductible, Member pays 20% Plan Coinsurance **After benefit is exhausted and there is no eye pathology indicated:** Not covered; Member pays 100% of all charges
Low vision evaluation and treatment including: • One comprehensive low vision evaluation every 5 years • Visual aids and devices such as high-power spectacles, magnifiers and telescopes as Medically Necessary • Four follow-up care visits for low vision services in a 5-year period Low vision services require Preauthorization.	**Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Fees related to the lens fitting of non-network issued frames; orthoptic therapy (i.e., eye training); evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures	

Oral Surgery	
Reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or non-dental cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth; and incision of salivary glands and ducts.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance

KFHPWA's medical director will determine whether the care or treatment required is within the category of Oral Surgery or Dental Services. Oral surgery requires Preauthorization.	**Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Care or repair of teeth or dental structures of any type; tooth extractions or impacted teeth; services related to malocclusion; services to correct the misalignment or malposition of teeth; any other services to the mouth, facial bones or teeth which are not medical in nature	

Outpatient Services	
Covered outpatient medical and surgical services in a provider's office including, but not limited to blood, blood products and blood storage, services and supplies of a blood bank, chronic disease management, routine costs during clinical trials, therapeutic injections, supplies, treatment arising from sexual assault, and Medically Necessary genetic testing. See Preventive Services for additional information related to chronic disease management. Office visits include visits provided in a clinic, outpatient hospital or ambulatory surgical center (ASC). All other services performed in the office, not billed as an office visit, or that are not related to the actual visit (separate surgical services or laboratory/radiology fees billed in conjunction with the office visit, for example) are not considered an office visit. See Hospital - Inpatient and Outpatient for outpatient hospital medical and surgical services, including ambulatory surgical centers.	After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance

Plastic and Reconstructive Surgery	
Plastic and reconstructive services: • Correction of a congenital disease or congenital anomaly in newborns and dependent children. • Correction of a Medical Condition following an injury or resulting from surgery which has produced a major effect on the Member's appearance, when in the opinion of KFHPWA's medical director such services can reasonably be expected to correct the condition.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance

• Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed. Members are covered for all stages of reconstruction on the non-diseased breast to produce a symmetrical appearance. Complications of covered mastectomy services, including lymphedemas, are covered. Plastic and reconstructive surgery requires Preauthorization.	For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Cosmetic services including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services	

Podiatry	
Medically Necessary foot care. Routine foot care covered when such care is directly related to the treatment of diabetes and other clinical conditions that affect sensation and circulation to the feet.	After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Exclusions: All other routine foot care	

Preventive Services	
Preventive services in accordance with the well care schedule established by KFHPWA. The well care schedule is available in Kaiser Permanente medical centers, at www.kp.org/wa, or upon request from Member Services. Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force (USPSTF). Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians. Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines. Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices. Flu vaccines are covered when provided by a non-network provider.	No charge; Member pays nothing

Preventive services include, but are not limited to, well adult and well child physical examinations; immunizations and vaccinations; preferred over-the-counter drugs as recommended by the USPSTF when obtained with a prescription; pap smears; preventive services related to preconception, prenatal and postpartum care; routine mammography screening, routine prostate cancer screening, colorectal cancer screening for Members who are age 45 or older or who are under age 45 and at high risk; obesity screening/counseling; healthy diet; physical activity counseling; and depression screening in adults, including maternal depression, pre-exposure prophylaxis (PrEP) for Members at high risk for HIV infection, screening for physical, mental, sexual, and reproductive health care needs arising from a sexual assault. Preventive care for chronic disease management includes treatment plans with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, quality of care measurement and results, and education and tools for patient self-management support. In the event preventive, wellness or chronic care management services are not available from a Network Provider, non-network providers are covered under this benefit when Preauthorized. Services provided during a preventive services visit, including laboratory services, which are not in accordance with the KFHPWA well care schedule are subject to Cost Shares. Eye refractions are not included under preventive services.	
Exclusions: Those parts of an examination and associated reports and immunizations that are not deemed Medically Necessary by KFHPWA for early detection of disease; diagnostic services	

Rehabilitation and Habilitative Care (massage, occupational, physical, speech therapy, pulmonary and cardiac rehabilitation) and Neurodevelopmental Therapy	
Rehabilitation services to restore function following illness, injury or surgery, limited to the following restorative therapies: occupational therapy, physical therapy, massage therapy and speech therapy. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery. Outpatient services require a prescription or order from a physician that reflects a written plan of care to restore function and must be provided by a rehabilitation team that may include a physician, nurse, physical therapist,	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance

occupational therapist, massage therapist or speech therapist. Preauthorization is not required. Rehabilitation care is limited to a combined total of 30 inpatient days and 25 outpatient visits per calendar year. Habilitative care includes Medically Necessary services or devices designed to help a Member keep, learn, or improve skills and functioning for daily living. Services may include occupational therapy, physical therapy, speech therapy, aural therapy, and health care devices when prescribed by a physician. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Habilitative care is limited to a combined total of 30 inpatient days and 25 outpatient visits per calendar year. Outpatient services include services provided by a school district that are not delivered pursuant to the Individuals with Disabilities Education Act (IDEA) or an Individual Education Plan (IEP). Treatments for cancer, and other chronic conditions are not included under rehabilitative or habilitative care. Services with mental health diagnoses are covered with no limit. Neurodevelopmental therapy to restore or improve function, including maintenance in cases where significant deterioration in the Member's condition would result without the services, is limited to the following therapies: occupational therapy, physical therapy and speech therapy. There is no visit limit for neurodevelopmental therapy services. Non-Emergency inpatient hospital services require Preauthorization.	
Cardiac rehabilitation is covered when clinical criteria are met. Preauthorization is required after initial visit.	After Deductible, Member pays 20% Plan Coinsurance
Pulmonary rehabilitation is covered when clinical criteria are met. Preauthorization is required after initial visit.	After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Specialty treatment programs; specialty rehabilitation programs including "behavior modification programs"; recreational, life-enhancing, relaxation or palliative therapy	

