



Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation

Portland, Oregon

Large Group Traditional Copayment Plan

Group Agreement for Willamette University

Group Number: 2014 Subgroup: 005

Term of Agreement

April 1, 2009 through March 31, 2010

Anniversary date

April 1

A handwritten signature in black ink, appearing to be "S. Smith", written over a horizontal line.

Authorized representative

E-O-LG-TRAD-XX-0109

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INTRODUCTION

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

TERM OF AGREEMENT, ACCEPTANCE OF AGREEMENT, AND RENEWAL

Term of Agreement

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

Acceptance of Agreement

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

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

Renewal

This *Agreement* is guaranteed renewable, but does not automatically renew. If Group complies with all of the terms of this *Agreement*, Company will offer to renew this *Agreement*, upon 180 days prior written notice to Group, either by sending Group a new group agreement to become effective immediately after termination of this *Agreement*, or by extending the term of this *Agreement* pursuant to “Amendments Effective on Anniversary Date” in the “Amendment of *Agreement*” section. The new or extended group agreement will include a new term of agreement and other changes. If Group does not renew this *Agreement*, Group must give Company written notice as described under “Termination on Notice” in the “Termination of *Agreement*” section.

AMENDMENT OF AGREEMENT

Amendments Effective on Anniversary Date

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

Amendment Due to Tax or Other Charges

If a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Company or Participating Providers (or any of their activities), then upon 31 days prior written notice, Company may increase Group's Premium to include Group's share of the new or increased tax or charge. Group's share will be determined by dividing the number of Members enrolled through Group by the total number of Members enrolled in Company.

Other Amendments

Company may amend this *Agreement* at any time by giving written notice to Group, in order to: (a) address any law or regulatory requirement, which may include increasing Premium to reflect an increase in costs to Company or Participating Providers (Company will give group 31 days prior written notice of any such Premium increase); or (b) reduce or expand the Company Service Area; or (c) increase any benefits of any Medicare product approved by the Centers for Medicare and Medicaid Services (CMS), if applicable to this *Agreement*.

TERMINATION OF AGREEMENT

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

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

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

Termination on Notice

Group may terminate this *Agreement* by giving prior written notice to Company at least 30 days prior to the termination date and remitting all amounts payable relating to this *Agreement*, including Premium, for the period through the termination date.

Termination Due to Nonacceptance of Amendments

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

Termination for Nonpayment

Company will allow a grace period until the end of the month for which Premium is due. If Company has not received Premium 10 days before the end of the month for which Premium is due, Company may send Group notice of the past-due amount.

If Group fails to make past-due payment within 10 days after Company's initial written notice to Group of the past-due amount, Company may terminate this *Agreement* immediately by giving written notice to Group, and Group will be liable for all unpaid Premium through the termination date.

Termination for Fraud or Material Breach of Plan

Company may terminate this *Agreement* not less than 31 days prior written notice to Group, if Group commits fraud or materially breaches the Plan. For example, a material breach of the Plan occurs if Group intentionally furnishes incorrect or incomplete material information to Company or is aware that incorrect or incomplete material information has been provided to Company on enrollment or other Company forms.

Termination for Violation of Contribution or Participation Requirements

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

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

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

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

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

Company may terminate this *Agreement* if the Director of the Department of Consumer and Business Services orders Company to discontinue coverage upon finding that continuation of coverage (A)

would not be in the best interests of the Members; or (B) would impair Company's ability to meet its contractual obligations.

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

Company may terminate this *Agreement* if it is unable to reach an agreement with the health care providers to provide Services within a specific service area. Company must: (A) cease to offer and cease to renew this Plan for all groups within the service area; and (B) at least 90 days prior to discontinuance, notify the Director of the Department of Consumer and Business Services and each group in that service area of the decision to discontinue the Plan(s) and offer all other group Health Benefit Plans available in that service area.

CONTRIBUTION AND PARTICIPATION REQUIREMENTS

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

In Oregon Group must:

- Ensure that Subscribers work on a regularly scheduled basis, with a normal work week of 17.5 or more hours or a different minimum number of hours approved in writing by Company.
- Meet all Company underwriting requirements set forth in the Rating and Underwriting Assumptions policy.
- With respect to all persons entitled to coverage under Group's Plan(s), offer enrollment in Company to all such persons on conditions no less favorable than those for any other Plan available through Group.
- Permit Company to examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*.

MISCELLANEOUS PROVISIONS

Administration of Agreement

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

Assignment

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

Attorney Fees and Costs

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

Delegation of Claims Review Authority

Group delegates to Company the discretion to determine whether a Member is entitled to benefits under this *Agreement*. In making these determinations, Company has discretionary authority to review claims in accord with the procedures contained in this *Agreement* and to construe this *Agreement* to determine whether the Member is entitled to benefits. For health benefit plans that are subject to the Employee Retirement Income Security Act (ERISA), Company is a named fiduciary to review claims under this *Agreement*.

Governing Law

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

Litigation Venue

Venue for all litigation between Group and Company shall lie in Multnomah County, Oregon.

No Waiver

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

Notices

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

Notices from Company to Group will be sent to:

Group Contact Suzie Torre
Group Name..... Willamette University
Group Address..... 900 State Street
Group Address..... Salem, OR 97301

Broker Contact.....Rico Bocala
Broker NameUSI Northwest
Broker Address.....700 NE Multnomah St. #1300
Broker Address..... Portland, OR 97232

Note: When Company sends Group a new (or renewed) group agreement, Company will enclose a summary of changes that discusses the changes Company has made to this *Agreement*. Groups that

want information about changes before receiving the new group agreement may request advance information from Group's Company account manager. Also, if Group designates in writing a third party such as a "Broker of Record", Company may send the advance information to the third party rather than to Group (unless Group requests a copy also).

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

Kaiser Foundation Health Plan of the Northwest
P.O. Box 921008
Fort Worth, TX 76121

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

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

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

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

Reporting Membership Changes and Retroactivity

Group must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes. The time limit for retroactive membership changes is the calendar month when Company's Fort Worth Service Center receives Group's notification of the change plus the previous two months unless Company agrees otherwise in writing.

Social Security and Tax Identification Numbers

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

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

PREMIUM

Only Members for whom Company has received the appropriate Premium payment listed below are entitled to coverage under this *Agreement*, and then only for the period for which Company has received appropriate payment.

Premium Due Date

The payment due date for each bill group associated with Group will be reflected on the monthly membership invoice if applicable to Group (if not applicable, then as specified in writing by Company).

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

Monthly Premium

Group will pay Company the following Premium amount(s) for each Subscriber and his or her Dependents.

Subscriber only	\$ 431.69
Subscriber with one Family Dependent	\$ 617.32
Subscriber with two or more Family Dependents	\$ 902.24

Group will pay Company the following Premium amount(s) for each Member who does not enroll in Kaiser Permanente Senior Advantage.

For each Member age 65 or over, not entitled to Part A or enrolled in Part B of Medicare: \$ 925.36

For each Member who is enrolled in Part B of Medicare, but not entitled under Part A of Medicare: \$ 925.36

For each Member who is entitled to benefits only under Part A of Medicare, and not enrolled in Part B of Medicare: \$ 842.52

For each Member who is enrolled in Part B of Medicare and entitled to Part A and who has not elected to enroll in Kaiser Permanente Senior Advantage: \$ 674.64

MEDICARE ELIGIBLE AND MEMBERS AGE 65 OR OVER

Except for Members for whom Medicare is a secondary payor, the basic rate structure is based on the assumption that Company or its designee will receive Medicare payments for Medicare-covered services provided to Members age 65 or over and Members eligible for Medicare as primary coverage. Each such Member must comply with all of the following requirements:

- Enroll in all parts of Medicare for which he or she is eligible and continue that enrollment while a Member.
- Be enrolled through Group in Kaiser Permanente Senior Advantage.
- Complete and submit all documents necessary for Company to obtain Medicare payments for Medicare-covered services provided to the Member.

If a Member does not comply with all of these requirements for any reason, including election of COBRA continuation coverage, ineligibility under Medicare or inability to enroll in Kaiser Permanente Senior Advantage because he or she does not meet the Plan's eligibility requirement or the Plan is not available through Group, Group must pay the applicable rates to compensate for the lack of Medicare payments. If a Member with Medicare (both Parts A and B) enrolls in Kaiser Permanente Senior Advantage, Group will receive the Senior Advantage rate, and the Medicare Member will receive Kaiser Permanente Senior Advantage benefits.

Medicare as secondary payor. Medicare is the primary coverage except when federal law requires that Group's health care plan be primary and Medicare coverage be secondary. Members eligible for

Medicare as their secondary coverage are subject to the basic rate (for Subscriber and Family) and receive the same benefits as Members who are not eligible for Medicare. However, any such Members who meet the Kaiser Permanente Senior Advantage eligibility requirements may also enroll in Kaiser Permanente Senior Advantage. Group will pay the basic rate for any such Member, and that Member will receive Kaiser Permanente Senior Advantage benefits. Other Family members who are not eligible for Medicare will receive the active employee benefits.



Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Large Group Traditional Copayment Plan Evidence of Coverage

Group Name: Willamette University

Group Number: 2014

This *EOC* is effective April 1, 2009, through March 31, 2010

Printed: April 2, 2009

Membership Services

Monday through Friday (except
holidays)

8 a.m. to 6 p.m.

