KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

A nonprofit health maintenance organization

Small Group

HMO HSA
Evidence of Coverage

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Important Notice Under Federal Health Care Reform

Kaiser Foundation Health Plan of Washington ("KFHPWA") recommends that each Member choose a Network Personal Physician. This decision is important because the designated 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 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 contact Kaiser Permanente Member Services at 206-630-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

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. However, the health care professional may be required to comply with certain procedures, including obtaining Preauthorization for specific services, or following a pre-approved treatment plan, For a list of participating health care professionals who specialize in obstetrics or gynecology, please contact Kaiser Permanente Member Services at 206-630-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

Women's health and cancer rights
If the Member receives 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 lymphedema.

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 Evidence of Coverage (EOC).

Statement of Rights Under the Newborns' and Mothers' Health Protection Act
Carriers offering group health coverage may not, under federal law, restrict benefits for any hospital 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. Federal law 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). However, carriers may not, under federal law, require a provider to obtain authorization for prescribing a length of stay not more than 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.

Discussing treatment alternatives
While Kaiser Permanente doesn't cover every kind of treatment or procedure (no health plan does), Kaiser Permanente doesn't use financial incentives or penalties that encourage doctors or other clinicians to withhold Medically Necessary services or discourage them from discussing recognized medical alternatives with you. The only financial incentives used are rewards for medical groups and hospitals that meet quality care measures (such as cancer screenings) and patient satisfaction targets.

Important resources
Visit kp.org/wa/important-resources to learn about coverage documents, other plan documents, and preventive care schedules. You can also find information about our quality program hospital care, and safety ratings, women's health and cancer rights, and important health plan and pharmacy disclosures.

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Case management for chronic conditions
Registered nurses certified in case management offer phone-based support for managing chronic asthma, diabetes, high blood pressure, cholesterol, or heart disease. Call 1-866-656-4183.

Complex case management
A specially trained nurse — in partnership with your personal care doctor — can assist Members who need or want support managing multiple chronic conditions, medications, and providers. Call 1-866-656-4183.

For More Information

KFHPWA will provide information about the types of plans offered by KFHPWA to Members on request. Please contact Kaiser Permanente Member Services at 206-630-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

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I. Introduction

Note: This is a Health Savings Account (HSA) Qualified Health Plan. The health plan meets all requirements to be used in conjunction with a Member-initiated Health Savings Account. The provisions of the EOC do not override, or take the place of, any regulatory requirements for Health Savings Accounts. Participation in a Health Savings Account is not a requirement for enrollment or continued eligibility. Kaiser Foundation Health Plan of Washington ("KFHPWA") is not a trustee, administrator or fiduciary of any Health Savings Account which may be used in conjunction with the EOC. Please contact the Health Savings Account trustee or administrator regarding questions about requirements for Health Savings Accounts.

This Evidence of Coverage (EOC) describes benefits, exclusions and other provisions as set forth in the Group medical coverage agreement between KFHPWA and the Group. The benefits were approved by the Group who contracts with KFHPWA for health care coverage. This EOC is not the Group medical coverage agreement itself. In the event of a conflict between the Group medical coverage agreement and the EOC, the EOC language will govern.

The provisions of the EOC must be considered together to fully understand the benefits available. Words with special meaning are capitalized and defined in Section XII.

For benefit questions, contact Kaiser Permanente Member Services at 206-630-4636 or toll-free 1-888-901-4636.

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

- **Sign up for healthy lifestyle programs.** With our online wellness programs, you'll get advice, encouragement, and tools to help you create positive changes in your life. Our programs can help you lose weight, eat healthier, quit smoking, reduce stress, and manage ongoing conditions like diabetes or depression. Start with a Total Health Assessment, a simple online survey that provides an overview of your health. You can also share and discuss the results with your doctor. Visit kp.org/healthylifestyles.
- **Get a wellness coach.** If you need a little extra support, we offer Wellness Coaching by Phone. You'll work one-on-one with your personal coach to develop a plan to help you reach your health goals. Visit kp.org/wellnesscoach.
- **Join health classes.** You can sign up for health classes and support groups. Classes vary at each location, and some may require a fee. Visit kp.org/classes.
- **Self-care.** Manage stress, improve your mood, sleep better, and more with the help of wellness apps, available to adult members. Visit kp.org/selfcareapps.
- **Health guides.** Stay informed on popular health subjects or discover something new through our healthy living guides. Visit kp.org/livehealthy.

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

II. How Covered Services Work

A. Accessing Care.

1. Members are entitled to Covered Services from the following:
Your Provider Network is KFHPWA's Core (Network). Members are entitled to Covered Services only at Network Facilities and from Network Providers, except for Emergency services and for 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, provided that: (1) the service is within the lawful scope of

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the nurse's license, and (2), this EOC would have provided coverage if the 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 visiting www.kp.org/wa. Information available online includes each physician's location, education, credentials, and specialties. KFHPWA also uses Health Care Benefit Managers for certain services. A current list of Health Care Benefit Managers is available at https://healthy.kaiserpermanente.org/washington/support/forms by selecting the "Health Care Benefit Managers (HCBMs) " link.

Receiving Care in another Kaiser Foundation Health Plan Service Area
If you are visiting another Kaiser Permanente service area or service area of a Health Plan affiliate visiting member services may be available from designated providers in that Kaiser Permanente or Health Plan affiliate service area if the services are covered under this EOC. Services are subject to the provisions of this EOC including, but not limited to, Preauthorization and cost sharing. For more information about receiving visiting member services in other Kaiser Permanente or Health Plan affiliate service areas, including provider and facility locations, contact Kaiser Permanente Member Services at 206-630-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636. Information is also available 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 or 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 cost. Amounts paid for non-Covered Services do not apply 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 personal physician may be selected for each family member. To select or change Network Personal Physicians, or to obtain a list of participating personal physicians, contact Kaiser Permanente Member Services at 206- 630-4636 in the Seattle area, or toll-free in Washington at 1-888-901-4636 or visit www.kp.org/wa. The change will be effective within 24 hours of the receipt of 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 assist you in obtaining access to a Network personal physician.

To find a personal physician, contact Member Services or visit www.kp.org/wa to view physician profiles, which include location, education, credentials, and specialties.

Members may choose a personal physician from the following specialties:
- Family medicine
- Adult medicine/internal medicine
- Pediatrics/adolescent medicine (for children up to 18)

Members should check that the physician they are considering is accepting new patients.

If a selected physician does not meet a Member's need, the Member may change personal physicians at any time and for any reason. If a Member does not select a physician upon enrollment, KFHPWA will assign a physician to ensure the Member has access to care when needed.

If a Member's personal physician no longer participates in the KFHPWA Network, the Member will continue to have access to that physician for up to 60 days following a written notice and will be offered a selection of new Network personal physicians.

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3. **Specialty Care Provider Services.**
Unless otherwise indicated in Section II. or Section IV., Preauthorization is required for specialty care services provided by specialists that are not KFHPWA-designated Specialists and who are not providing care at facilities owned and operated by Kaiser Permanente.