Reproductive Health	
Medically Necessary medical and surgical services for reproductive health, including consultations, examinations, procedures and devices, including device insertion and removal. See Maternity and Pregnancy for pregnancy care and termination of pregnancy services Reproductive health is the care necessary to support the reproductive system and the ability to reproduce. Reproductive health includes contraception, cancer and disease screenings, termination of pregnancy, maternity, prenatal and postpartum care.	**Hospital - Inpatient:** No charge; Member pays nothing **Hospital - Outpatient:** No charge; Member pays nothing **Outpatient Services:** No charge; Member pays nothing
All methods for Medically Necessary FDA-approved (including over-the-counter) contraceptive drugs, devices and products. Condoms are limited to 120 per 90-day supply. Contraceptive drugs may be allowed up to a 12-month supply and, when available, picked up in the provider's office. Note: Over-the-counter contraceptives can be purchased at any KFHPWA-designated pharmacy. Designated pharmacies may submit the claim. If self-payment is made at a non-KFHWA-designated pharmacy, a reimbursement claim may be made by utilizing the Member Reimbursement Drug Claim Form which can be obtained in the "Forms & Publications" section on www.kp.org/wa or by calling Member Services. To request an exception for quantity limits on condoms, members may submit a request online at www.KP.org/wa/formulary or by contacting Member Services.	No charge; Member pays nothing

Sexual Dysfunction	
One consultation visit to diagnose sexual dysfunction conditions.	After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Specific diagnostic services, treatment and prescription drugs.	Not covered; Member pays 100% of all charges
Exclusions: Diagnostic testing and medical treatment of sexual dysfunction regardless of origin or cause; devices, equipment and supplies for the treatment of sexual dysfunction	

Skilled Nursing Facility	
Skilled nursing care in a skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending physician, limited to a total of 60 days per calendar year. Care may include room and board; general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by a skilled nursing facility; services provided by a licensed behavioral health provider, and short-term restorative occupational therapy, physical therapy and speech therapy. Skilled nursing care in a skilled nursing facility requires Preauthorization.	After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Personal comfort items such as telephone and television; rest cures; domiciliary or Convalescent Care	

Sterilization	
FDA approved female sterilization procedures, services and supplies. See Preventive Services for additional information. Non-Emergency inpatient hospital services require Preauthorization.	No charge; Member pays nothing
Vasectomy and supplies. Non-Emergency inpatient hospital services require Preauthorization.	No charge; Member pays nothing
Exclusions: Procedures and services to reverse a sterilization	

Substance Use Disorder	
Substance use disorder services including, treatment provided in an outpatient or home health setting, and inpatient Residential Treatment; diagnostic evaluation and education; organized individual and group counseling; and/or prescription drugs unless excluded under Sections IV. or V. Substance use disorder means a substance-related or addictive disorder listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). For the purposes of this section, the definition of Medically Necessary shall be expanded to include those services necessary to treat a substance use disorder condition that is having a clinically significant impact on a Member's emotional, social, medical and/or occupational functioning.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, no charge, Member pays nothing. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance **Group Visits:** No charge, Member pays nothing

Substance use disorder services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57), a psychologist (licensed under RCW 18.83), a substance use disorder treatment program licensed for the service being provided by the Washington State Department of Social and Health Services (pursuant to RCW 70.96A), a master's level therapist (licensed under RCW 18.225.090), an advance practice psychiatric nurse (licensed under RCW 18.79) or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located. The severity of symptoms designates the appropriate level of care and should be determined through a thorough assessment completed by a licensed provider who recommends treatment based on medical necessity criteria. Court-ordered substance use disorder treatment shall be covered only if determined to be Medically Necessary. Preauthorization is required for outpatient, intensive outpatient, and partial hospitalization services. Preauthorization is required for residential treatment and non-Emergency inpatient hospital services provided at out-of-state facilities. Preauthorization is not required for Residential Treatment and non-Emergency inpatient hospital services provided in-state. Member is given two days of treatment and is then subject to medical necessity review for continued care. Member or facility must notify KFHPWA within 24 hours of admission, or as soon as possible. Member may request prior authorization for Residential Treatment and non-Emergency inpatient hospital services. Members may contact Member Services to request Preauthorization.	
Withdrawal Management Services for Alcoholism and Substance Use Disorder. Withdrawal management services means the management of symptoms and complications of alcohol and/or substance withdrawal. The severity of symptoms designates the appropriate level of care and should be determined through a thorough assessment completed by a licensed provider who recommends treatment based on medical necessity criteria. Outpatient withdrawal management services means the symptoms resulting from abstinence are of mild/moderate severity and withdrawal from alcohol and/or other drugs can be managed with medication at an outpatient level of care by an appropriately licensed clinician.	**Emergency Services Network Facility:** After Deductible, Member pays 20% Plan Coinsurance **Emergency Services Non-Network Facility:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance

Preauthorization is required for outpatient withdrawal management services. Coverage for inpatient withdrawal management services are provided without Preauthorization. Members must notify KFHPWA by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Member is given no less than two days of treatment, excluding weekends and holidays, in a behavioral health agency that provides inpatient or residential substance use disorder treatment; and no less than three days in a behavioral health agency that provides withdrawal management services prior to conducting a medical necessity review for continued care. Member or facility must notify KFHPWA within 24 hours of admission, or as soon as possible. Members may request preauthorization for Residential Treatment and non-Emergency inpatient hospital services by contacting Member Services. KFHPWA reserves the right to require transfer of the Member to a Network Facility/program upon consultation between a Network Provider and the attending physician. If the Member refuses transfer to a Network Facility/program, all further costs incurred during the hospitalization are the responsibility of the Member.	
Exclusions: Wilderness programs; aversion therapy; facilities and treatments programs which are not certified by the Department of Social Health Services	

Telehealth Services	
Telemedicine Services provided by the use of real-time interactive audio and video communications or store and forward technology between the patient at the originating site and a Network Provider at another location. Audio-only communication requires an Established Relationship. Store and forward technology means sending a Member's medical information from an originating site to the Provider at a distant site for later review. The Provider follows up with a medical diagnosis for the Member and helps manage their care. Services must meet the following requirements: • Be a Covered Service under this EOC. • The originating site is qualified to provide the service. • If the service is provided through store and forward technology, there must be an associated office visit between the Member and the referring provider • Is medically necessary	No charge; Member pays nothing

