Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Certificate of Coverage
Public Employees Benefit Program (PEBB)
2008 Medical Benefits
Active Employees–Classic Plan

Published under the direction of the Washington State Health Care Authority (HCA)

This *COC* is effective January 1, 2008 through December 31, 2008

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

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Introduction

This Certificate of Coverage (*COC*), including the "Benefit Summary," describes the health care coverage of this Plan provided under the Agreement between Kaiser Foundation Health Plan of the Northwest, sometimes referred to as "Kaiser," "we," "our," or "us," and the Washington State Health Care Authority (HCA) for the Public Employees Benefit Program (PEBB). For benefits provided under any other plan, refer to that plan's certificate of coverage. Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *COC;* please see the "Definitions" section for terms you should know.

If there is a conflict between the Plan Agreement and this *COC*, this *COC* will govern.

Definitions

Allowable Charge: means the customary and reasonable charge for any necessary health care Service when the Service is covered at least in part under any of the plans involved. When a plan provides benefits in the form of Services rather than cash payments, the reasonable cash value of each Service provided will be considered an Allowable Charge.

Members enrolled in this Plan are not responsible for payment of the Allowable Charge described above when Services are received from Participating Providers other than for any Coinsurance or Copayment, or the amount in excess of stated benefit maximum and charges for non-covered Services.

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

Calendar Year: A period of 12 consecutive months beginning January 1.

Certificate of Coverage (*COC*): This *Certificate of Coverage* document provided to the Subscriber that specifies and describes benefits and conditions of coverage.

Coinsurance: The percentage of the Allowable Charge that Members are responsible to pay when the Plan provides benefits at less than 100% coverage.

Copayment: A defined dollar amount Members pay when receiving specific Services.

Custodial/Convalescent Care: Care that is designed primarily to assist the Member in activities of daily living, including institutional care that serves primarily to support self-care and provide room and board. Custodial/Convalescent Care includes, but is not limited to, help walking, getting into and out of bed, bathing, dressing, feeding, preparing special diets, and supervision of medications that are ordinarily self-administered. Kaiser reserves the right to determine which Services constitute Custodial or Convalescent Care.

Designated Facility: Any health facility, including those that provide outpatient Services, or hospital employed, owned, or operated by or under contract with Kaiser to deliver covered Services to Members.

Emergency: A condition (including a psychiatric condition) in which the immediate onset of symptoms, including severe pain, would lead a prudent layperson to reasonably expect that immediate medical attention is needed to:

- Avoid serious impairment of organs or bodily functions, or
- Avoid a serious threat to the health of the individual or fetus in the case of a pregnant woman.

Family: A Subscriber and all of his or her enrolled dependents.

Family Planning Services: Those medical care Services related to planning the birth of children through the use of birth control methods, including elective sterilization.

Formulary: A list of outpatient prescription drugs, selected by the plan and revised periodically, which are covered when prescribed by a Participating Provider and filled at a Participating Pharmacy.

Group: Washington Public Employees Benefits Program (PEBB).

Kaiser: Kaiser Foundation Health Plan of the Northwest provides Services and benefits for Members enrolled in this Plan - Public Employees Benefits (PEBB) Program.

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Kaiser, and the Medical Group, which is Northwest Permanente PC, Physicians & Surgeons, a professional corporation of physicians organized under the laws of the state of Oregon. Medical Group contracts with the Kaiser to provide professional medical services to Members and others primarily on a capitated, prepaid basis in Designated Facilities.

Medical Group: Northwest Permanente PC, Physicians & Surgeons, is a professional corporation of physicians organized under the laws of the state of Oregon. Medical Group contracts with the Kaiser to provide professional medical services to Members and others primarily on a capitated, prepaid basis in Designated Facilities.

Medically Necessary: A Service that in the judgment of a Primary Care Provider (PCP) or Participating Provider is required to prevent, diagnose, or treat a medical condition. A Service is Medically Necessary only if a PCP or Participating Provider 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.

A service is "Medically Necessary" if it is recommended by the Member's treating provider and Kaiser Permanente's Medical Director or provider designee and if all of the following conditions are met:

1. The purpose of the Service or intervention is to treat a medical condition;
2. It is the appropriate level of Service or intervention considering the potential benefits and harm to the patient;
3. The level of Service or intervention is known to be effective in improving health outcomes;
4. The level of Service or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention; and
5. For new interventions, effectiveness is determined by scientific evidence. Existing interventions are determined effective first by scientific evidence, then by professional standards, then by expert opinion.

Applicable terms:

A health "intervention" is a Service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a medical condition (i.e., disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of "Medical Necessity," a health "intervention" means not only the intervention itself, but also the medical condition and patient indications for which it is being applied. "Effective" is an intervention, supply or level of service that can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

An intervention or Service may be medically indicated yet not be a covered benefit or meet the standards of this definition of "Medical Necessity." Medical Group may choose to cover interventions, or Services that do not meet this definition of "Medical Necessity," however, is not required to do so.

"Treating provider" is a health care provider who has personally evaluated the patient.

"Health outcomes" are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

An intervention is considered to be new if it is not yet in widespread use for the medical condition and patient indications being considered.

"New interventions" for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion (see "existing interventions" below).

"Scientific evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

For "existing interventions," the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of "medical necessity." If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet Kaiser Permanente's definition of "medical necessity" in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

A level of service, supply or intervention is considered "cost effective" if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative. Cost-effective does not necessarily mean lowest price.

Member: Refers to an employee, retiree, dependent (including surviving dependent), or domestic partner who is eligible and enrolled under this *COC*, and for whom Kaiser has received applicable premium. This *COC* 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 enrolled under this *COC*.

Non-Participating Provider: A hospital, facility, physician, or other duly licensed health care professional who does not have a participation agreement with Kaiser and is not a Participating Provider.

Participating Pharmacy: Any pharmacy owned and operated by Kaiser and listed in the *Medical Directory* for our Service Area.

Participating Provider: Any licensed provider who has a contract with Medical Group or is employed by Medical Group to provide health care services to Members.

Participating Providers agree not to bill Members for any charges above the amount agreed upon by Medical Group and the provider, except for any Coinsurance, or Copayments, amounts in excess of stated benefit maximums, and charges for non-covered Services for which the Member is responsible. Services must be within the scope of the provider's license, and providers must agree to standards related to:

- Provision, Utilization Review, and cost containment of health Services;
- Management and administrative procedures; and
- Provision of cost-effective and clinically efficacious health Services.

Plan: The Public Employee Benefit Program (PEBB) health benefit plan of coverage agreed to between PEBB and Kaiser Foundation Health Plan of the Northwest (Kaiser).

Primary Care Provider (PCP): A provider who provides, prescribes, or directs all phases of a Member's care, including appropriate referrals to Non-Participating Providers. The PCP has the responsibility for supervising, coordinating, and providing primary health care to members, initiating referrals for specialist care, and maintaining the continuity of Member care. PCPs, as designated by Medical Group, may include, but are not limited to, Pediatricians, Family Practitioners, General Practitioners, Internists, Physicians Assistant (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP).

Proof of Continuous Coverage: The Certificate of Creditable Coverage provided to the Member by the Member's prior health plan; or a letter from the Member's employer, on the employer's letterhead, providing the time period the Member and/or dependent(s) of the Member were covered by health insurance.

Service Area: Kaiser Foundation Health Plan of the Northwest's service area consists of the following ZIP codes within the following counties:

In Washington

Clark: All ZIP codes

Cowlitz: All ZIP codes

Lewis: 98591, 98593, 98596

Skamania: 98639, 98648

Wahkiakum: 98612, 98647

Out-of-State: Oregon

Benton: 97330, 97331, 97333, 97339, 97370

Clackamas: 97004, 97009, 97011, 97013, 97015, 97017, 97022, 97023, 97027, 97034, 97035, 97036, 97038, 97042, 97045, 97049, 97055, 97067, 97068, 97070, 97222. 97267, 97268

Columbia: All ZIP codes

Hood River: 97014

Linn: 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97389

Marion: 97002, 97020, 97026, 97032, 97071, 97071, 97137, 97301, 97302, 97303, 97305, 97306, 97307, 97308, 97309, 97310, 97311, 97312, 97313, 97314, 97316, 97317, 97325, 97342, 97346, 97352, 97359, 97362, 97373, 97375, 97381, 97383, 97384, 97385, 97392

Multnomah: All ZIP codes

Polk: All ZIP codes

Washington: All ZIP codes

Yamhill: All ZIP codes

Services: Health care services, supplies, or items.

Subscriber: Means the employee, surviving dependent, or retiree who provides the basis for eligibility for enrollment under the Plan as defined in this *COC*.

Utilization Review: The formal application of techniques to monitor the use of or evaluate the medical necessity, appropriateness, effectiveness, or efficiency of a specific Service, procedure, or setting.

Benefit Summary

Annual deductible	None
Annual out-of-pocket limit	Copayments and Coinsurance paid by a Member for covered Services throughout the Calendar Year shall not be more than $750 per Member or $1,500 per Family. This annual out-of-pocket limit applies to combined expenses covered under this Plan for: • Ambulance Services; • Chemical dependency Services; • Emergency Services; • Maternity and interrupted pregnancy Services; • All inpatient hospital admissions; • Office visits (including professional Services such as mental health, dialysis treatment, and physical, occupational, speech, and massage therapy); • Outpatient surgery Services; • Skilled Nursing Facility Services; • Laboratory, X-ray, imaging, and special procedures; • Organ transplants. • The following charges will not accumulate toward the annual out-of-pocket limit: • Outpatient prescriptions drugs and injections; • Medical supplies; • Durable medical equipment; • Corrective appliances and artificial aids, such as eyeglasses, hearing aids, prosthetic devices, orthopedic braces, and learning aids; • Contraceptive devices; • Clinical trial care and services; • Any services excluded from this Plan, such as cosmetic surgery, dental care, and dental X-rays; • Health Education; • Orthognathic surgery for temporomandibular disorder (TMD); • Blood and blood products; • Self-referred spinal manipulation therapy Services; • Any amount not covered under this Plan on the basis Kaiser covered the benefit maximum amount or paid the maximum number of visits for a Service.

Benefits will be provided at the payment levels specified below and in the benefits section of this *COC* up to the benefit maximum limits. The numbered Services below correspond with the benefit descriptions in the following section, "Benefit Details." Please read the "Benefit Details" and the "Benefit Exclusions and Limitations" sections for specific benefit limitations, maximums, and exclusions.

COVERED SERVICE	BENEFIT
1. Accidental injury to teeth	100% subject to $10 Copayment per visit
2. Ambulance Services	
Air ambulance	100% subject to $75 Copayment
Ground ambulance	100% subject to $75 Copayment
3. Ambulatory surgical center	100% subject to $100 Copayment
4. Blood and blood derivatives	100%

COVERED SERVICE	BENEFIT
5. Chemical dependency Services	$14,000 per 24 consecutive-calendar-month period
Inpatient	100% subject to inpatient hospital Copayment
Outpatient	100% subject to $10 Copayment per visit
6. Diabetic education	100% subject to $10 Copayment per visit
7. Diagnostic testing, laboratory, mammograms, and X-ray	100%
8. Dialysis	
Outpatient	100% subject to $10 Copayment per visit
Home	100%
9. Durable medical equipment, supplies, and prostheses	80%
10. Emergency room Services *(Copayment waived if admitted directly as inpatient from emergency room)*	100% subject to $75 Copayment per visit
11. Hearing Examinations	
Hearing exams	100% subject to $10 Copayment per exam
Hearing aids	100%; benefit maximum of $300 every 36 months
12. Home health	100% up to 130 visits per Calendar Year
13. Hospice care (including respite care)	100%
14. Hospital Services	
Inpatient hospital Services	100% subject to $200 Copayment per day; maximum $600 per person per Calendar Year
Inpatient professional Services	100%
Outpatient hospital Services	100% subject to $100 Copayment
Outpatient surgery professional Services	100%
15. Mental Health Services	
Inpatient	100% subject to inpatient hospital Copayment
Outpatient	100% subject to $10 Copayment per visit/50 visits per Calendar Year
16. Neurodevelopmental therapy for children age 6 and younger	
Inpatient-60 days per Calendar Year	100% subject to inpatient hospital Copayment
Outpatient-60 visits per Calendar Year	100% subject to $10 Copayment per visit
17. Obstetrical care	
Inpatient hospital Services	100% subject to inpatient hospital Copayment
Professional inpatient and outpatient Services	100%
18. Office Visits(including specialty care visits)	100% subject to $10 Copayment per visit

COVERED SERVICE	BENEFIT
19. Organ transplants	
Inpatient facility Services	100% subject to inpatient hospital Copayment
Inpatient professional Services	100%
20. Phenylketonuria (PKU) supplements	100% when provided for the disorder
21. Physical, occupational, speech, and massage, therapies	
Inpatient-60 days per Calendar Year	100% subject to inpatient hospital Copayment
Outpatient-60 visits per Calendar Year for all therapies combined	100% subject to $10 Copayment per visit
22. Prescription drugs, insulin, and diabetic supplies	
Retail-Up to a 30-day supply	
All disposable diabetic supplies, all insulin, and Formulary generic drugs	100% subject to $10 Copayment per prescription or refill
Formulary brand-name drugs	100% subject to $25 Copayment per prescription or refill
Mail-order-Up to a 90-day supply	
All disposable diabetic supplies, all insulin, and Formulary generic drugs	100% subject to $20 Copayment per prescription or refill
Formulary brand-name drugs	100% subject to $50 Copayment per prescription or refill
23. Preventive care	100%
24. Radiation-chemotherapy Services	100%
25. Reconstructive surgery	Payment levels are determined by the setting in which the Service is provided
26. Skilled nursing facility *(150 days per Calendar Year)*	100% subject to inpatient hospital Copayment
27. Spinal manipulations	
Self-referred manipulative therapy of the spine and extremities in accordance with Medical Group Criteria up to 10 visits per Member per Calendar Year. Additional visits may be covered if prior approval is received.	100% subject to $10 Copayment per visit
28. Temporomandibular joint dysfunction (TMJ) (Medical)	50% to $1,000 per Calendar Year
29. Tobacco cessation	$65 class fee
30. Vision care (routine)	
Routine eye exams: one exam annually	100% subject to $10 Copayment per exam
Hardware every 2 Calendar Years: either lenses and frames, or contact lenses	100% to $150 benefit maximum
31. Weight Control and Obesity Treatment Bariatric surgery for clinically severe obesity only when all of the following requirements have been met: • A Participating Provider determines that the surgery meets Utilization Review criteria approved by Medical Group and adopted by Kaiser. • The Member fully complies with the Kaiser Permanente Severe Obesity Evaluation and Management Program's contract for participation approved by Kaiser.	100% subject to inpatient hospital Copayment

Annual 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 *COC* with the same Group number printed on this *COC*. This annual out-of-pocket maximum shown in the "Benefit Summary" is per Calendar Year for a Member or for an entire Family. Amounts paid for qualifying Services by each Member enrolled under the Member's plan count toward the individual maximum and toward the Family maximum. After you reach the annual out-of-pocket maximum, you are not required to pay Copayments and Coinsurance for the remainder of the Calendar Year for the Services listed below. Membership Services can provide the amount you have paid toward your out-of-pocket maximum and will issue a waiver card when the maximum has been met.

