Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation

Portland, Oregon

Exhibit B-2A

Oregon Public Employees' Benefit Board (PEBB) Traditional Plan Evidence of Coverage

Group Name: Oregon Public Employees' Benefit Board (PEBB)
Group Number: 7029 (Part-Time Employees)

This *EOC* is effective: January 1, 2008 to December 31, 2008

Printed: January 1, 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

E-O-LG-NEG-OR-PEBB-PTTRAD-XX-0108

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BENEFIT SUMMARY

This is a summary of the most frequently asked questions about benefits and the Copayments and Coinsurance. This chart does not describe benefits, the benefit limitations, or exclusions in full. To see what is covered for each benefit (including exclusions and limitations), and for complete explanations, and for additional benefits that are not included in this summary, please refer to the "Copayments, Coinsurance and Benefits," "Exclusions and Limitations" and "Reductions" sections within this *EOC*.

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Annual Out-Of-Pocket Maximum	
For one Member	$1,500
For an entire Family Unit	$3,000
Annual Deductible	
For one Member	None
For an entire Family Unit	None
Lifetime Maximum	None
Outpatient Services	**You Pay**
Routine preventive physical exam *(includes adult and well child)*	No charge
Primary care visit *(includes OB/GYN visits, routine medical office visits, routine hearing exam appointments, and Urgent Care and Diabetic Outpatient self-management training and education, including medical nutrition therapy)*	$30
Specialty care visit *(includes TMJ therapy and Diabetic Outpatient self-management training and education, including medical nutrition therapy; see Primary care for OB/GYN visits)*	$30
Scheduled prenatal care and first postpartum visit	No charge
Routine eye exam	$30
All injections provided in the Nurse Treatment Area	$5
Immunizations	No charge
Rehabilitative therapy visit	$30
Outpatient surgery visit	$30
Emergency Department visit	$100 plus any other charges that normally apply
X-rays, imaging, laboratory, and special diagnostic procedures	$10
Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	$500 per admission

Outpatient prescription drugs, supplies, and supplements	You Pay
	$10 generic/$25 brand drugs. No charge for diabetic supplies and insulin. You get up to a 30-day supply. When you use mail delivery you get up to a 90-day supply of maintenance drugs.
Ambulance Services per transport	**You Pay**
	$75 per transport
Durable Medical Equipment	**You Pay**
	50%
Mental Health Services	**You Pay**
Outpatient Services	$30
Inpatient Hospital Services	$500 per admission
Residential or day treatment Services	$50 per day up to $250 maximum per admission for up to 45 days per calendar year
Chemical Dependency Services	**You Pay**
Outpatient Services	$30
Inpatient Hospital Services	$500 per admission
Residential or day treatment Services	$50 per day, up to $250 maximum per admission

Home Health Services	You Pay
	No charge
Infertility Services	**You Pay**
	50% for diagnosis and treatment
Skilled Nursing Facility Care	**You Pay**
	No charge for up to 100 days per year
Student Out-of-Area Coverage	**You Pay**
Routine, continuing, and follow-up Services The maximum benefit is $1,200 per Calendar Year	20% of the allowed amount plus any fees that exceed the allowed amount. The allowed amount is the lesser of (1) the provider's actual fee, or (2) the 70th percentile of the fees for the same or similar Service in the geographic area where the Service was received, according to the most current survey data published by MedIndex.
Hospice Services	**You Pay**
	No charge
Hearing Aids	**You Pay**
	10% up to a maximum of $4,000 every four years

INTRODUCTION

This Evidence of Coverage (*EOC*) describes the health care coverage of the Traditional Plan provided under the Agreement between Kaiser Foundation Health Plan of the Northwest, and Oregon Public Employees' Benefit Board (PEBB). This plan is not a federally qualified Health Benefit Plan. For benefits provided under any other plan, refer to that plan's evidence of coverage. In this *EOC*, Kaiser Foundation Health Plan of the Northwest is sometimes referred to as "Health Plan," "we," "our" or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*; please see the "Definitions" section for terms you should know. The benefits under this Plan are not subject to a pre-existing waiting period.

Term of this *EOC*

This *EOC* is effective for the period January 1, 2008 through December 31, 2008, unless amended. Your Group's benefits administrator can tell you whether this *EOC* is still in effect.

About Kaiser Permanente

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

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

- "Referrals to Non-Plan Providers," in the "How to Obtain Services" section
- "Emergency Services, Urgent Services, and Routine Services" in the "How to Obtain Services" section
- Limited coverage for students outside our Service Area as described in the "Student Out-of-Area Coverage" section

DEFINITIONS

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

Allied Plan: Group Health Cooperative located in Washington and Northern Idaho

Annual Out-of-Pocket Maximum: Refer to the "Annual Out-of-Pocket Maximum" heading listed in the "Benefits, Copayments and Coinsurance" section of this *EOC*.

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

Charges: is used to describe the following:

- The dollar amount Medical Group or Kaiser Foundation Hospitals Charge as described in Health Plan's schedule for health care Services of Medical Group and Kaiser Foundation Hospitals provided to you and your Dependents.

- The dollar amount charged for Services a provider (other than Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis that Health Plan negotiates with the capitated provider.
- The dollar amount a Kaiser Permanente owned and operated pharmacy would charge a Member if the Member's benefit Plan did not cover the pharmacy item.
- All other dollar amounts charged for Services, provided by Kaiser Permanente minus the Copayment, or Coinsurance.

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

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

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

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

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

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

Emergency Services: Those Services furnished in an emergency department (and all ancillary Services routinely available to an emergency department) to the extent they are required for stabilization of a patient. Emergency Services includes an emergency medical screening exam.

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

- Injury to one or both eyes
- Suspected heart attack or stroke
- Sudden or extreme difficulty in breathing
- Sudden loss of consciousness
- Severe bleeding
- Severe abdominal pain

EOC: This Evidence of Coverage document provided to the Subscriber that specifies and describes benefits and conditions of coverage. This document, on its own, is not designed to meet the requirements of a Summary Plan Description (SPD).

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

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

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

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

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

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

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

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

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

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 Company to provide professional medical services to Members and others primarily on a capitated basis in Participating Facilities.

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

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

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

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

Plan Facility: Any facility listed in the Kaiser Permanente *Medical Directory* for our Service Area. Plan Facilities are subject to change.

Plan Hospital: Any hospital listed in the Kaiser Permanente *Medical Directory* for our Service Area. Plan Hospitals are subject to change.

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

Plan Pharmacy: Any pharmacy owned and operated by Kaiser Permanente and listed in the *Medical Directory* for our Service Area, except that Plan Pharmacies are subject to change. Most Plan Pharmacies are located within Plan Medical Offices.

Plan Physician: Any licensed physician who is an employee of Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A general term which means a Plan Hospital, Plan Physician, Medical Group, Plan Pharmacy, or other health care provider that we designate as a Plan Provider. A Plan Provider may include an optometrist, psychologist, duly licensed and certified nurse practitioner.

Premium: Monthly membership charges paid by Group.

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

Services: Health care Services, supplies or items.

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

Specialist: Any licensed Plan Provider, who practices in a specialty care area of medicine (not family medicine, pediatrics, gynecology, obstetrics, general practice or internal medicine) in which a referral by Plan Physician is required in order to receive Covered Services. **Spouse:** Your legal husband or wife. If your Group permits coverage of domestic partners, then for the purposes of this *EOC*, the term "Spouse" includes your domestic partner in accord with your Group's requirements that we have approved in writing.

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

Urgent Services: Treatment for an unforeseen illness, injury, or complication of an existing condition that requires prompt medical attention to keep it from becoming more serious, but is not an Emergency Medical Condition. We cover Urgent Services only when they meet the coverage requirements stated in other sections of this *EOC*.

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

PREMIUM, ELIGIBILITY, AND ENROLLMENT

Premium

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

Who Is Eligible

General

The Public Employees' Benefit Board (PEBB) eligibility rules are governed under provisions of the *Oregon Administrative Rules*, Chapter 101. You should refer to the *PEBB eligibility rules* for detailed information and program requirements.

HOW TO OBTAIN SERVICES

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

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

Our Advice Nurses

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

Your Primary Care Plan Physician

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

You may select a primary care Plan Physician from family practice, obstetrics/gynecology, pediatrics, or internal medicine. Female Members may designate a women's health care provider as a primary care Plan Physician as long as the women's health care provider accepts designation as a primary care Plan Physician. For the purpose of this "Your Primary Care Plan Physician" section, a women's health care provider is an obstetrician or gynecologist, physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health, or certified nurse midwife, practicing within their applicable scope of practice.