Telephone Services and Online (E-visits) Scheduled telephone visits with a Network Provider are covered. Online (e-visits): A Member logs into the secure Member site at www.kp.org/wa and completes a questionnaire. A KFHPWA medical provider reviews the questionnaire and provides a treatment plan for select conditions, including prescriptions. Online visits are not available to Members during in-person visits at a KFHPWA facility or pharmacy. More information is available at https://wa.kaiserpermanente.org/html/public/services/e-visit.	No charge; Member pays nothing
Exclusions: Fax and e-mail; telehealth services with non-contracted providers; telehealth services in states where prohibited by law; all other services not listed above	

Temporomandibular Joint (TMJ)	
Medical and surgical services and related hospital charges for the treatment of temporomandibular joint (TMJ) disorders including: • Medically Necessary orthognathic procedures for the treatment of severe TMJ disorders, which have failed non-surgical intervention. • Radiology services. • TMJ specialist services. • Fitting/adjustment of splints. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
TMJ appliances. See Devices, Equipment and Supplies for additional information.	After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Treatment for cosmetic purposes; bite blocks; dental services including orthodontic therapy and braces for any condition; any orthognathic (jaw) surgery in the absence of a diagnosis of TMJ or severe obstructive sleep apnea; hospitalizations related to these exclusions	

Tobacco Cessation	
Individual/group counseling and educational materials.	No charge; Member pays nothing
Approved pharmacy products. See Drugs – Outpatient Prescription for additional pharmacy information.	No charge; Member pays nothing

Transplants	
Transplant services, including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, liver transplants, and bone marrow and stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy. Services are limited to the following: • Inpatient and outpatient medical expenses for evaluation testing to determine recipient candidacy, donor matching tests, hospital charges, procurement center fees, professional fees, travel costs for a surgical team and excision fees. Donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees. • Follow-up services for specialty visits. • Rehospitalization. • Maintenance medications during an inpatient stay. Artificial organ transplants based on an issuer's medical guidelines and manufacturer recommendation. Transplant services must be provided through locally and nationally contracted or approved transplant centers. All transplant services require Preauthorization. Contact Member Services for Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance For the first 3 primary care provider office visit claims received and processed per calendar year, Member pays $40 Copayment. Deductible does not apply Following these 3 office visit claims: After Deductible, Member pays 20% Plan Coinsurance
Exclusions: Donor costs to the extent that they are reimbursable by the organ donor's insurance; treatment of donor complications; living expenses except as covered under Section II.G. Utilization Management	

Urgent Care	
Inside the KFHPWA Service Area, urgent care is covered at a Kaiser Permanente medical center, Kaiser Permanente urgent care center or Network Provider's office. Outside the KFHPWA Service Area, urgent care is covered at any medical facility. Urgent care includes provider services, facility costs and supplies. See Section XII. for a definition of Urgent Condition.	**Network Emergency Department:** After Deductible, Member pays 20% Plan Coinsurance **Network Urgent Care Center:** After Deductible, Member pays 20% Plan Coinsurance **Network Provider's Office:** After Deductible, Member pays 20% Plan Coinsurance **Non-Network Provider:** After Deductible, Member pays 20% Plan Coinsurance

V. General Exclusions

In addition to exclusions listed throughout the EOC, the following are not covered:

1. Benefits and related services, supplies and drugs that are not Medically Necessary for the treatment of an illness, injury, or physical disability, that are not specifically listed as covered in the EOC, except as required by federal or state law.

2. Services Related to a Non-Covered Service: When a service is not covered, all services related to the non-covered service (except for the specific exceptions described below) are also excluded from coverage. Members who have received a non-covered service, such as bariatric surgery, and develop an acute medical complication (such as band slippage, leak or infection) as a result, shall have coverage for Medically Necessary intervention to stabilize the acute medical complication. Coverage does not include complications that occur during or immediately following a non-covered service. Additional surgeries or other medical services in addition to Medically Necessary intervention to resolve the acute medical complications resulting from non-covered services shall not be covered.

3. Services or supplies for which no charge is made, or for which a charge would not have been made if the Member had no health care coverage or for which the Member is not liable; services provided by a family member, or self-care.

4. Academic/career counseling, counseling for overeating, work/school ordered assessments, relationship counseling, custodial care, Convalescent Care.

5. Services to the extent benefits are "available" to the Member as defined herein under the terms of any vehicle, homeowner's, property or other insurance policy, except for individual or group health insurance, pursuant to medical coverage, medical "no fault" coverage, personal injury protection coverage or similar medical coverage contained in said policy. For the purpose of this exclusion, benefits shall be deemed to be "available" to the Member if the Member receives benefits under the policy either as a named insured or as an insured individual under the policy definition of insured.

6. Services or care needed for injuries or conditions resulting from active or reserve military service, whether such injuries or conditions result from war or otherwise. This exclusion will not apply to conditions or injuries resulting from previous military service unless the condition has been determined by the U.S. Secretary of Veterans Affairs to be a condition or injury incurred during a period of active duty. Further, this exclusion will not be interpreted to interfere with or preclude coordination of benefits under Tri-Care.

7. Services provided by government agencies, except as required by federal or state law.

8. Services covered by the national health plan of any other country.

9. Experimental or investigational services.

   KFHPWA consults with KFHPWA's medical director and then uses the criteria described below to decide if a particular service is experimental or investigational.

   a. A service is considered experimental or investigational for a Member's condition if any of the following statements apply to it at the time the service is or will be provided to the Member:
      1) The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted.
      2) The service is the subject of a current new drug or new device application on file with the FDA.
      3) The service is the trialed agent or for delivery or measurement of the trialed agent provided as part of a qualifying Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial.
      4) The service is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy as among its objectives.
      5) The service is under continued scientific testing and research concerning the safety, toxicity or efficacy of services.
      6) The service is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity or efficacy.

7) The prevailing opinion among experts, as expressed in the published authoritative medical or scientific literature, is that (1) the use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity or efficacy of the service.

b. The following sources of information will be exclusively relied upon to determine whether a service is experimental or investigational:
   1) The Member's medical records.
   2) The written protocol(s) or other document(s) pursuant to which the service has been or will be provided.
   3) Any consent document(s) the Member or Member's representative has executed or will be asked to execute, to receive the service.
   4) The files and records of the Institutional Review Board (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.
   5) The published authoritative medical or scientific literature regarding the service, as applied to the Member's illness or injury.
   6) 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.