The applicable Copayments and Coinsurance you pay for the following covered Services apply toward the annual out-of-pocket maximum:

- Ambulance Services.
- Chemical dependency Services.
- Emergency Services.
- Maternity and interrupted pregnancy Services.
- Inpatient hospital 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.
- Laboratory, X-ray, imaging, and special procedures Services.
- Organ transplants.

The following expenses do not apply toward the annual out-of-pocket maximum and once the out-of-pocket maximum is met, Copayments or Coinsurance still apply for these Services:

- Outpatient prescription drugs and injections.
- Medical supplies, such as splints, bandages, and slings.
- Durable medical equipment.
- Corrective appliances and artificial aids, such as eyeglasses, hearing aids, prosthetic devices, orthopedic braces, and learning aids.
- Contraceptive devices.
- Clinical trial care and services.
- Any services excluded from this Plan, such as cosmetic surgery, dental care, and dental X-rays.
- Health Education.
- Orthognathic surgery for temporomandibular disorder (TMD).
- Blood and blood products.
- Self-referred spinal manipulation therapy and Alternative Care Services.
- Any amount not covered under this Plan on the basis Kaiser covered the benefit maximum amount or paid the maximum number of visits for a Service.

Benefit Details

All benefits are subject to the exclusions, limitations, and eligibility provisions contained in this *COC* and in the "Benefits Exclusions and Limitations" section. Kaiser Permanente provides Services through all types of health care providers licensed under state law. Benefits are payable for preventive care and Medically Necessary Services that are provided by Participating Providers or obtained in accordance with referral or authorization requirements, except for Emergency Services or as provided under coordination of benefits provisions. Authorization and referral requirements are described in the "Prior and Concurrent Authorization" section of this *COC*. Services received after termination of this Plan's coverage will not be covered, except when required by law. Services that are provided by mental health Participating Providers to Members diagnosed as having a mental disorder will be covered as mental health care, regardless of the cause of the disorder.

1. Accidental injury to teeth

The Services of a licensed dentist will be covered subject to a $10 office visit Copayment for repair of accidental injury to natural teeth. Evaluation of the injury and development of a written treatment plan must be completed within 30 days from the date of injury. Treatment must be completed within the period established in the treatment plan unless delay is medically indicated and the written treatment plan is modified. Services for the following are not covered: Injuries caused by biting or chewing; malocclusion resulting from an accidental injury, except for Emergency stabilization; orthodontic treatment; dental implants; conditions not directly resulting from the accident; and treatment not completed within the time period established in the written treatment plan.

2. Ambulance Services

Emergency ground ambulance Services are subject to a $75 Copayment per trip to a Designated Facility, or the nearest facility where care is available. If ground ambulance Services are not appropriate for transporting the Member to the nearest facility, the Plan covers Emergency air ambulance subject to a $75 Copayment per trip. The Service must meet the definition of an Emergency and be considered the only appropriate method of transportation, based solely on Medical Necessity. If Medical Group approves a Member's transfer from one facility to another, the ambulance transportation Copayment will not apply.

3. Ambulatory surgical center

Services at an ambulatory surgical center (discharged within 24 hours of admission) are covered subject to a $100 Copayment per surgery or procedure. Services must be provided at a Designated Facility.

General anesthesia Services and related facility charges in conjunction with any dental procedure performed in an ambulatory surgical center are covered subject to a $100 facility Copayment if such anesthesia Services and related facility charges are Medically Necessary because the Member:

- Is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
- Has a medical condition that the Member's PCP determines would place the Member at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the Member's PCP.

For the purpose of this section, "general anesthesia Services" means Services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command. Nitrous oxide analgesia is not reimbursable as general anesthesia.

4. Blood and blood derivatives

Blood and blood derivatives, including but not limited to, synthetic factors, plasma expanders, and their administration, are covered in full when Medically Necessary.

5. Chemical dependency Services

Medically Necessary inpatient and outpatient chemical dependency treatment and supporting Services are covered on the same basis as other chronic illness or disease, subject to the inpatient hospital or office visit Copayment. The Member's PCP or Participating Provider must authorize all chemical dependency treatment in advance, and a Designated Facility for an approved treatment program must provide the Services. Court-ordered treatment will be covered only if it is determined by the PCP or Participating Provider to be Medically Necessary. Members are eligible to receive a benefit maximum of $14,000 for covered chemical dependency treatment during any two Calendar Years or 24 consecutive calendar month period.

Chemical dependency is an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

Inpatient prescription drugs prescribed in connection with chemical dependency treatment are covered. All other prescription drugs are paid according to the provisions under "Prescription Drugs, Insulin and Diabetic Supplies."

When the Member is not yet enrolled in a dependency treatment program, Medically Necessary detoxification is covered as a medical Emergency. Medical Emergency treatment for detoxification is not included in the calculation of the $14,000 benefit maximum, and is subject to the Emergency Services Copayment.

For purposes of this chemical dependency treatment provision, the meaning of "Medically Necessary" is as indicated in the Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II as published in 2001 by the American Society of Addiction Medicine.

6. Diabetic education

Medically Necessary diabetic education is covered subject to the $10 office visit Copayment for each visit. Member's PCP or Participating Provider must prescribe the Services.

7. Diagnostic testing

Laboratory or diagnostic imaging, including X-rays, ultrasound, mammography, nuclear medicine, and allergy testing, prescribed by the Member's PCP or Participating Provider, and provided at a Designated Facility are covered in full. Screening and diagnostic procedures during pregnancy, and related genetic counseling when Medically Necessary for prenatal diagnosis of congenital disorders, are included.

8. Dialysis—outpatient

Outpatient professional and facility Services necessary for dialysis when referred by the Member's PCP or Participating Provider are covered in full subject to the $10 office visit Copayment for each dialysis treatment. Home dialysis is 100% covered. Dialysis is covered while you are temporarily absent from our Service Area. A temporary absence is an absence lasting less than twenty-one (21) days. Services must be preauthorized prior to departure from our Service Area.

9. Durable medical equipment, supplies, and prostheses

This Plan covers the rental or purchase of durable medical equipment, medical supplies, and prostheses at 80 percent (80%) of Allowed Charges, subject to preauthorization by the Member's PCP or Participating Provider and if obtained through a Designated Facility. Disposable supplies used for treatment of diabetes are covered under the "Prescription Drugs, Insulin, and Diabetic Supplies" benefit.

Durable medical equipment (DME) is equipment that:

- is prescribed by the Member's PCP or Participating Provider;
- is Medically Necessary;
- is primarily and customarily used only for a medical purpose;
- is designed for prolonged use; and
- serves a specific therapeutic purpose in the treatment of the Member's illness or injury.

Covered Services include:

- the rental or purchase (at the option of Kaiser Permanente) of durable medical equipment such as wheelchairs, hospital beds, and respiratory equipment (combined rental fees shall not exceed full purchase price);
- diabetic equipment and supplies including external insulin pumps, infusion devices, glucose monitors diabetic foot care appliances, injection aids, and lancets not covered in the pharmacy benefit;
- casts, splints, crutches, trusses, or braces;
- oxygen and rental equipment for its administration;
- ostomy supplies;
- artificial limbs or eyes (including implant lenses prescribed by a Participating Provider and required as a result of cataract surgery or to replace a missing portion of the eye);
- the initial external prosthesis and bra necessitated by surgery of the breast, and replacement of these items when necessitated by normal wear, a change in medical condition or when additional surgery is performed that warrants a new prosthesis and/or bra; prosthetic bras are limited to two every six months.
- penile prosthesis when impotence is caused by a covered medical condition (not psychological), is a complication which is a direct result of a covered surgery, or is a result of an injury to the genitalia or spinal cord and other accepted treatment has been unsuccessful;
- a wig or hairpiece to replace lost hair due to radiation therapy or chemotherapy for a covered condition, up to a lifetime benefit maximum payment of $100 per person; and
- breast pumps.

10. Emergency room Services

Emergency visits at an emergency room facility are covered subject to a $75 Copayment per visit. If the Member is transferred from the emergency room to an observation bed, there is no additional Copayment. If the Member is admitted as an inpatient directly from the emergency room or from an observation bed, the emergency Copayment will be waived, and the inpatient hospital Copayment will be applied. Use of a hospital emergency room for a non-medical emergency is not covered.

11. Hearing Examinations

Hearing examinations to determine hearing loss are covered, subject to a $10 Copayment for each visit, when authorized by the Member's PCP and obtained through a Participating Provider.

Hearing aids and rental/repair, including fitting and follow-up care, are covered to a benefit maximum payment of $300 every 36 months.

12. Home health

When provided by a Participating Provider (home health agency) and approved by the Member's PCP, the following home health Services are covered in full: Part-time or intermittent skilled nursing care, physical therapy and speech therapy; home infusion therapy; ancillary Services, including occupational therapy, clinical social Services, durable medical equipment, and intermittent home health aide Services, when provided in conjunction with the above skilled Services. Home health visits are limited to 130 visits per year.

13. Hospice Services (including respite care)

Medically Necessary or palliative hospice Services and durable medical equipment for terminally ill Members are covered in full for up to six months. Coverage may be provided beyond the initial six-month period when preauthorized by Medical Group. Services must be part of a written program of care by a state-licensed or Medicare-approved hospice program as provided by Participating Providers. Respite care is covered in the most appropriate setting for a maximum of five consecutive days per month of hospice care. Bereavement Services associated with hospice are covered, subject to a $10 office visit Copayment, up to eight sessions within a 12-month period.

14. Hospital Services

Inpatient hospital Services. This Plan covers Medically Necessary hospital accommodation and inpatient Services, durable medical equipment, and drugs prescribed by a Participating Provider for treatment of covered conditions (including, but not limited to, general nursing care, surgery, diagnostic tests and exams, radiation and X-ray therapy, blood and blood derivatives, bone and eye bank Services, and take-home medications dispensed by the hospital at the time of discharge). Inpatient hospital Services are subject to a $200 Copayment per day to a maximum of $600 per person per Calendar Year. Convalescent, custodial, or domiciliary care is not covered.

Inpatient professional Services are covered in full. Covered Services under this benefit include those provided by the PCP and Participating Providers (specialist, surgeon, assistant surgeon, and anesthesiologist) when deemed Medically Necessary.

Kaiser must be notified of Emergency admissions on the first working day following admission or as soon as reasonably possible, by calling 503-571-4540 or, toll free, 1-877-813-5993. Kaiser reserves the right to require the Member's admission or transfer to a Designated Facility of Kaiser's choice upon consultation with the Member's physician. If the Member refuses to transfer to the specified facility, all costs incurred after the date the transfer could have occurred will be the Member's responsibility to pay.

Outpatient hospital Services. Services for outpatient surgery, day surgery, or short-stay obstetrical Services (discharged within 24 hours of admission) are covered subject to a $100 Copayment per surgery or procedure. Services must be provided at a Designated Facility.

Dental anesthesia—inpatient/outpatient. General anesthesia Services and related facility charges in conjunction with any dental procedure performed in a hospital are covered subject to the applicable inpatient/outpatient facility Copayment if such anesthesia Services and related facility charges are Medically Necessary because the Member:

- Is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
- Has a medical condition that the Member's PCP or Participating Provider determines would place the Member at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the Member's PCP or Participating Provider.

For the purpose of this section, "general anesthesia Services" means Services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command. Nitrous oxide analgesia is not reimbursable as general anesthesia.

15. Mental Health Services

We cover the following mental health Services subject to Utilization Review criteria developed by Medical Group and approved by Kaiser. You may request these criteria by calling Membership Services. We cover inpatient hospital Services and inpatient and outpatient Services of Participating Providers and other mental health Participating Providers, as performed, prescribed, or directed by the Member's PCP or mental health Participating Provider, when they are necessary for:

- Evaluation,
- Crisis intervention,
- 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.

Services are subject to the benefit period, day or benefit limits, exclusions, and limitations listed in this "Mental Health Services" section.

Benefit Period

The benefit period for coverage described in this "Mental Health Services" section is per Calendar Year.

Inpatient. Professional and facility Services for diagnosis and treatment of mental illness are covered at a $200 Copayment per day; maximum $600 per person per Calendar Year, subject to Utilization Review criteria preauthorization requirements as described in the "Prior and Concurrent Authorization" section of this *COC,* and use of the Participating Providers. This includes Medically Necessary diagnosis and treatment of eating disorders (bulimia and anorexia nervosa).

Outpatient. Services for diagnosis and treatment of mental illness are covered at a $10 Copayment per visit up to 50 visits per Calendar Year, subject to the requirements to obtain prior authorization as described in the "Prior and Concurrent Authorization" section of this *COC* and the use of Participating Providers. This includes Medically Necessary diagnosis and treatment of eating disorders (bulimia and anorexia nervosa). Visits for the sole purpose of medication management do not apply to the 50-visit limit, and are instead covered as medical conditions.

Preauthorization is not required for Emergency admissions, including involuntary commitment to a state hospital. This Plan will cover court-ordered treatment only if determined to be Medically Necessary by a Participating Provider. All costs for mental health Services in excess of the coverage provided under this *COC*, including the cost of any care for which the Member failed to obtain preauthorization or any Services received from someone other than a Participating Provider will be the Member's sole responsibility to pay.

Kaiser and state law have established standards to assure the competence and professional conduct of mental health service providers, to guarantee your right to informed consent to treatment, to assure the privacy of your medical information, to enable you to know which Services are covered under this Plan and to know the limitations on your coverage. If you would like a more detailed description than is provided here of covered benefits for mental health Services under this Plan, or if you have a question or concern about any aspect of your mental health benefits, please call Membership Services.

If you would like to know more about your rights under the law, or if you think anything you received from this Plan may not conform to the terms of this *COC* or your rights under the law, you may contact the Washington Office of the Insurance Commissioner at 1-800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health Participating Provider, please call the State Health Department at 1-800-525-0127 or their customer service department in Health Professions Quality Assurance at 360-236-4902.

16. Neurodevelopmental therapy for children age 6 and younger

Subject to the inpatient hospital Copayment, Kaiser will pay up to 60 days of inpatient hospital Services per Calendar Year for Medically Necessary neurodevelopmental therapies for covered dependent children age six and under. Outpatient Services for neurodevelopmental therapies for covered dependent children age six and under are provided in full subject to the $10 office visit Copayment for each visit, up to a benefit maximum of 60 visits per Calendar Year for all therapies combined. Benefits include only the Services of Participating Providers authorized to deliver occupational therapy, speech therapy, and physical therapy and must be prescribed by the Member's PCP or Participating Provider. Benefits are payable only for Medically Necessary Services where significant deterioration in the child's condition would result without such Services, or to restore and improve function of the child.