Female Members have direct access to a women's health-care Plan Physician for at least one annual preventive women's health examination, for Medically Necessary follow-up visits resulting from the annual preventive women's health examination, and for pregnancy care.

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

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

Prior and Concurrent Authorization

Some Services are subject to Utilization Review based on Utilization Review criteria developed by the Medical Group and/or other organization utilized by Medical Group and approved by Health Plan and may require prior or concurrent authorization in order to be covered. Your Plan Physician 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 Health Plan without notice):

- Breast reduction surgery
- Drug formulary exceptions
- Outpatient Durable medical equipment
- Hospice and home health Services
- Inpatient hospital Services
- Non-emergency medical transportation
- Open MRI
- Orthognathic surgery
- Referrals for non-Plan Provider Services
- Rehabilitative Therapy Services
- Routine foot Services
- Skilled Nursing Facility Services
- Transplants Services

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

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

Referrals

Referrals to Plan Providers and Plan Facilities

Primary care Plan Physicians provide primary medical care, including pediatric care and obstetrics/gynecology care. Plan Specialists provide Specialty Care in areas such as surgery, orthopedics, cardiology, oncology, urology, dermatology, and allergy/immunology. A Plan Physician will refer you to a Plan specialist when appropriate. In most cases you will need a referral to see a Specialist for the first time. Please see the *Medical Directory* or call Membership Services for information about specialty Services that require a referral. In some cases a standing referral may be allowed according to ORS 745.856.

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

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

Referrals to Non-Plan Providers and Non-Plan Facilities

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

Plan Provider and Plan Facilities Contracts

Plan Providers and Plan 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. Medical Group may directly or indirectly make capitation payments to Plan Providers and Plan Facilities only for the professional Services they deliver, and not for Services provided by other physician group hospitals, or facilities. Please call Membership Services if you would like to learn more about the ways Plan Physicians and Plan Facilities are paid to provide or arrange medical and hospital care for Members.

Our contracts with Plan Providers and Plan Facilities provide that you are not liable for any amounts we owe. You will be liable for the cost of excluded Services and Services that you receive without a required prior authorization as described in this *EOC*.

Providers Whose Contracts Terminate

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

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

- Has retired
- Has died
- No longer holds an active license

- Has moved outside our Service Area
- Has gone on sabbatical
- Is prevented from continuing to care for patients because of other circumstances

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

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

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

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

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

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

International Travel Clinic

The Kaiser Permanente International Travel Clinic can help you with immunizations, travel-related medications, and travel-related health information. A phone call is all it takes to order travel related medications you will need while you are away. We will also arrange for any immunizations recommended for the areas you plan to visit. In most cases, you can just tell us the Plan Facility you use and we will take care of the details. Then, you can just stop in before your trip to pick up any prescriptions, and to get any immunization shots you need. Check the "Benefit Summary" in your *EOC* for Deductible, Copayment, and Coinsurance information for immunizations you receive at the nurse treatment room. To use the International Travel Clinic, call 1-800-888-8540 Monday through Friday, 7 a.m. to 4 p.m. Pacific Time. After hours and on weekends, you can leave a message, and we will call you back as soon as possible. Call 1-800-735-2900 for TTY from Oregon and Washington. When you call, be ready with your Kaiser Permanente health record number (shown on your ID card); travel dates and destinations. Also be ready with any medical problems, allergies to medications, current medications (including over-the counter medications), and recent immunizations. You should call eight weeks before departure. If you will be gone longer than three months or doing any medical work abroad, you should call about four months before you leave. Many airports ask to see a letter from a doctor if you need to carry syringes (for insulin and other medications) aboard airlines. It is a good idea to call before you travel to confirm your airline's requirements.

Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas

Visiting Member Services ensure that you can receive Services when you are temporarily visiting another Kaiser Permanente region or Allied Health Plan area. You can get Visiting Member Services when you are temporarily visiting a Kaiser Foundation Health Plan region or an Allied Plan service area. Visiting Member

Services are generally limited to 90 days. This 90-day limit does not apply if you are a registered college student Dependent attending an accredited college or accredited vocational school.

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

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

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

If you would like to receive one of our *When You Are Away From Home* brochures, please call Membership Services and one will be sent to your home. The brochure includes all of the facility locations in other service areas and telephone numbers.

Using Your Identification Card

Each Member has a Health Plan ID card with a health record number on it, which is useful when you call for advice, make an appointment, or go to a provider for care. Your health record number is used to identify your medical records and membership information. You should always have the same health record number. If we ever inadvertently issue you more than one health record number, please let us know by calling Membership Services. If you need to replace your ID card, please call Membership Services.

Your ID card is for identification only. To receive covered Services, you must be a current Member. You may receive covered Services as soon as your coverage starts, even if you have not received your ID card. Anyone who is not a Member will be billed as a non-Member for any Services he or she receives. If you let someone else use your ID card, we may keep your card and terminate your membership (see the "Termination for Cause" section).

Getting Assistance

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

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

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

COPAYMENTS, COINSURANCE AND BENEFITS

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

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

Copayments And Coinsurance

The Copayment or Coinsurance you must pay for each covered Service is shown in the "Benefit Summary". Copayments or Coinsurance are due when you receive the Service. If we must bill you, an accounting fee of $10 or more will be added to offset handling costs. If you miss an appointment without canceling you may owe a missed appointment fee.

Annual Out-Of-Pocket Maximum

There is a maximum to the total amount of Copayments and Coinsurance that you must pay for the covered Services that you receive within the same Calendar Year under this or any other Evidence of Coverage with the same Group number printed on this *EOC*. The limit is shown in the "Benefit Summary" per Calendar Year for a Member or for an entire Family. Membership Services can provide you with the amount you have paid toward your out-pocket 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, (Membership Services can provide you with the amount you have paid toward your Out-of-Pocket Maximum). Remember, only Copayments and Coinsurance that you pay for covered Services apply toward the Out-of-Pocket maximum, other payments that are not a Copayment or Coinsurance do not apply.

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

- Inpatient
- Ambulance Services
- Chemical Dependency Services
- Emergency Services
- Home health Services
- Hospice care
- Infertility Services
- Maternity and interrupted pregnancy Services
- Hospital inpatient Services
- Office visits (including professional Services such as mental health, dialysis Services treatment, and physical, occupational, respiratory, and speech therapy)
- Outpatient surgery Services

- Skilled Nursing Facility Services
- Laboratory, x-ray, imaging, and special procedure Services

Benefits for Outpatient Services

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

- Routine preventive physical exam (includes adult and well child visits)
- Primary care visit for internal medicine, gynecology, family medicine, and pediatrics
- Specialty care visit
- Allergy testing and treatment materials
- Treatment for Temporomandibular Joint Disorder (TMJ). Splint therapy for TMJ. .
- Prenatal care after confirmation of pregnancy, including prenatal diagnosis of congenital disorders, all routine prenatal visits and the first postpartum visit
- Prostate cancer screening (PSA testing)
- Routine eye exam
- Routine hearing exam
- Nurse treatment room visits, to receive injections, (including allergy injections)
- Immunizations (including those required for travel) and vaccines approved for use by the federal Food and Drug Administration (FDA) when administered to you in a Plan Medical Office
- Rehabilitative (such as physical, occupational, speech, and respiratory) therapy. This benefit is subject to the benefit limitations described under the "Rehabilitative Therapy Services" section.
- Multidisciplinary rehabilitation therapy in an outpatient multidisciplinary rehabilitation facility or program. (This benefit is subject to the benefit limitations described under the "Rehabilitative Therapy Services" section.)
- Outpatient surgery Services and other outpatient procedures (including interrupted pregnancy surgery performed in an outpatient setting)
- Emergency department Services: (subject to the copay shown in the Benefit Summary plus any other charges that normally apply)
- Urgent Services visits in Plan Medical Offices and Urgent Services Plan facilities
- Drugs, injectables, and radioactive materials used for therapeutic purposes, if they are administered to you in a Plan Medical Office or during home visits, subject to the drug formulary and exclusions described in the "Limited Outpatient Prescription Drugs, Supplies, and Supplements" section.
- House calls inside our Service Area when care can best be provided in your home as determined by a Medical Group physician
- Blood, blood products, and their administration

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

- Ambulance Services
- Chemical Dependency Services

- Dialysis Services
- Outpatient Durable Medical Equipment, External Prosthetics and Orthotics
- Health Education Services
- Hearing Aids
- Home Health Services
- Hospice Services
- Infertility Services
- Mental Health Services
- Outpatient Laboratory, x-ray, Imaging, and Special Diagnostic Procedures
- Limited Outpatient Prescription Drugs, Supplies, and Supplements
- Reconstructive Surgery Services
- Rehabilitative Therapy Services
- Transplant Services