Appeals regarding KFHPWA denial of coverage can be submitted to the Member Appeal Department, or to KFHPWAs medical director at P.O. Box 34593, Seattle, WA 98124-1593.

10. Hypnotherapy and all services related to hypnotherapy.

11. Directed umbilical cord blood donations.

12. Prognostic (predictive) genetic testing and related services, unless specifically provided in Section IV. Testing for non-Members.

13. Autopsy and associated expenses.

14. Job skills training for specific occupations or educational therapy.

15. Expenses for services and supplies incurred as a result of any work-related injury or illness. This includes individuals who are partners, proprietors or corporate officers who are not covered by a Workers' Compensation Act or other similar law.

16. Over-the-counter items such as hearing aids unless specifically listed as covered in Section IV.

17. Court-ordered or forensic treatment, including reports and summaries, not considered Medically Necessary.

VI. Eligibility, Enrollment and Termination

A. Eligibility.

In order to be accepted for enrollment and continuing coverage, individuals are eligible as set forth below.

1. Contract Holders.
Must establish and maintain permanent residency in the KFHPWA Service Area for duration of enrollment.

2. Dependents.
The Contract Holder may also enroll the following:

a. The Contract Holder's legal spouse; or

b. The Contract Holder's state-registered domestic partner (as required by Washington state law); or the Contract Holder's non-state registered domestic partner provided that application has been submitted to approved by KFHPWA.

c. The Contract Holder's children who are under the age of 26.

"Children" means the children of the Contract Holder, spouse or eligible domestic partner, including adopted children, stepchildren, children for whom the Contract Holder has a qualified court order to provide coverage.

Eligibility may be extended past the Dependent's limiting age for a person enrolled as a Dependent on their 26th birthday if the Dependent is totally incapable of self-sustaining employment because of a developmental or physical disability incurred while eligible and enrolled under the EOC and is chiefly dependent upon the Contract Holder for support and maintenance. Enrollment for such a Dependent may be continued for the duration of the continuous total incapacity, provided enrollment does not terminate for any other reason. Medical proof of incapacity and proof of financial dependency must be submitted to KFHPWA within 31 days of the date a Dependent reaches the limiting age. Proof must also be furnished to KFHPWA upon request, but not more frequently than annually after the 2-year period following the Dependent's attainment of the limiting age.

3. Temporary Coverage for Newborns.
When a Member gives birth, the newborn is entitled to the benefits set forth in the EOC from birth through 3 weeks of age. All provisions, limitations and exclusions will apply. After 3 weeks of age, no benefits are available unless the newborn child qualifies as a Dependent and is enrolled.

4. Other KFHPWA Individual and Family Plans.
A Contract Holder enrolled on this Individual and Family Plan who subsequently wishes to change coverage for all Members covered under the plan to another Individual and Family Plan may change to any other open Individual and Family Plan, provided that all premium, Out-of-Pocket Expenses and charges incurred for non-Covered Services are paid in full during the annual open enrollment periods or during a special enrollment period as long as they meet a qualifying event.

5. Ineligible Persons.

a. Persons may not be enrolled under more than one individual KFHPWA medical coverage EOC at the same time.

b. Persons may not enroll in this plan who are enrolled for benefits under the Federal Medicare program.

c. KFHPWA reserves the right to refuse enrollment to any persons whose coverage under any medical coverage EOC issued by Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc. has been terminated for nonpayment or cause, as set forth in Subsection F. below.

B. Application for Enrollment.
Application for enrollment and adding or removing dependents must be made on an application approved by KFHPWA or through the Washington Health Benefit Exchange, as applicable for the Member's type of plan. Under the federal Patient Protection and Affordable Care Act of 2010, you cannot be denied health insurance, but coverage must be purchased during a limited period of time. Special enrollment periods may apply if there is a qualifying event. If one of the qualifying events listed below occurs, you have 60 days to buy coverage. The following qualifying events apply to all individual health plans:

- Loss of health coverage, including an employer plan.
- Loss of Apple Health (Medicaid) eligibility.
- Change of permanent residence outside the service area of the Member's current coverage.
- Change of permanent residence where additional health insurance plan options are available.

- Birth or adoption.
- COBRA eligibility/coverage ends.
- Dependent loss of eligibility on an employer plan due to age.
- Marriage or domestic partnership (dependents also qualify).
- Dissolution of marriage or domestic partnership.
- Discontinuation of Washington State Health Insurance Pool (WSHIP) coverage.
- Demonstrate that the health insurer violated an important provision of its contract with you, such as non-payment of claims for covered health care treatments.
- Loss of coverage due to errors made by the Washington Health Benefit Exchange.
- Become a legal resident.
- Change in income or household status that affects eligibility for tax credits or cost-sharing reductions.
- The Washington Health Benefit Exchange discontinues your coverage.
- Native American Members are allowed to change plans once a month.

In order for a person 17 years of age or younger to be enrolled, KFHPWA reserves the right to require a guarantor who is 18 years of age or older to cosign the EOC.

C. When Coverage Begins.

1. Effective Date of Enrollment.

- Enrollment for a newly eligible Contract Holder and listed Dependents is effective on the date specified by KFHPWA or the Washington Health Benefit Exchange following acceptance by KFHPWA and the Member.
- Enrollment for a newly dependent person, other than a newborn or adoptive child, is effective on the first of the month following the date eligibility requirements are met.
- Enrollment for newborns is effective from the date of birth.
- Enrollment for adoptive children is effective from the date that the adoptive child is placed with the Contract Holder for the purpose of adoption or the Contract Holder assumes total or partial financial support of the child.

2. Commencement of Benefits for Persons Hospitalized on Effective Date.

Members who are admitted to an inpatient facility prior to their enrollment will receive covered benefits beginning on their effective date, as set forth in Subsection C.1. above. If a Member is hospitalized in a non-Network Facility, KFHPWA reserves the right to require transfer of the Member to a Network Facility. The Member will be transferred when a Network Provider, in consultation with the attending physician, determines that the Member is medically stable to do so. If the Member refuses to transfer to a Network Facility, all further costs incurred during the hospitalization are the responsibility of the Member.

D. When Coverage Ends

Coverage ends on the last day of the month in which you lose eligibility, provided all premium amounts have been paid. Coverage for Dependent children will terminate at the end of the calendar year in which they reach the limiting age. In the case of non-payment of premium, coverage ends on the last day of the month for which premium has been received.

