



Kaiser Foundation Health Plan of Washington
A nonprofit health maintenance organization

2020 Evidence of Coverage

PEBB HSA (CDHP) Plan for Retired Employees

Important Notice Under Federal Health Care Reform

Kaiser Foundation Health Plan of Washington (“KFHPWA”) recommends each Enrollee choose a Network Personal Physician. This decision is important since the designated Network Personal Physician provides or arranges for most of the Enrollee’s health care. The Enrollee has the right to designate any Network Personal Physician who participates in one of the KFHPWA networks and who is available to accept the Enrollee or the Enrollee’s family members. For information on how to select a Network Personal Physician, and for a list of the participating Network Personal Physicians, please call Kaiser Permanente Member Services at (206) 630-0107 in the Seattle area, or toll-free in Washington, 1-866-648-1928.

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

The Enrollee does not need Preauthorization from KFHPWA or from any other person (including a Network Personal Physician) to access obstetrical or gynecological care from a health care professional in the KFHPWA network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Preauthorization for certain services, following a pre-approved treatment plan, or procedures for obtaining Preauthorization. For a list of participating health care professionals who specialize in obstetrics or gynecology, please call Kaiser Permanente Member Services at (206) 630-0107 in the Seattle area, or toll-free in Washington, 1-866-648-1928.

Women’s health and cancer rights

If the Enrollee is receiving benefits for a covered mastectomy and elects breast reconstruction in connection with the mastectomy, the Enrollee will also receive coverage for:

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

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

Statement of Rights Under the Newborns’ and Mothers’ Health Protection Act

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

For More Information

KFHPWA will provide the information regarding the types of plans offered by KFHPWA to Enrollees on request. Please call Kaiser Permanente Member Services at (206) 630-0107 in the Seattle area, or toll-free in Washington, 1-866-648-1928.

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I. Introduction

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

This EOC is a statement of benefits, exclusions and other provisions as set forth in the Group medical coverage agreement between Kaiser Foundation Health Plan of Washington (“KFHPWA”) and the Group. The benefits were approved by the Group who contracts with KFHPWA for health care coverage. This EOC is not the Group medical coverage agreement itself. In the event of a conflict between the Group medical coverage agreement and the EOC, the EOC language will govern.

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

Contact Kaiser Permanente Member Services at 206-630-0107 or toll-free 1-866-648-1928 for benefits questions.

II. How Covered Services Work

A. Accessing Care.

1. Enrollees are entitled to Covered Services from the following:

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

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

A listing of Core Network Personal Physicians, specialists, women’s health care providers and KFHPWA-designated Specialists is available by contacting Member Services or accessing the KFHPWA website at www.kp.org/wa.

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

2. Primary Care Provider Services.

KFHPWA recommends that Enrollees select a Network Personal Physician when enrolling. One personal physician may be selected for an entire family, or a different personal physician may be selected for each family member. For information on how to select or change Network Personal Physicians, and for a list of participating personal physicians call Kaiser Permanente Member Services at (206) 630-0107 in the Seattle area, or toll-free in Washington at 1-866-648-1928 or by accessing the KFHPWA website at www.kp.org/wa. The change will be made within 24 hours of the receipt of the request if the selected physician’s caseload permits. If a personal physician accepting new Enrollees is not available in your area,

contact Kaiser Permanente Member Services, who will ensure you have access to a personal physician by contacting a physician's office to request they accept new Enrollees.

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

3. Specialty Care Provider Services.

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

KFHPWA-designated Specialist.

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

4. Hospital Services.

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

5. Emergency Services.

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

6. Urgent Care.

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

7. Women's Health Care Direct Access Providers.

Female Enrollees may see a general and family practitioner, physician's assistant, gynecologist, certified nurse midwife, licensed midwife, doctor of osteopathy, pediatrician, obstetrician or advance registered nurse practitioner who is contracted by KFHPWA to provide women's health care services directly, without Preauthorization, for Medically Necessary maternity care, covered reproductive health services, preventive services (well care) and general examinations, gynecological care and follow-up visits for the above services. Women's health care services are covered as if the Enrollee's Network Personal Physician had been consulted, subject to any applicable Cost Shares. If the Enrollee's women's health care provider diagnoses a condition that requires other specialists or hospitalization, the Enrollee or her chosen provider must obtain Preauthorization in accordance with applicable KFHPWA requirements.