Benefits for Hospital Inpatient Services

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

- Anesthesia
- Blood, blood products, and their administration
- Detoxification
- Drugs and radioactive materials used for therapeutic purposes, except for the types of drugs excluded under the "Limited Outpatient Prescription Drugs, Supplies and Supplements" section.
- Durable medical equipment and medical supplies
- Dialysis Services (this benefit is subject to the benefit limitations described under "Dialysis Services" in this "Copayments, Coinsurance and Benefits" section)
- General and special nursing care
- Internally implanted devices except for internally implanted insulin pumps, artificial hearts, and artificial larynx which are not covered.
- Interrupted pregnancy surgery when performed in an inpatient setting
- Laboratory, x-rays and other imaging, and special diagnostic procedures
- Maternity hospital care for mother and baby. We will not limit the length of a maternity hospital stay for a mother and baby to less than 48 hours for vaginal delivery and 96 hours for a cesarean section delivery. The length of inpatient stay is determined by an attending Plan Physician, in consultation with the mother. Our policy complies with the Federal Newborns' and Mothers' Health Protection Act (NMHPA) of 1996. Except for covered Emergency Services, deliveries are covered only at hospitals within the Service Area.
- Medical social services and discharge planning
- Obstetrical care and delivery (including cesarean section)

- Operating and recovery rooms
- Orthognathic surgery for treatment of a congenital anomaly
- Rehabilitative therapy Services such as physical, occupational, speech, and respiratory therapy, and multidisciplinary rehabilitation Services, subject to the benefit limitations described under "Rehabilitative Therapy Services" section
- Plan Physician's Services, including consultation and treatment by specialists
- Prescription drugs, including injections
- Room and board, including a private room if Medically Necessary
- Medical foods and formulas if Medically Necessary
- Specialized care and critical care units
- Temporomandibular Joint (TMJ) surgery for the treatment of TMJ disorders subject to Utilization Review (UR) criteria developed by and approved by Medical Group as part of Health Plan's UR standards.

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

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

Benefit Specific Provisions

Ambulance Services

Except for emergency ambulance Services described under the "Emergency Services, Urgent Services, and Routine Services" sections, we cover ambulance Services only when both of the following are true:

- Your condition requires the use of medical Services that only a licensed ambulance can provide. You will be responsible for paying any Copayments or Coinsurance directly to the ambulance service provider. We will pay the ambulance service provider directly for covered ambulance Services.
- The ambulance transports you to or from a location where you receive covered Services and a Medical Group physician determines that the use of other means of transportation would endanger your health.

Ambulance Services Exclusion

We do not cover transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider or Plan Facility.

Bariatric Surgery

We cover Medical Necessary bariatric surgery for clinically severe obesity only when all of the following requirements have been met; except:

- where surgery is contraindicated,
- or when the Member refuses to sign or fails to comply with the Severe Obesity Evaluation and Management Program's contract for participation. Copayments may apply to specific activities included in the Severe Obesity Evaluation and Management Program Surgical treatment of morbid obesity (bariatric surgery). You must be at least 18 years of age or older and have either (1) a body mass index (BMI) of 50 or greater or (2) a BMI of 40 up to 49.9 when you have 1 or more life threatening or 2 or more severe comorbidities.
  - Sleep apnea uncontrolled with C-PAP therapy
  - Diabetes uncontrolled with prescription medications
  - Degenerative joint disease of weight-bearing joints
  - Hypertension uncontrolled with prescription medications
  - Congestive heart failure and/or cardiomyopathy
  - Other severe or life-threatening conditions directly related to obesity, when recommended by your Plan provider

Note: You will need to meet the above qualifications before your Plan provider will refer you to our bariatric surgery program. In addition, you must complete a minimum of a 6 month program during which you will be referred to other Plan providers to determine if you meet the additional criteria necessary for bariatric surgery, including nutritional, psychological, medical, and social readiness for surgery. You must sign and comply with the "Severe Obesity Evaluation and Management Program Contract for Participation." Final approval for surgical treatment will be required from the Northwest Permanente Medical Group's designated physician.

- A Medical Group physician determines that the surgery meets Utilization Review criteria approved by Medical Group
- You fully comply with the Severe Obesity Evaluation and Management Program's contract for participation
- You pay the applicable Copayment or Coinsurance specified under "Hospital Inpatient Care" in this Benefits, Copayments and Coinsurance" section.

Chemical Dependency Services

We cover the Medically Necessary Services listed in this "Chemical Dependency Services" section subject to Utilization Review criteria approved by Medical Group and adopted by Health Plan. You may request these criteria by calling Membership Services. Coverage includes medical treatment for withdrawal symptoms (including methadone maintenance by referral). . Chemical Dependency Services do not include Services for addiction to, or dependency on: Tobacco, Tobacco products or foods. Emergency detoxification for medical conditions associated with acute alcohol, drug, or other substance abuse is covered without prior authorization.

Outpatient Services for Chemical Dependency

We cover individual office visits and group therapy visits for Chemical Dependency. Any applicable visit limits are shown in the "Benefit Summary".

Inpatient Hospital Services for Chemical Dependency

We cover inpatient hospital Services for Chemical Dependency.

Residential or Day Treatment Services

We cover residential or day treatment Services in a residential or day treatment program.

Dialysis Services

We cover dialysis Services for acute renal failure and end-stage renal disease if:

- The Services are provided inside our Service Area
- You satisfy all Utilization Review criteria approved by Medical Group as adopted by Health Plan

Outpatient dialysis treatment Services are considered a rehabilitative therapy visit

Home dialysis is covered. Coverage includes necessary equipment, training, and medical supplies.

Dialysis Services are covered in the hospital or in a Skilled Nursing Facility.

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

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

External prosthetics and orthotics Defined

External prosthetic devices are rigid or semi-rigid external devices that are required to replace all or any part of a body organ or extremity. Orthotic devices are rigid or semi-rigid external devices (other than casts) that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body. Internally implanted, as opposed to external, devices are not covered under this "External Prosthetics and Orthotics" section (see "Hospital Inpatient Care" in this "Benefits, Copayments, and Coinsurance" section).

DME Formulary

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

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

We cover outpatient durable medical equipment (DME), prosthetics and orthotics according to the DME formulary guidelines. DME must be for use in your primary residence (or another location used as your primary residence) inside our Service Area. Coverage is limited to the standard supply or equipment that adequately meets your medical needs. We decide whether to rent or purchase the DME, and we select the vendor.

If you live outside the Service Area, we do not cover most DME for use in your home. However, our DME formulary guidelines allow certain DME (such as crutches and canes) for use in your home to be picked up from Plan Providers even if you live outside the Service Area. To find out whether we will cover a particular DME item if you live outside our Service Area, call Membership Services.

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

- Fitting and adjustments
- Repair or replacement (unless due to loss or misuse)
- Therapeutic shoes and inserts to prevent and treat diabetes-related complications
- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity. This includes but is not limited to ostomy and urological supplies.
- Rigid and semi-rigid orthotic devices required to support or correct a defective body part
- Prosthetic devices for treatment of temporomandibular joint conditions.
- External prostheses after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres every twelve months.
- Billirubin lights
- Halo vests
- Compression garments for burns
- Lymphedema wraps and garments
- Diabetic equipment and supplies including: external insulin pumps, infusion devices, glucose monitors, diabetic foot care appliances, injection aids, and lancets. We do not cover the following items under this "Durable Medical Equipment, External Prosthetics and Orthotics" section: glucose and ketone test strips, blood glucose test strips, glucagon emergency kits, and disposable needles and syringes. See the "Prescription Drugs, Supplies, and Supplements" in this " Copayments, Coinsurance and Benefits" section.
- Maxillofacial Prosthetic Devices: Coverage is limited to the least costly clinically appropriate treatment as determined by a Plan Physician. We cover maxillofacial prosthetic devices if they are necessary for restoration and management of head and facial structures that cannot be replaced with living tissue and are defective because of disease, trauma, or birth and developmental deformities when this restoration and management are performed for the purpose of:
  - Controlling or eliminating infection;
  - Controlling or eliminating pain; or
  - Restoring facial configuration or functions such as speech, swallowing, or chewing, but not including cosmetic procedures rendered to improve the normal range of conditions.
- Enteral supplements and formula

- Tracheotomy equipment
- Enteral pump and supplies. For coverage information on Enteral supplements, refer to "Limited Outpatient Prescription Drugs, Supplies, and Supplements" in this *EOC*
- CADD (Computerized Ambulatory Drug Delivery) pumps
- Occular prosthesis for children age 12 or younger.
- Osteogenic bone stimulators
- Osteogenic spine stimulators
- Ventilators

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

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

Emergency Services, Urgent Services, and Routine Services

Emergency Care

If you have an Emergency Medical Condition, call 911 or go to the nearest emergency medical facility. When you have an Emergency Medical Condition, we cover Emergency Care from Plan Providers and non-Plan Providers anywhere in the world, except that we cover ambulance Services that are not ordered by us only if in the judgment of a Plan Physician your condition requires use of the medical Services that only a licensed ambulance can provide and the use of another means of transportation, whether or not available, would endanger your health.