E. Eligibility for Medicare.

Individuals eligible for Medicare are not required to enroll in Medicare Parts A and B. An individual shall be deemed eligible for Medicare when they have the option to receive Part A Medicare benefits. Members who become eligible for Medicare benefits may continue coverage under the EOC or may enroll in coverage with the KFHPWA Medicare Advantage Plan as follows:

1. Continuation of Coverage under the Evidence of Coverage.

Members who become eligible to purchase Medicare are not required to enroll in both Medicare Parts A and B to remain eligible under the EOC, when Members continue to submit payment of the applicable premium set forth in the premium schedule.

2. Enrollment in KFHPWA's Medicare Advantage Plan.
Medicare-eligible Members residing inside the Medicare Advantage Service Area upon enrollment in both Medicare Parts A and B may enroll in a KFHPWA Medicare Advantage Plan. Once a Member has transferred from an individual plan to the Medicare Advantage Plan, they are not eligible or entitled to re-enrollment in an individual plan. A condition of coverage under the KFHPWA Medicare Advantage Plan requires that a Member be continuously fully qualified and enrolled for the hospital (Part A) and medical (Part B) benefits, available from the Social Security Administration and sign any papers that may be required by KFHPWA or Medicare. All applicable provisions of the KFHPWA Medicare Advantage Plan are fully set forth in each Medicare Evidence of Coverage.

F. Termination of Coverage.
This is a guaranteed renewable EOC and cannot be terminated except as provided in compliance with the KFHPWA or Washington Health Benefit Exchange terms and guidelines.

1. Non-payment of Premium.
2. The Member violates published policies applicable to this Plan which have been approved by the Washington State Insurance Commissioner.
3. The Member voluntarily disenrolls from this plan.
4. The Member commits fraudulent acts.
5. The Member materially breaches the terms of this contract or fails to meet all eligibility requirements.
6. There is a change in federal or state laws that no longer permit KFHPWA to continue offering this Plan.
7. Covered persons who fail to pay any deductible or copayment amount owed to the carrier and not the provider of health care services

The Member may appeal termination of coverage within 180 days from the date of the termination letter. See Section VIII. Appeals for complete details on the appeals process.

VII. Grievances

Grievance means a written or verbal complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or non-provision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier. The grievance process is outlined as follows:

Step 1: It is recommended that the Member contact the person involved or the manager of the medical center/department where they are having a problem, explain their concerns and what they would like to have done to resolve the problem. The Member should be specific and make their position clear. Most concerns can be resolved in this way.

Step 2: If the Member is still not satisfied, they should call or write to Member Services at P.O. Box 34590, Seattle, WA 98124-1590, 206-630-4640 or toll-free 1-800-290-8900. Most concerns are handled by phone within a few days. In some cases, the Member will be asked to write down their concerns and state what they think would be a fair resolution to the problem. An appropriate representative will investigate the Member's concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Member Rights and Responsibilities statement. This process can take up to 30 days to resolve after receipt of the Member's written or verbal statement.

If the Member is dissatisfied with the resolution of the complaint, they may contact Member Services. Assistance is available to Members who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process.

VIII. Appeals

Members are entitled to appeal through the appeals process if/when coverage for an item or service is denied due to an adverse determination made by the KFHPWA medical director. The appeals process is available for a Member to seek reconsideration of an adverse benefit determination (action). Adverse benefit determination (action) means any

of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate KFHPWA will comply with any new requirements as necessary under federal laws and regulations. Assistance is available to Members who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process. The most current information about your appeals process is available by contacting KFHPWA's Member Appeal Department at the address or telephone number below.

1. **Initial Appeal**
   If the Member or any representative authorized in writing by the Member wishes to appeal a KFHPWA decision to deny, modify, reduce or terminate coverage of or payment for health care services, they must submit a request for an appeal either orally or in writing to KFHPWA's Member Appeal Department, specifying why they disagree with the decision. The appeal must be submitted within 180 days from the date of the initial denial notice. KFHPWA will notify the Member of its receipt of the request within 72 hours of receiving it. Appeals should be directed to KFHPWA's Member Appeal Department, P.O. Box 34593, Seattle, WA 98124-1593, toll-free 1-866-458-5479.

   A party not involved in the initial coverage determination and not a subordinate of the party making the initial coverage determination will review the appeal request. KFHPWA will then notify the Member of its determination or need for an extension of time within 14 days of receiving the request for appeal. Under no circumstances will the review timeframe exceed 30 days without the Member's written permission.

   For appeals involving experimental or investigational services KFHPWA will make a decision and communicate the decision to the Member in writing within 20 days of receipt of the appeal.

   There is an **expedited/urgent appeals process** in place for cases which meet criteria or where delay using the standard appeal review process will seriously jeopardize the Member's life, health or ability to regain maximum function or subject the Member to severe pain that cannot be managed adequately without the requested care or treatment. The Member can request an expedited/urgent appeal in writing to the above address, or by calling KFHPWA's Member Appeal Department toll-free 1-866-458-5479. The nature of the patient's condition will be evaluated by a physician and if the request is not accepted as urgent, the Member will be notified in writing of the decision not to expedite and given a description on how to grieve the decision. If the request is made by the treating physician who believes the Member's condition meets the definition of expedited, the request will be processed as expedited.

   The request for an expedited/urgent appeal will be processed and a decision issued no later than 72 hours after receipt of the request.

   The Member may also request an external review at the same time as the internal appeals process if it is an urgent care situation or the Member is in an ongoing course of treatment.

   If the Member requests an appeal of a KFHPWA decision denying benefits for care currently being received, KFHPWA will continue to provide coverage for the disputed benefit pending the outcome of the appeal. If the KFHPWA determination stands, the Member may be responsible for the cost of coverage received during the review period.

   The U.S. Department of Health and Human Services has designated the Washington State Office of the Insurance Commissioner's Consumer Protection Division as the health insurance consumer ombudsman. The Consumer Protection Division Office can be reached by mail at Washington State Insurance Commissioner, Consumer Protection Division, P.O. Box 40256, Olympia, WA 98504-0256 or at toll-free 1-800-562-6900. More information about requesting assistance from the Consumer Protection Division Office can be found at http://www.insurance.wa.gov/your-insurance/health-insurance/appeal/.