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

All other areas 1-800-813-2000

TTY

All areas..... 1-800-735-2900

**Language interpretation
services**

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

kaiserpermanente.org

BENEFIT SUMMARY

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

Out-Of-Pocket Maximum	
For one Member	\$750 per Calendar Year
For an entire Family	\$1,500 per Calendar Year
Lifetime Benefit Maximum	Unlimited
Outpatient Services	You Pay
Routine preventive physical exam (includes adult, well baby, and well child)	\$20 (\$0 for age 0-2)
Primary care visit (includes routine OB/GYN visits, routine medical office visits, routine hearing exam appointments, Urgent Care and diabetic outpatient self-management training and education, including medical nutrition therapy)	\$20
Specialty care visit (includes diabetic outpatient self-management training and education, including medical nutrition therapy)	\$20
TMJ therapy	\$20
Scheduled prenatal care and first postpartum visit	\$0
Routine eye exam	\$20
Injections provided in the Nurse Treatment Area	\$5
Emergency Care Services Department visit	\$75
Immunizations	\$0
Outpatient surgery visit	\$50
House calls inside the Service Area	\$0
Blood, blood products, and their administration	\$0
Inpatient Hospital Services	You Pay
Room and board, surgery, anesthesia, X-ray, imaging, laboratory, and drugs.	\$100 per admission
Ambulance Services	You Pay
Per transport	\$75

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Bariatric Surgery Services	You Pay
Inpatient hospital Services	\$100 per admission
Chemical Dependency Services	You Pay
Outpatient Services	\$20
Inpatient hospital Services	\$100 per admission
Residential Services	\$100 per admission
Day treatment Services	\$20 per day
Dialysis Services	You Pay
Outpatient dialysis	\$20
Home dialysis	\$0
Inpatient hospital	\$0
Participating Skilled Nursing Facility	\$0
Health Education Services	You Pay
Primary care visit	\$20
Specialty care visit	\$20
Home Health Services	You Pay
	\$0 up to 130 visits per Calendar Year
Hospice Services	You Pay
Palliative and comfort care	\$0
Infertility Services	You Pay
Diagnosis and treatment	50% Coinsurance
Limited Outpatient Prescription Drugs, Supplies, Supplements	You Pay
Medical foods and formulas	\$0
Certain self-administered IV drugs, fluids, additives, and nutrients including the supplies and equipment required for their administration	\$0
Oral chemotherapy medications used for the treatment of cancer	\$0
Post-surgical immunosuppressive drugs after covered transplant Services	\$0
Drugs, injectables, and radioactive materials used for therapeutic purposes	\$0
Mental Health Services	You Pay
Outpatient Services	\$20
Intensive outpatient Services	\$20 per day
Inpatient hospital Services	\$100 per admission
Residential Services (limited to 45 days per Calendar Year)	\$100 per admission
Outpatient Durable Medical Equipment (DME), External Prosthetics, and Orthotics	You Pay
Outpatient Durable Medical Equipment (DME), external prosthetics and orthotics	20% Coinsurance

Enteral pump and supplies, enteral supplements; CADD (continuous ambulatory drug delivery) pumps; ocular prosthesis for children age 12 or younger; osteogenic bone stimulators; osteogenic spine stimulators; and ventilators	\$0
Outpatient Laboratory , X-ray, Imaging, and Special Diagnostic Procedures	You Pay
Laboratory, X-ray, imaging, and special diagnostic procedures	\$0
Reconstructive Surgery Services	You Pay
Inpatient hospital Services	\$100 per admission
Outpatient surgery Services	\$50
Rehabilitative Therapy Services	You Pay
Chemotherapy/radiation therapy	\$20
Outpatient Physical, Speech, and Occupational therapies (up to 20 visits per therapy per Calendar Year)	\$20
Outpatient Respiratory therapy	\$20
Multidisciplinary rehabilitation (limited to a combined total of 60 days per condition per Calendar Year for inpatient and outpatient rehabilitation)	
Inpatient multidisciplinary rehabilitation	\$100 per admission
Outpatient multidisciplinary rehabilitation	\$20
Skilled Nursing Facility Services	You Pay
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	\$0
Student Out-of-Area Coverage	You Pay
Routine, continuing, and follow-up Services	20% of the allowed amount plus any fees that exceed the allowed amount. The allowed amount is the lesser of (1) the provider's actual fee, or (2) the 70 th percentile of the fees for the same or similar Service in the geographic area where the Service was received, according to the most current survey data listed in Medicode's Ingenix UCR database or published by another national service designated by Company.
Up to \$1,200 per Calendar Year	
Dependent Limiting Ages	Limiting Ages
General	23
Student	23
Transplant Services	You Pay
Inpatient hospital Services	\$100 per admission

Please see the following pages for additional benefit riders purchased:	
Benefit Riders	You Pay
Alternative Care	Not covered
Hearing Aids	Not covered
Outpatient Prescription Drugs, Supplies, and Supplements	\$15 per prescription. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two Copayments. Kaiser Permanente formulary applies. We cover nonformulary drugs only when you meet exception criteria.
Vision Hardware Optical Services	Balance after \$150 credit every 24 months

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INTRODUCTION

This *Evidence of Coverage (EOC)*, including the “Benefit Summary” and any benefit riders attached to this *EOC*, describes the health care coverage of the Large Group Traditional Copayment Plan provided under the *Agreement* between Kaiser Foundation Health Plan of the Northwest and your Group. This Plan is not a federally qualified health benefits Plan. For benefits provided under any other Plan, refer to that Plan’s evidence of coverage. In this *EOC*, Kaiser Foundation Health Plan of the Northwest is sometimes referred to as “Company,” “we,” “our,” or “us.” Members are sometimes referred to as “you.” Some capitalized terms have special meaning in this *EOC*; please see the “Definitions” section for terms you should know. The benefits under this Plan are not subject to a pre-existing waiting period.

Term of this EOC

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

About Kaiser Permanente

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

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

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

DEFINITIONS

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

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

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

Benefit Summary. A section printed separately but bound into this *EOC*, which briefly addresses some of the most frequently asked questions about benefits, Copayments, and Coinsurance.

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

Charges. Charges means the following:

- For Services provided by Medical Group and Kaiser Foundation Hospitals, the charges in Company’s schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members.

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

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

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

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

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

Creditable Coverage. Prior health care coverage as defined in 42 U.S.C. 300gg as amended. Creditable Coverage includes: group coverage, including FEHBP and Peace Corps; individual coverage, including student health plans; Medicaid; Medicare; TRICARE; Indian Health Service or tribal organization coverage; high risk pool coverage; and public health plans. Creditable Coverage does not include coverage only for a specified disease or illness or hospital indemnity (income) insurance.

Dependent. A Member who meets the eligibility requirements as a Dependent.

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

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

Emergency Care. Medically Necessary Services to evaluate and stabilize an Emergency Medical Condition if one of the following is true:

- You receive the Services in a hospital emergency department.
- You receive the Services in an inpatient hospital after being admitted from the emergency department. Emergency Care does not include any Services you receive after your condition is clinically stable. (“Clinically stable” means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during your discharge or transfer from the hospital.)

Emergency Medical Condition. A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

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

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

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

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

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

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

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

Limiting Age. The ages established by your Group for Dependent eligibility that are approved by Company and shown in the “Benefit Summary.”

Medical Directory. The Kaiser Permanente *Medical Directory* lists primary care and specialty care Participating Providers; includes addresses, maps, and telephone numbers for Participating Medical Offices and other Participating Facilities; and provides general information about getting care at Kaiser Permanente. You will receive the *Medical Directory* after you enroll, and then once a year.

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

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

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

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

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

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

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

Out-of-Pocket Maximum. The maximum amount of covered Charges you will be responsible to pay in a Calendar Year.

Participating Facility. Any facility listed in the *Medical Directory* for our Service Area. Participating Facilities are subject to change.

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

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

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

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

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

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

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

Premium. Monthly membership charges paid by Group.

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

Services. Health care services, supplies, or items.

Specialist. Any licensed Participating Provider, who practices in a specialty care area of medicine (not family medicine, pediatrics, gynecology, obstetrics, general practice, or internal medicine) in which a referral by a Participating Physician is required in order to receive covered Services.

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

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

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

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

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

PREMIUM, ELIGIBILITY, AND ENROLLMENT

Premium

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

Who Is Eligible

General

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

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

Subscribers

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

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

Dependents

If you are a Subscriber, the following persons are eligible to enroll as your Dependents:

- Your Spouse.
- An unmarried person who is under the general or student Limiting Age specified in the "Benefit Summary" and who is any of the following:
 - Your or your Spouse's child.
 - Your enrolled Dependent's newborn child.

- A child adopted by you or your Spouse, or for whom you or your Spouse have assumed a legal obligation for total or partial support in anticipation of adoption.
 - Any other person primarily supported by you or your Spouse and for whom you or your Spouse is a court-appointed guardian.
- An unmarried person who is under the student Limiting Age specified in the “Benefit Summary” and who is a full-time registered student at an accredited college or accredited vocational school and is any of the following:
 - Your or your Spouse’s child.
 - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed a legal obligation for total or partial support in anticipation of adoption.
 - Any other person primarily supported by you or your Spouse and for whom you or your Spouse is a court-appointed guardian.
 - An unmarried person of any age who is primarily dependent upon you or your Spouse for support and maintenance if the person is incapable of self-sustaining employment by reason of developmental disability or physical handicap which occurred prior to his or her reaching the general Limiting Age specified in the “Benefit Summary,” if the person is any of the following:
 - Your or your Spouse’s child.
 - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed a legal obligation for total or partial support in anticipation of adoption.
 - Any other person for whom you or your Spouse is a court-appointed guardian and was a court-appointed guardian prior to the person’s reaching the Limiting Age specified in the “Benefit Summary.”

You must give us proof of incapacity and dependency annually if we request it, but only after the two-year period following attainment of the general Limiting Age specified in the “Benefit Summary.”

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

When You Can Enroll and When Coverage Begins

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

New Employees and Their Dependents

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

Open Enrollment

Your Group will inform you of your open enrollment period and effective date of coverage. You may enroll as a Subscriber along with any eligible Dependents if you or your Dependents were not previously enrolled. If you are an existing Subscriber, you may add eligible Dependents not previously enrolled by submitting a Company-approved enrollment application to your Group during the open enrollment period. If you do not

enroll when you are first eligible or during open enrollment and later want to enroll, you must wait until the next open enrollment unless one of the sections described below applies.

Adding New Dependents to an Existing Account

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

- **Newborn child.** Newborns are covered from the moment of birth for the first 31 days of life. In order for coverage to continue beyond this 31-day period you must submit an enrollment application to your Group within 60 days after the child's birth if additional Premium is required to add the Dependent. If additional Premium is not required, the application requirement is waived; however, please notify Membership Services of the birth so that we may update our records for more efficient provision of covered Services.
- **Newly Adopted child.** Newly adopted children or children for whom you or your Spouse have newly assumed a legal obligation for total or partial support in anticipation of adoption are covered for 31 days following the date of adoption or the date you or your Spouse assume legal obligation. In order for coverage to continue beyond this 31-day period, you must submit an enrollment application to your Group within 60 days after the date of adoption or the date you or your Spouse assumed legal obligation if additional Premium is required. If additional Premium is not required, the application requirement is waived and Company will add the child to your Plan upon notification of the adoption. Assumption of legal obligation means when the adopting parent assumes and retains the legal obligation for total or partial support of the child in anticipation of the adoption of the child. Placement terminates upon termination of the legal obligations.

Special Enrollment of a Family due to Marriage

Along with your new Spouse and other Dependents, you may enroll yourself as a Subscriber by submitting a Company approved enrollment application within 31 days of marriage. The effective date of an enrollment resulting from marriage is no later than the first day of the month following the timely submission of your enrollment application.

Special Enrollment due to Newly Acquired Dependents

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

The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

- **Newborn child.** Newborns are covered from the moment of birth for the first 31 days. In order for coverage to continue beyond this 31-day period, you must submit an enrollment application to your Group within 60 days after the child's birth if additional Premium is required to add the Dependent.
- **Newly Adopted child.** Newly adopted children or children for whom you or your Spouse have newly assumed a legal obligation are covered for 31 days from the date of adoption or from the date you or your Spouse assumed legal obligation for total or partial support of the child. In order for coverage to continue beyond the 31-day period, you must submit an enrollment application to your Group within 60 days after the date of adoption or the date you or your Spouse assumed legal obligation if additional Premium is required. If additional Premium is not required, the application requirement is waived; however, please notify Company of the adoption so that we may update our records for more efficient provision of covered Services. Assumption of legal obligation means when the adopting parent assumes and retains the legal obligation for total or partial support of the child in anticipation of the adoption of the child. Placement terminates upon termination of the legal obligations.