The Member will not be eligible for both the "Physical, Occupational, Speech, and Massage Therapy" benefit and this benefit for the same Services for the same condition.

17. Obstetric and newborn care

This Plan covers Services, including supplies for pregnancy and pregnancy complications. There is no pre-existing condition waiting period. Services must be determined by the Member's PCP or women's health care Participating Provider, in conjunction with the mother, to be Medically Necessary and appropriate based on accepted medical practice. Professional Services covered in full include prenatal and postpartum care, prenatal testing (in accordance with the standards set forth by the Board of Health), normal or cesarean delivery, home births, and complications resulting from pregnancy.

Kaiser Permanente will not limit the length of a maternity inpatient 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 hospital stay is determined by the Member's PCP or Participating Provider, in consultation with the mother.

Medically Necessary inpatient hospital Services are covered for obstetrical care, subject to the inpatient hospital Copayment. Routine newborn nursery care will be covered during hospitalization of the mother receiving maternity benefits under this Plan, and will not be subject to a Copayment. Use of birthing centers for delivery must be preauthorized as described in the "Prior and Concurrent Authorization" section of this C*OC*.

Hospitalization for newborn children for other than routine newborn care will be covered subject to the inpatient hospital Copayment for the first 31 days from the date of birth, provided the mother is covered by this Plan. Benefits for professional and other Services for necessary follow-up care for newborns are provided subject to any applicable Copayment amounts for the first 31 days from the date of birth provided the mother is covered by this Plan. Benefits for Services received by the newborn beyond the initial 31 days are subject to the eligibility requirements of this Plan, including submission of any PEBB Benefits Services Program application for coverage, and payment of any required premium If premium is not due, the application requirement is waived; however, please notify PEBB Benefits Services Program or your employer of the birth so that your records may be updated.

Services related to voluntary and involuntary termination of pregnancy on an outpatient basis are covered, subject to the ambulatory surgical center Copayment. Inpatient hospital Services related to voluntary and involuntary termination of pregnancy are covered, subject to the inpatient hospital Copayment.

18. Office visits

Services provided by the Member's Primary Care Provider (PCP), or a specialist when referred by the Member's PCP, are covered in full subject to a $10 Copayment for each home or office visit. The $10 office visit Copayment also applies to qualifying urgent Services received from Participating Providers within the Service Area and from Non-Participating Providers outside the Service Area. Family Planning Services are covered when provided by the Member's PCP or women's health care Participating Provider.

19. Organ transplants

This Plan covers Services related to organ transplants, including professional and Designated Facility fees for inpatient accommodation, diagnostic tests and exams, surgery and follow-up care, subject to inpatient hospital or office visit Copayments and preauthorization requirements as described in the "Prior and Concurrent Authorization" section of this *COC*. This benefit includes covered donor expenses if the donor recipient is a Member of this Plan. See other benefits of this Plan for related Services, such as prescription drugs and outpatient laboratory and X-ray.

Organ transplants are covered when preauthorized as described in the "Prior and Concurrent Authorization" section of this *COC*, performed in a Designated Facility, and meet all the following criteria:

- The Service is required because of a disease, illness, or injury and is performed for the primary purpose of preventing, improving, or stabilizing the disease, illness, or injury.
- There is sufficient evidence to indicate that the Service will directly improve the length or quality of the Member's life. Evidence is considered to be sufficient to draw conclusions if it is peer-reviewed (as defined by the National Association of Insurance Commissioners), is well-controlled; directly or indirectly relates the Services to the length or quality of life, and is reproducible both within and outside of research settings.
- The Service's expected beneficial effects on the length or quality of life outweigh its expected harmful effects.
- The Service is a cost-effective method available to address the disease, illness, or injury. "Cost-effective" means there is no other equally effective intervention available and suitable for the Member which is more conservative or substantially less costly.

Organ transplant recipient. If a Member is accepted into a Designated Facility's transplant program and continues to follow that program's prescribed protocol, all organ transplant Services for the Member receiving the organ are covered according to the transplant benefit protocol. This includes transportation to and from a Designated Facility (beyond that distance the Member would normally be required to travel for most hospital Services).

Organ transplant donor. The costs related to organ removal, as well as the cost of treating complications directly resulting from the surgery, are covered, provided the organ recipient is a Member of this Plan, and provided the donor is not eligible for coverage under any other health care plan or government-funded program.

Benefit limitations. Transplants that are not preauthorized or are not performed in a Designated Facility are not covered. Benefits for costs relating to donor searches are provided only for allogeneic bone marrow transplants. Direct medical costs for up to 15 searches are covered. No other benefits are provided for Services relating to locating a donor for organ transplants.

20. Phenylketonuria (PKU) supplements

Phenylketonuria supplements are covered in full for treatment of this disorder.

Equipment and supplies for the administration of enteral and parenteral therapy are covered under Durable Medical Equipment, Supplies, and Prostheses.

Dietary formulas, oral nutritional supplements, special diets and prepared foods/meals, except treatment of phenylketonuria (PKU) and total parenteral and enteral nutritional therapy as set forth above are excluded.

21. Physical, occupational, speech, and massage therapies

Treatment that is prescribed by the Member's PCP and provided by a Participating Provider is covered for inpatient and outpatient physical, occupational, speech, and massage therapy Services to restore or improve physical functioning due to a covered illness or injury.

Inpatient Services are covered in full to a benefit maximum of 60 days per Calendar Year, subject to the hospital inpatient Copayment when provided as part of an acute medical inpatient hospitalization or skilled nursing facility (SNF) stay.

Outpatient therapy Services are covered in full to a benefit maximum of 60 visits for all therapies combined per Calendar Year, subject to the office visit Copayment. The Member will not be eligible for both the "Neurodevelopmental Therapy" benefit and this benefit for the same Services for the same condition.

22. Prescription drugs, insulin, and diabetic supplies

Retail. Up to a one-month supply or refill of outpatient prescription drugs, insulin, and disposable diabetic supplies necessary for the treatment of diabetes, is covered subject to the Copayments explained below, or the actual cost of the prescription if less than the Copayment. The Member may obtain up to a three-month supply for an individual prescription at one filling, with the payment of two single-month Copayments. In order to receive a quantity sufficient for a three-month supply, the prescription should specify that each fill is for three months. Prescriptions written for a quantity sufficient for only a one-month supply with the ability to refill for an additional 30 days or longer may be limited to a one-month supply per fill. Single-dose, long-acting drugs, and drugs packaged or dispensed in a single unit (such as inhalers) are subject to a single Copayment.

Generic drugs will be dispensed unless a suitable generic is not available. Generic drugs are prescription drugs that are sufficiently similar to brand-name products to have achieved an AB-rating from the Food and Drug Administration (FDA). Approved drugs include federal legend drugs and insulin when prescribed by the Member's PCP or Participating Provider. Any exclusion of drugs and medicines will also exclude their administration.

Under the Formulary process, Members pay the Copayments listed below for drugs listed on the Formulary. The Formulary is a listing of preferred pharmaceutical substances and formulas. A group of Participating Providers who are physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. These preferred drugs are included on the Formulary after consideration regarding safety, efficacy, cost, and compliance. Participating Providers can request the review of any drug at any time. Drugs may be added or removed from the Formulary as information warrants. For more information about the Formulary process or to find out if a particular drug is on the Formulary, Members can talk to their PCP or Participating Provider or stop by any Participating Pharmacy.

Prescription contraceptive supplies and devices, such as, but not limited to, contraceptive drugs, IUDs, diaphragms, cervical caps, emergency contraception, and long-acting progestational agents determined most appropriate by the PCP or women's health care Participating Provider for use by the Member are also covered under the prescription drug benefit. Retail up to a one-month supply:

- $10 Copayment per prescription or refill for all disposable diabetic supplies, all insulin, and Formulary generic drugs.
- $25 Copayment per Formulary brand-name drugs.

The applicable generic or brand-name Copayment applies for non-Formulary drugs deemed Medically Necessary through the exception process.

Kaiser Permanente reserves the right to limit the quantity fill on an initial prescription to assure that the patient can tolerate the medication. Kaiser Permanente also reserves the right to limit the prescription quantity of any drug where a restricted dosage would constitute medically prudent and efficacious treatment.

Exceptions are part of the Formulary process. For most patients, Formulary drugs are the best treatment alternative. However, this is not always the case. Members pay in full for non-Formulary drugs unless the non-Formulary drug meets certain criteria. When a Participating Provider believes that a non-Formulary drug is the most appropriate therapy to meet a patient's individual medical needs, the PCP or Participating Provider may make an exception based on one of the following:

- The patient is intolerant of Formulary alternatives.
- The patient has experienced treatment failure with Formulary alternatives.
- The patient is allergic to Formulary alternatives.
- The patient is a new Member currently using a non-Formulary drug. (A transition period is available while new Members change to the Formulary alternative.

The non-Formulary drug is for a dosage form or strength used in titrating a dose. Titration is a process of gradually changing a patient from one dosage level to another. When an exception is granted, the drug is covered subject to the applicable Copayment.

If the Member disagrees with the exception review decision, they may submit a written appeal within 185 days. The Member's case will be reviewed by a Participating Provider on the Kaiser Permanente Formulary and Therapeutics Committee who was not involved in the original review.

Drugs must be prescribed by a PCP or Participating Provider and purchased at a Participating Pharmacy. A limited supply of prescription drugs purchased from a non-Designated Facility or non-Participating Pharmacy is covered subject to the applicable pharmacy Copayment when dispensed or prescribed in connection with covered Emergency treatment.

Mail-order benefit. Kaiser operates a centralized automated refill system that provides a Mail-Delivery Pharmacy Service for Members. Covered drugs prescribed by a PCP or Participating Provider, based upon sound clinical guidelines are available through the Mail-Delivery Pharmacy Service for up to a 90-day supply subject to the Copayments set forth below. A prescription processed through the Mail-Delivery Pharmacy Service may be automatically provided for up to a 90-day supply at the Copayments specified below when the drug is appropriate for use as prescribed. In all cases, Kaiser reserves the right to limit the quantity fill on an initial prescription to assure the patient can tolerate the medication, based upon sound clinical guidelines, or in any case where a restricted dosage constitutes medically prudent and efficacious treatment.

Mail-order up to a 90-day supply:

- $20 Copayment per prescription or refill for all disposable diabetic supplies, all insulin, and Formulary generic drugs.
- $50 Copayment per Formulary brand-name drugs.

The applicable generic or brand-name Copayment applies for non-Formulary drugs deemed Medically Necessary through the exception process.

Some over-the-counter diabetic and home care products not covered by the prescription benefit are also available through the Mail-Delivery Pharmacy Service. Certain drugs that require special handling are not provided through the Mail-Delivery Pharmacy Service. This may include drugs that are time or temperature sensitive, drugs that cannot legally be sent by U.S. mail, certain high cost drugs, and drugs that require professional administration or observation.

Members can order prescriptions by telephone, online, or by mail. To order by telephone or online, Members will need to provide their health record number, the prescription number, the name of the drug, and credit card information. Call 503-778-2678 from the Portland area or 1-800-548-9809 from other areas. Visit Kaiser Permanente online at **kaiserpermanente.org.**

To order by mail, complete a prescription refill order form and mail it with a bank card number. Allow about 7-10 business days for an order to arrive; however, most orders arrive sooner. Delivery is by U.S. mail.

Off-label drugs. FDA-approved drugs used for off-label indications will be provided only if recognized as effective for treatment: 1) in one of the standard reference compendia; 2) in the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or 3) by the Federal Secretary of Health and Human Services. No benefits will be provided for any drug when the FDA has determined its use to be contra-indicated.

a. "Off-label" means the prescribed use of a drug which is other than that stated in its FDA-approved labeling.

b. "Standard reference compendia" means:

   1. The American Hospital Formulary Service-Drug Information;

   2. The American Medical Association Drug Evaluation;

   3. The United States Pharmacopoeia-Drug Information; or

   4. Other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services or the insurance commissioner.

c. "Peer-reviewed medical literature" means scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

Member's rights to safe and effective pharmacy Services. State and federal laws establish standards to assure safe and effective pharmacy Services, and to guarantee the Member's right to know what drugs are covered under this Plan and what coverage limitations are in the Member's *COC*. If the Member would like more information about the drug coverage policies under this Plan, or if the Member has a question or concern about their pharmacy benefit, please contact Membership Services.

If the Member would like to know more about their rights under the law, or if they think anything they received from this Plan may not conform to the terms of the *COC*, Members may contact the Washington Office of the Insurance Commissioner at 1-800-562-6900. For concerns about the pharmacists or pharmacies serving Members, please call the Washington State Department of Health at 1-800-896-0522.

23. Preventive Services

Preventive Services are covered as described below:

- Services provided by the Member's PCP or women's health care Participating Provider are covered in full. Well-baby and well-child Services are covered from birth to age 18.
- Immunizations are covered in full. After age 18, routine physical examinations are covered every five years and every two years after age 50.
- Mammograms are covered every year after age 40; breast exams are covered every year; pelvic exams and Pap tests are covered every year or as recommended by your PCP or Participating Provider.
- Prostate cancer screening exams for men are covered upon recommendation of the Member's Participating Provider.
- Digital rectal exam and Prostate Specific Antigen (PSA) tests are covered once each year after age 50. Bone mass measurement is covered for those at risk.
- Colorectal screening tests (one fecal occult blood test per year, one flexible sigmoidoscopy every 5 years, one colonoscopy every 10 years, or one double contrast barium enema every 5 years) are covered for Members age 50 and older. These tests are covered more frequently if your Participating Provider recommends them because you are at high risk for colorectal cancer or disease.

24. Radiation and chemotherapy Services

Radiation and chemotherapy Services are covered in full when provided by a Participating Provider.

25. Reconstructive surgery

We cover reconstructive surgery 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.

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

Payment levels will be determined by the Service provided (e.g., external prostheses will be provided at no charge, reconstruction of the breast will be paid at the surgery payment level as described under "Hospital Services," and post-mastectomy bras are covered at the durable medical equipment level).

26. Skilled nursing facility Services

Medically Necessary care in a skilled nursing Designated Facility is covered in full up to 150 days per Calendar Year, subject to hospital inpatient Copayments. Additional coverage may be approved by Medical Group if the stay is in lieu of hospitalization. Participating Provider visits while in a skilled nursing Designated Facility are covered in full. Skilled nursing facility confinement for mental health conditions, mental retardation, or for care which is primarily domiciliary, convalescent, or custodial in nature is not covered.

27. Spinal manipulations

Self-referrals for manipulative therapy of the spine and extremities are covered up to a benefit maximum of ten (10) visits per Member per Calendar Year subject to a $10 Copayment per visit. Additional visits require referral by your PCP or Participating Provider and must be preauthorized as described in the "Prior and Concurrent Authorization" section of this *COC*.