Emergency Services are those Services furnished in an emergency department (and all ancillary Services routinely available to an emergency department) to the extent they are required for stabilization of a patient. Emergency Services include an emergency medical screening exam. Emergency Care does not require prior authorization. You are responsible for your emergency Services Copayments plus any other charges which may apply.

"Emergency medical screening exam" the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

Inside our Service Area

Plan Hospital emergency departments inside our Service Area are listed in the *Medical Directory* . Emergency Care is available seven days a week, 24 hours a day, at the following Plan Hospitals:

In the Portland area:

- Kaiser Sunnyside Medical Center
- Providence St. Vincent Medical Center
- In addition to these two hospitals in Portland, Emergency Care for children under age 17 is also available at Oregon Health & Science University's (OHSU) Doernbecher Children's Hospital

In Salem:

- Salem Hospital

In Vancouver:

- Southwest Washington Medical Center

When you use these Plan Hospitals, information about your condition and treatment is transferred to our medical information system so that it is available to your health care team when you visit a Plan Facility for follow-up care.

Post-stabilization care is the Services you receive after your treating physician determines that your Emergency Medical Condition is clinically stable. If you are treated at a non-Plan Facility, your post-stabilization care will only be covered if a Plan Provider provides it or if we authorize your receiving the care from a non-Plan Provider before you receive the care.

To request prior authorization for post-stabilization care, you must call us at 503-571-4540 or, toll free, 1-877-813-5993 before you receive the care if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible). After we are notified, we will discuss your condition with the non-Plan Provider. If we decide that your post-stabilization care would be covered if you received it from a Plan Provider, we will authorize your care from the non-Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to have a Plan Hospital, licensed Skilled Nursing Facility, or designated non-Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider.

We cover Emergency Care for an Emergency Medical Condition at any hospital outside our Service Area. If you are admitted to the hospital, you must call us within 24 hours or as soon as you reasonably can. Call 503-571-4540 or, toll free, 1-877-813-5993. We may require that you be moved to a Plan Hospital or other designated hospital after your condition is stable in order to receive coverage for continued hospitalization. If you refuse to be moved to another hospital or fail to contact us within 24 hours or as soon as you reasonably can, we may not cover Charges for continued hospitalization. We understand that extraordinary circumstances can delay your ability to call us, for example, if you are unconscious, or if there is no parent or

guardian with a young child. In these cases, you must call us as soon as reasonably possible. Please keep in mind that anyone can call us for you.

Urgent Services

When you are sick or injured, you may need Urgent Services.

Inside our Service Area

We cover Services for an Urgent Services visit inside our Service Area at Plan Medical Offices, or when Plan Medical Offices are closed, at designated Urgent Services facilities. Urgent Services locations and hours are listed in the *Medical Directory*. Inside our Service Area, we do not cover Urgent Services at any other facilities, including hospital emergency departments.

Outside our Service Area

If you are temporarily outside our Service Area you may need care for unforeseen illness, injury, or complication of an existing condition (including pregnancy). We cover Medically Necessary Services you receive from a non-Plan Provider if we find the Services were necessary to prevent serious deterioration of your (or your unborn child's) health and the Services could not be delayed until you returned to our Service Area.

If you have an Urgent Services need outside our Service Area, you should try to find a medical office or Urgent Care facility. If you obtain Urgent Care from a hospital emergency department instead of a medical office or Urgent Services facility, you will have to pay the Copayment or Coinsurance for emergency department visits.

Payment and Reimbursement For Emergency and Urgent Care

If you receive covered Emergency Services or Urgent Services from a non-Plan Provider, the provider may agree to bill for the Services, or may require that you pay for the Services at that time. In either case, to request payment or reimbursement, you must file a claim as described under "Post Service Claims–Services Already Received" in the "Requesting Medical Services and Benefits" section. You do not need to file a claim for Services that you receive at a Plan Medical Office or Plan Hospital.

Routine Care

We cover routine Services discussed in this section only if it meets the coverage requirements stated in other sections of this Copayments, Coinsurance and Benefits" section. If you need to make a routine Services appointment, please refer to the *Medical Directory* for appointment telephone numbers, or go to **kaiserpermanente.org** to request an appointment online. Routine appointments are for medical needs that are not urgent such as checkups and follow-up visits that can wait more than a day or two. Try to make your routine Services appointments as far in advance as possible. Except as described under "Student Out-of-Area Coverage" or the "Visiting Other Kaiser Foundation Health Plan or Allied Plan Services Areas" sections, or in the case of an authorized referral, we do not cover any Services you receive from non-Plan Providers for: follow-up care or routine Services that you could have received before you left our Service Area.

Copayments and Coinsurance for Emergency Services, Urgent Services, and Routine Services

The Copayments and Coinsurance for covered emergency Services, urgent Services, or routine Services are the same ones you would pay if the Services were not emergency, urgent, or routine. For example, if you receive covered inpatient hospital Services, you pay the Copayment or Coinsurance listed in the "Benefit Summary" under "Hospital Inpatient Services," regardless of whether the Services also constitute emergency Services, urgent Services, or routine Services. Similarly, if you receive covered Services in an emergency department, you pay the emergency department visit Copayment or Coinsurance listed in the "Benefit

Summary" under "Outpatient Services," as well as Copayments or Coinsurance for any other Services that apply.

Student Out-Of-Area Coverage

This limited Student Out-of-Area benefit is available to Dependents who temporarily live outside our Service Area if the Subscriber gives us written certification that the Dependent is a registered full-time student, carrying a minimum of 12 credit hours per semester or term, at an accredited college or accredited vocational school.

We make limited payments for Medically Necessary routine, continuing, and follow-up Services that a qualifying student Dependent receives from non-Plan Providers outside our Service Area but inside the U.S. (which for the purpose of this benefit means the 50 states, the District of Columbia, and U.S. territories). These Student Out-of-Area Coverage benefits are subject to special limits and Member cost sharing that are described in the "Benefit Summary". This Student Out-of-Area benefit cannot be combined with any other benefit, so we will not pay under this "Student Out-of-Area Coverage" for a Service we are covering under another section, such as:

- Emergency Services and Urgent Services covered in "Emergency Services, Urgent Services, and Routine Services" in this "Copayments, Coinsurance Services" section.
- Visiting member care as described in "Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas" in the "How to Obtain Services" section.
- Transplant Services

Health Education Services

We cover a variety of Services to help you take an active role in improving and maintaining your health, such as individual and group visits, and phone-based health consultant Services. This includes:

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

You pay the Primary care visit or Specialty care visit Copayment listed in the "Benefit Summary" under "Outpatient Services".

In addition, we offer a variety of health education classes and phone based Services, such as smoking cessation, which includes Free and Clear telephone counseling, stress management, and weight management. These are value-added Services rather than covered benefits. For more information about these offerings, please see our *Healthy Living* catalog. You can pick up a catalog in any Plan Medical Office or request that one be sent to you in the mail by calling Membership Services. The fees associated with each health education Services class are listed in the *Healthy Living* catalog.

Health education publications about maintaining physical and emotional health and preventing illness or injury are also available. For more information about Kaiser Permanente's health education Services programs, please contact your local Health Education Services department or call Membership Services, or go to **kaiserpermanente.org**.

Health Education Services Exclusion

Educational and clinical programs for weight control.

Hearing Aids

Hearing Exams

Exams to determine the need for hearing correction are covered at the copay shown in the Benefit Summary. In addition, we cover visits to determine the appropriate hearing aid model, visits to verify that the hearing aid conforms to the prescription and visits for fitting, counseling, adjustment, cleaning, and inspection. These visits are also covered at the copay shown in the Benefit Summary.

Hearing Aids

Your plan provides a maximum allowance for the purchase of hearing aids within the benefit period shown in the Benefit Schedule. The benefit period begins when the first hearing aid is ordered and the allowance applies to all hearing aids obtained in that benefit period. You will be responsible for any Charges exceeding the maximum. If you wish to return a hearing aid, you will be refunded the amount you paid, less 20% of the cost of the hearing aid.