- **All Other Dependents.** For all other Dependents, the first of the month following the date the change of enrollment application is received by your Group.

Special Enrollment due to Loss of Other Coverage

You may enroll as a Subscriber along with any eligible Dependents if you or your Dependents were not previously enrolled. If you are an existing Subscriber, you may add eligible Dependents not previously enrolled, by submitting a Company-approved enrollment or change of enrollment application to your Group within 30 days after loss of other coverage, if all of the following are true:

- You or your eligible Dependent had other coverage when you or the eligible Dependent previously declined Company coverage (some groups require you to have stated in writing when declining Company coverage was the reason).
- You did not enroll when you were first eligible and your Group did not provide us a written statement that verified you signed a document that explained restrictions about enrolling in the future.
- The loss of the other coverage is due to one of the following:
 - Exhaustion of COBRA coverage.
 - In the case of non-COBRA coverage, loss of eligibility or termination of employer contributions (but not termination for cause or for failure to make timely Premium payments).
 - Termination of Medicaid coverage.
 - Current Plan's lifetime benefit maximum has been met.

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

The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives the enrollment application from the Subscriber.

Enrollment of Child due to Court or Administrative Order

A court or administrative agency may order a child who meets the eligibility requirements to be added as a Dependent outside of the open enrollment period or at a time other than when you are first eligible to enroll yourself and your Dependents. If the order is received, the Group will let us know who to enroll under the order and the effective date of the enrollment.

HOW TO OBTAIN SERVICES

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

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

Using Your Identification Card

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

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

Getting Assistance

We want you to be satisfied with the health care Services you receive. If you have any questions or concerns, please discuss them with your primary care Participating Physician or with other Participating Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Most Participating Facilities have an administrative office staffed with representatives who can provide assistance if you need help obtaining Services. Membership Services representatives are also available to assist you Monday through Friday (except holidays), from 8 a.m. to 6 p.m. From Portland, call 503-813-2000; from all other areas, call 1-800-813-2000. For TTY for the hearing and speech impaired, call 1-800-735-2900. For language interpretation services, call 1-800-324-8010. You may also e-mail us by registering on our Web site at kaiserpermanente.org.

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

Our Advice Nurses

If you have questions about your medical condition, or if you would like to discuss a medical concern, call one of our advice nurses. During regular office hours, call the advice number at a Participating Medical Office near you. Telephone numbers and office hours are listed by facility in the *Medical Directory*. On evenings, weekends, and holidays, call 503-813-2000 from the Portland area or 1-800-813-2000 from all other areas any time to discuss medical concerns. For TTY for the hearing and speech impaired, call 1-800-735-2900. For language interpretation services, call 1-800-324-8010. You may also use the Member section of our Web site, kaiserpermanente.org, to send *nonurgent* questions to an advice nurse or pharmacist.

Your Primary Care Participating Provider

Your primary care Participating Provider plays an important role in coordinating your health care needs, including Participating Hospital stays and referrals to Specialists. We encourage you and your Dependents to each choose a primary care Participating Provider. You may change your primary care Participating Provider by calling Membership Services. The change will be effective the first day of the following month.

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

If you need to make a routine care appointment, please refer to the *Medical Directory* for appointment telephone numbers, or go to kaiserpermanente.org to request an appointment online. Routine appointments are for medical needs that are not urgent, such as checkups and follow-up visits that can wait

more than a day or two. Try to make your routine care appointments as far in advance as possible. For information about getting other types of care, refer to the “Emergency, Post-Stabilization, and Urgent Care” section.

Women’s Health Services

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

We cover annual mammograms for women 40 years of age or older, with or without a referral from your primary care Participating Physician, and more frequently if your primary care Participating Physician recommends it because you are at high risk for breast cancer or disease. We also cover breast examinations, pelvic examinations, and Pap tests annually for women 18 or older, and any time with a referral from your primary care Participating Physician.

Prior and Concurrent Authorization and Utilization Review

Some Services are subject to Utilization Review based on Utilization Review criteria developed by the Medical Group and/or other organizations utilized by Medical Group and approved by Company and may require prior or concurrent authorization in order to be covered. Your Participating Provider will request this authorization when necessary. The following are examples of Services that require prior or concurrent authorization (this list is subject to change at any time by Company without notice):

- Bariatric surgery Services.
- Breast reduction surgery.
- Cosmetic surgery.
- Drug formulary exceptions.
- Durable Medical Equipment.
- Hospice and home health Services.
- Inpatient hospital Services.
- Non-emergency medical transportation.
- Open MRI.
- Orthognathic surgery for congenital anomalies.
- Plastic surgery.
- Referrals for Non-Participating Provider Services.
- Rehabilitative Therapy Services.
- Routine foot Services.
- Skilled Nursing Facility Services.
- Transplant Services.

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

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

Referrals

Referrals to Participating Providers and Participating Facilities

Primary care Participating Providers provide primary medical care, including pediatric care and obstetrics/gynecology care. Participating Specialists provide Specialty Care in areas such as surgery, orthopedics, cardiology, oncology, urology, dermatology, and allergy/immunology. A Participating Provider will refer you to a participating Specialist when appropriate. In most cases you will need a referral to see a Specialist the first time. Please see the *Medical Directory* for information about specialty Services that require a referral or discuss your concerns with your primary care Participating Provider. In some cases, a standing referral may be allowed to a participating Specialist for a time period that is in accord with your individual medical needs as determined by the Participating Physician and Company.

Some specialty care is available in Participating Medical Offices without a referral. Please see the *Medical Directory*, or call Membership Services to schedule routine appointments in the following departments that do not require a referral:

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

Referrals to Non-Participating Providers and Non-Participating Facilities

If your Participating Physician decides that you require Services not available from Participating Providers or Participating Facilities, he or she will recommend to Medical Group and Company that you be referred to a Non-Participating Provider or Non-Participating Facility inside or outside our Service Area. If the Medical Group's assigned Participating Provider determines that the Services are Medically Necessary and are not available from a Participating Provider or Participating Facility and Company determines that the Services are covered Services, Company will authorize your referral to a Non-Participating Provider or Non-Participating Facility for the covered Services. The Copayments and Coinsurance for these approved referral Services are the same as those required for Services provided by a Participating Provider. You will need written authorization in advance in order for the Services to be covered. If Company authorizes the Services, you will receive a written "Authorization for Outside Medical Care" approved referral to the Non-Participating Provider, and only Services that are listed on the written referral will be covered, subject to any benefit limitations and exclusions applicable to these Services.

Participating Providers and Participating Facilities Contracts

Participating Providers and Participating Facilities may be paid in various ways, including salary, per diem rates, case rates, fee-for-service, incentive payments, and capitation payments. Capitation payments are based

on a total number of Members (on a per-Member per-month basis), regardless of the amount of Services provided. The Company may directly or indirectly make capitation payments to Participating Providers and Participating Facilities only for the professional Services they deliver, and not for Services provided by other physicians, hospitals, or facilities. Please call Membership Services if you would like to learn more about the ways Participating Providers and Participating Facilities are paid to provide or arrange medical and hospital care for Members.

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

Provider Whose Contract Terminates

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

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

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

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

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

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

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

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

- The 45th day after the birth; or
- As long as you continue under an active course of treatment, but not later than the 120th day after you receive notice of the provider's termination.

Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas

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

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

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

Your visiting Member Services may be different from the Services available to you in our Service Area. You may have to pay Copayments and Coinsurance.

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

Student Out-of-Area Coverage

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

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

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

- Services covered in the “Emergency, Post-Stabilization, and Urgent Care” section and under “Your Primary Care Participating Physician” in the “How to Obtain Services” section.
- “Transplant Services.”
- Visiting Member Services as described under “Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas” of this *EOC*.

EMERGENCY, POST-STABILIZATION, AND URGENT CARE

Coverage, Copayments, and Coinsurance, and Reimbursement

If you receive Emergency Care, post-stabilization care, or Urgent Care from a Participating Provider or Participating Facility, we cover those Services only if they are covered under the “Copayments, Coinsurance, and Benefits” section (subject to the “Exclusions and Limitations” section).

If you receive Emergency Care, post-stabilization care, or Urgent Care from a Non-Participating Provider or Non-Participating Facility, we cover those Services only if they meet both of the following requirements:

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

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

You do not need to file a claim for Services that you receive from a Participating Provider or Participating Facility. If you receive covered Emergency Care, post-stabilization care, or Urgent Care from a Non-Participating Provider or Non-Participating Facility, the Non-Participating Provider or Non-Participating Facility may agree to bill you for the Services or may require that you pay for the Services when you receive them. In either case, to request payment or reimbursement from us, you must file a claim as described under “Post-Services Claims—Services Already Received” in the “Requesting Medical Services and Benefits” section.

Emergency Care

If you have an Emergency Medical Condition, call 911 or go to the nearest hospital emergency department. When you have an Emergency Medical Condition, we cover Emergency Care that you receive in a hospital from Participating Providers, Participating Facilities, Non-Participating Providers, and Non-Participating Facilities anywhere in the world. Emergency Care does not require prior authorization.

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

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

Emergency Care is available seven days a week, 24 hours a day, at Participating Hospital emergency departments inside our Service Area. Please contact Membership Services or see our *Medical Directory* for locations of these emergency departments.

Post-Stabilization Care

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

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

To request prior authorization for your receiving post-stabilization care from a Non-Participating Provider or Non-Participating Facility, you or someone on your behalf must call us at 503-735-2596 or, toll free at

1-877-813-5993, before you receive the Services if it is reasonably possible to do so. We understand that extraordinary circumstances can delay your ability to call us, for example if you are unconscious or if there is no parent or guardian with a young child. In these cases, you must call us as soon as reasonably possible. After we are notified, we will discuss your condition with the Non-Participating Provider. If we decide that the post-stabilization care is Medically Necessary and would be covered if you received it from a Participating Provider or Participating Facility, we will either authorize your receiving the Services from the Non-Participating Provider or Non-Participating Facility, or arrange to have a Participating Provider or Participating Facility (or other designated provider or facility) provide the Services. If we decide to arrange to have a Participating Provider or Participating Facility (or other designated provider or facility), provide the Services, we may authorize special transportation Services that are medically required to get you to the provider or facility. This may include transportation that is otherwise not covered.

Urgent Care

Inside our Service Area

We cover Urgent Care inside our Service Area at Participating Medical Offices, some of which offer extended hours for Urgent Care. Please contact Membership Services or see our *Medical Directory* for Participating Medical Offices locations and hours. We may also cover Urgent Care during certain hours at designated Urgent Care facilities. Our *Medical Directory* lists these Urgent Care facilities and the hours when you may visit them for covered Urgent Care. You can also get this information by contacting Membership Services.