28. Temporomandibular joint dysfunction (TMJ)

Medical Services for Medically Necessary treatment of temporomandibular joint dysfunction (TMJ), except for upper and lower jaw augmentation or reduction Services and/or orthognathic surgery, are covered at 50 percent up to the Calendar Year benefit maximum plan payment of $1,000 combined for inpatient and outpatient Services. This exception to coverage does not apply to children with congenital anomalies.

29. Tobacco cessation

Members may attend classes to learn the latest and most effective techniques for kicking the tobacco habit for good. Classes include:

- Relaxation techniques.
- Understanding tobacco addiction.
- Practicing effective ways to remain tobacco free.

These classes are offered through Kaiser for health education. Members pay a $65 class fee to participate. For more information or to register, call 503-286-6816 in the Portland area or 360-604-2070 from Washington.

30. Vision Services (routine)

Routine eye examinations, including refractions, when provided by an ophthalmologist or optometrist Participating Provider, are covered annually subject to the office visit Copayment. An allowance of $150 toward prescription eyeglass lenses and frames, or contact lenses, including expenses associated with their fitting, is provided once every two years when obtained through a Designated Facility.

31. Weight Control and Obesity Treatment.

Bariatric surgery for clinically severe obesity is covered only when all of the following requirements have been met:

- A Participating Provider determines that the surgery meets Utilization Review criteria developed by Medical Group and approved by Kaiser.
- The Member fully complies with the Kaiser Permanente Severe Obesity Evaluation and Management Program's contract for participation approved by Kaiser. Services are paid at 100% after a $200 Copayment per day up to a maximum $600 per person per Calendar Year.

Benefit Exclusions and Limitations

In addition to any exclusion listed in the previous pages, this Plan does not cover the following:

1. Services not provided by a Participating Provider or obtained in accordance with Kaiser's standard referral and authorization requirements, except for Emergency and urgent Services or as covered under coordination of benefits provisions.
2. Non-Participating Providers are not covered inside or outside of the Service Area except for: Emergency and urgent Services; as specifically provided in the student eligibility section; or when otherwise specifically provided.
3. Experimental or investigational Services, supplies and drugs.
4. That additional portion of a physical exam beyond a routine physical that is specifically required for the purpose of employment, travel, immigration, licensing or insurance and related reports.
5. Services for which no charge is made, or for which a charge would not have been made if the Member had no health care coverage or for which the Member is not liable; Services provided by a family member.
6. Drugs and medicines not prescribed by a PCP or Participating Provider, except for Emergency and urgent Services.
7. Cosmetic Services except: to restore function, for reconstructive surgery of a congenital anomaly, or reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
8. Skilled nursing facility confinement or residential mental health treatment programs for mental health conditions, mental retardation, or for care which is primarily domiciliary, convalescent, or custodial in nature.
9. Conditions caused by or arising from acts of war.
10. Dental care including:
    - orthognathic surgery (except for children with congenital anomalies);
    - myofascial pain dysfunction (MPD); and
    - dental implants.
11. Sexual reassignment surgery and related Services.
12. Reversal of voluntary sterilization.
13. Testing and treatment of infertility and sterility, including but not limited to artificial insemination, and in-vitro fertilization.
14. Services provided solely for the comfort of the Member, except palliative care provided under the "Hospice Services" benefit.
15. Coverage for an organ donor, unless the recipient is a Member of this Plan.
16. Weight Control and Obesity Treatment.

    Non-surgical: Any weight loss or weight control programs, treatments, Services, even when prescribed by a physician, including, but not limited to, prescription and over-the-counter drugs, exercise programs (formal or informal), exercise equipment, or nutritional counseling (except as specified in the Diabetic Education benefit in this *COC*). Travel expenses associated with non-surgical or surgical weight control or obesity Services are not covered.

Surgical: Surgery for dietary or weight control, and any direct or non-direct complications arising from such non-covered surgeries, whether prescribed or recommended by a physician, including surgeries such as:

1. gastric banding (including adjustable gastric/lap banding and vertical banded gastroplasty)
2. mini-gastric banding (gastric bypass using a Billroth II type of anastomosis)
3. distall gastric bypass (long limb gastric bypass)
4. billopancreatic bypass and billopancreatic with duodenal switch
5. jejunoileal bypass
6. gastric stapling or liposuction
7. removal of excess skin
8. bariatric surgery if you had bariatric surgery within the past 10 years.

The surgical exclusion for weight control and obesity treatment will not apply to pre-authorized, Medically Necessary bariatric surgery of adult morbid obesity as specifically set forth in this *COC* and the Kaiser Permanente Bariatric Management criteria. More than one bariatric surgery for you or your enrolled dependents will not be covered under this Plan.

17. Evaluation and treatment of learning disabilities, including dyslexia, except as provided for neurodevelopmental therapies.
18. Orthoptic therapy (eye training); vision Services, except as specified for "Vision Services." Surgery to improve the refractive character of the cornea, including any direct complications.
19. Orthotics, except foot care appliances for prevention of complications associated with diabetes which are covered.
20. Services for which a Member has contractual right to recover cost under homeowner's or other no-fault coverage, to the extent that it can be determined that the Member received double recovery for such Services.
21. Any medical Services not specifically listed as covered.
22. Direct complications arising from excluded Services except Emergency Service to stabilize the Member.
23. Pharmaceutical treatment or prevention of impotence or sexual dysfunction.
24. When Medicare coverage is primary, charges for Services provided to Members through a "private contract" agreement with a physician or practitioner who does not provide Services through the Medicare program.
25. Replacement of lost or stolen medications.
26. Recreation therapy.

How to Obtain Care Within the Service Area

Primary Care Providers

Members must select a Primary Care Provider (PCP) at any Kaiser Permanente medical office in their Service Area when enrolling in this Plan. One PCP may be selected for the entire Family or a different PCP may be selected for each Family Member. Except for qualifying Emergencies or authorized referrals, Members must use Designated Facilities. The Member may change from one PCP to another by contacting Membership Services. The change will be made immediately if the selected PCP's caseload permits. If the selected PCP's caseload is full, the Member will be given a list of PCPs available in the Designated Facility of their choice.

Once the Member changes PCPs, any referrals that were made by the previous PCP are valid as long as the referral was authorized by Medical Group. The Member should notify the new PCP that he or she has been receiving specialty Services from a Participating Provider so the PCP can make arrangements for the Member to continue to receive specialty Services.

Referrals to Participating Providers and Designated Facilities

PCPs provide primary medical care, including pediatric care and obstetrics/gynecology care. Participating Providers provide specialty Services in areas such as surgery, orthopedics, cardiology, oncology, urology, dermatology, and allergy/immunology. A PCP or Participating Provider will refer you to a Participating Provider who specializes in your medical condition when appropriate. Please call Membership Services for information about specialty Services that require a referral or discuss it with your PCP.

Generally, Members need a referral to see a specialist the first time. Any PCP can make a referral to a Participating Provider specialist when needed. Once a Member has been referred to a Participating Provider specialist, he or she will not need a referral for return visits for the same condition. In some cases, a standing referral may be allowed to a Participating Provider who specializes in a particular type of medicine for a time period that is in accord with your individual medical needs as determined by the PCP and Kaiser.

Some specialty Services are available in Designated Facilities without a referral. Please call Membership Services to schedule routine appointments in the following departments that do not require a referral:

- Chemical dependency Services.
- Cancer Counseling.
- Contact lenses.
- Mental Health.
- Obstetrics/Gynecology.
- Occupational Health.
- Ophthalmology.
- Optometry (routine eye exams).
- Social Services.
- Spinal manipulation therapy self-referred Services.

Referrals to Non-Participating Providers and Non-Designated Facilities

If your PCP decides that you require Services not available from Participating Providers or Designated Facilities, he or she will recommend to Medical Group and Kaiser that you be referred to a Non-Participating Provider or non-Designated 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 Designated Facility and Kaiser determines that the Services are covered Services, Kaiser will authorize your referral to a Non-Participating Provider or non-Designated Facility for the covered Services. The Copayments or Coinsurance for these approved referral Services are the same as those required for Services provided by a Participating Provider or Designated Facility. You will need written authorization in advance in order for the Services to be covered. If Kaiser authorizes the Services, you will receive a written "Authorization for Outside Medical Care" approval referral to the Non-Participating Provider or non-Designated Facility, and only Services that are listed on the written referral will be covered, subject to any benefit limitations and exclusions applicable to such Services.

Prior and Concurrent Authorization

Some Services are subject to Utilization Review based on Utilization Review criteria developed by the Medical Group and approved by Kaiser and may require prior or concurrent authorization in order to be covered. Your PCP or 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 Kaiser):

- Alternative Care Services.
- Bariatric surgery Services.
- Breast reduction surgery.
- Chemical dependency Services.
- Cosmetic surgery.
- Drug Formulary exceptions.
- Durable medical equipment.
- Hospice and home health Services.
- Inpatient hospital Services, including birthing centers.
- Mental health Services.
- Non-emergency medical transportation.
- Open MRI.
- Orthognathic surgery for congenital anomalies.
- Plastic surgery.
- Referrals for Non-Participating Provider Services.
- Routine foot care.
- Skilled nursing facility Services.
- Organ transplant Services.

For more information about Utilization Review, a copy of the complete Utilization Review criteria developed by Medical Group and approved by Kaiser 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 Membership eligibility are binding on Kaiser if obtained no more than five business days before the Service is received. Prior authorization determinations that relate to whether the Service is Medically Necessary or are covered under this Plan are binding on Kaiser if obtained no more than 30 days before receiving the Service. Kaiser may revoke or amend an authorization for Services not yet received if membership terminates, coverage changes, or Member loses eligibility.

Compensation for Participating Providers and Designated Facilities

Participating Providers and Designated 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. Kaiser may directly or indirectly make capitation payments to Participating Providers and Designated 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 Designated Facilities are paid to provide or arrange medical and hospital Services for Members.

Our contracts with Participating Providers and Designated Facilities provide that Members are not liable for any amounts owed by Kaiser. However, the Member will be liable for the cost of non-covered Services received from a Participating Provider or Designated Facility, as well as unauthorized Services obtained from Non-Participating Providers and non-Designated Facilities.

Second opinions

Members have the right to a second opinion regarding a medical diagnosis or treatment plan from a qualified Participating Provider of the Member's choice. Members may obtain a list of Participating Providers by calling Membership Services.

Individual case management

When Medically Necessary and cost-effective, Kaiser may provide Alternative Care Services to a Member on a case-by-case basis. In order for Kaiser to provide Alternative Care Services, a written agreement that specifies Services, benefits, and limitations must be signed by the Member and the PCP. Kaiser reserves the right to terminate these extended benefits when the Services are no longer Medically Necessary, cost-effective, feasible, or at any time by sending written notice to the Member.

Home health care alternative to hospitalization

When provided at equal or lesser cost, the benefits of this Plan will be available for home health care instead of hospitalization or other institutional care when furnished by a home health, hospice, or home care agency Participating Provider. Substitution of less expensive or less intensive Services will be made only with the consent of the Member, and when the Member's PCP or Participating Provider advises that the Services will adequately meet the Member's needs. Kaiser will base the decision to substitute less expensive or less intensive Services on the Member's individual medical needs. Kaiser may require a written treatment plan which is approved by the Member's PCP or Participating Provider. Care will be covered on the same basis as for the institutional care substituted. Benefits will be applied to the maximum Plan benefit payable for hospital or other institutional expenses, and will be subject to any applicable Copayment or Coinsurance amounts required by this Plan.

Self-referral for women's health Services

Women Members shall have direct and timely access to Participating Providers specializing in women's health care (WHC) Services. WHC Services are provided by a family practice Participating Physician, physician's assistant, gynecologist, certified nurse midwife, doctor of osteopathy, obstetrician, and advanced register nurse practitioner, practicing within their applicable scope of practice.

Medically appropriate maternity care, including prenatal, delivery, and postnatal care, covered reproductive Services, preventive Services, general examinations, gynecological Services, and follow-up visits are provided to women Members directly from a Participating Provider, without a referral from their PCP WHC Services also include any appropriate Services for other health problems discovered and treated during the course of a visit to a WHC Participating Provider for women's Services.

Emergency Services

Emergency Services. In cases of accidental injury or medical Emergency where a Designated Facility and/or Participating Provider is not available, the Member may obtain Services from the most conveniently available licensed health care provider. The Member must notify Kaiser within 24 hours of receiving Services, or as soon as is medically reasonable, to ensure maximum coverage. When the Member's medical condition is stabilized, Kaiser may require the Member to be transferred to the care of a Participating Provider or Designated Facility. If the Member refuses to transfer to the specified facility, all costs incurred after the date the transfer could have occurred will be the Member's responsibility to pay.

Outside of Service Area

- **Student dependents.** Members must permanently reside within the Service Area in order to enroll in this Plan. If one or more dependents live outside the area temporarily while attending an accredited secondary school, college, university, vocational school, or school of nursing, they may receive benefits through any licensed physician. Claims for those providers will be paid as if the Service had been received through a Participating Provider. The dependents will be responsible for the same Copayments that apply to in-area Members. Kaiser must authorize all Services, including routine care, in advance except when Emergency or urgent Services are needed.
- **Visiting another health plan or an affiliated plan.** When Members are temporarily away from the Northwest region Service Area, they are covered for Emergency and urgent Services. Members can also get Services as a visiting Member at Kaiser Foundation Health Plan facilities around the country and at the facilities of Group Health. Members are visiting Members if they are temporarily in another Kaiser Foundation Health Plan service area for less than 90 days. If a Member is moving to another Kaiser Foundation Health Plan service area or visiting for more than 90 days, Members should contact Membership Services.

  When Members use a pharmacy in another Kaiser Foundation Health Plan service area, they receive the same prescription drug benefit (including Copayments, Formulary, exclusions, and limitations) as their home Service Area benefit. Members using Kaiser Foundation Health Plan facilities in other areas they are visiting are covered for most Services their Plan covers at home. Benefits and what they pay for Services may not be identical to those they receive in the Northwest region.

  Some Services must be authorized in advance by the Northwest region before Members can receive them in another area. These Services include inpatient rehabilitation Services, organ transplants, and some mental health and alcohol dependency Services. Members may be asked to pay in full for some Services, even though their Northwest region Plan may cover some or all of the cost. These include eyeglasses, durable medical equipment, and hearing aids. Members can file a claim in the Northwest region to receive reimbursement for the value of their benefit. Members should save the receipts and check with Membership Services for information on how to file these claims.

  When visiting, as a Member of Kaiser Foundation Health Plan of the Northwest, Members can use the facilities of Group Health Cooperative located in Washington and northern Idaho. At Group Health Cooperative facilities, Members can receive most of the care and Services that this Plan covers. Members need advance authorization to receive some Services. Benefits and what Members pay for Services may not be identical to those they receive at Kaiser Foundation Health Plan of the Northwest region facilities. There are no claim forms to file.