2. Next Level of Appeal

If the Member is not satisfied with the decision regarding medical necessity, medical appropriateness, health care setting, level of care, or if the requested service is not efficacious or otherwise unjustified under evidence-based medical criteria, or if KFHPWA fails to adhere to the requirements of the appeals process, the Member may request a second level review by an external independent review organization not legally affiliated with or controlled by KFHPWA. KFHPWA will notify the Member of the name of the external independent review organization and its contact information. The external independent review organization will accept additional written information for up to 5 business days after it receives the assignment for the appeal. The external independent review will be conducted at no cost to the Member. Once a decision is made through an independent review organization, the decision is final and cannot be appealed through KFHPWA.

If the Member request an appeal of a KFHPWA decision denying benefits for care currently being received, KFHPWA will continue to provide coverage for the disputed benefit pending the outcome of the appeal. If the KFHPWA determination stands, the Member may be responsible for the cost of coverage received during the review period.

A request for a review by an independent review organization must be made within 180 days after the date of the initial appeal decision notice.

IX. Claims

Claims for benefits may be made before or after services are obtained. KFHPWA recommends that the provider requests Preauthorization. In most instances, contracted providers submit claims directly to KFHPWA. If your provider does not submit a claim, to make a claim for benefits, a Member must contact Member Services, or submit a claim for reimbursement as described below. Other inquiries, such as asking a health care provider about care or coverage, or submitting a prescription to a pharmacy, will not be considered a claim for benefits.

If a Member receives a bill for services the Member believes are covered, the Member must, within 90 days of the date of service, or as soon thereafter as reasonably possible, either (1) contact Member Services to make a claim; (2) pay the bill and submit a claim for reimbursement of Covered Services; or (3) for out-of-country claims (Emergency care only) – submit the claim and any associated medical records, including the type of service, charges, and proof of travel to KFHPWA, P.O. Box30766, Salt Lake City, UT 84130-0766. In no event, except in the absence of legal capacity, shall a claim be accepted later than 1 year from the date of service.

KFHPWA will generally process claims for benefits within the following timeframes after KFHPWA receives the claims:

- Immediate request situations – within 1 business day.
- Concurrent urgent requests – within 24 hours.
- Urgent care review requests – within 48 hours.
- Non-urgent preservice review requests – within 5 calendar days.
- Post-service review requests – within 30 calendar days.

Timeframes for pre-service and post-service claims can be extended by KFHPWA for up to an additional 15 days. Members will be notified in writing of such extension prior to the expiration of the initial timeframe.

X. Coordination of Benefits

The coordination of benefits (COB) provision applies when a Member 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 according to 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. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings.

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

All health plans have timely claim filing requirements. If the Member or the Member's provider fails to submit the Member's claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If the Member experiences delays in the processing of the claim by the primary health plan, the Member or the Member's provider will need to submit the claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

If the Member is covered by more than one health benefit plan, the Member or the Member's provider should file all the Member's claims with each plan at the same time. If Medicare is the Member's primary plan, Medicare may submit the Member's claims to the Member's secondary carrier.

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. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

   1. Plan includes: group, individual or blanket disability insurance contracts and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans; unless permitted by law.

   Each contract for coverage under Subsection 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 Member 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 must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim. This means that when this plan is secondary, it must pay the amount which, when combined with what the primary plan paid, totals 100% of the allowable expense. In addition, if this plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the primary plan) and record these savings as a benefit reserve for the covered Member. This reserve must

be used by the secondary plan to pay any allowable expenses not otherwise paid, that are incurred by the covered person during the claim determination period.

D. Allowable Expense. Allowable expense is a health care expense, coinsurance or copayments and without reduction for any applicable deductible, 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 Member 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 Member is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

   3. If a Member 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. An expense or a portion of an expense that is not covered by any of the plans covering the person is not an allowable expense.

E. Closed panel plan is a plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily 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 Member 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 under any other plan.

B. (1) Except as provided below (subsection 2), a plan that does not contain a coordination of benefits provision that is consistent with this chapter 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 is excess to any other parts of the plan provided by the Contract Holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

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 Member other than as a Dependent, for example as an employee, member, policyholder, Contract Holder or retiree is the primary plan and the plan that covers

the Member 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 Member as a Dependent, and primary to the plan covering the Member 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 Member as an employee, member, policyholder, Contract Holder or retiree is the secondary plan and the other plan is the primary plan.

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

   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
      - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

   b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;
      ii. If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
      iii. 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 a) above determine the order of benefits;
      iv. 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 Subsection a) above determine the order of benefits; or
      v. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         - The plan covering the custodial parent, first;
         - The plan covering the spouse of the custodial parent, second;
         - The plan covering the non-custodial parent, third; and then
         - The plan covering the spouse of the non-custodial parent, last.

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

3. Active employee or retired or laid-off employee. The plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same Member as a retired or laid off employee is the secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same Member 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 under Section D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a Member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the Member as an employee, member, Contract Holder or retiree or covering the Member as a Dependent of an employee, member, Contract Holder 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 under Section D.1. can determine the order of benefits.

5. Longer or shorter length of coverage. The plan that covered the Member as an employee, member, Contract Holder or retiree longer is the primary plan and the plan that covered the Member the shorter period of time is the secondary plan.

6. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of this Plan.
When this plan is secondary, it must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total allowable expense for that claim. However, in no event shall the secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings. In no event should the Member be responsible for a deductible amount greater than the highest of the two deductibles.

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. KFHPWA may get the facts it needs 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 Member claiming benefits. KFHPWA need not tell, or get the consent of, any Member to do this. Each Member claiming benefits under this plan must give KFHPWA any facts it needs to apply those rules and determine benefits payable.

Facility of Payment.
If payments that should have been made under this plan are made by another plan, KFHPWA has the right, at its discretion, to remit to the other plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other plan are considered benefits paid under this plan. To the extent of such payments, KFHPWA is fully discharged from liability under this plan.

Right of Recovery.
KFHPWA has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. KFHPWA may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

Questions about Coordination of Benefits? Contact the State Insurance Department.

Effect of Medicare.
Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status, and will be adjudicated by KFHPWA as set forth in this section. KFHPWA will pay primary to Medicare when required by federal law. When Medicare, Part A and Part B or Part C are primary, Medicare's allowable amount is the highest allowable expense.