Outside our Service Area

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

COPAYMENTS, COINSURANCE, AND BENEFITS

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

- You are a current Member at the time Services are rendered.
- A Participating Provider determines that the Services are Medically Necessary,
- The Services are provided, prescribed, authorized, or directed by a Participating Physician except where specifically noted to the contrary in this *EOC*.
- You receive the Services inside our Service Area from a Participating Provider, Participating Facility, or from a Participating Skilled Nursing Facility, except where specifically noted to the contrary in this *EOC*.

Copayments and Coinsurance

The Copayment or Coinsurance for each covered Service is shown in the “Benefit Summary.” Copayments or Coinsurance are due when you receive the Service. If we must bill you, an accounting fee of \$10 or more may be added to offset handling costs.

Out-of-Pocket Maximum

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

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

- Ambulance Services.
- Chemical Dependency Services.
- Emergency Care.
- Infertility Services.
- Inpatient hospital Services.
- Laboratory, X-ray, imaging, and special procedures Services.
- Maternity and interrupted pregnancy Services.
- Office visits (including professional Services such as mental health, dialysis treatment, and physical, occupational, respiratory, and speech therapy).
- Outpatient surgery Services.
- Skilled nursing facility Services.

Benefits for Outpatient Services

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

- Routine preventive physical exam (includes adult and well child visits).
- Primary care visit for internal medicine, gynecology, family medicine, and pediatrics.
- Specialty care visit.
- Allergy testing and treatment materials.
- Treatment for temporomandibular joint disorder (TMJ).
- Prenatal care after confirmation of pregnancy, including prenatal diagnosis of congenital disorders, all routine prenatal visits, and the first postpartum visit.
- Prostate cancer screening (PSA testing).
- Routine eye exam.
- Routine hearing exam.
- Nurse treatment room visits to receive injections, including allergy injections.
- Urgent Care visits.
- Emergency department Services.
- Immunizations (including those required for travel) and vaccines approved for use by the U.S. Food and Drug Administration (FDA) when administered to you in a Participating Medical Office.
- Outpatient surgery and other outpatient procedures (including interrupted pregnancy surgery performed in an outpatient setting).
- Drugs, injectables, and radioactive materials used for therapeutic purposes, if they are administered to you in a Participating Medical Office or during home visits, subject to the drug formulary and exclusions described under the “Limited Outpatient Prescription Drugs, Supplies, and Supplements” section.

- Rehabilitative (such as physical, occupational, and speech) therapy. For more information about this benefit, refer to the “Rehabilitative Therapy Services” section.
- Respiratory therapy.
- Multidisciplinary rehabilitation therapy in an outpatient multidisciplinary rehabilitation facility or program: This benefit is subject to the benefit limitations described under the “Rehabilitative Therapy Services” section.
- House calls inside our Service Area when care can best be provided in your home as determined by a Medical Group physician.
- Blood, blood products, and their administration.

Outpatient Services of the following types are covered only as described under the following sections in this “Copayments, Coinsurance, and Benefits” section:

- “Ambulance Services.”
- “Chemical Dependency Services.”
- “Dialysis Services.”
- “Outpatient Durable Medical Equipment (DME), External Prosthetics, and Orthotics.”
- “Health Education Services.”
- “Home Health Services.”
- “Hospice Services.”
- “Infertility Services.”
- “Mental Health Services.”
- “Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures Services.”
- “Limited Outpatient Prescription Drugs, Supplies, and Supplements.”
- “Reconstructive Surgery Services.”
- “Rehabilitative Therapy Services.”
- “Transplant Services.”

Benefits for Inpatient Hospital Services

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

- Anesthesia.
- Blood, blood products, and their administration.
- Emergency detoxification.
- Dialysis Services (this benefit is subject to the benefit limitations described under “Dialysis Services” in this “Copayments, Coinsurance, and Benefits” section).
- Drugs and radioactive materials used for therapeutic purposes, except for the types of drugs excluded under the “Limited Outpatient Prescription Drugs, Supplies, and Supplements” section.
- Durable Medical Equipment and medical supplies.
- General and special nursing care.

- Internally implanted devices except for internally implanted insulin pumps, artificial hearts, and artificial larynx which are not covered.
- Interrupted pregnancy surgery when performed in an inpatient setting.
- Laboratory, X-rays and other imaging, and special diagnostic procedures.
- Maternity hospital care for mother and baby. We will not limit the length of a maternity hospital stay for a mother and baby to less than 48 hours for vaginal delivery and 96 hours for a cesarean section delivery. The length of inpatient stay is determined by an attending Participating Provider, in consultation with the mother. Our policy complies with the federal Newborns' and Mothers' Health Protection Act of 1996 (NMHPA).
- Medical foods and formulas if Medically Necessary.
- Medical social Services and discharge planning.
- Obstetrical care and delivery (including cesarean section).
- Operating and recovery rooms.
- Orthognathic surgery for treatment of a congenital abnormality subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.
- Participating Physician's Services, including consultation and treatment by Specialists.
- Prescription drugs, including injections.
- Rehabilitative therapy Services such as physical, occupational, speech, and respiratory therapy, and multidisciplinary rehabilitation Services, subject to the benefit limitations described under the "Rehabilitative Therapy Services" section.
- Room and board, including a private room if Medically Necessary.
- Specialized care and critical care units.
- Temporomandibular joint (TMJ) surgery for the treatment of TMJ disorders subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

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

- "Bariatric Surgery Services."
- "Chemical Dependency Services."
- "Dialysis Services."
- "Health Education Services."
- "Home Health Services."
- "Hospice Services."
- "Infertility Services."
- "Mental Health Services."
- "Reconstructive Surgery Services."
- "Skilled Nursing Facility Services."
- "Transplant Services."

Ambulance Services

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

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

Ambulance Services Exclusions

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

Bariatric Surgery Services

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

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

Chemical Dependency Services

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

Outpatient Services for Chemical Dependency

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

Inpatient Hospital Services for Chemical Dependency

We cover inpatient hospital Services for Chemical Dependency.

Residential Services

We cover residential Services in a residential program.

Day Treatment Services

We cover day treatment Services in a day treatment program.

Dialysis Services

We cover two types of dialysis: hemodialysis and peritoneal dialysis. We cover dialysis Services for acute renal failure and end-stage renal disease if:

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

We cover treatment at outpatient dialysis facilities.

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

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

Health Education Services

We cover a variety of health education Services to help you take an active role in improving and maintaining your health, such as individual and group visits. These Services include:

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

You may also use our free phone-based “Talk with a Health Consultant” service. To use this service, call 503-286-6816 or 1-866-301-3866 (toll free) and select option 2.

Health Education Services Exclusions

- Educational and clinical programs for weight control.

Home Health Services

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

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

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

The following types of Services are covered in the home only as described under these headings in this “Copayments, Coinsurance, and Benefits” section:

- “Dialysis Services.”
- “Outpatient Durable Medical Equipment (DME), External Prosthetics, and Orthotics.”

Home Health Services Exclusions

- Private duty or continuous nursing Services.
- Services that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. These Services are excluded even if we would cover the Services if they were provided by a qualified medical professional in a hospital or skilled nursing facility.

- Nonmedical, custodial, or housekeeping services except by home health aides as ordered in the approved plan of treatment.
- “Meals on Wheels” or similar food services.
- Nutritional guidance.
- Services performed by family members.
- Services not included in an approved plan of treatment.
- Supportive environmental materials such as handrails, ramps, telephones, air conditioners, and similar appliances and devices.

Hospice Services

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

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

- A Medical Group physician has diagnosed you with a terminal illness and determines that your life expectancy is six months or less.
- The Services are provided in your home (including a friend’s or relative’s home even if you live there temporarily.)
- The Services are provided by a licensed hospice agency approved by Kaiser Foundation Hospitals.
- The Services are necessary for the palliation and management of your terminal illness and related conditions.
- The Services meet Utilization Review by Company using criteria developed by Medical Group and approved by Company.

We cover the following hospice Services:

- Counseling and bereavement Services for up to one year.
- Home health aide and Homemaker Services.
- Medical social Services.
- Medical supplies and appliances.
- Outpatient Durable Medical Equipment.
- Participating Physician Services.
- Rehabilitative therapies for purposes of symptom control or to enable you to maintain activities of daily living.
- Services of volunteers.
- Short-term inpatient Services including respite care and care for pain control and acute and chronic symptom management. Inpatient respite care is limited to no more than five consecutive days in a 30-day period.

- Skilled nursing Services, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers.

Infertility Services

The following inpatient and outpatient infertility Services are covered:

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

Infertility Services Exclusions

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

Limited Outpatient Prescription Drugs, Supplies, and Supplements

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

Covered Drugs, Supplies, and Supplements

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

- Certain self-administered IV drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as IV or intraspinal-infusion) for up to a 30-day supply, including the supplies and equipment required for their administration.
- Drugs, injectables, and radioactive materials used for therapeutic purposes, if they are administered to you in a Participating Medical Office or during home visits.
- Medical foods and formulas necessary for the treatment of phenylketonuria (PKU), severe intestinal malabsorption, specified inborn errors of metabolism, or other metabolic disorders.
- Oral chemotherapy medications used for the treatment of cancer.

About Our Drug Formulary

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

Drug Formulary Exception Process

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

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

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

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

Limited Outpatient Prescription Drugs, Supplies, and Supplements Exclusions

- Any packaging, such as blister or bubble repackaging, other than the dispensing pharmacy’s standard packaging.
- Drugs prescribed for an indication if the U.S. Food and Drug Administration (FDA) determined that use of that drug for that indication is contraindicated.
- Drugs prescribed for an indication if the FDA has not approved the drug for that indication, except that this exclusion does not apply if the Oregon Health Resources Commission or our Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health and Human Services.
- Drugs, supplies, and supplements that are available without a prescription, even if the nonprescription item is in a different form or different strength (or both), except that this exclusion does not apply to drugs, supplies, or supplements that our drug formulary lists for your condition.
- Drugs that the FDA has not approved.
- Drugs used in weight management.
- Drugs used to enhance athletic performance.
- Extemporaneously compounded drugs, unless the formulation is approved by our Regional Formulary and Therapeutics Committee.
- Injectable drugs that are self-administered.
- Mail-order drugs for anyone who is not a resident of Oregon or Washington.
- Replacement of drugs, supplies, and supplements due to loss, damage, or carelessness.

- The following are excluded, but you may have coverage for them if your Group purchased an outpatient prescription drug rider:
 - Prescription drugs, supplies, and supplements that are dispensed on an outpatient basis, except those listed under “Covered Drugs, Supplies, and Supplements” of this “Limited Outpatient Prescription Drugs, Supplies, and Supplements” section.
 - Contraceptives including injectable contraceptives.
 - Drugs for treatment of infertility.
 - Drugs used for the treatment or prevention of sexual dysfunction disorders.