How to Submit Claims

Post-service claims—Services already received

In general, if a Member has a medical bill from a Non-Participating Provider or non-Designated Facility, Claims Administration will handle the claim. Membership Services can assist with questions about a specific claim or about the claim procedures in general.

If a Member receives Non-Participating Provider or non-Designated Facility Services following an authorized referral from Kaiser, the Non Participating Provider or non-Designated Facility will send the bill to Claims Administration directly. The Member is not required to file the claim.

However, if a Member receives Services from a Non-Participating Provider or non-Designated Facility without an authorized referral and believes Kaiser should cover the Services the Member needs to send a completed *Non-Plan Care Information form* (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

The Member can request a claim form from Membership Services or download it from our Web site. To download a claim form, go to **kaiserpermanente.org** and select the appropriate link.

The claim must include a copy of the medical records from the Non-Participating Provider or non-Designated Facility if it is available. If a Member does not submit the medical records and we determine they are necessary to decide the claim, we will notify the Member.

The Non-Participating Provider or non-Designated Facility may bill us directly. We accept the CMS 1500 claim form for professional Services and UB-92 form for hospital claims. The Member still needs to send the Non-Plan Care Information form even if the provider bills us directly.

Claims must be submitted within 90 days after the Services are received, or as soon as reasonably possible. Kaiser will not review a claim if we do not receive a complete claim form within 12 months from the time the completed claim form is due, unless the Member lacks legal capacity to file the claim within 12 months.

We will reach a decision on the claim and pay the covered charges within 30 calendar days unless additional information is required to make a decision. If the 30-day period must be extended, the Member will be notified in writing with an explanation about why. The written notice will tell the Member how long the time period may be extended depending on the requirements of applicable state and federal laws.

The Member will receive written notification regarding the claim determination. This notification will provide an explanation for any unpaid amounts. It will also tell the Member how to appeal the determination if he or she is not satisfied with the outcome, along with other important disclosures required by state and federal laws.

For questions or concerns about a bill from Kaiser, contact Membership Services for an explanation. If a Member believes the charges are not appropriate, Membership Services will advise the Member how to proceed.

If a Member believes charges are not appropriate due to concerns involving our Services or his or her benefits, the Member may file a grievance. If the Member thinks the charges are in error (such as a bill for Services not received or paid by the Member at the time of service), Membership Services can give assistance. If it is determined the charges are accurate, the Member will be given an explanation along with information about how to file a grievance. Refer to the “Member Satisfaction” section of this *COC* for more information on filing a grievance.

Pre-service claims—Requesting future care or service

When Services are needed, the Member should talk with his or her Participating Provider about his or her medical needs or requests for medical Services. Kaiser Permanente provides treatment and Services based on medical necessity and appropriateness. The Member’s Participating Provider will use his or her judgment to determine if a treatment or Service is Medically Necessary and appropriate. Some Services are subject to approval through Utilization Review, based on criteria developed by the Medical Group or another organization. If a specific Service is needed, the Member should talk with his or her Participating Provider. The Member’s Participating Provider will discuss the needs and recommend the most appropriate course of treatment. If the Member’s request for Service(s) is urgent, we will respond to the Member as quickly as the condition requires, not to exceed two business days or 72 hours, whichever is shorter.

- If a Member requests Services that his or her Participating Provider believes is not medically appropriate or necessary and there is a disagreement, the Member may ask for a second opinion from another Participating Provider. For PCP Services, the Member can request a different PCP at any time. The Member also has the right to request a pre-Service determination in writing. Contact the manager in the area where the Participating Provider is located. Membership Services can connect the Member with the correct manager, who will listen to the issues and discuss the Member's request with the Participating Provider. If the Participating Provider continues to believe the Service requested by the Member is not Medically Necessary, we will send the Member a denial letter within two business days of the contact with the manager. The letter will explain the reason for the determination along with instructions for filing a first-level appeal.
- If the Member requests a Service that must be approved through Utilization Review as described above and his or her Participating Provider believes it is Medically Necessary, the Participating Provider will submit the request for review on the Member's behalf. If the request is denied, we will send the Member a letter 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 a first-level appeal.
- If the Member requests a Service, but learns there may be coverage limitations or exclusions, and has questions or disagrees, the Member should contact Membership Services. If the Member is not satisfied after talking with Membership Services, he or she may request a pre-Service benefit determination in writing. We will generate a benefit determination within two business days. If the Member is not satisfied after receiving the benefit determination, he or she may file a first-level appeal.

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

Release of Information

Members may be required to provide Kaiser or the HCA with information necessary to determine eligibility, administer benefits or process claims. This could include, but is not limited to, medical records. Benefits could be denied if Members fail to provide such information when requested. Kaiser Permanente does not disclose medical information related to the Member's mental health, genetic testing results, and drug and alcohol abuse treatment records to third parties without the Member's special consent/authorization or as required or permitted by law.

Federal regulations protecting Member's personal health information (oral, written, and electronic) went into effect on April 14, 2003. To comply with these privacy practices, a Notice of Privacy Practices is available to all Members summarizing the federal and related state laws protecting their privacy. Members can get this notice at all medical offices through Membership Services, and on our Web site at **kaiserpermanente.org**.

When the Member has other Medical Coverage

This Coordination of Benefits (COB) provision applies when the Member has health care coverage under more than one Plan. The Member and the provider should file all claims with each Plan at the same time. If Medicare is your Primary Plan, Medicare may submit your claims to your Secondary Plan for you.

Plan and other important terms that apply only to this provision are defined below.

The order of benefit determination rules described in this "When the Member has other Medical Coverage" section determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its contract 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% of the total Allowable Expense.

Definitions for this "When the Member has other Medical Coverage" section:

Plan. A Plan is any of the following that provides benefits or Services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate Plan.

- Plan includes: Group, individual or blanket disability insurance contracts, and group or individual insurance contracts issued by health care service contractor or health maintenance organizations (HMO), Closed Panel Plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental Plan, as permitted by law.
- Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental Plans, unless permitted by law.

Each contract for coverage 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.

This Plan. This Plan means 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.

Primary Plan/Secondary Plan. 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, Kaiser determines payment for the benefits first before those of any other Plan without considering any other Plan's benefits. Kaiser will not reduce the Member's benefits under This Plan. When This Plan is secondary, Kaiser determines the benefits after those of another Plan and must make payment in an amount so that when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim equal 100% of the total Allowable Expense for that claim. This means that when This Plan is secondary, Kaiser must pay the amount which, when combined with what the Primary Plan paid, totals 100% of the highest Allowable Expense. In addition, if This Plan is secondary, Kaiser must calculate the savings (the amount paid subtracted from the amount Kaiser would have paid had Kaiser been the Primary Plan) and record these savings as a medical benefit reserve for the covered person. This reserve must be used to pay any medical expenses during that Calendar Year, whether or not they are an Allowable Expense under This Plan. If This Plan is Secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

Allowable Expense. Allowable Expense is a health care expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of Services, the Charges of each Service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense.

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

- The difference between the cost of a semi-private hospital room and a private hospital room is unless one of the Plans provides coverage for private hospital room expenses
- 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 method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit
- 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

Closed Panel Plan. Closed Panel Plan is a Plan that provides health care benefits to covered persons in the form of Services through a panel of providers who are primarily contracted by the Plan, and that excludes coverage for Services provided by other providers, except in cases of emergency or referral by a panel provider.

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

Order of Benefit Determination Rules

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

- The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- A Plan that does not contain a COB provision that is consistent with state regulations is always primary unless the provisions of both Plans state that the complying Plan is primary.
- Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
- 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.

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

Subscriber or Dependent. The Plan that covers the person as a Subscriber 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 a Subscriber (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as Subscriber is the Secondary Plan and the other Plan is the Primary Plan.

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:

- 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.
- For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
  - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;
  - If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for health care expenses, the Plan of the parent assuming financial responsibility is primary;
  - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, 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;
  - 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 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; or
  - If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    1. The Plan covering the Custodial Parent
    2. The Plan covering the spouse of the Custodial Parent
    3. The Plan covering the non-Custodial Parent
    4. The Plan covering the spouse of the non-Custodial Parent
- For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the above provisions determine the order of benefits as if those individuals were the parents of the child.

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 "Order of Benefit Determination Rules" section can determine the order of benefits.

COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the 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 "Order of Benefit Determination Rules" section can determine the order of benefits.

Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than we would have paid had we been the Primary Plan.

Effect on the Benefits of This Plan. When This Plan is secondary, we may reduce the benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim equal one hundred percent of the total Allowable Expense for that claim. Total Allowable Expense is the highest Allowable Expense of the Primary Plan or the Secondary Plan. In addition, the Secondary Plan must credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

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. Kaiser may get the facts needed 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. Kaiser is not required to tell, or obtain the consent of, any person to do this. Each person claiming benefits under This Pan must give us any facts we need to apply those rules and determine benefits payable.

Facility of Payment. If payments that should have been made under This Plan are made by another Plan, Kaiser has the right, at our discretion, to remit to the other Plan the amount we determine appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered benefits paid under This Plan. To the extent of such payments, Kaiser is fully discharged from liability under This Plan.

Right of Recovery. Kaiser has the right to recover excess payment whenever we pay Allowable Expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. We may recover excess payment from any person to whom or for whom payment was made or any other issuers or Plans.

Questions About Coordination of Benefits?

Contact Your State Insurance Department

When the Member has Medicare coverage

Benefits are coordinated with Medicare coverage in the same way as they are coordinated with other coverage. This Plan is usually secondary to Medicare coverage. This Plan will pay as primary for retirees enrolled in Medicare when the Service is covered by This Plan but not by Medicare, such as for prescription drugs. Medicare-eligible Plan Members may still be required to pay Copayments in these situations, such as when Medicare Deductibles have not been met, or when a Service is not covered by Medicare

How to submit Medicare claims

Medicare pays a portion of the bill. The Part B Medicare administrator will send a copy of each claim to Kaiser for all outpatient Services. It is not necessary to send paper claims to Kaiser for the secondary benefit for those claims. For inpatient Services and for outpatient Services received in other states, Medicare sends the Member an "Explanation of Medicare Benefits" (EOMB) and the Member must send a copy of the EOMB to Kaiser. Please contact Membership Services at the numbers listed on the front cover of this *COC* for help with questions regarding benefits or reimbursement when coverage is available from more than one health plan.

When a Third Party is Responsible for Injury or Illness (Subrogation)

Injuries or Illnesses Alleged to be Caused by Third Parties

To the extent that you obtain a settlement with a judgment against a third party, you must pay Kaiser for covered Services that you receive for an injury or illness caused by such third party's act or omission or on the premises of such third party or when a no-fault insurance provision applies, except that you do not have to pay Kaiser to the extent that the payment would leave you less than fully compensated for your injury or illness. The covered Services include amounts paid for claims and all charges for Services provided by Kaiser Permanente.

If there is no recovery, you are only responsible for the applicable cost-sharing under this Plan benefits.

To the extent permitted by law, Kaiser has 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. Kaiser will be subrogated only to the extent of the total covered charges for the relevant Services.

To secure Kaiser's rights, Kaiser will have a lien on the proceeds of any judgment or settlement you obtain against a third party. The proceeds of any judgment or settlement that you obtain shall only be applied to satisfy Kaiser's lien after you are reimbursed the total amount of the actual losses and damages you incurred.

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 Kaiser. In order for Kaiser to determine the existence of any rights we may have and to satisfy those rights, you must complete and send Kaiser 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 Kaiser directly. You must not take any action prejudicial to Kaiser's rights.

You must provide Kaiser written notice before you settle a claim, obtain a judgment, or if it appears you will make a recovery of any kind. If you recover any amounts from any third party for relevant Services already paid by Kaiser, you must repay Kaiser after you are reimbursed the total amount of the actual losses and damages you incurred, or place the funds in a specifically identifiable account and retain control over the recovered amounts to which Kaiser may assert a right.

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

Workers' Compensation or Employer's Liability

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

In addition, we or our Participating Providers will be permitted to seek reimbursement for such Services directly from the responsible employer or the government agency that administers such law.

Member Satisfaction

We want you to be satisfied with the Services you receive from us. If you have questions about your coverage or how to use our Services, or if you need help finding the right health care resource, call 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 will share your comments with the employees who assisted you and their supervisors.

Discuss any issues about your care with your PCP or Participating Provider or another member of your health care team. If you are not satisfied with your PCP or Participating Provider, you may request another. Contact Membership Services for assistance. You always have the right to a second opinion from a qualified Participating Provider at the applicable Copayment or Coinsurance shown in the "Benefit Summary."

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

Grievances

A grievance is an oral or written complaint submitted by or on behalf of a covered person regarding: a denial of health care Services or payment for health care Services; or issues other than health care Services or payment for health care Services including dissatisfaction with health care Services, delays in obtaining health care Services, conflicts with our staff or Participating Providers, and dissatisfaction with our practices of action unrelated to health care Services. You may file either an oral or written complaint.

Oral Complaints

If you want to talk with someone because you are dissatisfied with a denial of Services, 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, procedures, or any denials you received.

If we denied a request for Services or denied coverage for or payment of Services you already received and you want us to reconsider, you may file an appeal without first filing a complaint (see "Appeals").

To file an oral complaint, contact the administrative office in the Designated Facility where you are having the problem or contact Membership Services for assistance. Discuss your complaint fully with the staff who acknowledges receipt of your complaint and be specific about how you want the matter to be resolved. You will receive a response within 30 days or within 72 hours if your complaint is urgent.

Complaints are considered urgent if taking the standard time to review would seriously jeopardize your life or health or the life or health of a fetus, or your ability to regain maximum function.

Written Complaints

To file a written complaint, outline your concerns in writing. Send your written complaint to:

Member Relations
Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
503-813-4480 or 1-800-813-2000 and ask for Member Relations

Member Relations will acknowledge receipt of your written complaint. Member Relations will forward your written complaint 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 or within 72 hours if your complaint is urgent. If you need assistance or if your complaint is urgent, contact Membership Services.

If you remain dissatisfied after filing either an oral or written complaint, you may file one appeal, either orally or in writing. Follow the procedures described in "First Appeals," which is the last step for complaints.

Appeals

Adverse determination (denials) and non-certification (denied request for authorization) are decisions made by us to deny, modify, reduce, or terminate payment, coverage, authorization or provision of health care Services or benefits including the admission to or continued stay in a facility.

If you disagree with the decision to deny coverage or payment for Services you already received or charges for which you were billed, you have 185 days from the date on the denial notice or bill for charges to submit an oral or written appeal.

If you disagree with a denial for future Services or continuing Services following a Utilization Review determination requested by you or your Participating Provider, you have 185 days from the date of the denial notice to submit an oral or written appeal.