8. Process for Medical Necessity Determination.

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

First Level Review:

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

Second Level (Practitioner) Review:

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

B. Administration of the Evidence of Coverage.

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

C. Confidentiality.

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

D. Modification of the Evidence of Coverage.

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

E. Nondiscrimination.

KFHPWA does not discriminate on the basis of physical or mental disabilities in its employment practices and services. KFHPWA will not refuse to enroll or terminate a Enrollee's coverage on the basis of age, sex, race, religion, occupation or health status.

F. Preauthorization.

Refer to Section IV. for information regarding which services KFHPWA require Preauthorization. Failure to obtain Preauthorization when required may result in denial of coverage for those services; and the Enrollee may be responsible for the cost of these non-Covered services. Enrollees may contact Member Services to request Preauthorization.

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

- Standard requests – within 5 calendar days

- If insufficient information has been provided a request for additional information will be made within 5 calendar days to provide the necessary information. The provider or facility has 5 calendar days to provide the necessary information. A decision will be made within 4 calendar days of receipt of the information or the deadline for receipt of the requested information.
- Expedited requests – within 2 calendar days
 - If insufficient information has been provided a request for additional information will be made within 1 calendar day. The provider or facility has 2 calendar days to provide the necessary information. A decision will be made within 2 calendar days of receipt of the information or the deadline for receipt of the requested information.

G. Recommended Treatment.

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

H. Second Opinions.

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

I. Unusual Circumstances.

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

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

J. Utilization Management.

All benefits, including travel and lodging reimbursement, are limited to Covered Services that are Medically Necessary and set forth in the EOC. KFHPWA may review an Enrollee's medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent or retrospective review, KFHPWA may deny coverage if, in its determination, such services are not Medically Necessary. Such determination shall be based on established clinical criteria and may require Preauthorization.

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

III. Financial Responsibilities

A. Premium.

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

B. Financial Responsibilities for Covered Services.

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

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

1. Annual Deductible.

Note: Covered Services may be subject to an annual Deductible. The annual Deductible amount an Enrollee must pay is determined by whether the Enrollee is a sole Subscriber or has enrolled Dependents.

Subscriber Only Coverage (individual coverage).

Charges subject to the annual Deductible shall be borne by the Subscriber during each calendar year until the annual Deductible is met.

Family Coverage (coverage for the Subscriber plus one (1) or more Dependents).

Charges subject to the annual Deductible shall be borne by the Subscriber during each calendar year until the total family annual Deductible is met. The total family annual Deductible can be met by one member or by all family members in combination. Until the total family annual Deductible is met, benefits will not be provided for any family member.

2. Plan Coinsurance.

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

3. Copayments.

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

4. Out-of-pocket Limit.

Note: The Enrollee's Out-of-pocket Limit is determined by whether the Enrollee is a sole Subscriber or has enrolled Dependents.

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

C. Financial Responsibilities for Non-Covered Services.

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

IV. Benefits Details

Benefits are subject to all provisions of the EOC. Enrollees are entitled only to receive benefits and services that are Medically Necessary and clinically appropriate for the treatment of a Medical Condition as determined by KFHPWA's medical director and as described herein. All Covered Services are subject to case management and utilization management. "Case management" means a care management plan developed for an Enrollee whose diagnosis requires timely coordination.