Mental Health Services

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

- Crisis intervention.
- Evaluation.
- Treatment of mental disorders that in the judgment of a mental health Participating Provider, are subject to significant improvement through therapeutic management, or chronic conditions which are responsive to therapeutic management.

We cover mental health Services subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request the criteria by calling Membership Services. We cover Participating Provider Services under this “Mental Health Services” section only if they are provided by a licensed psychiatrist, licensed psychologist, or licensed social worker.

Outpatient Services

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

Inpatient Hospital Services

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

Residential Services

We cover residential Services in a residential facility up to the day maximum shown in the “Benefit Summary.” Your day maximum will be exhausted (used up) when the total residential days that we have covered, including any residential days we covered during the same benefit period under this or any other evidence of coverage with the same group number printed on this *EOC*, add up to the day maximum shown in the “Benefit Summary.” After you reach the day maximum during a benefit period, we will not cover any more residential Services during that benefit period.

Psychological Testing

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

Mental Health Services Exclusions and Limitations

- Mental health Services, including evaluations and psychological testing, on court order or as a condition of parole or probation, unless Medically Necessary. Court-ordered sex offender treatment programs are excluded regardless of whether they are Medically Necessary.

- Psychological testing for ability, aptitude, intelligence, or interest.
- Mental health Services for the following disorders listed by their diagnostic codes as set out in the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition), published by the American Psychiatric Association:
 - (Mental retardation) codes 317, 318.0, 318.1, 318.2, and 319.
 - (Learning disorders) codes 315.00, 315.1, 315.2, and 315.9.
 - (Paraphilias) codes 302.2, 302.4, 302.81, 302.82, 302.83, 302.84, 302.89, and 302.9.
 - (Gender identity disorders in adults) 302.6, 302.85, and 302.9 (This exclusion does not apply to anyone 18 years of age or younger).
 - (Life transition problems referred to as “V” codes) codes V15.81 through V62.81 and V62.83 through V71.09. This exclusion does not apply to anyone 5 years of age or younger for code V61.20 (parent-child relational problems) or code V61.21 (neglect, physical abuse, or sexual abuse of child).
- Mental health Services for substance related disorders, except as covered under “Chemical Dependency Services” in this “Copayments, Coinsurance, and Benefits” section.
- In home mental health Services, unless all of the following are true:
 - You are substantially confined to your home (or a friend’s or relative’s home), or the care is provided in lieu of Medically Necessary hospitalization.
 - Your Participating Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home.
 - You receive prior authorization from Company in accordance with Utilization Review criteria developed by Medical Group and approved by Company.

Outpatient Durable Medical Equipment (DME), External Prosthetics, and Orthotics

We cover outpatient Durable Medical Equipment (DME), external prosthetics, and orthotics according to the DME formulary guidelines. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. DME must be for use in your primary residence (or another location used as your primary residence). Coverage is limited to the standard supply or equipment that adequately meets your medical needs. We decide whether to rent or purchase the DME, and we select the vendor.

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

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

DME Defined

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

External Prosthetics and Orthotics Defined

External prosthetic devices are rigid or semi-rigid external devices required to replace all or any part of a body organ or extremity. Orthotic devices are rigid or semi-rigid external devices (other than casts) required to

support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

Unless otherwise indicated below, covered DME, external prosthetics, and orthotics include:

- Billirubin lights.
- CADD (continuous ambulatory drug delivery) pumps.
- Compression garments for burns.
- Diabetic equipment and supplies including external insulin pumps, infusion devices, glucose monitors, diabetic foot care appliances, injection aids, and lancets.
- Enteral pump and supplies.
- Enteral supplements and formula.
- External prostheses after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres every 12 months.
- Fitting and adjustments.
- Halo vests.
- Lymphedema wraps and garments.
- Maxillofacial prosthetic devices. Coverage is limited to the least costly clinically appropriate treatment as determined by a Participating Physician. We cover maxillofacial prosthetic devices if they are necessary for restoration and management of head and facial structures that cannot be replaced with living tissue and are defective because of disease, trauma, or birth and developmental deformities when this restoration and management are performed for the purpose of:
 - Controlling or eliminating infection;
 - Controlling or eliminating pain; or
 - Restoring facial configuration or functions such as speech, swallowing, or chewing, but not including cosmetic procedures rendered to improve the normal range of conditions.
- Ocular prosthesis for children age 12 or younger.
- Osteogenic bone stimulators.
- Osteogenic spine stimulators.
- Prosthetic devices for treatment of temporomandibular joint (TMJ) conditions.
- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity. This includes but is not limited to ostomy and urological supplies.
- Repair or replacement (unless due to loss or misuse).
- Rigid and semi-rigid orthotic devices required to support or correct a defective body part.
- Therapeutic shoes and inserts to prevent and treat diabetes-related complications.
- Tracheotomy equipment.
- Ventilators.

DME Formulary

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

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

Outpatient Durable Medical Equipment (DME), External Prosthetics, and Orthotics Exclusions

- Artificial hearts.
- Artificial larynx.
- Comfort, convenience, or luxury equipment or features.
- Corrective orthotic devices such as items for podiatric use (such as shoes and arch supports, even if custom-made, except footwear described above for diabetes-related complications).
- Dental appliances and dentures.
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies).
- Electronic monitors of bodily functions.
- Exercise or hygiene equipment.
- Internally implanted insulin pumps.
- Modifications to your home or car.
- More than one corrective appliance or artificial aid or item of Durable Medical Equipment, serving the same function or the same part of the body, except for necessary repairs, adjustments and replacements as specified under this "Outpatient Durable Medical Equipment (DME), External Prosthetics, and Orthotics" section.
- Non-medical items, such as sauna baths or elevators.
- Replacement of lost DME items.
- Replacement of lost prosthetic and orthotic items.
- Spare or duplicate use DME.

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

We cover outpatient Services for laboratory, X-ray, imaging, and special diagnostic procedures. Special diagnostic procedures may or may not involve radiology or imaging technology. Examples include X-ray, MRI, CT scans, mammograms, colorectal cancer screening tests, pulmonary function studies, sleep studies, and nerve conduction studies.

The special diagnostic procedure Copayment or Coinsurance does not apply to procedures that are usually for treatment purposes, even if that procedure might also be performed for diagnostic reasons, such as

colonoscopy, endoscopy, and laparoscopy. For these Services, the outpatient surgery visit Copayment or Coinsurance applies.

Women between the ages of 40 and 75, who are seeking routine mammograms, may contact the Radiology Department directly to set up appointments.

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

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

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

Reconstructive Surgery Services

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

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

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

Prosthetics and orthotic devices are covered under this section and subject to the “Outpatient Durable Medical Equipment (DME), External Prosthetics, and Orthotics” section.

Rehabilitative Therapy Services

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

Physical, Occupational, or Speech Therapy Services

Therapy Services (physical, occupational, and speech) are covered for the treatment of acute conditions which, in the judgment of the Participating Physician will show measurable improvement of the Member’s condition within 60 days as a result of the prescribed therapy. Prescribed outpatient therapy Services must receive prior-authorization as described under “Prior and Concurrent Authorization and Utilization Review” in the “How to Obtain Services” section.

Physical, Occupational, and Speech Therapy Services Limitations

- Occupational therapy Services are limited to those necessary to restore or improve functional abilities when physical and/or sensori-perceptual impairment exists due to injury, illness, stroke, or surgery.
- Physical therapy visits are limited to those necessary to restore or improve functional abilities when physical and/or sensori-perceptual impairment exists due to injury, illness, stroke, or surgery.

- Speech therapy Services are covered for speech impairments of specific organic origin such as cleft palate, or when speech, language, or the swallowing function is lost due to injury, illness, stroke, or surgery.
- The “Benefit Summary” shows a visit maximum for each rehabilitative therapy. That visit maximum will be exhausted (used up) for the Calendar Year when the number of visits that we covered during the Calendar Year under this *EOC* plus any visits we covered during the Calendar Year under any other evidence of coverage with the same group number printed on this *EOC* add up to the visit maximum. After you reach the visit maximum, we will not cover any more visits for the remainder of the Calendar Year. This limitation does not apply to hospital inpatient Services.

Multidisciplinary Inpatient Rehabilitation and Multidisciplinary Day Treatment Program Services

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

Multidisciplinary rehabilitation Services are covered for the treatment of conditions which, in the judgment of a Participating Physician are subject to significant improvement in function within 60 days and must receive prior authorization as described under the “Prior and Concurrent Authorization and Utilization Review” in the “How to Obtain Services” section.

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

Multidisciplinary Rehabilitation and Multidisciplinary Day Treatment Program Services Limitations

- This benefit is limited to a maximum of 60 days per condition per Calendar Year for inpatient hospital and outpatient day treatment program Services combined.

Rehabilitative Therapy Services Exclusions

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

Chemotherapy and Radiation Therapy Services

We cover prescribed chemotherapy and radiation therapy Services subject to the applicable outpatient rehabilitative or inpatient hospital Copayment or Coinsurance.

Respiratory Therapy Services

We cover respiratory therapy in the inpatient hospital or outpatient setting when prescribed by a Participating Physician.

Skilled Nursing Facility Services

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

The “Benefit Summary” shows a day maximum for skilled nursing facility Services under “Skilled Nursing Facility Services.” That day maximum will be exhausted (used up) for a Calendar Year when the number of days that we covered during the Calendar Year under this *EOC* plus any days we covered during the Calendar Year under this or any other evidence of coverage with the same group number printed on this *EOC* add up

to the day maximum. After you reach the day maximum, we will not cover any more days for the remainder of the Calendar Year.

We cover the following:

- Room and board.
- Nursing Services.
- Medical social Services.
- Medical and biological supplies.
- Blood, blood products, and their administration.
- Dialysis Services (this benefit is subject to the benefit limitations described under “Dialysis Services” in this “Copayments, Coinsurance, and Benefits” section).
- Rehabilitative therapy (this benefit is subject to the benefit limitations shown in the “Benefit Summary” under “Rehabilitative Therapy Services”).
- Drugs prescribed by a Participating Physician as part of your plan of care in the Participating skilled nursing facility in accord with our drug formulary guidelines if they are administered to you in the Participating skilled nursing facility by medical personnel.

Transplant Services

We cover the listed transplants under this “Transplant Services” section at National Transplant Network Facilities if you meet Utilization Review criteria developed by Medical Group and approved by Company. For these covered Services that you receive, you will pay the Copayment and Coinsurance you would pay if the Services were not related to a transplant. We cover post-surgical immunosuppressive drugs without Charge.

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

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

We cover only the following transplants at National Transplant Networks Facilities:

- Bone marrow transplants.
- Cornea transplants.
- Heart transplants.
- Heart-lung transplants.
- Kidney transplants.
- Liver transplants.
- Lung transplants.
- Pancreas transplants.
- Pancreas after kidney transplants.
- Simultaneous kidney-pancreas transplants.