If your appeal involves Kaiser's decision to modify, reduce, or terminate an otherwise covered Service that you are receiving through Kaiser and Kaiser's decision was based on a finding that the Service is no longer Medically Necessary, we will continue providing that Service until your appeal has been decided. If your appeal is denied, you may have to pay the full charges of that continued care Services.

To submit an appeal, call 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 appeal any written comments, documents, records, and other information relating to the claim.

Receipt of appeals will be acknowledged and will be decided within 14 days after we receive them unless you are notified that additional time is needed to complete the review. The extension will not delay the decision beyond 30 days without your written consent. Member Relations or the area manager will conduct an independent review of your appeal and provide a written response.

If your appeal involves urgently needed future or continuing care Services, a request for an expedited appeal may be submitted orally or in writing. 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 Services or 24 hours for urgent concurrent care Services. Appeals are considered urgent if taking the standard time to review would seriously jeopardize your life or health or the life or health of a fetus, or your ability to regain maximum function.

Appeals requiring quality review, medical necessity, Utilization Review criteria application, or experimental service determination, will be reviewed by a physician who practices in the same or similar specialty that treats the medical condition involved, who was neither involved in a previous review nor is a subordinate of a previous physician reviewer, or by an appeal review panel made up of individuals who were not involved in previous decisions.

First Appeals

If we denied a request for Services or denied coverage for or payment of Services you already received and you disagree, or you are unhappy with the decision on a complaint about the delivery of Services, you or the designated representative you have authorized in writing to represent you may file an appeal.

To file an appeal, call or send your appeal to Member Relations. They will direct it to the appropriate location for investigation and handling. You have the right to include with your appeal any written comments, documents, records, and other information relating to the claim, which we will take into consideration when making our decision.

Member Relations
Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
503-813-4480 or 1-800-813-2000 and ask for Member Relations

If your appeal is denied, the written notice you receive will explain the basis for the decision and will advise you how to respond to the appeal.

Final Appeals

If you are unhappy with the decision made on your first appeal, you may submit a final appeal.

To request a final appeal, follow the steps listed in the written notice you receive or the steps listed under "First Appeals." You have 185 days from the date on the denial notice to submit an oral or written final appeal.

If your final appeal is denied, the written notice you receive will explain the basis for the decision and will advise you how to request an additional independent external review by an independent review organization (IRO).

While you are encouraged to use our grievance and appeal procedure, you have the right to contact the Washington Office of the Insurance Commissioner. Contact them by mail, telephone, over the Internet, or by email at:

Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504
1-800-562-6900
www.insurance.wa.gov

External Review by an IRO under Washington Law

Adverse determinations made by us are eligible for review by a certified IRO after the appeal has been exhausted within Kaiser, or after the timeline for responding to an appeal has been exceeded without good cause and without a decision. 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.

The adverse determinations eligible for review by an IRO are decisions by us to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care Services or benefits including the admission to or continued stay in a facility.

If you are dissatisfied with an adverse determination and have exhausted your appeal rights within Kaiser, you may ask for an external review within 185 days of the date on the final denial letter. To determine if your appeal is eligible for external review or to file your request for external review, contact Member Relations. Member Relations will forward your request to the IRO not later than the third business day after the date they receive your request for review. They will include written information received in support of the appeal along with medical records and other documents relevant in making the determination.

If your request for external review involves Kaiser's decision to modify, reduce, or terminate an otherwise covered Service that you are receiving when you submit your request for external review and Kaiser's decision was based on a finding that the Service is considered no longer Medically Necessary, we will continue providing the Service, if requested by you, until an external review determination has been made. If the determination affirms Kaiser's decision, you may have to pay the full charges of that continued care Service.

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

Experimental or Investigational Determination and Appeals

If a Service or claim is denied because it is experimental or investigational, you or your authorized representative may file an appeal. Please refer to the "Dispute Resolution" section for instructions in filing an appeal.

Decisions on appeals regarding experimental or investigational Services will be will be made and communicated in writing within 20 business days of receipt of a fully documented request, unless you consent in writing to an extension of time. Urgent appeals which meet the criteria for urgent appeals described in the "Dispute Resolution" section will be expedited to meet the clinical urgency of the situation, not to exceed 72 hours.

If, on appeal, the decision to deny Services is upheld, the final decision will specify (i) the name and professional qualifications of the individual(s) who made the final decision; and (ii) the basis for the final decision.

Experimental and Investigational Services

Kaiser covers new Services and technologies if, after careful review, we find that specific standards for coverage are satisfied. In our review, we consult with Kaiser Permanente's Interregional New Technologies Committee, physicians, and other experts inside and outside of Kaiser. We look at medical records and research, including written protocols. We examine the policies of health insurance carriers and health maintenance organizations. We also determine if a Service or technology will be generally and customarily available within the Service Area.

Kaiser does not cover experimental or investigational services or technologies. In general, a service (or technology) is experimental or investigational if any of the following statements are true about the service.

- The service cannot be sold in the United States without Food and Drug Administration (FDA) approval, and such approval has not been granted.
- The service is the subject of a current new drug or new device application on file with the FDA.
- The service is provided as part of a clinical research trial.
- The service is provided under a written protocol or other document that indicates that its safety, toxicity, or efficacy is under evaluation.
- The service is subject to the approval or review of an Institutional Review Board or other body that approves or reviews research.

- The service is provided under informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for safety, toxicity, or efficacy.
- The prevailing opinion of experts is that the use of the service should be limited to research settings or that further research is necessary to determine the safety, toxicity, or efficacy of the service.

Determinations and appeals. If we deny the Member's claim for a service because we find that it is experimental or investigational, the Member may appeal our determination. Refer to "Appeals" for instructions on filling an appeal.

Eligibility

(See "When Plan coverage begins" to determine when coverage for eligible Members begins.)

Eligible employees

Employees (referred to in this book as "employees," "Subscribers" or, in some cases, "Members") of state government, higher education, participating K-12 school districts, educational service districts, and employer groups are eligible for enrollment in PEBB medical plans as described in PEBB eligibility rules in Chapter 182-12 WAC. Employees who have more than one source of eligibility for enrollment in PEBB insurance coverage are limited to one plan enrollment. Employees may waive plan coverage as indicated under "Waiver of Coverage" later in this booklet.

Eligibility for employees of participating "employer groups" may follow PEBB rules or rules determined by collective bargaining agreement, if approved by the HCA in accordance with Chapter 182-12 WAC.

Eligible dependents

Eligible Subscribers may enroll dependents in their plan if the dependent is eligible as stated below and the dependent is not enrolled in a PEBB medical plan under another subscriber. For example, a dependent child who is eligible for enrollment under two or more parents or stepparents who are employed by PEBB-participating employers may be enrolled as a dependent under the plan of one parent or stepparent, but not more than one. The following dependents are eligible:

1. The Subscriber's lawful spouse
2. The Subscriber's domestic partner qualified by the PEBB declaration of domestic partnership that meets all of the following criteria:
   a. Partners have a close personal relationship in lieu of a lawful marriage;
   b. Partners are not married to anyone;
   c. Partners are each other's sole domestic partner and are responsible for each other's common welfare;
   d. Partners are not related by blood as close as would bar marriage; and
   e. Partners are barred from a lawful marriage.
3. The Subscriber's same-sex domestic partnership qualified by the certificate of state registered domestic partnership or registration card issued by the Secretary of State's office.
4. The Subscriber's dependent children through age 19. Children includes: the Subscriber's biological children, stepchildren, legally adopted children, children for whom the Subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child, children of the Subscriber's qualified domestic partner, or children specified in a court order or divorce decree; the Subscriber's married child who qualifies as a dependent of the Subscriber under the Internal Revenue Code; and extended dependents in the legal custody or legal guardianship of the Subscriber, their spouse or their

qualified domestic partner approved by the PEBB Benefits Services Program. Dependent children beyond the age of 19 are eligible under the following conditions:

a. Students age 20 through age 23 are eligible if they are attending high school or are registered students at an accredited secondary school, college, university, vocational school, or school of nursing. Dependent student coverage begins the first day of the month in which the quarter/semester for which the dependent is registered begins and ends the last day of the month in which the student stops attending or in which the quarter/semester ends. In order to certify and recertify eligibility the Subscriber must submit a Student Certification Form to the PEBB Benefits Services Program for review. PEBB may request current or previous documents to verify student eligibility at any time. Misrepresentation or failure to notify the PEBB Benefits Services Program of changes in status resulting in loss of eligibility, including changes in student status, may result in the Subscriber being responsible for payment of Services received. Dependent student coverage continues year-round for those who attend three of the four school quarters or two semesters, and for three full calendar months following graduation as long as the Subscriber is covered at the same time, the dependent has not reached age 24, and the dependent meets all other eligibility requirements.

b. Dependent children of any age are eligible if they are incapable of self-support and are individuals with disabilities, developmental disabilities, mental illness, or mental retardation, provided that their condition occurs prior to age 20, or during the time they met the criteria for student coverage under PEBB rules. The Subscriber must complete an application and provide proof that such disability occurred either (a) before the dependent became 20 years old or (b) during the time the dependent met the criteria for student coverage [as described in subsection (a)]. The Subscriber must submit the application to the PEBB Benefits Services Program for approval by Kaiser. The PEBB Benefits Services Program will, on behalf of Kaiser, request recertification of disability as frequently as necessary to verify the ongoing eligibility status of the dependent during the first two-year period following the child's attainment of the limiting age, and may request proof of disability annually thereafter.

5. Dependent parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as (a) the parent maintains continuous enrollment in a PEBB medical plan, (b) the parent continues to qualify under the Internal Revenue Code as a dependent of an eligible Subscriber, (c) the Subscriber who claimed the parent as a dependent continues enrollment in a PEBB medical plan and (d) the parent is not covered by any other group medical insurance. Dependent parents may be enrolled in a different PEBB medical plan than that selected by the eligible Subscriber; however, dependent parents may not add additional family members.

6. Dependents of an active employee who were previously covered under a K-12 or employer group medical plan, and who are not otherwise eligible for PEBB insurance coverage, may continue insurance coverage under a PEBB medical plan for up to 36 consecutive months. In order to be eligible for this continuation, the PEBB medical plan must be immediately replacing a K-12 or employer group medical plan with no lapse in insurance coverage.

Verification of the dependency status of anyone enrolled under PEBB medical coverage may be requested at any time by the PEBB Benefits Services Program or Kaiser.

Appeals of determinations of ineligibility for benefits

Decisions of Kaiser concerning eligibility determinations may be appealed to the Health Care Authority. All appeals must be received by the PEBB Appeals Manager within 90 days from the date of the denial of eligibility notice. Guidance on filing an appeal can be obtained in WAC chapter 182-16 (which governs appeals), the HCA Web site's "Contact Us" page, **www.pebb.hca.wa.gov**, or by contacting the PEBB Appeals Manager through the PEBB Benefits Services Program customer service phone line at 1-800-200-1004.

Medicare entitlement

If a Member becomes entitled to Medicare, they should contact the nearest Social Security Office to inquire about the advantages of immediate or deferred Medicare enrollment.

For employees and their spouses or qualified domestic partners age 65 and older, this Plan will provide primary medical coverage, and Medicare coverage will be secondary. However, active employees 65 and older may choose Medicare as their primary insurer. If an employee does so, the employee will not be allowed to re-enroll in a PEBB medical plan. However, the employee will remain enrolled in PEBB dental, life, and long-term disability insurance coverage.

In most situations, employees and their spouses/qualified domestic partners can elect to defer Medicare Part B enrollment, without penalty, up to the date the employee terminates or retires. If your retirement is due to a disability, contact Medicare regarding deferral. Upon retirement, Medicare will become the primary insurer, and the PEBB medical plan becomes secondary.

Please contact the PEBB Benefits Services Program for information about retiree eligibility and benefit information.

Enrollment

(See "When Plan coverage begins" to determine when insurance medical coverage for eligible employees and dependents begins.)

Employees and their eligible dependents may enroll in this Plan within 31 days of the date the employee first becomes eligible to apply for PEBB insurance coverage as described in the section titled "Eligibility." Enrollment forms are furnished by the employee's payroll, personnel, or insurance office and should be returned to that office within 31 days of the date of eligibility.

Eligible dependents who are not enrolled when they are initially eligible may be enrolled in the Subscriber's medical plan if the dependent loses insurance coverage under another medical plan. Dependents losing insurance coverage under another medical plan must be enrolled within 60 days after termination of the other medical plan. Dependents will be required to provide evidence of continuous coverage to the PEBB Benefits Services Program in order to establish eligibility to enroll mid-year.

Eligible employees and dependents may be added to insurance coverage during any open enrollment period determined by the PEBB Benefits Services Program or, in most cases, if the employee acquires a new dependent as a result of marriage, qualified domestic partnership, birth, adoption, or when the Subscriber or spouse or their qualified domestic partner assumes legal obligation for total or partial support in anticipation of adoption of a child. Eligible employees and dependents may be added in these situations without evidence of continuous coverage.

An employee/dependent is eligible to enroll in only one PEBB medical plan even if eligibility criteria are met by two or more Subscribers.

Waiver of insurance coverage

Employees have the option of waiving medical coverage if they are enrolled in other comprehensive group medical coverage. To waive medical coverage, the employee must complete an enrollment/change form that identifies the employee and dependents who are waiving medical coverage. If an employee waives medical coverage, medical coverage is automatically waived for all eligible dependents. An employee may choose to enroll only him/herself, and waive medical coverage for any or all dependents.

An employee may only waive medical coverage. The employee must remain enrolled in the dental, life, and long-term disability insurance coverage. The enrollment/change form must be received prior to the date medical coverage is to be waived.

Once medical coverage is waived, enrollment is only allowed during the next open enrollment period, or within 60 days of loss of other medical coverage. To enroll in medical coverage within 60 days of loss of other medical coverage, the employee must provide evidence that enrollment in other comprehensive group medical coverage was continuous from the date PEBB medical coverage was waived and the period between loss of coverage and application for PEBB medical coverage is 60 days or less.

Employees who waive medical plan enrollment may have an additional opportunity to enroll in the event of acquisition of a new dependent as a result of marriage, qualified domestic partnership, birth, adoption, assumption of legal obligation for total or partial support in anticipation of adoption of a child, or placement for adoption, provided that enrollment is requested within 60 days after the date of marriage or establishment of a qualified domestic partnership, birth, adoption, legal obligation for total or partial support in anticipation of adoption, or placement for adoption.

Enrolling a dependent acquired after the Subscriber's effective date of medical coverage

Subscribers may enroll eligible dependents. Newly eligible dependents must be enrolled as indicated below or wait to be added during an open enrollment period:

1. Newborn or adoptive children must be enrolled within 60 days of eligibility if addition of the child increases the premium. When additional premium is not required, the Subscriber should notify their personnel, payroll, or insurance office of the birth, or the placement of the adoptive child, as soon as possible in order to ensure timely payment of claims.