A Plan Provider will provide the services and select the vendor used for the covered hearing aid. Covered hearing aids are electronic devices worn on the person for the purpose of amplifying sound and assisting in the process of hearing, including an ear mold, if necessary, and are limited to one of the following models: (i) in-the-ear; (ii) behind-the-ear (iii) on-the-body (Body Aid Model); (iv) in the eyeglass temple; and (v) canal/digital aids.

Exclusions

- Replacement parts and batteries
- Replacement of lost or broken hearing aids
- Repair of hearing aids beyond the two-year warranty period
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first.

Home Health Care

We cover home health Services when you have received prior authorization and the Services are provided by a Plan Provider or Plan Physician which includes Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists and if all of the following are true:

- You are substantially confined to your home (or a friend's or relative's home) due to your health problem or illness; or the care is provided in lieu of Medically Necessary hospitalization
- A Medical Group physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home
- You received prior authorization from Health Plan in accordance with Utilization Review criteria approved by Medical Group
- Home Health is provided by a home health agency that is a licensed participating agency that specialized in giving skilled nursing Services and other therapeutic Services, such as physician therapy, in the patient's home

A home health Service is a personal contact in your place of residence to provide covered medical Services. The Services are part-time intermittent Medically Necessary Services to help minimize the effects of a disability or pain; promote, maintain, or protect health; and prevent premature or inappropriate institutionalization.

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

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

Home Health Services Exclusions

- Custodial and maintenance Services
- Private duty or continuous nursing Services
- House keeping or meal Services
- Homemaker type Services
- Care that an unlicensed Family Member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if we would cover the care if it were provided by a qualified medical professional in a hospital or Skilled Nursing Facility.

Hospice Services

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

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

- A Medical Group physician has diagnosed you with a terminal illness and determines that your life expectancy is six months or less
- The Services are provided inside our Service Area (including a friend's or relative's home even if you live there temporarily)
- The Services are provided by a licensed hospice agency approved by Medical Group
- The Services are necessary for the palliation and management of your terminal illness and related conditions

We cover the following hospice Services:

- Medical Group Physician Services
- Skilled nursing Services, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your Family, and instruction to caregivers.
- Rehabilitative therapies for purposes of symptom control or to enable you to maintain activities of daily living
- Medical social Services
- Medical supplies and appliances
- Services of volunteers
- Home health aide and homemaker services
- Outpatient Durable medical equipment (DME)

- Short-term inpatient Services including respite care and care for pain control and acute and chronic symptom management. Inpatient respite care is limited to no more than five consecutive days in a 30-day period.

Infertility Services

The following infertility Services are covered:

- Diagnosis and treatment of involuntary infertility
- Artificial insemination

We do not cover drugs in this "Infertility Services" section. See "Limited Outpatient Prescription Drugs, Supplies, and Supplements" in this *EOC*

Infertility Services Exclusions

- Donor semen and donor eggs, and Services related to their procurement and storage
- Services related to conception by artificial means, such as In Vitro Fertilization (IVF), ovum transplants, Gamete Intrafallopian Transfer (GIFT), and Zygote Intrafallopian Transfer (ZIFT), except artificial insemination is covered as indicated above.
- Services to reverse voluntary, surgically induced infertility
- Drugs, both oral and injectable, used in the treatment of infertility

Mental Health Services

We cover the following mental health Services listed in this "Mental Health Services" section subject to Utilization Review criteria developed by Medical Group and approved by Health Plan. You may request these criteria by calling Membership Services. We cover hospital Services and inpatient and outpatient Services of Plan Physicians and other mental health Plan professionals, as performed, prescribed, or directed by a Plan Physician or mental health Plan Provider, when they are necessary for:

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

Services are subject to the exclusions and limitations listed in this "Mental Health Services" section.

Outpatient Services

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

Inpatient Hospital Services

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

Residential or Intensive Outpatient Services

We cover residential or intensive outpatient Services in a residential or intensive outpatient facility. The benefit maximum for residential treatment is 45 days per Calendar Year.

Psychological Testing

If, in the professional judgment of a Plan Physician or a Medical Group psychologist, you require Psychological testing as part of diagnostic evaluation, prescribed tests are covered in accord with this "Mental Health Services" section. We do not cover court-ordered testing unless Medically Necessary, or testing for ability, aptitude, intelligence, or interest.

Mental Health Services Exclusions and Limitations

- Mental health Services, including evaluations and psychological testing, on court order or as a condition of parole or probation regardless of whether they are Medically Necessary Services.
- Psychological testing for ability, aptitude, intelligence, or interest is excluded.
- Mental health Services are excluded for the following conditions after diagnosis when received in a residential treatment or intensive outpatient facility, if in the professional judgment of a Plan Physician, the condition is not responsive to therapeutic management:
  - Chronic psychosis, except that we will cover Services for acute episodes due to chronic psychotic conditions if you have been cooperative and respond favorably to an ongoing treatment plan
  - Organic psychosis
  - Intractable personality disorders
- Mental health Services are excluded for mental retardation after diagnosis
- Marriage counseling is excluded, unless Medically Necessary

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

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

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

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

The special diagnostic procedure Copayment or Coinsurance does not apply to procedures that are usually for treatment purposes, even if that procedure might also be performed for diagnostic reasons, such as colonoscopy, endoscopy, and laparoscopy. For these Services, the outpatient surgery visit Deductible, Copayment or Coinsurance applies. If you have questions about your Copayment or Coinsurance, call Membership Services, or ask one of the Membership Services representatives in your medical office.

Limited Outpatient Prescription Drugs, Supplies, and Supplements

We cover take-home drugs, supplies and supplements specified in this "Limited Outpatient Prescription Drugs, Supplies and Supplements" section. For information about coverage for drugs that require administration by medical personnel or observation by medical personnel during self-administration, refer to

"Outpatient Care," "Hospital Inpatient Care," and "Skilled Nursing Facility Care" in this "Benefits Copayments and Coinsurance" section.

Most Plan Medical Offices include a Plan Pharmacy where you can pick up new prescriptions and refills. Our postage-paid mail-delivery service makes getting prescription refills even easier. For Plan Pharmacy locations and for information on using the mail-delivery service, please see the *Medical Directory* or call Membership Services.

Covered Drugs, Supplies and Supplements

We cover the following outpatient drugs, supplies and supplements from a Plan Pharmacy when prescribed by a Plan Physician (or by a licensed dentist) in accordance with drug formulary guidelines:

- Drugs, injectables, and radioactive materials used for therapeutic purposes, if they are administered to you in a Plan Medical Office or during home visits.
- Medical foods and formulas necessary for the treatment of phenylketonuria (PKU), severe intestinal malabsorption, specified inborn errors of metabolism, or other metabolic disorders are covered at no charge.
- Drugs for which a prescription is required by law. This includes contraceptive drugs, intrauterine devices, diaphragms and cervical caps. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary.
- Insulin for treatment of Diabetes along with glucose and ketone test strips for urine-testing, blood glucose test strips, glucagon emergency kits, disposable needles and syringes (additional diabetic equipment and supplies are covered under "Outpatient Durable Medical Equipment and Prosthetics and Orthotics" in this "Copayments, Coinsurance and Benefits" section.)

Copayments and Coinsurance for Covered Drugs, Supplies, and Supplements

When you pick up a prescription at a Plan Pharmacy for one of the items listed above, you pay the copays shown in the Benefit Summary. The copay applies for each prescription consisting of up to a 30-day supply. If you use our postage-paid mail-delivery service, the Copayment will be as shown in the Benefit Summary for up to a 90-day supply.

- Elemental enteral formula for home treatment of severe intestinal malabsorption when the formula comprises the sole or essential source of nutrition are covered at no charge.

Note: If Charges for a drug, supply, or supplement are less than the Copayment, you will pay the lesser amount.

Day Supply Limit

Your Copayment or Coinsurance applies for the day supply limit described above under "Copayments and Coinsurance for Covered Drugs, Supplies, and Supplements." Plan Physicians determine the amount of a drug, supply or supplement that is Medically Necessary within the day supply limit specified.

About Our Drug Formulary

Our drug formulary includes the list of drugs that have been approved by our Regional Formulary and Therapeutics Committee (RFTC) for our Members. The RFTC, which meets monthly and is comprised primarily of Medical Group physicians, selects drugs for the formulary based on a number of factors including safety and effectiveness as determined from a review of the scientific literature. If you would like to request a copy of our drug formulary, or to receive additional information regarding the formulary process, please call Membership Services. The formulary is also available on the Member website at **kaiserpermanente**.org The presence of a drug on our drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition.

Our drug formulary guideline allow you to obtain non-formulary prescription drugs (those not listed on our drug formulary for your condition) if they would otherwise be covered and a Plan Physician determines that they are Medically Necessary except that some non-formulary drugs require additional Medical Group approval. When a Plan Physician determines that a non-formulary drug is the most appropriate therapy to meet a patient's individual medical needs, the physician may request an exception.