- Small bowel transplants.
- Small bowel/liver transplants.
- Stem cell transplants.

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

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

Transplant Services Exclusions

- Non-human and artificial organs and their implantation.

EXCLUSIONS AND LIMITATIONS

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

Acupuncture. Services for acupuncture are limited to the following: (a) when a Participating Physician makes a referral for Services in accord with Medical Group criteria; or (b) or your employer Group has purchased the Alternative Care (self-referred Acupuncture Services) rider.

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

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

Cosmetic Services. Those Services that are intended primarily to change or maintain your appearance and that will not result in significant improvement in physical function are limited to Services that are specifically covered under “Reconstructive Surgery Services” in the “Copayment, Coinsurance, and Benefits” section.

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

Dental Services. Dental care including dental X-rays; dental services following accidental injury to teeth; dental appliances; dental implants; orthodontia; and dental services necessary for or resulting from medical treatment such as surgery on the jawbone and radiation treatment is limited to: (a) emergency dental services; or (b) extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.

Also, general anesthesia and related facility services in conjunction with non-covered dental Services are excluded, except when Medically Necessary for Members who:

- are children under the age of 7, or are physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
- have a medical condition that your Participating Physician determines would place you at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by your Participating Physician.

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

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

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

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

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

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

- Your medical records.
- The written protocols and other documents pursuant to which the Service has been or will be provided.
- Any consent documents you or your representative has executed or will be asked to execute, to receive the Service.

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

If two or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

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

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

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

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

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

Hearing aids. Hearing aids, tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid are excluded, unless your Group has purchased the Hearing Aid rider.

Hypnotherapy. All Services related to hypnotherapy.

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

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

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

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

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

Services related to a non-covered Service. When a Service is not covered, all Services related to the non-covered Service are also excluded. However, this exclusion does not apply to Services we would otherwise cover if they are to treat complications which arise from the non-covered Service.

Sexual re-assignment surgery.

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

Travel and lodging. Transportation or living expenses for any person, including the patient, are limited to: (a) Medically Necessary ambulance Service covered under “Ambulance Services” in this *EOC*, and (b) certain expenses that we preauthorize in accord with our travel and lodging guidelines under “Transplant Services” in this *EOC*. Your transplant coordinator can provide information about covered travel and lodging expenses.

Vision hardware optical Services. Corrective lenses, eyeglasses and contact lenses are excluded unless your Group has purchased the Vision Hardware Optical Services rider.

Vision therapy and orthoptics or eye exercises. Services related to vision therapy and orthoptics and eye exercises are excluded.

Professional Services for fitting and follow-up care for contact lenses. These Services are excluded unless your Group has purchased the Vision Hardware Optical Services rider.

Low-vision aids. These aids are excluded.

REDUCTIONS

Coordination of Benefits

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

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

Definitions

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

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

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

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

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one

COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

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

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

- (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
 - (2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
 - (3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
 - (4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.
 - (5) The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- E. Closed panel Plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

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

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
 - (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
 - (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel Plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - (1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is the Secondary Plan and the other Plan is the Primary plan.
 - (2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
 - (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the Plan is given notice of the court decree;
 - (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
 - (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The Plan covering the Custodial parent;
The Plan covering the spouse of the Custodial parent;
The Plan covering the non-custodial parent; and then
The Plan covering the spouse of the non-custodial parent.

- (c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
- (3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
- (6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of this Plan

- A. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a covered person is enrolled in two or more Closed panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel Plan, COB shall not apply between that Plan and other Closed panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. We may get the facts 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 person claiming benefits. We need not tell, or get the consent of, any

person to do this. Each person claiming benefits under this Plan must give us any facts we need to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

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

**Questions about coordination of benefits?
Contact your state insurance department.**

Hospitalization on Your Effective Date

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

Injuries or Illnesses Alleged to be Caused by Third Parties

This “Injuries or Illnesses Alleged to be Caused by Third Parties or Covered by No-fault Insurance” section applies if you receive covered Services for an injury or illness alleged to be caused by a third party’s acts or omissions or received on the premises of a third party. If you obtain a settlement or judgment from or on behalf of a third party, you must pay us Charges for covered Services that you receive for the injury or illness, except that you do not have to pay us more than the amount you receive from or on behalf of the third party. This “Injuries or Illnesses Alleged to be Caused by Third Parties or Covered by No-fault Insurance” section does not affect your obligation to make any applicable Copayment and Coinsurance payments for these covered Services, but we will credit any such payments toward the amount you must pay us under this paragraph.

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

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

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

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

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

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, trust agreements, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly.

You must place and hold in trust a portion of the proceeds of your recovery that is sufficient to satisfy our claims under this "Injuries or Illnesses Alleged to be Caused by Third Parties or Covered by No-fault Insurance" section pending final resolution of the claims. You must provide us with written notice before you settle a claim or obtain a judgment against any third party based on your injury or illness.

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

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

Workers' Compensation or Employer's Liability

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

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

REQUESTING MEDICAL SERVICES AND BENEFITS

Important Information for Members Whose Benefit Plans are Subject to ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulates employee benefits, including the claim and appeal procedures for benefit Plans offered by certain employers. If an employer's benefit Plan is subject to ERISA, each time you request Services that must be approved before the Service is provided, you are filing a "pre-Service claim" for benefits. You are filing a "post-Service claim" when you ask us to pay for or cover Services that have already been received. You must follow our procedures for filing claims, and we must follow certain rules established by ERISA for responding to claims.

If you are not satisfied with the decision made on your pre-Service or post-Service claim, you are only required to file one appeal before you have the right to take legal action under Section 502(a) of ERISA. The following Company departments or committees review appeals: Medical Office Administration, Member Relations, Continuing Care Services, and Patient Care Coordination for pre-Service and concurrent care

claims, and Member Relations for post-Service claims. Additional levels of voluntary appeal are available within Kaiser Permanente. We will not impose fees as part of any appeal process. If you are not sure whether these ERISA laws apply to your benefit Plan, you should contact your employer for more information.

Post-Service Claims—Services Already Received

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

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

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

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

You can request a claim form from Membership Services or download it from **kaiserpermanente.org**. When you submit the claim, you must include a copy of your medical records from the Non-Participating Provider or Non-Participating Facility if you have them. If medical records are deemed necessary to decide the claim, you will be notified and required to submit them.

Company accepts CMS 1500 claim forms for professional Services and UB-92 forms for hospital claims. Even if the provider bills the Company directly, you still need to submit the claim form.

You must submit a claim within 90 days after receiving Services, or as soon as reasonably possible. We will not review a claim if it is not submitted within 12 months from the time it is due, unless you lack the legal capacity to file the claim within 12 months.

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

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

If you have questions or concerns about a bill from Company, you may contact Membership Services for an explanation. If you believe the Charges are not appropriate, Membership Services will advise you on how to proceed. If you believe the Charges are not appropriate due to concerns involving Services or benefits, you may file a written grievance. If you think the Charges are in error (such as a bill for Services you did not receive or that were paid at the time of Service), Patient Business Services can assist you. If Patient Business Services determines the Charges are accurate, you will be given an explanation along with information about how to file a grievance if dissatisfied.

Pre-Service Claims—Requesting Future Services

When you need Services, you should talk with your Participating Provider about your medical needs or your request for Services. Your Participating Provider provides Services that are Medically Necessary and

appropriate. Participating Providers will use their own judgment to determine if Services are medically appropriate. Some Services are subject to approval through Utilization Review, based on Utilization Review criteria developed by Medical Group or another organization utilized by the Company and approved by Company. If you seek a specific Service, you should talk with your Participating Provider. Your Participating Provider will discuss your needs and recommend the most appropriate course of treatment. If your request for Service(s) is urgent, we (or our appropriate designee) will respond to the request within two business days or 72 hours, whichever is shorter.

If you request Services that the Participating Provider believes are not Medically Necessary or appropriate, you may ask for a second opinion from another Participating Provider. For primary care Services, you can request a different Participating Provider at any time. You also have the right to request a pre-Service determination in writing. You should contact the manager in the area where the Participating Provider is located. Membership Services can connect you with the correct manager, who will listen to your issues and discuss the request with the Participating Provider. If the Participating Provider who provides the second opinion believes the Services requested are not Medically Necessary, we will send you a pre-Service denial letter. The letter will explain the reason for the determination along with instructions for filing an appeal.

If you request Services that must be approved through Utilization Review, as previously described, and the Participating Provider believes they are Medically Necessary, the Participating Provider may submit the request for review on your behalf. If the request is denied, we will send a letter to you within two business days of the Participating Provider's request for approval. The letter will explain the reason for the determination along with instructions for filing an appeal. You may request a copy of the complete Medically Necessary criteria used to make the determination. Please contact Member Relations at 503-813-4480 or 1-800-813-2000 and ask for Member Relations.

If you request Services but learn there may be coverage limitations or exclusions, and you have questions or disagree, you should contact Membership Services. If you are not satisfied after talking with Membership Services, you may request a pre-Service benefit determination in writing. We will generate a benefit determination within two business days. If you are not satisfied after receiving the benefit determination, you then may file an appeal.

If you are covered under an ERISA benefit Plan and additional information is required to make a determination on your pre-Service request, you will be notified and given a specified period of time to provide the information. This may extend the decision period past two business days.

Expedited procedures are available for urgent requests for Services. A request is urgent if the normal decision time frames would cause a delay that would seriously jeopardize your life, health, or ability to regain maximum function. It also applies if your Participating Provider who is familiar with your medical condition believes the delay would subject you to severe pain that cannot be managed adequately without the requested Service. In urgent situations, Company will respond to you as quickly as the condition requires, not exceeding two business days or 72 hours, whichever is shorter. Certain requests to extend previously approved Services that involve Urgent Care (such as continued inpatient or skilled nursing facility Services) are responded to within 24 hours of receipt.

DISPUTE RESOLUTION

Complaints, Grievances, and Appeals—Member Satisfaction

We want you to be satisfied with the Services you receive from Kaiser Permanente. If you have questions about your coverage or how to use our Services, or if you need help finding the right health care resource, contact Membership Services. If you have a compliment or suggestion, please call or send a letter to the administrator of the facility where you received care. We'll share your comments with the employees who assisted you and their supervisors.

Discuss any issues about your care with your Participating Provider or another member of your health care team. If you are not satisfied with your Participating Provider, you may request another. Contact Membership Services for assistance. You always have the right to a second opinion within Kaiser Permanente.

Most issues can be resolved with your health care team. If you feel that additional assistance is needed, complaint and grievance procedures are available to help. All complaints and grievances are handled in a confidential manner.

Oral Complaints

If you want to talk with someone because you are dissatisfied with the availability, delivery, or quality of our Services, benefits, or other administrative matters, you can file an oral complaint. Examples include, but are not limited to, things like appointment delays, the manner of communication by our staff, or concerns about our policies and procedures. If you have a concern involving a denial of future care, refer to “Appeals.” If your concern involves a denial for Services you already received, refer to “Written Grievances.”