   When a newborn or adoptive child becomes eligible before the 16th day of the month and the addition of the child increases the premium, the new full month's premium is charged; otherwise, the new premium will begin with the next full calendar month.

2. Dependents who lose other medical coverage must enroll within 60 days after the date their other medical coverage ends. Dependents will be required to provide evidence of continuous enrollment in other comprehensive medical coverage. If the dependent meets enrollment criteria and premiums are paid, medical coverage will begin the first day of the month following the date other coverage is terminated.
3. Eligible dependents may be added during any open enrollment period determined by the PEBB Benefits Services Program without proof of continuous enrollment in comprehensive group medical coverage.

Subscribers should contact their personnel, payroll or insurance office, or the PEBB Benefits Services Program for an enrollment/change form.

Disenrolling a dependent

Employees should contact their payroll, personnel, or insurance office for forms and information on how to update their records. A dependent may be removed from insurance coverage by submitting an enrollment/change form to the employee's personnel, payroll, or insurance office. Failure to notify the PEBB Benefits Services Program of changes in status resulting in loss of eligibility may result in termination of insurance coverage and the Subscriber being responsible for payment of Services received. Please refer to the section titled "Options for Continuing Benefits" in this *COC*, for more information.

Enrollment changes should be made as soon as possible. Eligibility changes not reported within 60 days after an event that creates a change in premium or loss of eligibility may result in a loss of premiums and a loss of the Member's right to continuation coverage.

When medical coverage begins

For enrolled employees and their enrolled dependents, medical coverage will begin as follows:

FOR EMPLOYEES:

1. **PERMANENT EMPLOYEES, CAREER SEASONAL EMPLOYEES, AND INSTRUCTIONAL YEAR EMPLOYEES:** Medical coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of a month, medical coverage begins on the date of employment.
2. **NONPERMANENT EMPLOYEES:** For nonpermanent employees who work half-time or more for six consecutive months, medical coverage begins on the first day of the seventh calendar month following the date of employment.
3. **PART-TIME FACULTY AND PART-TIME ACADEMIC EMPLOYEES:** For part-time faculty and part-time academic employees, medical coverage begins on the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, medical coverage begins at the beginning of the second consecutive quarter/semester.
4. **APPOINTED AND ELECTED OFFICIALS AND JUDGES:** For legislators, medical coverage begins on the first day of the month following the date their term begins. If their term begins on the first working day of a month, medical coverage begins on the first day of their term.

   For all other elected and full-time appointed officials of the legislative and executive branches of state government, and judges, medical coverage begins on the first day of the month following the date their term begins, or the first day of the month following the date they take the oath of office, whichever occurs first. If their term begins, or oath of office is taken, on the first working day of a month, medical coverage begins on the date the term begins, or the oath of office is taken.
5. **EMPLOYEES OF PARTICIPATING EMPLOYER GROUPS:** Medical coverage begins as described above unless the effective date of insurance coverage for eligible employees is determined by the terms of employment or collective bargaining agreement and those terms related to the effective date are approved by the HCA. Participation of the bargaining unit or non-represented employees is subject to approval by the HCA.

FOR DEPENDENTS:

For eligible dependents, medical coverage begins on the first day of the month in which the Subscriber's medical coverage begins if the Subscriber lists the dependents on the enrollment/change form and indicates their enrollment is for medical coverage.

For newly acquired dependents (except newborns or children that are adopted or proposed for adoption) who are enrolled in accordance with PEBB rules, medical coverage begins on the first day of the month after the date of acquisition or declaration. If the date of acquisition or declaration is the first day of a month, medical coverage will begin on the first day of the month of acquisition or declaration.

For a newborn child, medical coverage begins at birth. For an adoptive child, medical coverage begins on the date that the Member assumes a legal obligation for total or partial support in anticipation of adoption of the child.

For other eligible dependents, medical coverage begins on the first day of the month after the date eligibility is established and approved by the PEBB Benefits Services Program. If eligibility is established and approved as the first day of a month, medical coverage will begin on the date dependency is established.

SPECIAL ENROLLMENT FOR EMPLOYEES AND THEIR DEPENDENTS WHO PREVIOUSLY WAIVED COVERAGE:

For eligible employees and their dependents whose medical coverage was previously waived will be effective as described below. The employee must enroll in order to enroll dependents.

1. For eligible employees and dependents enrolling within 60 days of the loss of other medical coverage, medical coverage will begin on the first day of the month following the date the other medical coverage terminated. The enrollment/change form must be received by the employee's payroll, personnel, or insurance office within 60 days after termination of other group medical coverage, and evidence of other continuous coverage must be provided.
2. For eligible employees and dependents enrolling following a marriage or establishment of a qualified domestic partnership, medical coverage will begin on the first day of the month following the date of marriage or the date that the domestic partnership qualifies based on the declaration or certificate. If the date of marriage is the first calendar day of the month, medical coverage will begin on the date of marriage. The application for medical enrollment must be received by the employee's payroll, personnel, or insurance office within 60 days after the date of marriage or date that the domestic partnership qualifies based on the declaration or certificate.
3. For eligible employees and dependents enrolling following a birth or placement of a child for adoption, medical coverage will begin on the first day of the month in which the birth or placement occurred. For a newborn child, medical coverage will begin at birth. For a child placed for adoption, medical coverage will begin on the date that the employee assumes a legal obligation for total or partial support in anticipation of adoption of the child. The application for medical enrollment must be received by the employee's payroll, personnel, or insurance office within 60 days of the birth or date of placement.
4. A special enrollment right is created when the department of health and social services has formally determined that the employee and/or eligible dependents is more cost-effectively enrolled in PEBB medical than a medical assistance program.

Changing medical plans

Subscribers may change medical plans in the following situations:

1. During an open enrollment period announced by the PEBB Benefits Services Program.
2. If an enrollee changes residence during the year, the Subscriber may change medical plan enrollment within 60 days of the move under the following conditions: if an enrollee moves from their medical plan's service area, the Subscriber may enroll in any medical plan available in the new locality, or if a medical plan has not been available to the enrollee and they move into that medical plan's service area, the Subscriber may enroll in that medical plan. All such medical plan enrollment changes take effect on the first day of the month following the date the enrollee moves.
3. If a court order requires a Subscriber to provide medical coverage for an eligible spouse, domestic partner, or child, the Subscriber may change medical plans and add the dependent immediately, with the change effective retroactive to the effective date of the court order or the dependent's effective date of coverage, whichever is later.
4. If a Subscriber retires for any reason, the Subscriber may change medical plans at the time of application for retiree medical coverage. The change will become effective on the first day of the month following the retirement date.
5. Subscribers may change medical plans when they or an eligible dependent becomes entitled to Medicare or enrolls in a Medicare Part D plan.
6. Seasonal employees whose off-season occurs during open enrollment may change medical plans within 60 days of returning to work.

7. If an employee's medical plan becomes unavailable, the employee may choose another medical plan within 60 days after notification by the PEBB Services Benefits Program. Anyone that does not choose another medical plan within this time period will be enrolled in the contracted vendor's successor medical plan if one if available or will be enrolled in the Uniform Medical Plan PPO by default. Anyone defaulted to the Uniform Medical Plan PPO may not change medical plans until the next open enrollment.
8. If the Subscriber exercises the special enrollment right to add newly acquired dependents due to marriage, qualification of a domestic partnership, birth, adoption, legal obligation for total or partial support in anticipation of adoption, or placement for adoption. The enrollment application must be submitted to the employee's payroll, personnel, or insurance office within 60 days after:
   - The marriage or qualification of domestic partnership; or
   - Birth, adoption, assumption of legal obligation for total or partial support in anticipation, or placement for adoption of a child.
9. If the Members' physician stops participation with the Member's medical plan and the PEBB appeals manager determines that a continuity of care issue exists. Refer to WAC 182-08-198(2)(f) for specific details.

However, if the employee is having premiums taken from payroll on a pre-tax basis, a medical plan change will not be approved if it would conflict with provisions of the benefits contribution plan authorized under RCW 41.05.300.

To change medical plans, Subscribers must fill out an enrollment/change form. Subscribers should contact their payroll, personnel, or insurance offices for forms and information on how to update their records.

NOTE: If a Member's PCP, Participating Provider or Designated Facility discontinues participation with Kaiser, the Member may not change medical plans until the next open enrollment period, except as described in WAC 182-08-198(2)(h). Kaiser, Medical Group, and Kaiser Foundation Hospitals cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us. Also, if an employee transfers from one employing agency to another during the year, the Member is not permitted to change medical plans, except as outlined above or in WAC 182.08.197.

When medical enrollment ends

Medical enrollment ends on the earliest of the following dates:

1. For any individual who ceases to be eligible for PEBB insurance, coverage ends on the end of the month in which eligibility ends.
2. For any person enrolled in PEBB medical, coverage ends on the date the health plan terminates, if that should occur. Persons losing coverage will be given the opportunity to enroll in another PEBB medical plan.
3. For an employee who declines the opportunity or is ineligible to continue coverage on a self-pay basis, medical coverage ends for the employee and dependents (subject to the dependent's rights to continue coverage) at 12 o'clock midnight on the last day of the month in which the employee or dependent is eligible.
4. Premium payments are not prorated if a Member dies or terminates medical coverage prior to the end of the month.

If a Member, or newborn eligible for benefits under "Obstetric and Newborn Care," is confined in a hospital or skilled nursing facility for which benefits are provided this Plan coverage ends and the Member is not immediately covered by other health insurance coverage, benefits will be extended until:

1. the Member is discharged from the hospital or from a hospital to which the Member is directly transferred;
2. the Member is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization;
3. the Member is discharged from the skilled nursing facility or from a skilled nursing facility to which the Member is directly transferred;
4. the Member is covered by another health plan which will provide benefits for the Services; or
5. benefits are exhausted whichever occurs first.

When medical enrollment ends, the Member may be eligible for continuation of coverage or conversion to other health insurance coverage if application is made within the timelines explained in the following sections.

As a PEBB enrollee, it is the enrollee's responsibility to pay premiums when due. If the Member's account is delinquent, the enrollee's insurance coverage will be terminated the end of the month in which the last full premium was received. **If the enrollee's insurance coverage is terminated due to delinquency, the enrollee's eligibility to participate in the PEBB benefits will end.** If you enroll in continuation coverage through COBRA, State Continuation Coverage, or USERRA, you may be eligible to enroll in our Conversion Plan when your Plan continuation coverage ends. As a general rule, if you accept conversion coverage at the end of coverage under this Group health plan, you will not qualify as a HIPAA eligible individual.

The enrollee and their covered dependent(s) or beneficiary is responsible for reporting changes within 60 days after the event, such as divorce, termination of a qualified domestic partnership, death, or when no longer a dependent as defined in WAC 182-12-260.

Failure to report changes can result in loss of premiums and loss of your or your dependent's right to continue coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) law or PEBB rules. If you need assistance in obtaining the proper form for communicating changes to the PEBB Benefits Services Program, please call PEBB customer service staff at 1-800-200-1004.

Providers Whose Contracts Terminate

Members may be eligible to continue receiving covered Services from a PCP for a limited period of time after Kaiser's contract with the PCP is terminated.

If Kaiser directly or indirectly terminates the contract between Kaiser Permanente, Medical Group and/or any other Participating Provider or PCP while your Plan is in effect and while you are under the care of such provider, we will notify you. Kaiser will retain financial responsibility for care by that provider, in excess of any applicable Copayments or Coinsurance, until we can make arrangements for such Services to be provided by another PCP. If your PCP contract is being terminated directly or indirectly by Kaiser, Services by your provider will be covered for 60 days following the notice of termination to you.

Options for continuing PEBB benefits

Employees and their dependents covered by this Plan have options for continuing insurance coverage during temporary or permanent loss of eligibility. There are four continuation coverage options you may be eligible for as a Public Employees Benefits Board (PEBB) Member:

- The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- PEBB Extension of Coverage

- Leave Without Pay (LWOP) coverage
- PEBB retiree insurance coverage

The first three options above temporarily extend group insurance coverage if certain circumstances occur that would otherwise end your or your dependents' PEBB medical and dental coverage. COBRA continuation coverage is governed by eligibility and administrative requirements in federal law and regulation. PEBB Extension of Coverage is an alternative created for PEBB Members who are not eligible for COBRA. LWOP coverage is an alternative that may be appropriate in specific situations.

The fourth option above is only available to individuals who meet eligibility criteria defined in Washington Administrative Code (WAC) 182-12-171 or surviving dependents who meet eligibility criteria defined in WAC 182-12-250 or 182-12-265.

All four options are administered by the Health Care Authority (HCA). Refer to your PEBB Initial Notice of COBRA and of Continuation Coverage Rights for specific details or call the PEBB Benefits Services Program Customer Service at 1-800-200-1004.

Employees also have the right of conversion to individual medical insurance coverage when continuation of group medical insurance coverage is no longer possible. The dependents of employees also have options for continuing insurance coverage for themselves following loss of eligibility.

Family and Medical Leave Act of 1993

Employer contributions toward PEBB insurance coverage will continue up to the first 12 weeks of approved family leave in accordance with the Family and Medical Leave Act of 1993. Employees must also continue to pay the employee premium contribution during this period to maintain eligibility. After that, insurance coverage may be continued as explained in the section titled "Options for Continuing PEBB Benefits" in this *COC*.

Payment of premium during a labor dispute

Any employee or dependent, whose monthly premium is paid in full or in part by the employer, may pay the fees directly to HCA if the employee's compensation is suspended or terminated directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six (6) months.

During the period the employee's compensation is suspended or terminated, the employee shall be notified immediately by the HCA, in writing, by mail addressed to the last address of record with the HCA, that the employee may pay the premium as they become due as provided in this Section.

Conversion of coverage

Members have the right to switch from this Plan coverage to an individual conversion plan offered by Kaiser Foundation Health Plan of the Northwest when they are no longer able to continue this Plan coverage, or are not eligible for Medicare or another group insurance coverage that provides benefits for hospital or medical care. Members must apply for conversion coverage within 63 days after their group medical coverage ends.

Evidence of insurability is not required to obtain the conversion coverage. Members must meet conversion eligibility requirements and reside in the Service Area. The rates, coverage, and eligibility requirements of Kaiser's conversion program differ from those of the Member's current group medical program. Enrollment in a conversion program may limit the Member's ability to later purchase an individual health plan without health screening or a pre-existing condition waiting period. To obtain detailed information on conversion options under this Plan, call Membership Services, at the number on the front of this *COC*.

Relationship to Law and Regulations

The language of this *COC* is based on the rules that administer the Health Care Authority's PEBB Benefits Services Program in chapters 182-08, 182-12, and 182-16 WAC. In the case of a conflict between the rules and the language describing eligibility and enrollment in this Plan, the rules shall govern. This agreement between the Health Care Authority and the Kaiser for benefits shall be interpreted, administered, and enforced according to the laws and regulations of the state of Washington, except as preempted by federal law.