Criteria for exceptions include:

- The patient has experienced treatment failure with the formulary alternatives
- The patient is allergic to or intolerant of formulary alternatives

For some drugs, the patient's condition must meet additional medication-specific criteria. The pharmacy can provide a copy of the criteria upon request. In some cases, there may be a short delay filling the prescription while your information is being reviewed.

We do not exclude coverage of any such drug for a particular indication on the grounds that the drug has not been approved by the Federal Food and Drug Administration for that indication (off-label), if the drug is recognized as effective for treatment of that indication: (i) in one of the standard reference compendia; (ii) in the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or (iii) by the Federal Secretary of Health and Human Services.

If you want to purchase a drug that is not on the formulary and not approved through the formulary exception process, you may do so upon payment of 100 percent of Charges if a Plan Physician will still give you a prescription for the non-formulary drug.

Limited Outpatient Prescription Drugs, Supplies and Supplements Exclusions

- Injectable drugs that are self-administered (except insulin).
- Internally implanted time-release drugs (except for internally implanted time-release contraceptive drugs).
- Drug entities and/or specific strengths available over-the-counter unless the product is approved by RFTC and listed in our Drug Formulary.
- Extemporaneously compounded drugs, unless the formulation is approved by RFTC.
- Drugs used in weight management.
- Drugs used for the treatment or prevention of sexual dysfunction disorders.
- Drugs prescribed for a condition not approved by the FDA, unless the Oregon Health Resources Commission determines that the drug is recognized in independent medical or pharmaceutical journals as effective for that use. This includes coverage when the FDA has determined a drug to be contraindicated for a condition, or when the drug is experimental and not approved for any use by the FDA.
- Any packaging other than the dispensing pharmacy's standard packaging, such as blister or bubble repackaging.
- Replacement of drugs and accessories due to loss, damage, and/or carelessness.
- Drugs used to enhance athletic performance.
- Prescribed drugs that are necessary or related to a Service excluded under this *EOC*
- Prescription Drugs used for the treatment of infertility.
- Drugs that require special handling, which may include professional administration or observation, refrigeration or high cost are not provided through mail order.
- Mail delivery drugs for a non-Oregon or non-Washington resident.

- Prescription drugs, supplies, and supplements that are dispensed on an outpatient basis, except those listed under "Covered Drugs, Supplies, and Supplements" of this "Limited Outpatient Prescription Drugs, Supplies, and Supplements" section

Reconstructive Surgery Services

We cover reconstructive surgery Services as indicated below.

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

As required by the Women's Health and Cancer Rights Act of 1998, we also cover:

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

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

Rehabilitative Therapy Services

We cover hospital inpatient and outpatient physical, occupational speech, respiratory, and multidisciplinary rehabilitation and multidisciplinary program rehabilitative therapy Services, when prescribed by a Plan Provider, subject to the benefit descriptions and limitations contained in this section on "Rehabilitative Therapy Services.

Physical, Occupational or Speech Therapy Services

Therapy Services (physical, occupational and speech) are covered for the treatment of acute conditions which, in the judgment of the Plan Provider will show measurable improvement as a result of the prescribed therapy. Prescribed outpatient therapy Services must be prior-authorized as described in the "Prior and Concurrent Authorization" section.

Physical, Occupational and Speech Therapy Services Limitations

- Physical and occupational therapy Services are limited to those necessary to restore or improve functional abilities when physical and/or sensori-perceptual impairment exists due to injury, illness, stroke, or surgery.
- In Plan Medical Offices, this benefit is limited to 20 visits per therapy per Calendar Year. This limitation does not apply to hospital inpatient Services.
- Speech therapy Services are covered only for speech impairments of specific organic origin such as cleft palate, or when speech, language or the swallowing function is lost due to injury, accident or stroke

Respiratory Therapy Services

We cover respiratory therapy in the hospital inpatient or outpatient setting when prescribed by a Plan Provider. (Physical, occupational and speech therapy visit limits do not apply.).

Multidisciplinary Inpatient Rehabilitation and Multidisciplinary Day Treatment Program Services

We cover prescribed multidisciplinary rehabilitation Services in the hospital inpatient or outpatient day treatment program setting. Multidisciplinary rehabilitation services are limited to treatment for conditions which, in the judgment of a Plan Physician are subject to significant improvement within two months.

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

Multidisciplinary Rehabilitation and Multidisciplinary Day Treatment Program Services Limitations:

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

Rehabilitative Therapy Services Exclusions

- Cognitive rehabilitation programs
- Long-term rehabilitation
- Maintenance Rehabilitative Therapy Services

Skilled Nursing Facility Services

We cover skilled inpatient Services in a licensed Skilled Nursing Facility.

We cover skilled inpatient Services in a licensed Skilled Nursing Facility for 100 days maximum per Calendar Year (including any days we covered under any other evidence of coverage with the same group number printed on this EOC.) The skilled inpatient Services must be those customarily provided by Skilled Nursing Facilities. We cover the following:

- Room and board
- Nursing Services
- Medical social Services
- Medical and biological supplies
- Blood, blood products, and their administration
- Dialysis Services (this benefit is subject to the benefit limitations described under "Dialysis Services").
- Rehabilitative therapy Services (this benefit is subject to the benefit limitations described under "Rehabilitative Therapy Services").
- Drugs prescribed by a Plan Physician as part of your plan of care in the Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Skilled Nursing Facility by medical personnel.
- DME (this benefit is subject to the benefit limitations described under "Outpatient Durable Medical Equipment (DME), External Prosthetics and Orthotics" in this "Copayments, Coinsurance and Benefits" section).

Transplant Services

We cover the listed transplants in this "Transplant Services" section at the national Transplant Network Facilities if you meet Utilization Review criteria approved by Medical Group and adopted by Health Plan. We cover post-surgical immunosuppressive drugs without charge.

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

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

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

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

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

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

Transplant Services Exclusions

Non-human and artificial organs and their implantation

EXCLUSIONS, AND LIMITATIONS

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

Certain exams and Services. Physical examinations and related Services are excluded when: (a) required for obtaining or maintaining employment or participation in employee programs, (b) required for insurance or governmental licensing, or (c) required as part of a court order or required for parole or probation.

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

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

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

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

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

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

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

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

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

- They cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and the FDA has not granted this approval
- They are the subject of a current new drug or new device application on file with the FDA
- They are provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Services

- They are provided pursuant to a written protocol or other document that lists an evaluation of the Services' safety, toxicity, or efficacy as among its objectives
- They are subject to the approval or review of an Institutional Review Board ("IRB") or other body that approves or reviews research concerning the safety, toxicity, or efficacy of Services
- They are provided pursuant to informed consent documents that describe the Services as experimental or investigational, or in other terms that indicate that the Services are being evaluated for their safety, toxicity, or efficacy
- The prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that:
  - Use of the Services should be substantially confined to research settings, or
  - Further research is necessary to determine the safety, toxicity, or efficacy of the Services

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

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

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

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

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

Family Services. Services provided by a Member of your immediate Family are excluded.

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

Government Agency Responsibility. We do not reimburse the government agency for any Services that the law requires be provided only by or received only from a government agency. When we cover any such

Services we may recover the Charges for the Services from the government agency. However, this exclusion does not apply to Medicaid.

Hypnotherapy. All Services related to hypnotherapy are excluded.

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

Maintenance Care. Maintenance care is defined as any treatment program designed to maintain optimal health in the absence of symptoms and is excluded.

Massage Therapy Services without a referral

Naturopathy Services without a referral

Non-Medically Necessary Services. Services that are not required to prevent, diagnose, or treat a medical condition are excluded.

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

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

Sexual Re-assignment Surgery. Services related to sexual reassignment surgery are excluded.

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

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

Reductions

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

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

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

DEFINITIONS

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

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

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

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

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

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

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses.

(2) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

(3) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

(4) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis

of negotiated fees, the Primary **plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

(5) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the Plan provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

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

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.

B. (1) Except as provided in Paragraph (2), a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.

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

(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan**

covering the person as an employee, member, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan.**

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

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

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

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

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

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

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

The **Plan** covering the **Custodial parent**;

The **Plan** covering the spouse of the **Custodial parent**;

The **Plan** covering the **non-custodial parent**; and then

The **Plan** covering the spouse of the **non-custodial parent**.