To file a complaint, you can contact the administrative office in the Participating Facility where you are having the problem or contact Membership Services for assistance. Discuss your complaint fully with the staff and be specific about how you want the matter to be resolved.

If you remain dissatisfied, you can file a written grievance. If you decide to file a written grievance, follow the procedures described in “Written Grievances.”

Written Grievances

A grievance is a written complaint requesting a specific action, submitted by or on behalf of a Member.

You can file a written grievance:

- If you are not satisfied with our response to your complaint regarding the availability, delivery, or quality of our Services, benefits, or other administrative matters. Examples include complaints that you want reported and resolved, such as, a delay in hearing back from your Participating Physician’s office or about receiving an appointment in a timely manner.
- If you disagree with Charges on a bill from Kaiser Permanente. (This is an initial claim for benefits under ERISA)
- If we denied your claim for Services that you received from a Non-Participating Provider or Facility and you disagree with the claim determination. You must file the grievance within 185 days of the denial notice. (These grievances are post-Service appeals under ERISA)
- If we issued a benefit denial in writing after you requested a pre-Service benefit determination. This includes things like a pre-Service adverse benefit determination based on a decision that you are not eligible for benefits. Or, it could be a pre-Service denial based on any number of specific coverage exclusions such as, certain excluded infertility procedures, lack of special benefits like prescription drugs, vision hardware coverage, or due to benefit limitations like a maximum number of covered visits. You must file the grievance within 185 days of the denial notice. (These grievances are pre-Service appeals under ERISA)

To file a written grievance, outline your concerns in writing and be specific about your request. You may submit any written comments, documents, records, and other information related to your grievance. Send your grievance to:

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

If you need assistance filing a written grievance, or if your grievance is urgent, contact Member Relations at 503-813-4480 or 1-800-813-2000 and ask for Member Relations. We will acknowledge receipt of your grievance within seven days. Member Relations will forward your grievance to the correct manager or department for resolution. An independent review will be conducted and we will provide you with a written decision within 30 days except as follows. If you fail to provide necessary information to make a determination on a grievance that is an initial claim under ERISA and you are covered under an ERISA benefit Plan, we will allow you 50 days from the date on our written notification to submit the information. A decision will be reached within 15 days after receiving the information or within 15 days after the end of the 50-day period if we don't receive the information.

We will expedite a response on all grievances according to the clinical urgency of the situation, not to exceed 72 hours, if your grievance involves a denial of urgently needed care.

If your grievance included a specific request and that request is denied, the decision letter you receive will include detailed information about the basis for the decision, how to appeal the decision, and how to file a complaint with the Oregon Department of Consumer and Business Services (DCBS). (For Members covered under an ERISA benefit Plan, additional appeals are considered voluntary unless your grievance was classified as an initial claim under ERISA as described previously.)

Appeals—General Description

The process for requesting reconsideration of a denied grievance or a denial of care or Service following a Utilization Review determination requested by your Participating Provider is described in the following appeal procedures. These procedures reflect the requirements of state and federal laws. Members who are not covered under an ERISA benefit Plan have two levels of appeal following any denied grievance or following a denial of care or Service because it was not considered Medically Necessary or it did not meet Utilization Review criteria approved by Medical Group (Utilization Review determinations). These appeals are referred to as “first-level” and “second level” appeals. Members covered under an ERISA benefit Plan are only required to file one appeal before having a right to take legal action under ERISA. Receipt of appeals will be acknowledged within seven days.

First-level appeals

- If you disagree with the decision rendered following a written grievance, you have 185 days from the date on the denial notice to submit a first-level appeal. (For Members covered under an ERISA benefit plan, this level of appeal is considered voluntary.

Exception: If the grievance was a dispute regarding a bill from Kaiser Permanente, this appeal is the one required level of appeal under ERISA).

- If you disagree with a denial for future Services following a Utilization Review determination requested by your Plan Provider, you have 185 days from the date of the denial notice to submit a first-level appeal.
- If your appeal involves urgently needed future care, a request for an expedited appeal may be submitted orally or in writing.

To submit an appeal, follow the instructions in the denial letter you receive, or send your appeal to Member Relations. They will direct it to the appropriate location for handling. You have the right to include with your first-level appeal any written comments, documents, records, and other information relating to the claim.

First-level appeals will be decided within 30 days after we receive your appeal. A decision will be expedited to meet the clinical urgency of the situation, not to exceed 72 hours if it involves a denial of urgently needed future care. Member Relations or the area manager will conduct an independent review of your first-level appeal and provide a written response. If your first-level appeal is denied, the written notice you receive will

explain the basis for the decision, along with information about further appeal rights, how to file a complaint with the Oregon Department of Consumer and Business Services, and other important disclosures.

Second-level appeals

- If you disagree with the decision rendered on your first-level appeal, you have the right to submit a second-level written appeal
- If you decide to submit a second-level appeal, send your appeal in writing to Member Relations within 185 days of the date of the decision letter
- You have the right to include with your appeal any written comments, documents, records, and other information relating to the claim
- You have the right to appear in person or by telephone before a review panel which is comprised of persons not previously involved in the complaint. If you wish to participate in person or by telephone, you must indicate this in your written second-level appeal. You must also list anyone who will attend with you, including your relationship to them. Member Relations will coordinate the independent panel review and provide a written response

Second-level appeals will be decided within 30 days after we receive your appeal. A decision will be expedited to meet the clinical urgency of the situation, not to exceed 72 hours if it involves a denial of any urgently needed future care. **If your second-level appeal is denied, written notification will explain the basis for the denial and will advise you how to request an additional independent external review by an independent review organization (IRO).** It will also tell you how to file a complaint with the Oregon Department of Consumer and Business Services.

External review by an IRO under Oregon law

Certain requests may be eligible for external review by an IRO if both first and second-level appeals have been denied. If you are covered under an ERISA benefit plan, external review is considered another voluntary level of appeal and is only available once all voluntary appeals have been exhausted.

If your second-level appeal is denied, you have the right to request review by an IRO of an adverse decision that is based on one or more of the following:

- Whether a course or plan of treatment is Medically Necessary, experimental, or investigational.
- Whether a course or plan of treatment is required for continuity of care when a Participating Provider's contract with us is terminated.

You must submit your request for external review in writing to Member Relations within 185 days of the date of the final denial letter. Member Relations will forward your request to the director of the Oregon Department of Consumer and Business Services within two business days after receiving your request.

Your request for external review will be assigned to one of the IROs contracted by the Oregon Department of Consumer and Business Services along with any authorizations necessary no later than the next business day after the director receives your request for external review from us. They will provide you a written description of the IRO selected along with more information about the process. They will also notify us of the IRO selected so we can forward documents and information considered in making our adverse decision.

Your request for external review will be expedited if the ordinary time period for external review would seriously jeopardize your life, health, or your ability to regain maximum function.

If we don't have an appropriate authorization to disclose protected health information, including medical records that are pertinent to the external review, we must obtain a signed waiver from you. You are not responsible for the costs of the external review, and you may name someone else to file the appeal for you if you give permission in writing and include that with your request for external review. **Kaiser Permanente**

will be bound by and act in accordance with the decision of the IRO notwithstanding the definition of Medically Necessary care.

You also have the right to file a complaint or seek assistance from the Consumer Protection Unit at the Oregon Insurance Division. Contact them by mail, telephone, over the Internet, or by e-mail:

Department of Consumer and Business Services—Insurance Division
Consumer Protection Unit
Room 440-2
350 Winter St. NE
Salem, OR 97301
503-947-7984 or 1-888-877-4894
www.oregoninsurance.org
DCBS.INSMAIL@state.or.us

TERMINATION OF MEMBERSHIP

Your Group is required to inform the Subscriber of the date the Subscriber or any Dependent's membership terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. In addition, Dependents' memberships end at the same time the Subscribers' membership ends.

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

Termination during Confinement in a Hospital

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

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

Your coverage under this provision continues until the earlier of:

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

Termination Due to Loss of Eligibility

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

We will terminate all COBRA Members who permanently reside outside the Service Area or who permanently move outside the Service Area and do not work for any employer at least 50 percent of the time within our Service Area.

Termination for Cause

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

- You abuse or threaten the safety of Company personnel or of any person or property at a Participating Facility.
- You fail to comply with the provisions of the Plan.
- You knowingly commit fraud in connection with membership, Company, or a Participating Provider. Some examples of fraud include:
 - misrepresenting eligibility information about you or a Dependent.
 - presenting an invalid prescription or physician order for Services.
 - intentionally misusing a Company ID card (or letting someone else use your ID card to obtain Services pretending to be you).
 - giving us incorrect or incomplete material information.
 - failing to notify us of changes in Family status or Medicare coverage that may affect your eligibility or benefits.

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

If we terminate your membership for cause we will:

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

We may deduct any amounts you owe Company, Kaiser Foundation Hospitals, or Medical Group from any payment we make to you.

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

Termination of the *Group Agreement*

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

Termination of Certain Types of Health Benefit Plans by Us

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

Certificates of Creditable Coverage

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

CONTINUATION OF MEMBERSHIP

Strike, Lock-Out, or Other Labor Disputes

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

Illness, Temporary Plant Shut Down, or Leave of Absence

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

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

You may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. COBRA applies to most employees (and most of their covered Dependents) of most employers with 20 or more employees. Please contact your Group for details about COBRA continuation coverage, such as how to elect coverage and how much you must pay your Group for the coverage.

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

State Continuation Coverage for Surviving, Divorced, or Separated Spouses 55 or older in COBRA Groups

If your Group is subject to COBRA law, you and your Dependents may be able to continue your coverage under this *EOC* through your Group if you meet all of the following criteria:

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

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

Your premium may be up to 102 percent of the applicable Premium. The first premium payment must be paid within 45 days of your coverage election date. Your right to continue coverage as a surviving, separated, or divorced Spouse will end upon the earliest of the following events:

- You fail to pay your premium.

- The Group's *Agreement* with us terminates.
- You are covered under another group health coverage.
- You become, eligible for Medicare.

State Continuation Coverage for Non-COBRA Groups

If your Group is not subject to COBRA law, you and your Dependents may be able to continue coverage under this *EOC* for up to six months if you are not eligible for Medicare. To be eligible you must have lost your job or membership in the organization through which you are receiving coverage under this *EOC* and have been covered continuously under this *EOC* during the three-month period ending on the date you lost your job or organization membership. You must notify Membership Services in writing of your request for continued coverage not more than 10 days after the later of either:

- The date you lost your job or organization membership.
- The date on which your Group or Membership Services notified you of your right to continue coverage under this *EOC*.

However, you may not make your request for continued coverage more than 31 days after the date of job or organization membership termination.

Your Premium will be 100 percent of the applicable Premium. The first Premium payment must be paid within 31 days after the date on which your coverage would otherwise end.