Members' Rights and Responsibilities

Kaiser Foundation Health Plan of the Northwest believes that maintaining good health is a very important part of the Member's well-being. Providing the quality health care Services necessary to maintain good health requires a partnership between the Member and their health care professionals. Members need information to make appropriate decisions about their care and lifestyle choices. Health care professionals need the Member's involvement to ensure they receive appropriate and effective health care Services. Mutual respect and cooperation are essential to this partnership.

Exercise of Conscience

Kaiser Permanente recognizes the right to exercise religious beliefs and conscience. Any party to this contract may refuse to perform, cover, or receive specific Services for reasons of conscience or religion.

At Kaiser Foundation Health Plan of the Northwest, Members have the right to:

- Be treated fairly, with respect and consideration, without regard to race, religion, gender, sexual orientation, national origin, cultural background, disability, age, or financial status.
- Be supported in choosing and changing Participating Providers and seeking a second opinion within our Plan.
- Be involved in their health care decisions; be provided full information about their care, including unanticipated outcomes; the benefits and risks of and alternatives to recommended treatments or procedures regardless of cost or coverage; and realistic alternatives when hospital care is no longer appropriate.
- Get information about our policies, Services, facilities, and Member benefits and care in a way Members can understand. Be provided an interpreter if needed. Make recommendations about our policies (including Member rights and responsibilities) and Services.
- Consult with members of our ethics Services staff when faced with difficult medical ethics issues.
- Be supported if they change their mind about any procedure, refuse treatment, or decline to participate in medical training programs or research projects, and inform Members of the consequences of their decision.
- Make decisions about their future, and to specify their decisions in documents called advance directives.
- Be transferred only when medically appropriate and when the receiving facility is ready to accept them.
- Be provided with the names, professions, and educational backgrounds of the people treating them.
- Keep the Member's personal health information private and confidential. This includes all oral, written, and electronic records and communications about the Member's medical history, conditions, and care. All of our Participating Providers and staff—including contract providers—have agreed to this policy. We will use or disclose the Member's protected health information only when needed for treatment, payment, or health care operations such as measuring the quality of care. We will not use or disclose the Member's protected health information for any other purpose, except as described in our Notice of Privacy Practices. (See "Notice of Privacy Practices" for more information.)

- Expect an appropriate, confidential, and timely response, without sanction or reprisal, to any suggestions or complaints Members have about our policies or the care or Services we provide. Membership Services will inform Members of complaint and appeal procedures and resources to help them.
- Receive information about charges and payment methods. Receive an itemized statement of non-covered Services upon request, for an additional service charge. (Medicare members are not required to pay this charge.)

At Kaiser Foundation Health Plan of the Northwest, Members have the responsibility to:

- Participate in the development of their treatment plan, to follow it, and to let their Participating Provider know if changes need to be made.
- Improve the quality and safety of their care by fully informing Participating Providers serving them about their medical history, medications, and any changes in their condition.
- Ask questions if the Member does not understand any aspect of their medical or dental condition or treatment.
- Be aware of the daily lifestyle decisions that affect their health and choices that can reduce the risks to their health and the health of their family.
- Tell their health care team if they are satisfied or dissatisfied with any aspect of their care.
- Provide their family, Participating Provider, and hospital with a copy of any advance directive they wish Kaiser Permanente to follow, should they be unable to make their own decisions.
- Treat their health care team with consideration and respect.
- Treat other patients with consideration and respect. When the Member is in the hospital, avoid having the volume on television sets too loud, having too many visitors, or holding loud conversations that may disturb other patients.
- Comply with the no-smoking, no-weapons, and visiting-hours policies.
- Be familiar with their health care benefits.
- Notify Kaiser if they have other health coverage. We will coordinate benefits if the other plan is the Member's primary plan.
- Have their membership ID card handy when they call for an appointment or advice, or when they come in for care.
- Notify Kaiser in advance if they will be late for, or have to cancel, an appointment.
- Pay their bills on time and pay their Copayments when coming in for care.

Q & A About Kaiser Permanente Mental Health Services

What are the steps that must be taken to have outpatient mental health Services paid for by my plan?

About 80 percent of the initial appointments for outpatient mental health Services are self-referred: initiated by the patient. To make an appointment, you must first call for a brief (15–20 minute) evaluation over the telephone by a qualified mental health professional. The telephone numbers are listed at the end of this section.

If a Kaiser Permanente Participating Provider refers you to Mental Health using our electronic medical records system, then we will call you for the evaluation. Our goal is for patients to be offered an appointment for non-urgent mental health care within 10 working days, within 48 hours for urgent mental health care, or 2 hours for emergency mental health care.

We provide 90 percent of our mental health care within the Kaiser Permanente system. We also refer patients with special needs to a small panel of contracted mental health providers. These special needs can include non-English speakers, hearing-impaired, or cultural differences. Patients with such special needs should make this known during the initial telephone evaluation.

What does Kaiser Permanente do to protect the privacy of mental health information?

We have established policies and procedures to protect your privacy, including the confidentiality of mental health information. Only physicians and staff, whose job responsibilities require them to see your mental health or other medical information, may look at that information in your medical record. Staff or physicians who violate privacy laws or policies will be subject to corrective action, up to and including termination of employment.

Kaiser Permanente's electronic medical record system allows our physicians, nurse practitioners, physician assistants, pharmacists, and mental health practitioners to see your mental health information. We believe having mental health notes available to your PCP or Participating Provider who cares for you, will contribute to your safety, facilitate smoother referrals among providers who care for you, and allow for better coordination of care.

Do I have to pay a higher Copayment, Coinsurance or other charges than I pay for my other covered medical Services to get mental health Services under this Plan?

No, mental health Services Copayments and Coinsurance are the same as you would pay for any covered Service. See the "Benefit Summary" and the mental health section in this *COC* for Copayments, Coinsurance, and explanation of the mental health covered Services, or contact Membership Services.

What is the maximum number of Medically Necessary inpatient days and outpatient visits?

Most mental health treatment that results in positive outcomes is goal directed and combines therapy with appropriate medications. Medically Necessary inpatient days for mental health Services are determined by Utilization Review criteria for prior and concurrent authorization, not by a maximum number of days. Outpatient mental health visits are limited to 50 visits per Calendar Year.

What is the average number of outpatient visits this Plan pays for people who have been provided mental health Services?

In the past three years, it is most common for patients to have three to seven visits and/or phone consultations with a provider.

In which of the following circumstances where I might need mental health Services would I find them excluded or subject to the restrictions or limitations other than medical necessity?

Diagnostic testing is excluded unless a Participating Provider finds such testing necessary to determine what the treatment should be. Testing is not done for ability, intelligence, career aptitude assessment, learning disabilities, school mandated service, etc.

Special reports or eligibility reports for long term disability are not performed by the Mental Health Department.

Conditions that respond to episodic treatment are covered. Conditions that do not show improvement after a reasonable trial of treatment are excluded

Most requests for marital counseling are not covered. Our Health Education Services Department does offer communication classes that are often helpful for individuals and/or couples.

Marital counseling within the diagnosis of axis I disorder is covered if the counseling bears directly on the patient's mental health condition.

We do not provide Services in the home through the Mental Health Department. We do provide psychiatric nursing care in the home under the home health benefit if the patient is referred by a psychiatrist or psychiatric nurse practitioner Participating Provider.

Court-ordered treatment is excluded unless ordered by a Participating Provider. If the patient is in treatment, then treatment records can be made available to the court.

What is this Plan's most common goal in treatment in adults? in children?

The most common goal for Kaiser Permanente mental health treatment is for children and adults to return to their previous level of functioning. We provide ongoing maintenance of symptom management for patients who do well with infrequent medication checks.

More questions?

Contact Membership Services, located at most of our facilities, for information about our Mental Health Department or details about the coverage, exclusions, and limitations of your plan. Membership Services is also available by telephone 8 a.m. to 6 p.m., Monday through Friday. Or, you may sign on to **kaiserpermanente.org** and send an e-mail.

Portland area 503-813-2000
All other areas 1-800-813-2000

Language interpretation Services

All areas.. 1-800-324-8010

TTY

All areas.. 1-800-735-2900

Important numbers for Kaiser Permanente Mental Health:

Emergency psychiatric Services

Toll free for Washington and Oregon 1-866-453-3932
Portland area 503-331-6425

First appointments with Mental Health

Portland area (Beaverton, Interstate East, Mt. Scott, Sunset, and Tualatin medical offices, Eastman Parkway Office, and One Town Center)............... 503-249-3434

Clark County (Cascade Park and Salmon Creek medical offices).................. .360-571-3133

Longview-Kelso Medical Office 360-575-4821 503-316-2300
All other areas 1-800-972-7207

Q & A About Kaiser Permanente Pharmacy Services

We hope the following common questions and answers will help you get the most from your pharmacy benefits.

Does this Plan limit or exclude certain drugs my health care provider may prescribe? Does it encourage substitutions for some drugs?

Yes, this Plan has some limitations and exclusions. We also encourage using generic drugs when their brand-name equivalents do not provide better treatment.

A drug must be on our Formulary or meet exception criteria for you to pay your usual Copayment or Coinsurance. Drugs on the Formulary have been approved by the Food and Drug Administration. They have also been reviewed and approved by our Formulary and Therapeutics Committee. This committee includes

participating doctors and participating pharmacists. (Participating doctors and pharmacists are those included in this Plan.)

The committee looks at safety, effectiveness, and cost. We may not approve a drug if there is not enough scientific evidence that it is clinically effective. We may also exclude a drug if it does not have a clinical or cost advantage over comparable Formulary drugs. You can get a copy of the Formulary from one of our Participating Pharmacies. You can also see it online at **kaiserpermanente.org** (search by "Formulary").

Your Participating Provider can ask for an exception in special situations. He or she must feel that a non-Formulary drug is the most appropriate therapy for your medical needs. This might be because you have used Formulary drugs and they were not effective. Or it might be because you are allergic to the Formulary drugs or cannot tolerate them.

Dental prescriptions are limited to the FDA-approved prescription drugs listed on the dental Formulary. No exceptions are allowed.

The following *types* of drugs are excluded from the Formulary:

- Drugs that treat infertility.
- Drugs related to a service this Plan excludes.
- Over-the-counter drugs, unless they are on the Formulary.
- Drugs compounded in a pharmacy, unless they are on the Formulary.
- Drugs used for weight management, sexual dysfunction, or to improve athletic performance.
- Drugs that are replaced because of loss, damage, and/or carelessness.
- Mail-Delivery Pharmacy Service drugs that need special handling, such as refrigeration; that have an unusually high cost; or that must be given by a professional, or in the presence of one.

We also do not cover special packaging, such as bubble wrap, even when the drug is covered.

When can my plan change the approved drug list (Formulary)? If a change occurs, will I have to pay more to use a drug I have been using?

Our Formulary and Therapeutics Committee meets every month to review new drugs and reconsider old ones. Participating Providers can ask the committee to review a drug. After this review, we may add drugs to the Formulary or remove drugs from it.

Usually, if we remove a drug from the Formulary, you will need to switch to another comparable drug to keep paying just your Copayment. In some cases, your Participating Provider might find that the old drug meets the exception criteria.

When we remove a drug from the Formulary, we often send a letter to patients who use it, especially if the drug is very common. This gives them time to discuss the change with their Participating Provider.

What should I do if I want a change to limitations, exclusions, substitutions, or cost increases for any drug specified in my plan?

We have a process for reviewing what this Plan covers and how much you pay for drugs. That process has several steps. This first is an initial benefit determination. The next step involves internal appeals. If that does not resolve the issue, it can be reviewed by an independent review organization.

Once we receive all necessary information, initial benefit determinations are made within two days. Internal appeals are decided within 14 days of our receiving the appeal. Sometimes that is extended to 30 days. However, the process is faster if a delay would put your life or health at serious risk or cause you severe pain. In that case, we will respond within 72 hours or two business days, whichever is shorter.

How much do I have to pay to get a prescription filled?

See the Benefit Summary for Copayments and the "Prescription drugs, insulin, and diabetic supplies" section numbered 22.

Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?

To pay the Copayments or Coinsurance stated in this *COC,* you must fill prescriptions at a Participating Pharmacy listed in the *Medical Directory*.

You can also take advantage of our postage-paid Mail Delivery Pharmacy Service. You can order by calling 1-800-548-9809. (For TTY call 1-800-735-2900.) Or you can use the refill service on our Web site, **kaiserpermanente.org**.

How many days' supply of most medications can I get without paying another Copayment or other repeating charge?

Each Copayment covers up to a 30-day supply. If your Participating Provider prescribes a supply of less than 30 days, you will still pay the same Copayment, unless the actual cost of the drug is less. Your normal Copayment will also apply if you receive a smaller supply because of drug stability issues or therapy guidelines.

You can save money when you use our Mail Delivery Pharmacy Service for refills. For example, you might be able to get a 90-day supply of a maintenance drug for just two Copayments.

What other pharmacy Services does my health plan cover?

We have a Medication Management Program. In this program, participating pharmacists and other staff work with our Participating Providers. Their goal is to ensure quality care and improve health outcomes for Members. At the same time, they try to lower the cost of drug therapy.

The program focuses on reducing cardiovascular risk, especially by controlling lipid levels and high blood pressure. Staff educate patients, monitor and adjust drug doses, and link patients with their doctors. They also manage drug therapy for diabetes, asthma, and depression.

There is no extra charge for the Medication Management Program.

If you have questions about this process, call Membership Services 8 a.m. to 6 p.m., Monday through Friday. From Washington, call 1-800-813-2000. From Portland, call 503-813-2000. For TTY, call 1-800-735-2900. For language interpretation Services, call 1-800-324-8010. You can also sign on to **kaiserpermanente.org** and send us a secure electronic message.

Some terms

Brand-name drug—The first approved version of a drug. Marketed under a proprietary, trademark-protected name.

Food and Drug Administration (FDA)—The federal agency charged with reviewing and approving drugs and medical technology for use in the United States.

Formulary—A listing of preferred pharmaceutical substances and formulas.

Formulary process—A system for maximizing the safety, efficacy, and cost-effectiveness of drugs used by Members.

Generic drug—A drug that contains the same active ingredient as a brand-name drug and is equal in dosage, strength, quality, performance, and intended use. Must pass rigorous testing of equality from the FDA.

Non-Formulary—Non-Formulary drugs are drugs that are not on our Formulary list or are not used for the condition listed on the Formulary.

Therapeutic equivalent—Drug products within the same pharmacologic or therapeutic class that are expected to have similar effect and safety profiles when administered in equivalent doses.

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, 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 evidence of coverage 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 expenses of your child who is covered by this plan; and
  - You are the parent of the child 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 one 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