When a Network Provider renders care to a Member who is eligible for Medicare benefits, and Medicare is deemed to be the primary bill payer under Medicare secondary payer guidelines and regulations, KFHPWA will seek Medicare reimbursement for all Medicare covered services.

XI. Subrogation and Reimbursement Rights

The benefits under this EOC will be available to a Member for injury or illness caused by another party, subject to the exclusions and limitations of this EOC. If KFHPWA provides benefits under this EOC for the treatment of the injury or illness, KFHPWA will be subrogated to any rights that the Member may have to recover compensation or damages related to the injury or illness and the Member shall reimburse KFHPWA for all benefits provided, from any amounts the Member received or is entitled to receive from any source on account of such injury or illness, whether by suit, settlement or otherwise. This section more fully describes KFHPWA's subrogation and reimbursement rights, including but not limited to:

- Payments made by a third party or any insurance company on behalf of the third party;

- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate an Injured Person for injuries resulting from an accident or alleged negligence.

"Injured Person" under this section means a Member covered by the EOC who sustains an injury or illness and any spouse, dependent or other person or entity that may recover on behalf of such Member including the estate of the Member and, if the Member is a minor, the guardian or parent of the Member. When referred to in this section, "KFHPWA's Medical Expenses" means the expenses incurred and the value of the benefits provided by KFHPWA under this EOC for the care or treatment of the injury or illness sustained by the Injured Person.

If the Injured Person's injuries were caused by a third party giving rise to a claim of legal liability against the third party and/or payment by the third party to the Injured Person and/or a settlement between the third party and the Injured Person, KFHPWA shall have the right to recover KFHPWA's Medical Expenses from any source available to the Injured Person as a result of the events causing the injury. This right is commonly referred to as "subrogation." KFHPWA shall be subrogated to and may enforce all rights of the Injured Person to the full extent of KFHPWA's Medical Expenses.

By accepting benefits under this plan, the Injured Person also specifically acknowledges KFHPWA's right of reimbursement. This right of reimbursement attaches when this KFHPWA has provided benefits for injuries or illnesses caused by another party and the Injured Person or the Injured Person's representative has recovered any amounts from a third party or any other source of recovery. KFHPWA's right of reimbursement is cumulative with and not exclusive of its subrogation right and KFHPWA may choose to exercise either or both rights of recovery.

In order to secure KFHPWA's recovery rights, the Injured Person agrees to assign KFHPWA any benefits or claims or rights of recovery they may have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows KFHPWA to pursue any claim the Injured Person may have, whether or not they choose to pursue the claim.

KFHPWA's subrogation and reimbursement rights shall be limited to the excess of the amount required to fully compensate the Injured Person for the loss sustained, including general damages.

Subject to the above provisions, if the Injured Person is entitled to or does receive money from any source as a result of the events causing the injury or illness, including but not limited to any liability insurance or uninsured/underinsured motorist funds, KFHPWA's Medical Expenses are secondary, not primary.

The Injured Person and their agents shall cooperate fully with KFHPWA in its efforts to collect KFHPWA's Medical Expenses. This cooperation includes, but is not limited to, supplying KFHPWA with information about the cause of injury or illness, any potentially liable third parties, defendants and/or insurers related to the Injured Person's claim. The Injured Person shall notify KFHPWA within 30 days of any claim that may give rise to a claim for subrogation or reimbursement. The Injured Person shall provide periodic updates about any facts that may impact KFHPWA's right to reimbursement or subrogation as requested by KFHPWA, and shall inform KFHPWA of any settlement or other payments relating to the Injured Person's injury. The Injured Person and their agents shall permit KFHPWA, at KFHPWA's option, to associate with the Injured Person or to intervene in any legal, quasi-legal, agency or any other action or claim filed.

The Injured Person and their agents shall do nothing to prejudice KFHPWA's subrogation and reimbursement rights. The Injured Person shall promptly notify KFHPWA of any tentative settlement with a third party and shall not settle a claim without protecting KFHPWA's interest. The Injured Person shall provide 21 days advance notice to KFHPWA before there is a disbursement of proceeds from any settlement with a third party that may give rise to a claim for subrogation or reimbursement. If the Injured Person fails to cooperate fully with KFHPWA in recovery of KFHPWA's Medical Expenses, and such failure prejudices KFHPWA's subrogation and/or reimbursement rights, the Injured Person shall be responsible for directly reimbursing KFHPWA for 100% of KFHPWA's Medical Expenses.

To the extent that the Injured Person recovers funds from any source that in any manner relate to the injury or illness giving rise to KFHPWA's right of reimbursement or subrogation, the Injured Person agrees to hold such monies in trust or in a separate identifiable account until KFHPWA's subrogation and reimbursement rights are fully determined and that KFHPWA has an equitable lien over such monies to the full extent of KFHPWA's Medical Expenses and/or the Injured Person agrees to serve as constructive trustee over the monies to the extent of KFHPWA's Medical Expenses. In the event that such monies are not so held, the funds are recoverable even if they have been comingled with other assets, without the need to trace the source of the funds. Any party who distributes funds without regard to KFHPWA's rights of subrogation or reimbursement will be personally liable to KFHPWA for the amounts so distributed.

If reasonable collections costs have been incurred by an attorney for the Injured Person in connection with obtaining recovery, KFHPWA will reduce the amount of reimbursement to KFHPWA by the amount of an equitable apportionment of such collection costs between KFHPWA and the Injured Person. This reduction will be made only if each of the following conditions has been met: (i) KFHPWA receives a list of the fees and associated costs before settlement and (ii) the Injured Person's attorney's actions were directly related to securing recovery for the Injured Party.

Implementation of this section shall be deemed a part of claims administration and KFHPWA shall therefore have discretion to interpret its terms.