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

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. [Organization responsibility for **COB** administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. [Organization responsibility for **COB** administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give [Organization responsibility for **COB** administration] any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, [Organization responsibility for **COB** administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. [Organization responsibility for **COB** administration] will not have to pay that amount again. The term

"payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

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

Hospitalization on your Effective Date

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

Injuries or Illnesses Alleged to be Caused by Third Parties

If you receive benefits for covered Services related to an injury or illness that is alleged to be caused by a third party's act or omission, you must reimburse us the amount of such benefits, up to, but not above, the amount you receive from or on behalf of the third party. If there is no recovery, you are only responsible for the applicable cost-sharing under this *EOC*.

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

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

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

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

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

You must place and hold in trust a portion of the proceeds of your recovery that is sufficient to satisfy our claim(s) under this provision pending final resolution of the claim(s). You must provide us with written notice before you settle a claim or obtain a judgment against any third party for relevant Services already furnished or provided by us.

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

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

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

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

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

REQUESTING MEDICAL SERVICES AND BENEFITS

Post Service Claims—Services Already Received

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

If you receive Services from a non-Plan Provider following an authorized referral from Medical Group, the non-Plan Provider will send the bill to Claims Administration directly. You are not required to file the claim. If you receive Services from a non-Plan Provider or Facility without an authorized referral and you believe Kaiser Permanente should cover the Services, you need 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

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

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

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

We will reach a decision on the claim and pay those covered medical Charges within 30 calendar days from receipt unless additional information is required to make a decision. If the 30-day period must be extended, you will be notified in writing with an explanation about why. This written notice will explain how long the

time period may be extended depending on the requirements of applicable state and federal laws, including the Employee Retirement Income Security Act of 1974 (ERISA).

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

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

Pre-Service Claims—Requesting Future Care or Service

When you need Services, you should talk with your Medical Group physician about your medical needs or your request for Services. Your Medical Group Physician provides treatment and Services that are Medically Necessary and appropriate. Medical Group physicians will use their own judgment to determine if a treatment or Service is medically appropriate. Some treatments and Services are subject to approval through Utilization Review, based on Utilization Review criteria developed by the Medical Group or another organization utilized by Kaiser Permanente. If you seek a specific treatment or Service, you should talk with your Medical Group physician. Your Medical Group physician will discuss your needs and recommend the most appropriate course of treatment. If your request for treatment, Service(s), or equipment is urgent, Kaiser Permanente (or appropriate designee) will respond to the request within two business days or 24 hours or receipt whichever is shorter.

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

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

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

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

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

DISPUTE RESOLUTION

Complaints, Grievances, and Appeals—Member Satisfaction

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

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

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

Oral Complaints

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

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

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

Written Grievances

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

You can file a written grievance:

- If you are not satisfied with our response to your complaint regarding the availability, delivery, or quality of our Services, benefits, or other administrative matters. Examples include complaints that you want reported and resolved, such as, a delay in hearing back from your Plan Physician's office or about receiving an appointment in a timely manner

- If you disagree with Charges on a bill from Kaiser Permanente.
- If we denied your claim for Services that you received from a non-Plan Provider or Facility and you disagree with the claim determination. You must file the grievance within 185 days of the denial notice.
- If we issued a benefit denial in writing after you requested a pre-Service benefit determination. This includes things like a pre-Service adverse benefit determination based on a decision that you are not eligible for benefits. Or, it could be a pre-Service denial based on any number of specific coverage exclusions such as, certain excluded infertility procedures, lack of special benefits like prescription drugs, vision hardware coverage, or due to benefit limitations like a maximum number of covered visits. You must file the grievance within 185 days of the denial notice.

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

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

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

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

If your grievance included a specific request and that request is denied, the decision letter you receive will include detailed information about the basis for the decision, how to appeal the decision, and how to file a complaint with the Oregon Department of Consumer and Business Services (DCBS).

Appeals – General Description

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

First-level appeals:

- If you disagree with the decision rendered following a written grievance, you have 185 days from the date on the denial notice to submit a first-level appeal.
- If you disagree with a denial for future Services following a Utilization Review determination requested by your Plan Provider, you have 185 days from the date of the denial notice to submit a first-level appeal

- If your appeal involves urgently needed future care, a request for an expedited appeal may be submitted orally or in writing

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

First-level appeals will be decided within 30 days after we receive your appeal. A decision will be expedited to meet the clinical urgency of the situation, not to exceed 72 hours if it involves a denial of urgently needed future care. Member Relations or the area manager will conduct an independent review of your first-level appeal and provide a written response. If your first-level appeal is denied, the written notice you receive will explain the basis for the decision, along with information about further appeal rights, how to file a complaint with the Oregon Department of Consumer and Business Services, and other important disclosures. Members also have the right to appeal to PEBB staff and the PEBB under OAR 101-002-0015 (Appeal Procedure and Delegation)

Second-level appeals:

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

Second-level appeals will be decided within 30 days after we receive your appeal. A decision will be expedited to meet the clinical urgency of the situation, not to exceed 72 hours if it involves a denial of any urgently needed future care. **If your second-level appeal is denied, written notification will explain the basis for the denial and will advise you how to request an additional independent external review by an independent review organization (IRO).** It will also tell you how to file a complaint with the Oregon Department of Consumer and Business Services. Members also have the right to appeal to PEBB staff and the PEBB under OAR 101-002-0015 (Appeal Procedure and Delegation).

External review by an IRO under Oregon law:

Certain requests may be eligible for external review by an IRO if both first and second-level appeals have been denied.

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

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

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

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

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

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

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

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

TERMINATION OF MEMBERSHIP

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

You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except as provided under "Termination During Confinement in a Hospital" in this "Termination of Membership" section.

Termination During Confinement in a Hospital

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

- The coverage under this *EOC* is being immediately replaced by another insured group health insurance policy
- You are an inpatient receiving covered Services on the date your membership ends
- You must continue to pay any applicable Copayments and Coinsurance.
- Your coverage under this provision continues until the earlier of:
  - Your discharge from the hospital or
  - Your exhaustion of hospital benefits under this *EOC*.

Termination Due to Loss of Eligibility

You and your Dependents must remain eligible to maintain your Group coverage. You must report to your Group any changes in eligibility status, such as a Spouse's divorce or a Dependent's marriage, leaving school, or reaching the Dependent age limit within 60 days as required under PEBB rules. If you no longer meet the eligibility requirements described in this EOC, please confirm with your Group's benefits administrator when your membership will end.

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

Termination for Cause

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

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

If we terminate your Membership because you abuse or threaten the safety of Plan personnel or of any person or property at a Plan Facility, you and your Dependents will not be allowed to enroll in Health Plan in the future.

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

If we terminate your membership for cause we will:

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

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

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

Termination of the Group Agreement

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

Termination of a Product or all Products

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

Certificates of Creditable Coverage

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

CONTINUATION OF MEMBERSHIP

Strike, Lock-Out, or other Labor Disputes

If any portion of the Premium is paid by Group or by payroll deduction, and these payments are suspended directly or indirectly due to a strike, lock-out, or other labor dispute, then affected Subscribers (along with their covered Dependents) may continue coverage under this *EOC* for six months after the suspension or termination of compensation.

If coverage is continued under these circumstances, Subscribers will be instructed as to how and to whom to pay their Premium. Health Plan may terminate the membership of any Member for whom Health Plan does not receive Premium when due.

Nothing contained in this *EOC* limits Health Plan's rights under the terms of the Group Agreement to increase or decrease the Premium before, during, or after the suspension or termination of compensation.

If Group suspends or terminates Subscribers' compensation because of a strike, lock-out, or other labor dispute, Group will immediately notify each affected Subscriber of his or her rights of direct payment of Premium under this "Strike, Lock-Out, or Other Labor Disputes" section.

Illness, Temporary Plant Shutdowns and other Leaves of Absence

If you are off work due to illness, temporary plant shutdown, or other leave of absence authorized by your Group, you may make arrangements to make monthly payments for up to 3 months. If coverage is continued under these circumstances, you will be instructed as to how and to whom to pay the Premium. The 3 month period may be extended by advance arrangements confirmed in writing by Health Plan. Once the 3 month period is exhausted, you may also be eligible for Conversion Benefits, see the "Conversion to an Individual Plan" and "Portability Plans" sections.

Continuation of Group Coverage under Consolidated Omnibus Budget and Reconciliation Act "COBRA"

COBRA Notice

This notice includes important information about your rights and obligations under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Under federal COBRA law, the State of Oregon is required to offer covered Subscribers and their Dependents the opportunity for a temporary extension of health coverage (called "Continuation Coverage"). This Continuation Coverage is offered at group rates when coverage under the Plan would otherwise end due to certain qualifying events. This notice is intended to inform all Members, in a summary fashion, of their potential future options and obligations under the Continuation Coverage provisions. Should an actual qualifying event occur in the future, the COBRA Administrator will send the affected Member additional information and the appropriate election notice at that time.