Your right to continue coverage under this "State Continuation Coverage for Non-COBRA Groups" section will end upon the earliest of the following events:

- Six months have elapsed since the date on which coverage under this *EOC* would otherwise have ended.
- You fail to pay your Premium.
- You become eligible for Medicare.
- Your Group Agreement with us terminates.

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

If you are laid off and rehired within six months and you were eligible for coverage at the time of the lay off, you may re-enroll in the Group coverage without being subject to any waiting period even if you chose not to continue coverage under this "State Continuation Coverage for Non-COBRA Groups" section.

State Continuation Coverage after Workers' Compensation Claim

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

Conversion to an Individual Plan

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

Portability Plans

If you want to remain a Company Member, one option that may be available is a Kaiser Foundation Health Plan of the Northwest Portability Plan. The Premium and coverage under our Portability Plans will differ from those under this *EOC*. You may be eligible to enroll in one of our Portability Plans if you no longer meet the eligibility requirements described in "Who is Eligible" in the "Premium, Eligibility, and Enrollment" section. If you enroll in Group continuation coverage through COBRA, State Continuation Coverage, or USERRA, you may be eligible to enroll in one of our Portability Plans when your Group continuation coverage ends. As a general rule, if you accept portability coverage at the end of coverage under this Group health Plan, you will not qualify as a HIPAA eligible individual.

To be eligible for our Portability Plans, there must be no lapse in your coverage and we must receive your enrollment application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later). To request an application, please call Membership Services.

If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill. Because your coverage under our Portability Plan begins when your Group coverage ends (including Group continuation coverage), your first payment to us will include coverage from when your Group coverage ended through our current billing cycle. You must send us the Premium payment by the due date on the bill to be enrolled in our Portability Plan.

You may not convert to one of our Portability Plans if any of the following is true:

- You continue to be eligible for coverage under this *EOC* (not including COBRA, State Continuation Coverage, or USERRA).
- Your membership ends because our *Agreement* with your Group terminates and it is replaced by another Plan within 15 days after the termination date.
- We terminated your membership under "Termination for Cause" in the "Termination of Membership" section. If a Subscriber is terminated for cause, this will not preclude their eligible Dependents from enrolling in a Portability Plan.
- The number of days you were enrolled on an Oregon Group Health Benefit Plan is less than 180 days, or your total amount of prior Creditable Coverage is less than 18 months.
- You live in the service area of another Kaiser Foundation Health Plan or allied plan except that you or your Spouse's otherwise eligible children may be eligible to be covered Dependents even if they live in (or move to) the service area of another Kaiser Foundation Health Plan or allied plan (please refer to "Who Is Eligible" in the "Premium, Eligibility, and Enrollment" section for more information).
- You reside outside the state of Oregon and not within the Service Area of Company.
- You are covered under another group Plan, policy, contract, or agreement providing benefits for hospital or medical care.

To request more information regarding our Portability Plans, or for information about our other individual plans, Kaiser Permanente Plans for Individuals and Families, please call Membership Services.

HIPAA and Other Individual Plans

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health care coverage for workers and their families when they change or lose their jobs. If you lose group health care coverage and meet certain criteria, you are entitled to purchase individual (non-group) health care coverage from any health Plan that sells individual health care coverage.

Every company that sells individual health care coverage must offer individual coverage to an eligible person under HIPAA. The company cannot reject your application if you are an eligible person under HIPAA, you agree to pay the required premiums, and you live or work inside the company's service area. To be considered an eligible person under HIPAA you must meet the following requirements:

- You have 18 or more months of Creditable Coverage without a break of 90 days or more between any of the periods of Creditable Coverage or since the most recent coverage was terminated.
- Your most recent Creditable Coverage was under a group, government, or church Plan (COBRA coverage is considered group coverage).
- You were not terminated from your most recent Creditable Coverage due to nonpayment of premium or due to your fraud.
- You are not eligible for coverage under a group health Plan, Medicare, or Medicaid.
- You have no other health care coverage.
- You have elected and exhausted any continuation coverage you were offered.

For more information (including premium and complete eligibility requirements), please refer to the "Portability Plans" section. To request more information about our Portability Plans, or for information about our other individual plans, please call Membership Services.

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

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

MISCELLANEOUS PROVISIONS

Administration of Agreement

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

Advance Directives

The following legal forms help you control the kind of health care you will receive if you become very ill or unconscious:

- A *Durable Power of Attorney for Health Care* allows you name a designee to make health care decisions for you when you cannot speak for yourself. It also allows you to put in writing your desires regarding life support and other treatments with regard to your health care treatment.

- A *Living Will and a Natural Death Act Declaration to Physicians* enables you to put in writing your directives for receiving life support and other treatment

For additional information about advance directives, including how to obtain forms and instructions, contact Membership Services.

Agreement Binding on Members

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

Amendment of Agreement

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

Applications and Statements

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

Assignment

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

Attorney Fees and Expenses

Except as provided in the "Dispute Resolution" section of this *EOC*, in any dispute between a Member and Company or Medical Group or Kaiser Foundation Hospitals, each party will bear its own attorneys' fees and other expenses in any dispute.

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC*, and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*. If this *EOC* is part of a health benefit Plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this *EOC*.

Exercise of Conscience

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

Governing Law

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

Group and Members not Company Agents

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

Litigation Venue

Venue for all litigation between you and Company shall lie in Multnomah County, Oregon.

No Waiver

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

Nondiscrimination

We do not discriminate in our employment practices or in the delivery of Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

Notices

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

Overpayment Recovery

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

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers and facilities to protect your PHI. PHI is health information that includes your name, social security number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

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

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* explains our privacy practices in detail. To request a copy, please call Membership Services. Our *Notice of Privacy Practices* is also available at kaiserpermanente.org.

Unusual Circumstances

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

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST OUTPATIENT PRESCRIPTION DRUG RIDER

This rider is part of the *Evidence of Coverage (EOC)* to which it is attached. This rider becomes part of the *EOC* “Copayments, Coinsurance, and Benefits” section. The provisions of the *EOC* apply to this entire rider.

Note: We also cover some outpatient drugs, supplies, and supplements in the “Limited Outpatient Prescription Drugs, Supplies, and Supplements” section.

Covered Drugs, Supplies, and Supplements

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

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

Copayments and Coinsurance for Covered Drugs, Supplies, and Supplements

When you pick up a prescription at a Participating Pharmacy for one of the items listed above, you pay the Copayment or Coinsurance as shown in the “Benefit Summary.” This applies for each prescription consisting of up to the day supply limit shown in the “Benefit Summary.” The “Benefit Summary” shows the amounts applicable if you use our Mail-Delivery Pharmacy.

The following items require payment of a different Copayment or Coinsurance as indicated:

- Medical foods and formulas necessary for the treatment of phenylketonuria (PKU), severe intestinal malabsorption, specified inborn errors of metabolism, or other metabolic disorders: \$0.
- Certain self-administered IV drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as IV or intraspinal-infusion) for up to a 30-day supply, including the supplies and equipment required for their administration: \$0.

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

For the purposes of this section, maintenance drugs, supplies, or supplements are items that meet both of the following requirements:

- Our Regional Formulary and Therapeutics Committee determines that there is evidence that the drug is safe and effective to use for at least six months.
- The drug, supply, or supplement is prescribed for regular or scheduled use rather than on an as-needed basis.

Day Supply Limit

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

How to Get Covered Drugs, Supplies, or Supplements

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

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

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

About Our Drug Formulary

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

Drug Formulary Exception Process

Our drug formulary guidelines include an exception process that is available when a Participating Provider prescribes a drug, supply, or supplement that our drug formulary does not list for your condition, if the law requires the item to bear the legend “Rx only.” The exception process is not available for drugs, supplies, and supplements that the law does not require to bear this legend.

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

requirements are met:

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

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

Outpatient Prescription Drug Rider Limitations

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

Outpatient Prescription Drug Rider Exclusions

- Any packaging, such as blister or bubble repackaging, other than the dispensing pharmacy's standard packaging.
- Drugs prescribed for a condition not approved by the U.S. Food and Drug Administration (FDA), unless the Oregon Health Resources Commission determines that the drug is recognized in independent medical or pharmaceutical journals as effective for that use. This includes coverage when the FDA has determined a drug to be contraindicated for a condition, or when the drug is experimental and not approved for any use by the FDA.
- Drugs, supplies, and supplements that are available without a prescription, even if the non-prescription item is in a different form or different strength (or both), except that this exclusion does not apply to drugs, supplies, or supplements that our drug formulary lists for your condition.
- Drugs that the FDA has not approved.
- Drugs for treatment of infertility.

- Drugs used for the treatment or prevention of sexual dysfunction disorders.
- Drugs used in weight management.
- Drugs used to enhance athletic performance.
- Extemporaneously compounded drugs, unless the formulation is approved by our Regional Formulary and Therapeutics Committee.
- Internally implanted time-release drugs, except for internally implanted time-release contraceptive drugs.
- Mail-order drugs for anyone who is not a resident of Oregon or Washington.
- Drugs that require special handling, which may include professional administration or observation, refrigeration or high cost are not provided through mail delivery Pharmacy.
- Replacement of drugs, supplies, and supplements due to loss, damage, or carelessness.

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

This rider is part of the *Evidence of Coverage (EOC)* to which it is attached. All provisions of this rider become part of the *EOC* “Copayments, Coinsurance, and Benefits” section. This entire rider is therefore subject to all the terms and provisions of the *EOC*.

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

Eyeglasses and Contact Lenses

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

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

- \$60 for single vision and cosmetic contact lenses
- \$90 for multifocal lenses

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

An allowance can be used only when you order the item. If you do not use all of your allowance when you order the item, you cannot use it later.

Eyeglasses and Contact Lenses after Cataract Surgery

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

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

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

Vision Hardware Optical Services Exclusions

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

COORDINATION OF BENEFITS

CONSUMER EXPLANATORY BOOKLET

Important Notice

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

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

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

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

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the “primary” or “secondary” benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state’s COB rules will always be primary.

When This Plan is Primary

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

- **Your Own Expenses.** The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.
- **Your Spouse’s Expenses.** The claim is for your spouse, who is covered by Medicare, and you are not both retired.
- **Your Child’s Expenses.** The claim is for health care expense of your child who is covered by this plan; and
 - You are the parent and your birthday is earlier in the year than that of the other parent ”; or
 - You are separated or divorced and you have informed us of a court decree that makes you responsible for the child’s health care expenses; or
 - There is no court decree, but you have custody of the child.

Other Situations

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

How We Pay Claims When We are Primary

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

How We Pay Claims When We are Secondary

When we are knowingly the secondary plan, we will make a reasonable estimate of the primary plan payment and base our payment on that amount. After payment information is received from the primary plan, we may recover from the primary plan any excess amount paid under the “right of recover” provision in the plan. We may not delay our payments because of lack of information from the primary plan. We are required to pay claims within ninety days of receipt.

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

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

Questions about coordination of benefits?

Contact your state insurance department