KFHPWA-designated Specialist.
Preauthorization is not required for services provided by KFHPWA-designated Specialists at facilities owned and operated by Kaiser Permanente. To access a KFHPWA-designated Specialist, consult your KFHPWA personal physician. For a list of KFHPWA designated specialists, contact Member Services or view the Provider Directory 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 received at a Network Facility or non-Network Facility are covered. Members must notify KFHPWA by calling 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 believe you are experiencing an Emergency, go immediately to the nearest Emergency care facility or call 911. For an illness or injury that requires prompt medical attention but is not an Emergency, go to the closest urgent care center . Examples include, but are not limited to minor injuries, wounds, or cuts needing stitches; minor breathing issues; or minor stomach pain. If you are unsure whether urgent care is your best option, call the Consulting Nurse Service at 1-800-297-6877 or 206-630-2244 for advice.

If you require Emergency care while traveling and are admitted to a non-Network hospital, you or a family member must notify KFHPWA within 24 hours after care begins, or as soon as medically possible. Call the notification line listed on the back of your KFHPWA Member ID card to help ensure your claim is accepted. Keep all receipts and related documentation from non-Network care. These must be submitted with any claim for reimbursement after returning from travel.

Access to non-Emergency care across the Network Service Area: Your Plan provides access to all providers in the Network, including physicians and services at Kaiser Permanente medical facilities and other Network Facilities throughout the state. Provider information is available at www.kp.org/wa/directory or by contacting Member Services at 1-888-901- 4636.

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 regarding urgent care.

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

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7. **Women's Health Care Direct Access Providers.**
Female Members may obtain women's health care services directly, without Preauthorization, from 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. Covered Services include Medically Necessary maternity care, covered reproductive health services, preventive services (well-care), general examinations, gynecological care and follow-up visits for these services.

Women's health care services are covered as if the Member's Network Personal Physician had been consulted and are subject to any applicable Cost Shares. If a women's health care provider diagnoses a condition requiring other specialty care or hospitalization, the Member or the provider must obtain Preauthorization in accordance with applicable KFHPWA requirements. For a list of KFHPWA providers, contact Member Services or view the Provider Directory at www.kp.org/wa.

8. **Travel Advisory Services.**
The Travel Advisory Service provides recommendations for travel outside the United States. Nurses certified in travel health advise Members regarding vaccinations or medications based on destination, activities, and medical history. The consultation is not a covered benefit and a fee applies for a KFHPWA Member's first use of the service. Travel-related vaccinations and medications are generally not covered. For more information, visit www.kp.org/wa/travel-service.

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.

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 identified.

The reviewer consults with the health care team as needed to make informed medical necessity determination and may consult with a board-certified consultative specialist. All such consultations will be documented in the review record. If the requested service appears inappropriate based on application of the review criteria, the first-level reviewer will request a second-level review by a physician or designated health care professional.

Second-Level (Practitioner) Review:

The practitioner reviews the treatment plan and, when appropriate, discusses case circumstances and management options with the attending or referring physician. The reviewer consults with the health care team as needed to make an informed coverage decision and may consult with board-certified physicians from appropriate specialty areas

All such consultations will be documented in the review record. If the reviewer determines that the admission, continued stay or service requested is not a Covered Service, a notice of non-coverage is issued. Coverage based on medical necessity may be denied only by a physician, behavioral health practitioner (such as a psychiatrist, doctoral-level clinical psychologist, certified addiction medicine specialist), dentist

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or pharmacist who has appropriate clinical expertise related to the request under review and holds an unrestricted license.

B. Assignment

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

C. Confidentiality.

KFHPWA is required by federal and state law to maintain the privacy of Member's personal and health information and to provide notice describing how such information may be used and disclosed. 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.

D. Nondiscrimination.

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

E. Preauthorization.

For information about which services, equipment, and facility types KFHPWA require Preauthorization refer to Section IV. contact Member Services or visit https://healthy.kaiserpermanente.org/washington/support/forms#preauthorizationrequirementsforms (click on "Plan services and information" then "Pre-authorization requirements")

All Residential Treatment, non-Emergency inpatient hospital and non-Emergency ambulance services require Preauthorization. Failure to obtain required Preauthorization 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 based on Medical Necessity, eligibility, and benefits. KFHPWA will generally process requests and provides notification within the following timeframes:

- **Electronic standard requests:** within three calendar days, excluding holidays
  - If insufficient information is provided, a request for additional information will be made within one calendar day.
- **Electronic expedited prior authorization requests:** within one calendar day
  - If insufficient information is provided, a request for additional information will be made within one calendar day.
- **Nonelectronic standard requests:** within five calendar days
  - If insufficient information is provided, a request for additional information will be made within five calendar days.
- **Nonelectronic expedited requests:** within two calendar days
  - If insufficient information is provided, a request for additional information will be made within one calendar day.

F. Recommended Treatment.

KFHPWA's medical director will determine, in good faith, the necessity, nature and extent of treatment to be covered in each individual case. Members have the right to appeal coverage decisions (see Section VIII.) and 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 to pay for, or accept liability for the outcome, of such care.

New and emerging medical technologies are evaluated on an ongoing basis by Interregional New Technologies Committee, Medical Technology Assessment Committee, Medical Policy Committee, and Pharmacy and

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Therapeutics Committee. These committees evaluate a technology's benefits, whether it has been proven safe and effective, and the conditions under which its use may be appropriate. Their recommendations inform what is covered on KFHPWA health plans.

G. Second Opinions.

The Member may obtain a second opinion from a Network Provider regarding a medical diagnosis or treatment plan. The Member may request Preauthorization or may consult a KFHPWA-designated Specialist for a second opinion. When requested or indicated, second opinions are covered when obtained with Preauthorization or when provided by a KFHPWA-designated Specialist.

Coverage is determined in accordance with the Member's EOC; coverage of a second opinion does not guarantee coverage of any services or treatments recommended as a result of that opinion. Preauthorization for a second opinion does not authorize the Member to return to the physician providing the second opinion for any additional treatment. Services, drugs, and devices recommended or prescribed as a result of the consultation are covered only if otherwise included as Covered Services under the EOC.

H. Unusual Circumstances.

In the event of unusual circumstances such as a major disaster, natural disaster (e.g., earthquake, wildfire, hurricane or tornado), epidemic, pandemic, terrorism, war, riot, civil insurrection, government acts, changes in applicable law, disability of entities providing services to KFHPWA, disability of a large share of personnel at a Network Facility, complete or partial destruction of facilities, and labor dispute, 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.

Additionally, under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest Emergency department as described under "Emergency Services" in the "Accessing Care" section, and we will provide coverage and reimbursement as described in that section.

I. 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 to verify the delivery and coverage of services and items. Based on a prospective, concurrent, or retrospective review, KFHPWA may deny coverage if it determines that services are not Medically Necessary. Such determinations are based on established clinical criteria and may require Preauthorization.

KFHPWA will not retroactively deny coverage for services that were Preauthorized and have already provided to the Member except in cases of: (1) intentional misrepresentation of a material fact by the patient, Member, or provider;(2) coverage obtained based on inaccurate, false, or misleading information provided on the enrollment application; or (3) nonpayment of premiums.

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III. Financial Responsibilities

A. Premium.
The Subscriber is responsible for payment to the Group of their contribution toward the monthly premium, if any.

B. Financial Responsibilities for Covered Services.
Note: Various Cost Shares may or may not be eligible for determining the Member's annual Health Savings Account contribution limit. Please contact the Health Savings Account trustee or administrator regarding questions about requirements for Health Savings Accounts.