Note that Medicare entitlement, as referred to later in this provision, very seldom causes a loss of coverage, so very rarely triggers COBRA continuation.

The Plan Administrator is the Public Employees' Benefit Board (PEBB) located at 775 Court Street NE in Salem, Oregon. You can contact PEBB at (503) 373-1102 or 1-800-788-0520. COBRA continuation is administered by a third party administrator (TPA).

Continuation Coverage

COBRA coverage is continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. Continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, any covered Member becomes a qualified beneficiary.

Qualifying Events For Covered Employee

If you are an employee, you become a qualified beneficiary if you lose eligibility for group coverage for any of the following reasons (qualifying events):

1. A reduction in your hours of employment; or
2. Your employment ends for any reason.

Qualifying Events For a Covered Spouse

The covered Spouse (as defined earlier in this *EOC*) becomes a qualified beneficiary if the Spouse loses eligibility for group coverage for any of the following reasons (qualifying events):

1. Your death;
2. Termination of your employment or a reduction in your hours of employment;
3. You become enrolled in Medicare (Part A, Part B, or both); or
4. You and your Spouse divorce or legally separate or the Spouse otherwise ceases to qualify as a covered Spouse as defined earlier in this *EOC*.

Qualifying Events For Covered Dependent Children

Your dependent children become qualified beneficiaries if they lose eligibility for group coverage for any of the following reasons (qualifying events):

1. Your death;
2. Termination of your employment or reduction in your hours of employment;
3. You become enrolled in Medicare (Part A, Part B, or both);
4. You and your Spouse divorce or legally separate, or the Spouse otherwise ceases to qualify as a covered Spouse as defined earlier in this *EOC*.; or
5. The child ceases to qualify as a Dependent under PEBB eligibility.

Important Member Notification Requirements

Under the law, the affected Member is responsible to inform the agency's payroll/personnel office or benefits office within 60 days of the following qualifying events:

1. A divorce;
2. A legal separation;
3. A person ceasing to qualify as a Spouse or Dependent as defined in this *EOC*..

If this notification is not mailed within the 60 days, rights to Continuation Coverage will be forfeited.

Employer Notification Requirements

When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, or enrollment of the Subscriber in Medicare (Part A, Part B, or both), the Group must notify the COBRA Administrator of the qualifying event within 30 days of the date coverage ends.

Election Period

When the agency payroll/personnel or benefits office receives notification that one of these events has occurred, they will notify the COBRA Administrator. The Administrator will notify qualified beneficiaries by first class mail of their right to choose Continuation Coverage within 14 days. Under COBRA provisions, each individual covered on the active group plan on the day before the qualifying event or any newborn or adopted children added to your policy during the COBRA time period has the right to elect Continuation Coverage. You or your Spouse can elect continuation coverage for any combination of individuals who would otherwise lose coverage through this event.

Under the law, the Member has 60 days from the date the Member would lose coverage due to a qualifying event or the date on the notification letter; whichever is the later date, to elect Continuation Coverage. The Public Employees' Benefit Board (PEBB) Eligibility Rules allow an affected Member to change their plan choices upon experiencing a qualifying event. This means that not only is the Member given the right to continue coverage under COBRA, but the Member may also choose any medical plan then offered by the Group at the time of the COBRA election. If a qualified beneficiary does not elect Continuation Coverage within this period, rights to continue medical insurance will end.

If the Member chooses Continuation Coverage, PEBB is required to offer coverage that is identical to the coverage provided under the group plan to similarly situated active Subscribers and Members. Should coverage change or be modified for Subscribers under the Group Plan, then the change or modification will be made to the Continuation Coverage as well. COBRA participants will also be offered an annual open

enrollment period. This open enrollment period allows participants to change plans and add or delete eligible dependents. However, note that if you add family members, the family members will not be COBRA qualified beneficiaries and will not be permitted to make independent COBRA elections.

Length Of Continuation Coverage

The law requires that an affected Member receive the opportunity to maintain Continuation Coverage from the time of the qualifying event for the following periods:

1. Up to 18 months if you qualify due to termination or reduction in working hours;

2. Up to 29 months if you qualify due to termination or reduction in working hours and are deemed disabled by the Social Security Administration at the time of your qualifying event or at any time prior to or during the first 60 days of Continuation Coverage. You must inform the COBRA Administrator within 60 days of receipt of the Social Security disability determination and within the 18-month continuation period to qualify for this extended coverage which will be at an increased premium of up to 150%. Newborns and children placed for adoption must be disabled during the first 60 days after birth or placement to qualify for this extension.

3. Up to 36 months for a Spouse or dependent after the your enrollment in Medicare (if the enrollment is 18 months or less prior to termination of employment or reduction of hours), if you qualify due to Medicare entitlement (enrollment in), your death, divorce or legal separation, or other loss of eligibility as a Spouse, or if a dependent child who is no longer eligible to be on the plan.

4. Up to 10 years if for a Spouse who is 55 years of age or older and who qualifies due to death of the Subscriber or because of divorce or legal separation, or other loss of eligibility as a Spouse.

However, the law also provides that your Continuation Coverage will end for any of the following reasons:

1. The State of Oregon no longer provides group medical coverage to any of its employees;

2. Any required premium for Continuation Coverage is not paid in a timely manner;

3. A qualified beneficiary becomes covered, after the date of COBRA election, under another group health plan that does not exclude or limit coverage for specific conditions solely because they are pre-existing condition(s) which apply to you or to a covered dependent (this does not apply to CHAMPUS or Tri-Care);

4. A qualified beneficiary becomes covered (after the date of COBRA election) under Medicare.

5. The Social Security Administration no longer considers you disabled under the provision of the disability extension, but COBRA coverage will not terminate earlier than the end of the original 18 month continuation period.

6. A qualified beneficiary notifies the COBRA Administrator they wish to cancel COBRA continuation coverage.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follows.

If you or your Dependents become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated while the limitation is in effect. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, PEBB may terminate your COBRA coverage.

You must continue to reside or work for any employer at least 50% of the time within our Service Area to remain eligible for COBRA coverage.

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

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

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

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

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

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

- You fail to pay your premium
- The Group's Agreement with us terminates
- You are covered under another group health coverage
- You become, eligible for Medicare

State Continuation Coverage for Non-COBRA Groups

If your Group is not subject to COBRA law, you and your Dependents may be able to continue coverage under this *EOC* for up to six (6) months if you are not eligible for Medicare. To be eligible you must have lost your job or membership in the organization through which you are receiving coverage under this *EOC* and have been covered continuously under this *EOC* during the three-month period ending on the date you lost your job or organization membership. You must notify Membership Services in writing of your request for continued coverage not more than10 days after the later of either:

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

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

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

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

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

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

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

State Continuation Coverage after Workers' Compensation Claim

If you are a Subscriber and you file a workers' compensation claim for an injury or illness, you may be able to continue coverage under this *EOC* for up to 6 months after you would otherwise lose eligibility. Please contact your Group for details such as how to elect coverage and how much you must pay your Group for the coverage.

Conversion to an Individual Plan

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

Portability Plans

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

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

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

current billing cycle. You must send us the Premium payment by the due date on the bill to be enrolled in our Portability Plan.

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

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

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

HIPAA and Other Individual Plans

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

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

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

For more information (including Premium and complete eligibility requirements), please refer to the Conversion Plan. To request more information regarding our Conversion Plans, or for information about our other individual plans, Company Plans for Individuals and Families, please call Membership Services.

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

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

MISCELLANEOUS PROVISIONS

Administration of Agreement

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

Advance Directives

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

- A Durable Power of Attorney for Health Care allows you name a designee to make health care decisions for you when you cannot speak for yourself. It also allows you to put in writing your desires regarding life support and other treatments with regard to your health care treatment
- A Living Will and a Natural Death Act Declaration to Physicians enables you to put in writing your directives for receiving life support and other treatment

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

Agreement Binding on Members

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

Amendment of Agreement

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

Applications and Statements

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

Assignment

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

Attorney Fees and Expenses

Except as provided under the "Dispute Resolution" section of this *EOC*, in any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

Exercise of Conscience

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

Governing Law

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

Group and Members not Health Plan's Agents

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

Litigation Venue

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

Named Fiduciary

Under our Agreement with your Group, we have assumed the role of a "named fiduciary," to review and evaluate claims that arise under this *EOC*. This means that we are the party responsible for determining whether you are entitled to benefits under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*.

No Waiver

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

Nondiscrimination

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

Notices

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

Overpayment Recovery

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

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers and contracted facilities to protect your PHI. PHI is health information that includes

your name, social security number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

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

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

Unusual Circumstances

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