Annual Deductible	<p>Individual Only Coverage: Subscriber pays \$1,400 per calendar year for Subscriber only coverage</p> <p>Family Coverage: Enrollee pays \$2,800 per Family Unit per calendar year for family coverage</p>
Coinsurance	Plan Coinsurance: Enrollee pays 10% of the Allowed Amount
Lifetime Maximum	No lifetime maximum on covered Essential Health Benefits
Out-of-pocket Limit	<p>Limited to a maximum of \$5,100 per calendar year for Subscriber or \$10,200 per Family Unit per calendar year for family coverage</p> <p>Out-of-pocket Limit is determined by whether the Enrollee is a sole Subscriber or has enrolled Dependents</p> <p>The following Out-of-pocket Expenses apply to the Out-of-pocket Limit: All Cost Shares for Covered Services</p> <p>The following expenses do not apply to the Out-of-pocket Limit: Premiums, charges for services in excess of a benefit, charges in excess of Allowed Amount, charges for non-Covered Services</p>
Pre-existing Condition Waiting Period	No pre-existing condition waiting period

Acupuncture	
Acupuncture needle treatment limited to 12 visits per calendar year without Preauthorization. Additional visits are covered with Preauthorization.	After Deductible, Enrollee pays 10% Plan Coinsurance
No visit limit for treatment for Chemical Dependency	
Exclusions: Herbal supplements; any services not within the scope of the practitioner's licensure	

Allergy Services	
Allergy testing.	After Deductible, Enrollee pays 10% Plan Coinsurance
Allergy serum and injections	After Deductible, Enrollee pays 10% Plan Coinsurance

Ambulance	
Emergency ground or air transport to any facility. Air transport covered only when Medically Necessary.	After Deductible, Enrollee pays 10% Plan Coinsurance
Non-Emergency ground or air interfacility transfer to or from a Network Facility when Preauthorized by KFHPWA. Contact Member Services for Preauthorization.	After Deductible, Enrollee pays 10% Plan Coinsurance Hospital-to-hospital ground transfers: After Deductible, Enrollee pays nothing

Cancer Screening and Diagnostic Services	
Routine cancer screening covered as Preventive Services in accordance with the well care schedule established by KFHPWA and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in Kaiser Permanente medical centers, at www.kp.org/wa , or upon request from Member Services. See Preventive Services for additional information.	No charge; Enrollee pays nothing
Diagnostic laboratory and diagnostic services for cancer. See Laboratory and Radiology Services for additional information. Preventive laboratory/radiology services are covered as Preventive Services.	After Deductible, Enrollee pays 10% Plan Coinsurance

Chemical Dependency	
Chemical dependency services including inpatient Residential	Hospital - Inpatient: After Deductible, Enrollee

<p>Treatment; diagnostic evaluation and education; organized individual and group counseling; and/or prescription drugs unless excluded under Sections IV. or V.</p> <p>Chemical dependency means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages, and where the user's health is substantially impaired or endangered or their social or economic function is substantially disrupted. For the purposes of this section, the definition of Medically Necessary shall be expanded to include those services necessary to treat a chemical dependency condition that is having a clinically significant impact on an Enrollee's emotional, social, medical and/or occupational functioning.</p> <p>Chemical dependency services must be provided at a KFHPWA-approved treatment facility or treatment program.</p> <p>Chemical dependency services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57), a psychologist (licensed under RCW 18.83), a chemical dependency treatment program licensed for the service being provided by the Washington State Department of Social and Health Services (pursuant to RCW 70.96A), a master's level therapist (licensed under RCW 18.225.090), an advance practice psychiatric nurse (licensed under RCW 18.79) or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located.</p> <p>Court-ordered chemical dependency treatment shall be covered only if determined to be Medically Necessary.</p> <p>Residential Treatment and non-Emergency inpatient hospital services require Preauthorization.</p>	<p>pays 10% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Group Sessions: After Deductible, No charge; Enrollee pays nothing</p>
<p>Acute chemical withdrawal (detoxification) services for alcoholism and drug abuse. "Acute chemical withdrawal" means withdrawal of alcohol and/or drugs from an Enrollee for whom consequences of abstinence are so severe that they require medical/nursing assistance in a hospital setting, which is needed immediately to prevent serious impairment to the Enrollee's health.</p> <p>Coverage for acute chemical withdrawal (detoxification) is provided without Preauthorization. If an Enrollee is admitted as an inpatient directly from an emergency department, any Emergency services Copayment is waived. Coverage is subject to the hospital services Cost Share. Enrollees must notify KFHPWA by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible.</p> <p>KFHPWA reserves the right to require transfer of the</p>	<p>Emergency Services Network Facility: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Emergency Services Non-Network Facility: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p>