The Subscriber is responsible for payment of the applicable Cost Shares for Covered Services provided to the Subscriber and their Dependents. Payment of any amount billed must be received within 30 days of the billing date. Charges will be for the lesser of the applicable 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. The annual Deductible amount a Member must pay is determined by whether the Member is a sole Subscriber or has enrolled Dependents**.**

a. Subscriber Only Coverage (individual coverage).
Charges subject to the annual Deductible must be paid by the Subscriber each calendar year until the applicable annual Deductible is met.

b. Family Coverage (coverage for the Subscriber plus one (1) or more Dependents).
Benefits begin for each Member when each Member satisfies the individual annual Deductible. The total family annual Deductible can be met by all family members in combination. Benefits will begin for all family members when the family Deductible is met even if each Member has not met the individual annual Deductible.

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

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

3. Copayments.
Members are required to pay applicable Copayments at the time of service. Payment of a Copayment does not eliminate the possibility of 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 a calendar year will 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 Subscriber is responsible for payment of any fees charged for non-Covered Services provided to the Subscriber or their Dependents at the time of service. Payment of any amount billed must be received within 30 days of the billing date.

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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 in this EOC. All Covered Services are subject to case management and utilization management.

Annual Deductible	Member pays $X,XXX per Member per calendar year or $XX,XXX per Family Unit per calendar year Benefits begin for each Member when the individual Deductible is met. Benefits begin for all other family Members when the family Deductible is met. Several benefits are subject to the minimum Deductible: The minimum Deductible amount in order to meet state law requirements ($X,XXX individual/$X,XXX family). All other services are subject to the entire Annual Deductible. The minimum Deductible amount may increase as determined by federal law. Members will receive notification of any changes to the minimum Deductible amount. Benefits subject to the minimum Deductible are: • One regimen of human immunodeficiency virus postexposure prophylaxis • Epinephrine autoinjectors • Hearing devices and their fittings • Breast examinations following a breast cancer diagnosis • Termination of pregnancy • Reproductive Health services provided to men. • Vasectomies
Coinsurance	**Plan Coinsurance:** Member pays XX%
Lifetime Maximum	No lifetime maximum on covered Essential Health Benefits
Out-of-pocket Limit	Limited to a maximum of $X,XXX per Member or $XX,XXX 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
Preauthorization	Preauthorization may be required for some services. Refer to Section II. E for more information.

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Acupuncture	
Acupuncture needle treatment. Preauthorization is not required.	After Deductible, Member pays XX% Plan Coinsurance
Exclusions: Herbal supplements; any services not within the scope of the practitioner's licensure	

Allergy Services	
Allergy testing.	After Deductible, Member pays XX% Plan Coinsurance
Allergy serum and injections. Injection rooms: Most KFHPWA owned and operated medical centers have an area where injections and vaccines are administered by nurses. For additional information on appointment requirements go to www.kp.org/wa.	After Deductible, Member pays XX% 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 services are covered as Preventive Services.	After Deductible, Member pays XX% Plan Coinsurance

Circumcision	
Circumcision.	**Hospital - Inpatient:** After Deductible, Member pays XX% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays XX% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays XX% Plan Coinsurance Within 60 days of birth: After Deductible, Member pays nothing

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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.	**Hospital - Inpatient:** After Deductible, Member pays XX% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays XX% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays XX% 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 XXX% of all charges
Dental services (evaluation and treatment), 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 XX% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays XX% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays XX% Plan Coinsurance
General anesthesia services and related facility charges for dental procedures for Members who are under 9 years of age, 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.	**Hospital - Inpatient:** After Deductible, Member pays XX% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays XX% 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	

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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. Equipment must be ordered or prescribed by a Network Provider. • 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. • Prosthetic devices: Items which replace all or part of an external body part, or function thereof. • Sales tax for devices, equipment, and supplies. When provided in lieu of hospitalization, benefits will be the greater of benefits available for devices, equipment and supplies, home health, or hospitalization. See Hospice for durable medical equipment provided in a hospice setting.	After Deductible, Member pays XX% Plan Coinsurance Annual Deductible does not apply to strip-based blood glucose monitors, test strips, lancets, or control solutions.
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 XX% 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 XX% Plan Coinsurance Annual Deductible does not apply to strip-based blood glucose monitors, test strips, lancets, or control solutions.

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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):** After Deductible, Member pays XX% coinsurance up to a 90-day supply **Preferred brand name drugs (Tier 2):** After Deductible, Member pays XX% coinsurance up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays XX% coinsurance up to a 90-day supply **Specialty drugs (Tier 4):** After Deductible, Member pays XX% 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 $XX, 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). If you do not choose to enroll in Original Medicare Part B, applicable cost shares on this plan will apply. **Important things to know:** • The cost of dialysis can be substantial. We recommend calling Member Services to find in-network providers. • If you have end-stage renal disease (ESRD), you may be eligible for Original Medicare Part B. If you are eligible, this will reduce your costs substantially. Enrollment in Medicare is optional. • Original Medicare Part B has a waiting period, generally the first 90 days after dialysis starts. Original Medicare Part B doesn't start covering any of your costs until after that waiting period. As soon as you are enrolled in Original Medicare Part B, we will directly reimburse you for your Original Medicare Part B premiums, should you opt-in to this benefit. We will continue to reimburse your Original Medicare Part B premiums for as	After Deductible, Member pays XX% Plan Coinsurance

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long as you are enrolled in this plan, eligible for and enrolled in Original Medicare Part B due to ESRD.	
If you chose to enroll in Original Medicare Part B, Medicare may assist with your Member cost shares. Dialysis in an outpatient or home setting is covered for Members with end-stage renal disease (ESRD). Coordination of Benefit rules apply. If you do not choose to enroll in Original Medicare Part B, applicable cost shares on this plan will apply.	Medicare eligible charges: After Deductible, Member pays nothing
Injections administered by a Network Provider in a clinical setting during dialysis.	**Outpatient Services:** After Deductible, Member pays XX% Plan Coinsurance
Self-administered injectables. See Drugs – Outpatient Prescription for additional pharmacy information.	**Preferred generic drugs (Tier 1):** After Deductible, Member pays XX% coinsurance up to a 90-day supply **Preferred brand name drugs (Tier 2):** After Deductible, Member pays XX% coinsurance up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays XX% coinsurance up to a 90-day supply **Specialty drugs (Tier 4):** After Deductible, Member pays XX% coinsurance up to a 30-day supply

Drugs - Outpatient Prescription	
Prescription drugs, supplies and devices for a supply of 30 days or less include: • 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, • Prescription hormone therapy drugs (excluding glucagon-like peptide-1 or glucagon-like peptide-1 agonists such as Ozempic and Wegovy) which are able to be safely stored at room temperature without refrigeration may be allowed up to a 12-month supply. If the prescription hormone is a controlled substance, the prescription will be limited to the maximum fill allowed under state and federal regulations.	**Preferred generic drugs (Tier 1):** After Deductible, Member pays XX% coinsurance up to a 90-day supply **Preferred brand name drugs (Tier 2):** After Deductible, Member pays XX% coinsurance up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays XX% coinsurance up to a 90-day supply **Specialty drugs (Tier 4):** After Deductible, Member pays XX% coinsurance up to a 30-day supply Annual Deductible does not apply to strip-based blood glucose monitors, test strips, lancets, or control solutions.