XII. Definitions

Allowance	The maximum amount payable by KFHPWA for certain Covered Services.
Allowed Amount	The level of benefits which are payable by KFHPWA when expenses are incurred from a non-Network Provider. Expenses are considered an Allowed Amount if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies. Members shall be required to pay any difference between a non-Network Provider's charge for services and the Allowed Amount, except for Emergency services, including post stabilization and for ancillary services provided by a non-Network provider at a Network Facility. For more information about balance billing protections, please visit: https://healthy.kaiserpermanente.org/washington/support/forms and choose the "Billing forms" link.
Contract Holder	The primary individual in whose name the Evidence of Coverage is issued.
Convalescent Care	Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in walking, dressing, bathing, eating, preparation of special diets, and taking medication.
Copayment	The specific dollar amount a Member is required to pay at the time of service for certain Covered Services.
Cost Share	The portion of the cost of Covered Services for which the Member is liable. Cost Share includes Copayments, coinsurances and Deductibles.
Covered Services	The services for which a Member is entitled to coverage in the Evidence of Coverage.
Creditable Coverage	Coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated

	through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, the actuarial determination measures whether the expected amount of paid claims under KFHPWA's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.
Deductible	A specific amount a Member is required to pay for certain Covered Services before benefits are payable.
Dependent	Any member of a Contract Holder's family who meets all applicable eligibility requirements, is enrolled hereunder and for whom the premium has been paid.
Emergency	The emergent and acute onset of a medical, mental health or substance use disorder symptom or symptoms, including but not limited to severe pain or emotional distress, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily function or serious dysfunction of a bodily organ or part, or would place the Member's health, or if the Member is pregnant, the health of the unborn child, in serious jeopardy, or any other situations which would be considered an emergency under applicable federal or state law.
Essential Health Benefits	Benefits set forth under the Patient Protection and Affordable Care Act of 2010, including the categories of ambulatory patient 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.
Established Relationship	Member must have had at least one in-person appointment or at least one real-time interactive appointment using both audio and visual technology in the past year , with the provider providing audio only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by KFHPWA. Or the Member was referred to the provider providing audio-only telemedicine by a provider who they have had an in-person appointment within the past year.
Evidence of Coverage	The Individual and Family medical coverage agreement between KFHPWA and the Contract Holder.
Family Unit	A Contract Holder and all their Dependents.
Hospital Care	Those Medically Necessary services generally provided by acute general hospitals for admitted patients.
KFHPWA-designated Specialist	A specialist specifically identified by KFHPWA.
Medical Condition	A disease, illness or injury.
Medically Necessary	Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Members will be notified in writing when a determination has been made. Appropriate and clinically necessary services, as determined by KFHPWA's medical director according to generally accepted principles of good medical practice, which are rendered to a Member for the diagnosis,

	care or treatment of a Medical Condition and which meet the standards set forth below. In order to be Medically Necessary, services and supplies must meet the following requirements: (a) are not solely for the convenience of the Member, their family member or the provider of the services or supplies, including exercise equipment and home modifications such as ramps and walkways; (b) are the most appropriate level of service or supply which can be safely provided to the Member; (c) are for the diagnosis or treatment of an actual or existing Medical Condition unless being provided under KFHPWA's schedule for preventive services; (d) are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions; (e) are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the Member's condition or the quality of health services rendered; (f) as to inpatient care, could not have been provided in a provider's office, the outpatient department of a hospital or a non-residential facility without affecting the Member's condition or quality of health services rendered; (g) are not primarily for research and data accumulation; and (h) are not experimental or investigational. The length and type of the treatment program and the frequency and modality of visits covered shall be determined by KFHPWA's medical director. In addition to being medically necessary, to be covered, services and supplies must be otherwise included as a Covered Service and not excluded from coverage.
Medicare	The federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).
Medicare Advantage Plan	A plan of coverage for persons enrolled in Medicare Part A (hospital insurance) and Part B (medical insurance).
Member	Any enrolled Contract Holder or Dependent.
Network Facility	A facility (hospital, medical center or health care center) owned, or operated by Kaiser Foundation Health Plan of Washington or otherwise designated by KFHPWA, or with whom KFHPWA has contracted to provide health care services to Members.
Network Personal Physician	A provider who is employed by Kaiser Foundation Health Plan of Washington or Washington Permanente Medical Group, P.C., or contracted with KFHPWA to provide primary care services to Members and is selected by each Member to provide or arrange for the provision of all non-emergent Covered Services, except for services set forth in the EOC which a Member can access without Preauthorization. Network Personal Physicians must be capable of and licensed to provide the majority of primary health care services required by each Member.
Network Provider	The medical staff, clinic associate staff and allied health professionals employed by Kaiser Foundation Health Plan of Washington or Washington Permanente Medical Group, P.C., and any other health care professional or provider with whom KFHPWA has contracted to provide health care services to Members, including, but not limited to physicians, podiatrists, nurses, physician assistants, social workers, optometrists, psychologists, physical therapists and other professionals engaged in the delivery of healthcare services who are licensed or certified to practice in accordance with Title 18 Revised Code of Washington.
Out-of-pocket Expenses	Those Cost Shares paid by the Contract Holder or Member for Covered Services which are applied to the Out-of-pocket Limit.

Out-of-pocket Limit	The maximum amount of Out-of-pocket Expenses incurred and paid during the calendar year for Covered Services received by the Contract Holder and their Dependents within the same calendar year. The Out-of-pocket Expenses which apply toward the Out-of-pocket Limit are set forth in Section IV.
Plan Coinsurance	The percentage amount the Member is required to pay for Covered Services received.
Preauthorization	An approval by KFHPWA that entitles a Member to receive Covered Services from a specified health care provider. Services shall not exceed the limits of the Preauthorization and are subject to all terms and conditions of the EOC. Members who have a complex or serious medical or psychiatric condition may receive a standing Preauthorization for specialty care provider services.
Private Duty Nursing (or 24-hour nursing care)	The hiring of a nurse by a family or Member to provide long term and/or continuous one on one care with or without oversight by a home health agency. The care may be skilled, supportive or respite in nature.
Residential Treatment	A term used to define facility-based treatment, which includes 24 hours per day, 7 days per week rehabilitation. Residential Treatment services are provided in a facility specifically licensed in the state where it practices as a residential treatment center. Residential treatment centers provide active treatment of patients in a controlled environment requiring at least weekly physician visits and offering treatment by a multi-disciplinary team of licensed professionals.
Service Area	Washington counties of Benton, Columbia, Franklin, Island, King, Kitsap, Lewis, Mason, Pierce, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman and Yakima.
Urgent Condition	The sudden, unexpected onset of a Medical Condition that is of sufficient severity to require medical treatment within 24 hours of its onset.