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• HIV antiviral drugs approved by the federal food and drug administration. Prior authorization, step therapy and/or utilization management as described below, do not apply, 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 available in the KFHPWA Provider Directory or can be obtained by contacting Kaiser Permanente Member Services. Pre-exposure Prophylaxis (PrEP) services are covered under the Preventive Services section. For a list of PrEP medications, refer to the formulary at www.kp.org/wa/formulary and choose the "Preventive medication and preferred contraceptives" link. 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	Note: A Member will not pay more than $XX, not subject to Deductible, for a 30-day supply of each prescription for the following medications: insulin, and at least one inhaled corticosteroid, and at least one inhaled corticosteroid combination to comply with state law requirements. Any cost-sharing paid will apply toward the annual Deductible. Please refer to the formulary for additional information. After minimum Deductible, a Member will not pay more than $XX for at least one 2-pack of epinephrine autoinjectors. Any cost-sharing paid will apply toward the annual Deductible. Please refer to the formulary for additional information. One regimen of human immunodeficiency virus postexposure prophylaxis: After minimum Deductible, Member pays nothing

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prescription. When a Member uses an approved coupon for payment of their Cost Sharing, the coupon amount, and any additional payment made will accumulate to their Out-of-pocket Limit, however the coupon amount will not apply toward the Deductible. 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. Injection rooms: Most KFHPWA owned and operated medical centers have an area where injections and vaccines are administered by nurses. For additional information on appointment requirements go to www.kp.org/wa.	After Deductible, Member pays XX% Plan Coinsurance
Over-the-counter drugs not included under Preventive Care or Reproductive Health.	Not covered; Member pays XXX% of all charges
Mail order drugs dispensed through the KFHPWA-designated mail order service.	**Preferred generic drugs (Tier 1):** After Deductible, Member pays XX% coinsurance up to a 90-day supply **Preferred brand name drugs (Tier 2):** After Deductible, Member pays XX% coinsurance up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays XX% coinsurance up to a 90-day supply **Preferred specialty drugs (Tier 4):** After Deductible, Member pays XX% 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 $XX, not subject to Deductible, for a 30-day supply of each prescription for the following medications: insulin, and at least one inhaled corticosteroid, and at least one inhaled corticosteroid combination to comply with state law requirements. Any cost-sharing paid will apply toward the annual Deductible. After minimum deductible, a Member will not pay more than $XX for at least one 2-pack of epinephrine autoinjectors. Any cost-sharing paid will apply toward the annual Deductible. Please refer to the formulary for additional information.

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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 reviews the scientific evidence of these products and determines 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.

For a refill of a prescription previously covered by KFHPWA as non-transition benefit for a medically stable member that KFHPWA deems Medically Necessary for serious mental illness, KFHPWA will not require substitution of a non-preferred with a preferred non-interchangeable drug in the therapeutic class mid-plan year and will not increase cost-sharing obligation mid-plan year for the drug.

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 from the non-urgent 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 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 the Member to severe pain that cannot be managed adequately without the requested drug. KFHPWA will provide a determination and notification of the determination no later than 24 hours from the receipt of the request if the information provided is 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 the pharmaceutical 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 or prescribing provider elects 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 brand-name prescription drug Cost Share which does not apply to the Out-of-pocket Limit. The difference in cost between the brand and generic drug can be waived when medical necessity has been determined. The Member will never pay more than the actual cost of the prescription.

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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 day-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 may require close supervision and monitoring for serious and/or complex medication therapy. 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 visit www.kp.org/wa/formulary or contact Member Services at 206-630-4636 or toll-free at 1-888-901-4636.
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 206-630-4636 or toll-free 1-888-901-4636 or by visiting 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 actuarially equal to or greater than the Medicare Part D prescription drug benefit. Members who are also eligible for Medicare Part D can remain covered and will not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D plan at a later date If a Member experiences a break in Creditable prescription Coverage of 63 continuous days or longer Medicare may impose a Part D late enrollment penalty. The late enrollment penalty is a monthly amount added to the Member's Medicare Part D premium, and the amount of the penalty is based on the length of time the Member was without Medicare Part D or other creditable prescription drug coverage. In most cases, the Member will be required to pay this penalty for as long as the Member has Medicare Part D coverage. KFHPWA may notify the Member if a late enrollment penalty applies and, as a condition of coverage, bill the Member directly for the monthly penalty amount. A Member who discontinues coverage must meet eligibility requirements 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	**Network Facility:** After Deductible, Member pays XX% Plan Coinsurance **Non-Network Facility:** After Deductible, Member pays XX% Plan Coinsurance

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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.	
Emergency ambulance service is covered when: • Transport is to the nearest facility, including behavioral health Emergency services providers, 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 XX% Plan Coinsurance
Non-Emergency ground or air interfacility transfer to or from a Network Facility where you received Covered Services when Preauthorized by KFHPWA. Interfacility transfers are transfers from an acute care hospital bed to another facility for diagnostic evaluation or treatment and return to inpatient status.	After Deductible, Member pays XX% Plan Coinsurance **Hospital to hospital ground transfers:** After Deductible, Member pays nothing
Non-Emergency Medical Transportation Services (NEMT Services) are covered for travel inside the Service Area provided by Health Plan-designated transportation carriers, such as an ambulette, licensed stretcher/gurney van, or	After Deductible, Member pays nothing

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wheelchair van. Such NEMT Services are covered only if they are: • Ordered by a Physician after obtaining Prior Authorization AND • Medically Necessary.	
Exclusion: Other transportation by car, taxi, bus, minivan, and/or any other means (except for emergency ground ambulance or air ambulance as described above)	

Gender Health Services	
Medically Necessary medical and surgical services for gender affirmation. 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).	**Hospital - Inpatient:** After Deductible, Member pays XX% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays XX% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays XX% 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	

Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation are covered only when provided at KFHPWA-approved facilities. Cochlear implants when in accordance with KFHPWA clinical criteria. Covered Services for initial cochlear implants 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 – Inpatient:** After Deductible, Member pays XX% Plan Coinsurance **Hospital – Outpatient:** After Deductible, Member pays XX% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays XX% Plan Coinsurance
Hearing aids, bone conduction hearing devices, and Bone Anchored Hearing Systems (BAHS) hardware for hearing loss.	After minimum Deductible Member pays XX % Plan Coinsurance limited to an Allowance of one device per ear during any consecutive 36- month period After Allowance: Not covered; Member pays XXX% of all charges
Initial assessment, fitting, adjustments, auditory training, and ear molds as necessary to maintain optimal fit for hearing aids.	**Outpatient Services:** After minimum Deductible, Member pays XX% Plan Coinsurance

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Exclusions: Except as described above programs or treatments for hearing loss or hearing care associated with externally worn hearing or surgically implanted hearing aids, and the surgery and services necessary to implant them, and hearing screening tests required under the Preventive Services category; replacement costs of hearing aids due to loss, breakage or theft, unless at the time of such replacement the Member is eligible under the Allowance and benefit period; hearing aid repairs; replacement parts; replacement batteries; maintenance costs

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 or 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.	After Deductible, Member pays XX% 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	After Deductible, Member pays nothing

SAMPLE

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 care program.	
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. • Withdrawal management services. Outpatient hospitals include ambulatory surgical centers. Outpatient services include: • Outpatient surgical care • Anesthesia and anesthesia services • Surgical dressings and supplies • Facility costs See the Outpatient Services section for provider office visits and non-surgical hospital services. Alternative care arrangements may be covered as a cost-effective alternative in lieu of otherwise covered Medically Necessary hospitalization or other Medically Necessary	**Hospital - Inpatient:** After Deductible, Member pays XX% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays XX% Plan Coinsurance

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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 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 XX% Plan Coinsurance
Services related to conception by artificial insemination in compliance with KFHPWA clinical criteria.	After Deductible, Member pays XX% Plan Coinsurance
Treatment and prescription drugs.	Not covered; Member pays XXX% 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 (except artificial insemination) including 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.	After Deductible, Member pays XX% Plan Coinsurance
Administration of Medically Necessary infusion therapy in the home setting.	After Deductible, Member pays nothing

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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 visit www.kp.org/wa/formulary or contact Member Services.	
Associated infused medications include, but is not limited to: • Antibiotics. • Hydration. • Chemotherapy. • Pain management.	After Deductible, Member pays XX% 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 Preauthorization except when associated with Emergency services or inpatient services. Please contact Member Services for any questions regarding these services. Blood products and blood storage, services, and supplies of a blood bank. 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.	After Deductible, Member pays XX% Plan Coinsurance **Breast exam:** After minimum Deductible, Member pays applicable Cost Share for diagnostic imagery following a breast cancer diagnosis. (Includes diagnostic mammography, digital breast tomosynthesis/3D mammography, breast magnetic resonance imaging (MRI), or breast ultrasound) **Breast Exam:** Member pays nothing for screenings that precede a breast cancer diagnosis. (Includes diagnostic mammography, digital breast tomosynthesis/3D mammography, breast magnetic resonance imaging (MRI), or breast ultrasound) -

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. Utilization management is not required for the initial evaluation and management visit and up to six treatment visits with a contracting provider in a new episode of care. Rehabilitation services, such as massage or physical therapy, provided with manipulations are covered under the Rehabilitation and Habilitative Care (massage, occupational,	After Deductible, Member pays XX% Plan Coinsurance

SAMPLE

physical and speech therapy, pulmonary and cardiac rehabilitation) and Neurodevelopmental Therapy section	
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. Donor human milk will be covered during the inpatient hospital stay when Medically Necessary, provided through a milk bank, and ordered by a licensed Provider or board-certified lactation consultant. 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.	**Hospital - Inpatient:** After Deductible, Member pays XX% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays XX% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays XX% Plan Coinsurance
Termination of pregnancy.	**Hospital - Inpatient:** After minimum Deductible, Member pays nothing **Hospital - Outpatient:** After minimum Deductible, Member pays nothing **Outpatient Services:** After minimum Deductible, Member pays nothing
Exclusions: Birthing tubs; genetic testing of non-Members; fetal ultrasound in the absence of medical indications	

SAMPLE

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. Utilization management is not required for the initial evaluation and management visit and up to six treatment visits with a contracting provider in a new episode of care. 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. Partial hospitalization is covered subject to the 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. 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 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	**Hospital - Inpatient:** After Deductible, Member pays XX% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays XX% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays XX% Plan Coinsurance **Group Visits:** After Deductible, Member pays nothing.

SAMPLE

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 five 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. 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 XX% 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 XX% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays XX% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays XX% Plan Coinsurance

SAMPLE

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 XX% 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 formulas necessary for the treatment of phenylketonuria (PKU), specified inborn errors of metabolism, or other metabolic disorders.	After Deductible, Member pays XX% 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 XX% 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 XX% 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 XXX% 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	

SAMPLE

Oncology	
Radiation therapy, chemotherapy, oral chemotherapy. See Infusion Therapy for infused medications.	**Oral Chemotherapy Drugs:** After Deductible, Member pays XX% Plan Coinsurance up to a 90-day supply. **Radiation Therapy and Chemotherapy:** After Deductible, Member pays XX% Plan Coinsurance

Optical (adult vision)	
Members age 19 and over – routine eye examinations and refractions, limited to one per calendar year.	**Routine Exams:** After Deductible, Member pays XX% Plan Coinsurance
Eye and contact lens examinations for eye pathology and to monitor Medical Conditions when Medically Necessary.	**Exams for Eye Pathology:** After Deductible, Member pays XX% Plan Coinsurance
Members age 19 and over – 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 Allowance may be used toward any of the following combination: • Eyeglass frames • Eyeglass lenses (any type) including tinting and coating • Corrective industrial (safety) lenses • Corrective sunglass lenses and frames when prescribed by an eye care provider • Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation examinations • Replacement contact lenses • Replacement eyeglass lenses 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. When Medically Necessary for eye pathology, one replacement lens per diseased eye, including following cataract surgery (in lieu of an intraocular lens), is covered once every 12-month period. Replacement for loss or breakage is subject to the frames and lenses Allowance.	**Frames and Lenses:** Member pays nothing, limited to an Allowance of $XXX per calendar year After Allowance: Not covered; Member pays XXX% of all charges **Note:** This benefit is separate from the benefits of the Health Savings Account (HSA) Qualified Health Plan and not subject to the annual Deductible **Contact Lenses or framed lenses for Eye Pathology:** After Deductible, Member pays XX% Plan Coinsurance

SAMPLE

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

Optical (pediatric vision)	
Members to age 19 – One routine screening eye examination and one comprehensive examination with refraction, limited to one per calendar year.	**Routine Exams:** No charge; Member pays nothing
Eye and contact lens examinations for eye pathology and to monitor Medical Conditions when Medically Necessary	**Exams for Eye Pathology:** After Deductible, Member pays XX% 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 combinations: • 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 for 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. When Medically Necessary for eye pathology, one replacement lens per diseased eye, including following cataract surgery (in lieu of an intraocular lens), is covered once every 12-month period. 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 XX% Plan Coinsurance **After benefit is exhausted and there is no eye pathology indicated:** Not covered; Member pays XXX% 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	**Outpatient Services:** After Deductible, Member pays XX% Plan Coinsurance

SAMPLE

• Four follow-up care visits for low vision services in a 5-year period	
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. KFHPWA's medical director will determine whether the care or treatment required is within the category of Oral Surgery or Dental Services.	**Hospital - Inpatient:** After Deductible, Member pays XX% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays XX% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays XX% 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 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 surgical services, including ambulatory surgical centers.	After Deductible, Member pays XX% Plan Coinsurance

Plastic and Reconstructive Surgery	
Plastic and reconstructive services: • Correction of a congenital disease or congenital anomaly. • 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	**Hospital - Inpatient:** After Deductible, Member pays XX% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays XX% Plan Coinsurance

SAMPLE

KFHPWA's medical director such services can reasonably be expected to correct the condition. • 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 lymphedema, are covered. Plastic and reconstructive surgery requires Preauthorization.	**Outpatient Services:** After Deductible, Member pays XX% 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 for the prevention of complications associated with a Medical Condition, when approved by KFHPWA's medical director.	After Deductible, Member pays XX% Plan Coinsurance
Exclusions: Any routine foot care that is not Medically Necessary	

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) in effect on June 30, 2025, and as adopted by Washington State. 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 in effect on June 30, 2025, and as adopted by Washington State. Services, tests, screening, and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines in effect on June 30, 2025, and as adopted by Washington State. Immunizations recommended by the Department of Health. Flu vaccines are also covered when provided by a non-Network Provider.	No charge; Member pays nothing

SAMPLE

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 and physical activity counseling; depression screening in adults, including maternal depression, Pre-Exposure Prophylaxis (PrEP), including laboratory services and office visits, 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; all other diagnostic services not otherwise stated above	

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, sensory-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, occupational therapist, massage therapist, or speech therapist. Preauthorization is not required.	**Hospital - Inpatient:** After Deductible, Member pays XX% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays XX% Plan Coinsurance

SAMPLE

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). Utilization management is not required for the initial evaluation and management visit and up to six treatment visits with a contracting provider in a new episode of care. 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.	
Cardiac rehabilitation is covered when clinical criteria are met. Utilization management is not required for the initial evaluation and management visit and up to six treatment visits with a contracting provider in a new episode of care.	After Deductible, Member pays XX% Plan Coinsurance
Pulmonary rehabilitation is covered when clinical criteria are met. Utilization management is not required for the initial evaluation and management visit and up to six treatment visits with a contracting provider in a new episode of care.	After Deductible, Member pays XX% Plan Coinsurance

SAMPLE

Exclusions: Specialty treatment programs; specialty rehabilitation programs including "behavior modification programs;" recreational, life-enhancing, relaxation, or palliative therapy; implementation of home maintenance programs

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 Note: Reproductive Health services provided to men are required to be subject to the minimum Deductible amount, please see the Annual Deductible section for additional information.
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, additional condoms are available upon request 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-KFHPWA-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 contacting 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 Note: Reproductive Health services provided to men are required to be subject to the minimum Deductible amount, please see the Annual Deductible section for additional information.

Sexual Dysfunction	
One consultation visit to diagnose sexual dysfunction conditions.	After Deductible, Member pays XX% Plan Coinsurance
Specific diagnostic services, treatment, and prescription drugs.	Not covered; Member pays XXX% 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	

SAMPLE

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.	After Deductible, Member pays XX% 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.	No charge; Member pays nothing
Vasectomy services and supplies.	After minimum Deductible No charge; Member pays nothing Note: Vasectomies are required to be subject to the minimum Deductible amount, please see the Annual Deductible section for additional information.
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. 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	**Hospital - Inpatient:** After Deductible, Member pays XX% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays XX% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays XX% Plan Coinsurance **Group Visits:** After Deductible, Member pays nothing

SAMPLE

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. Utilization management is not required for the initial evaluation and management visit and up to six treatment visits with a contracting provider in a new episode of care. 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 specialty, 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 inpatient or residential substance use disorder treatment services provided in-state. The 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 prior to conducting a medical necessity review for continued care, initial length of authorized care will be no less than 14 days, subsequent authorization will be no less than 7 days. The Member or facility must notify KFHPWA within 24 hours of admission, or as soon as medically possible. The 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 mean 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 mean the symptoms resulting from abstinence are of mild/moderate	**Emergency Services Network Facility:** After Deductible, Member pays XX% Plan Coinsurance **Emergency Services Non-Network Facility:** After Deductible, Member pays XX% Plan Coinsurance **Hospital - Inpatient:** After Deductible, Member pays XX% Plan Coinsurance

SAMPLE

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. Subacute withdrawal management means symptoms associated with withdrawal from alcohol and/or other drugs can be managed through medical monitoring at a 24-hour facility or other outpatient facility. Preauthorization is required for outpatient withdrawal management services and subacute withdrawal management services. "Acute withdrawal management services" means the symptoms resulting from abstinence are so severe that withdrawal from alcohol and/or drugs require medical management in a hospital setting or behavioral health agency (licensed and certified under RCW 71.24.037), which is needed immediately to prevent serious impairment to the Member's health. Coverage for acute withdrawal management services is 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. The 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. The Member or facility must notify KFHPWA within 24 hours of admission, or as soon as medically 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 to transfer to a Network Facility/program, all further costs incurred during the hospitalization are the responsibility of the Member.	
Exclusions: Wilderness therapy; aversion therapy; facilities and treatments programs which are not certified by the Department of Social Health Services	

Telehealth Services	
Telemedicine Services provided using real-time interactive audio and video communications or store and forward technology between the	After Deductible, Member pays nothing

SAMPLE

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	
Virtual Care - Telephone and Online Services (E-Visits, Care Chat or E-consults) Scheduled telephone visits with a Network Provider are covered. Online (E-Visits, Care Chat, E-consults): 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. **Virtual Care:** A healthcare service provided via online technology, telephonic, or secure messaging transmission of member-initiated care from a remote location with a provider that is diagnostic- and treatment focused. The Member is NOT located at a healthcare site. Examples of online technology include the use of a computer, tablet, or smartphone. An example of a remote location includes the Member's home or work, or a non-clinical location. Services are allowed for commercial members.	After Deductible, 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:	**Hospital - Inpatient:** After Deductible, Member pays XX% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays XX% Plan Coinsurance

SAMPLE

• 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.	**Outpatient Services:** After Deductible, Member pays XX% Plan Coinsurance
TMJ appliances. See Devices, Equipment and Supplies for additional information.	After Deductible, Member pays XX% 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 recommendations. 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 XX% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays XX% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays XX% 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. I. Utilization Management	

SAMPLE

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 XX% Plan Coinsurance **Network Urgent Care Center:** After Deductible, Member pays XX% Plan Coinsurance **Network Provider's Office:** After Deductible, Member pays XX% Plan Coinsurance **Non-Network Provider:** After Deductible, Member pays XX% 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, which 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-overed Service (except for the specific exceptions described below) are also excluded from coverage. Members who have received a non-Covered Service, and develop an acute medical complication related to and/or as a result of that non-covered service, 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 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 responsible; services provided by a family member, or self-care.

4. 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 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.

SAMPLE

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 KFHPWA's 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.

SAMPLE

15. Expenses for services and supplies incurred because 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. Academic/career counseling, counseling for overeating, work/school ordered assessments, relationship counseling, custodial care.

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

19. Screenings related to obtaining or maintaining employment.

20. Surrogacy

Services in connection with a Surrogacy Arrangement, whether traditional or gestational, are excluded, except for otherwise covered Services provided to a Member who is acting as a surrogate.

A Surrogacy Arrangement is any arrangement in which a woman agrees to become pregnant and relinquish custody of the child or children to another person or persons, whether or not compensation is provided. This includes traditional surrogacy and gestational carriers and applies to pregnancies achieved through artificial insemination, intrauterine insemination, in vitro fertilization, or implantation of a fertilized egg of another person.

If a Member enters into a Surrogacy Arrangement, they must reimburse us for covered Services they receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services"). The total amount recoverable will not exceed the compensation or other payments payable to the Member or any other payee under the Surrogacy Arrangement. This provision does not affect a Member's obligation to pay applicable Cost Share.

By accepting Surrogacy Health Services, Members assign to KFHPWA their rights to receive any payments under the Surrogacy Arrangement, regardless of how those payments are characterized. KFHPWA will have a lien on such payments, including amounts held in escrow, trust, or similar accounts, which will be applied first to satisfy any Member reimbursement obligation. The assignment and lien will not exceed the amount owed to KFHPWA.

Within 30 days of entering a Surrogacy Arrangement, Members must provide written notice and documentation, including:

- Identification and contact information for all parties to the arrangement;
- Identification and contact information for any escrow agent or trustee;
- Identification and contact information for the intended parents and any insurance covering the child or children; and
- Copies of all contracts or related documents.

Members must also provide any consent, releases, authorizations, or lien forms reasonably requested to enable KFHPWA to enforce our rights. Members may not waive or limit our rights without KFHPWA prior written consent.

After relinquishment of the child to the legal parents, Members are not responsible for charges for services provided to the child; the legal parents are financially responsible for those Services.

If a Member's estate, parent, guardian, or conservator asserts claims related to the Surrogacy Arrangement, any recovery is subject to KFHPWA rights to the same extent as if they had asserted the claim directly. KFHPWA may assign rights under this section.

SAMPLE

Notice Address:
Surrogacy Other Party Liability Supervisor
Machinify
PO Box 2000
LaGrange, KY 40031
Phone: 1-855-967-6607

VI. Eligibility, Enrollment and Termination

A. Eligibility.

To be accepted for enrollment and continuing coverage, individuals must meet any eligibility requirements, reside, or work in the Service Area and meet all applicable requirements set forth below, except for temporary residency outside the Service Area for purposes of attending school, court-ordered coverage for Dependents or other unique family arrangements, when approved in advance by KFHPWA. KFHPWA has the right to verify eligibility.

1. Subscribers.

Bona-fide employees as established and enforced by the Group shall be eligible for enrollment. Please contact the Group for more information.

2. Dependents.

The Subscriber may also enroll the following:

a. The Subscriber's legal spouse; or

b. The Subscriber's state-registered domestic partner (as required by Washington state law) or if specifically included as eligible by the Group, the Subscriber's non-state registered domestic partner.

c. Children who are under the age of 26.

"Children" means the children of the Subscriber, spouse or eligible domestic partner, including adopted children, stepchildren, children for whom the Subscriber has a qualified court order to provide coverage and any other children for whom the Subscriber is the legal guardian.

Eligibility may be extended past the Dependent's limiting age as set forth above if the Dependent is totally incapable of self-sustaining employment because of a developmental or physical disability incurred prior to attainment of the limiting age and is chiefly dependent upon the Subscriber 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 31 days of age. All provisions, limitations and exclusions will apply except Subsection F. After 31 days of age, no benefits are available unless the newborn child qualifies as a Dependent and is enrolled.

B. Application for Enrollment.

Application for enrollment must be made on an application approved by KFHPWA. The Group is responsible for submitting completed applications to KFHPWA.

SAMPLE

KFHPWA reserves the right to refuse enrollment to any person whose coverage under any medical coverage agreement issued by Kaiser Foundation Health Plan of Washington Options, Inc. ("KFHPWAO") or Kaiser Foundation Health Plan of Washington has been terminated for cause.

1. **Newly Eligible Subscribers.**
Newly eligible Subscribers and their Dependents may apply for enrollment in writing to the Group within 31 days of becoming eligible.

2. **New Dependents.**
A written application for enrollment of a newly dependent person, other than a newborn or adopted child, must be made to the Group within 31 days after the dependency occurs.

A written application for enrollment of a newborn child must be made to the Group within 60 days following the date of birth when there is a change in the monthly premium payment as a result of the additional Dependent.

A written application for enrollment of an adoptive child must be made to the Group within 60 days from the day the child is placed with the Subscriber for the purpose of adoption, or the Subscriber assumes total or partial financial support of the child if there is a change in the monthly premium payment as a result of the additional Dependent.

When there is no change in the monthly premium payment, it is strongly advised that the Subscriber enroll the newborn or newly adoptive child as a Dependent with the Group to avoid delays in the payment of claims.

3. **Open Enrollment.**
KFHPWA will allow enrollment of Subscribers and Dependents who did not enroll when newly eligible as described above during a limited period specified by the Group and KFHPWA.

4. **Special Enrollment.**

   a. KFHPWA will allow special enrollment for persons:
      1) Who initially declined enrollment when otherwise eligible because such persons had other health care coverage and have had such other coverage terminated due to one of the following events:
         - Cessation of employer contributions for the other coverage.
         - Loss of eligibility for the other coverage, except for loss of eligibility for cause.
         - If the other coverage for which enrollment was declined was COBRA coverage, exhaustion of COBRA continuation coverage; or
      2) Who initially declined enrollment when otherwise eligible because such persons had other health care coverage and who have had such other coverage exhausted because such person reached a lifetime maximum limit.

      KFHPWA or the Group may require confirmation that when initially offered coverage such persons submitted a written statement declining because of other coverage. Application for coverage must be made within 60 days of the termination of previous coverage.

   b. KFHPWA will allow special enrollment for individuals who are eligible to be a Subscriber and their Dependents in the event one of the following occurs:
      1) Marriage or domestic partnership. Application for coverage must be made within 60 days of the date of marriage.
      2) Dissolution of Marriage or Termination of domestic partnership. Application for coverage must be made within 60 days of the dissolution/termination.
      3) Birth. Application for coverage for the Subscriber and Dependents other than the newborn child must be made within 60 days of the date of birth.

SAMPLE

4) Adoption or placement for adoption. Application for coverage for the Subscriber and Dependents other than the adopted child must be made within 60 days of the adoption or placement for adoption.
5) Eligibility for premium assistance from Medicaid or a state Children's Health Insurance Program (CHIP), provided such person is otherwise eligible for coverage under this EOC. The request for special enrollment must be made within 60 days of the eligibility for such premium assistance.
6) Coverage under a Medicaid or CHIP plan is terminated as a result of loss of eligibility for such coverage. Application for coverage must be made within 60 days of the date of termination under Medicaid or CHIP.
7) A permanent change in residence, work, or living situation. Voluntary and involuntary change where the Member's health plan coverage is not offered in the new area. Application for coverage must be made within 60 days of the change in residence, work, or living situation.
8) Loss of individual or group Health Benefit Exchange coverage due to error by the Health Benefit Exchange, the insurance carrier, or the U.S. Department of Health and Human Services. Application for coverage must be made within 60 days of the loss of coverage.
9) Applicable federal or state law or regulation otherwise provides for special enrollment.

C. When Coverage Begins.

1. Effective Date of Enrollment.

- Enrollment for a newly eligible Subscriber and listed Dependents is effective on the date eligibility requirements are met, provided the Subscriber's application has been submitted to and approved by KFHPWA. Please contact the Group for more information.
- 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 Subscriber for the purpose of adoption, or the Subscriber 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. Eligibility for Medicare.
Note: Eligibility for Medicare may affect the tax deductibility of Health Savings Account contributions.

An individual shall be deemed eligible for Medicare when they have the option to receive Part A Medicare benefits. Medicare secondary payer regulations and guidelines will determine primary/secondary payer status for individuals covered by Medicare.

A Member who is enrolled in Medicare has the option of continuing coverage under this EOC while on Medicare coverage. Coverage between this EOC and Medicare will be coordinated as outlined in Section X.

E. Termination of Coverage.
The Subscriber shall be responsible for payment of all charges for services and items provided to the Subscriber and all Dependents after the effective date of termination.

Termination of Specific Members.
Individual Member coverage may be terminated for any of the following reasons:

SAMPLE

a. Loss of Eligibility. If a Member no longer meets the eligibility requirements and is not enrolled for continuation coverage as described in Subsection F. below, coverage will terminate at the end of the month during which the loss of eligibility occurs, unless otherwise specified by the Group.

b. For Cause. In the event of termination for cause, KFHPWA reserves the right to pursue all civil remedies allowable under federal and state law for the collection of claims, losses, or other damages. Coverage of a Member may be terminated upon 10 working days written notice for:
   1) Material misrepresentation, fraud, or omission of information in order to obtain coverage.
   2) Permitting the use of a KFHPWA identification card or number by another person or using another Member's identification card or number to obtain care to which a person is not entitled.

c. Premium Payments. Nonpayment of premiums or contribution for a specific Member by the Group.

Individual Member coverage may be retroactively terminated upon 30 days written notice and only in the case of fraud or intentional misrepresentation of a material fact; or as otherwise allowed under applicable law or regulation. Notwithstanding the foregoing, KFHPWA reserves the right to retroactively terminate coverage for nonpayment of premiums or contributions by the Group as described above.

In no event will a Member be terminated solely on the basis of their physical or mental condition provided they meet all other eligibility requirements set forth in the EOC.

Any Member may appeal a termination decision through KFHPWA's appeals process.

F. Continuation of Coverage Options.

1. Continuation Option.
A Member no longer eligible for coverage (except in the event of termination for cause, as set forth in Subsection E.) may continue coverage for a period of up to 3 months subject to notification to and self-payment of premiums to the Group. This provision will not apply if the Member is eligible for the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This continuation option is not available if the Group no longer has active employees or otherwise terminates.

2. Leave of Absence.
While on a Group approved leave of absence, the Subscriber and listed Dependents can continue to be covered provided that:
- They remain eligible for coverage, as set forth in Subsection A.,
- Such leave is in compliance with the Group's established leave of absence policy that is consistently applied to all employees,
- The Group's leave of absence policy is in compliance with the Family and Medical Leave Act when applicable, and
- The Group continues to remit premiums for the Subscriber and Dependents to KFHPWA.

3. Self-Payments During Labor Disputes.
In the event of suspension or termination of employee compensation due to a strike, lock-out or other labor dispute, a Subscriber may continue uninterrupted coverage through payment of monthly premiums directly to the Group. Coverage may be continued for the lesser of the term of the strike, lock-out or other labor dispute, or for 6 months after the cessation of work.

If coverage under the EOC is no longer available, the Subscriber shall have the opportunity to apply for an individual KFHPWA group conversion plan or, if applicable, continuation coverage (see Subsection 4. below), or an individual and family plan at the duly approved rates.

The Group is responsible for immediately notifying each affected Subscriber of their rights of self-payment under this provision.

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4. Continuation Coverage Under Federal Law.

This section applies only to Groups who must offer continuation coverage under the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, or the Uniformed Services Employment and Reemployment Rights Act (USERRA) and only applies to grant continuation of coverage rights to the extent required by federal law. USERRA only applies in certain situations to employees who are leaving employment to serve in the United States Armed Forces.

Upon loss of eligibility, continuation of Group coverage may be available to a Member for a limited time after the Member would otherwise lose eligibility, if required by COBRA. The Group shall inform Members of the COBRA election process and how much the Member will be required to pay directly to the Group.

Continuation coverage under COBRA or USERRA will terminate when a Member becomes covered by Medicare or obtains other group coverage, and as set forth under Subsection E.

5. KFHPWA Group Conversion Plan.

Members whose eligibility for coverage, including continuation coverage, is terminated for any reason other than cause, as set forth in Subsection E., and who are not eligible for Medicare or covered by another group health plan, may convert to an individual KFHPWA group conversion plan. If coverage under the EOC terminates, any Member covered at termination (including spouses and Dependents of a Subscriber who was terminated for cause) may convert to a KFHPWA group conversion plan. Coverage will be retroactive to the date of loss of eligibility.

An application for conversion must be made within 31 days following termination of coverage or within 31 days from the date notice of the termination of coverage is received, whichever is later. A physical examination or statement of health is not required for enrollment in a KFHPWA group conversion plan.

Persons wishing to purchase KFHPWA's individual and family coverage should contact KFHPWA.

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, 206-630-4636 or toll-free 1-888-901-4636. 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.

SAMPLE

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, with respect to group health plans, 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 Member's receipt 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.

SAMPLE

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 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.

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. Box 30766, 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 clean claim review requests – within 30 calendar days.
- Post-service non-clean claim review requests – within 30 calendar days.
    - Requests for additional/missing information are to be submitted to the provider/facility within 21 calendar days of claim receipt

SAMPLE

- If the provider/facility doesn't provide the additional/missing information within 21 days of receipt of the KFHPWA request, then KFHPWA has 40 calendar days following the date that the carrier receives the requested information.

X. Coordination of Benefits

Note: If a Member participating in a Health Savings Account has other health care coverage (in addition to the coverage provided under the EOC), the tax deductibility of Health Savings Account contributions may be affected. Please contact the Health Savings Account trustee or administrator regarding questions about requirements for Health Savings Accounts.

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.

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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 XXX% 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 XXX% 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.

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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, Subscriber, 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, Subscriber or retiree is the secondary plan and the other plan is the primary plan.

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

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

   b) For a dependent child, whose parents are divorced or separated or not living together, whether or not they have ever been married:
      i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to 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.

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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, Subscriber or retiree or covering the Member as a Dependent of an employee, member, Subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule 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, Subscriber, or retiree longer is the primary plan and the plan that covered the Member for 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

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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, 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.

This section more fully describes KFHPWA's subrogation and reimbursement rights.

"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.

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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 XXX% 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.

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XII. Definitions

Allowance	The maximum amount payable by KFHPWA for certain Covered Services.
Allowed Amount	A term used to define the level of benefits which are payable by KFHPWA. 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 ground or air ambulance services and Emergency services, including post stabilization and for ancillary services received from an out of network provider in 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.
Care Chat	Care available online at www.kp.org/wa or through the KP mobile application. Chat with a Kaiser Permanente clinician to receive immediate care, treatment, and prescriptions.

Consulting Nurse Service	Advice available 24 hours a day by talking on the phone with a licensed care nurse.
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 Subscriber'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 within the past 3 years, 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 3 years.

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Evidence of Coverage	The Evidence of Coverage is a statement of benefits, exclusions and other provisions as set forth in the Group medical coverage agreement between KFHPWA and the Group.
Family Unit	A Subscriber and all their Dependents.
Group	An employer which has entered into a Group medical coverage agreement with KFHPWA.
Health Savings Account (HSA)	A tax-exempt savings account established exclusively for the purpose of paying qualified medical expenses and meeting other requirements under federal law.
High-Deductible Health Plan	A high-deductible health plan that meets regulatory requirements for use in conjunction with a Health Savings Account.
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).
Member	Any enrolled Subscriber or Dependent.

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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 Subscriber 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 Subscriber and their Dependents within the same 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.
Subscriber	A person employed by or belonging to the Group who meets all applicable eligibility requirements, is enrolled and for whom the premium has been paid.

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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.

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