<p>Enrollee to a Network Facility/program upon consultation between a Network Provider and the attending physician. If the Enrollee refuses transfer to a Network Facility/program, all further costs incurred during the hospitalization are the responsibility of the Enrollee.</p>	
<p>Exclusions: Experimental or investigational therapies, such as wilderness therapy; facilities and treatment programs which are not certified by the Department of Social Health Services or which are not listed in the Directory of Certified Chemical Dependency Services in Washington State</p>	

<p>Circumcision</p>	
<p>Circumcision.</p> <p>Non-Emergency inpatient hospital services require Preauthorization.</p>	<p>(After Deductible, Enrollee pays nothing if provided within 60 days of birth)</p> <p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance</p>

<p>Clinical Trials</p>	
<p>Notwithstanding any other provision of this document, the Plan provides benefits for Routine Patient Costs of qualified individuals in approved clinical trials, to the extent benefits for these costs are required by federal and state law.</p> <p>Routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.</p> <p>Clinical Trials are a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. "Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.</p> <p>Clinical trials require Preauthorization.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance</p>
<p>Exclusions: Routine patient costs do not include: (i) the investigational item, device, or service, itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis</p>	

Dental Services and Dental Anesthesia	
<p>Dental services including accidental injury to natural teeth.</p> <p>Dental Services necessitated by accidental injury to sound natural teeth.</p> <p>Evaluation and a written treatment plan must be completed within 30 days from the date of injury. Treatment must be completed within the treatment plan time frames.</p> <p>Dental services in preparation for treatment including but not limited to: chemotherapy, radiation therapy, and organ transplants. Dental services in preparation for treatment require Preauthorization.</p> <p>Dental problems such as infections requiring emergency treatment outside of standard business hours are covered as Emergency Services.</p>	<p>Accidental Injury: Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Other dental services: Not covered, Enrollee pays 100% of all charges</p>
<p>General anesthesia services and related facility charges for dental procedures for Enrollees who are under 7 years of age or are physically or developmentally disabled or have a Medical Condition where the Enrollee's health would be put at risk if the dental procedure were performed in a dentist's office.</p> <p>General anesthesia services for dental procedures require Preauthorization.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p>
<p>Exclusions: Injuries caused by biting or chewing; malocclusion as a result from an accidental injury reconstructive surgery to the jaw in preparation for dental implants, dental implants, orthodontia; treatment not completed within the written treatment plan time frame, unless treatment is delayed due to a medical condition and the treatment plan is modified; any other dental service not specifically listed as covered</p>	

Devices, Equipment and Supplies (for home use)	
<ul style="list-style-type: none"> • Durable medical equipment: Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and is used in the Enrollee's home. Durable medical equipment includes hospital beds, wheelchairs, walkers, crutches, canes, blood glucose monitors, external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters), oxygen and oxygen equipment, and therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease. KFHPWA will determine if equipment is made available on a rental or purchase basis. • Orthopedic appliances: Items attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function. 	<p>After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Covered wigs or hairpieces limited to \$100 lifetime maximum</p>

<ul style="list-style-type: none"> • Ostomy supplies: Supplies for the removal of bodily secretions or waste through an artificial opening. • Post-mastectomy bras/forms, limited to 2 every 6 months. Replacements within this 6 month period are covered when Medically Necessary due to a change in the Enrollee's condition. • Prosthetic devices: Items which replace all or part of an external body part, or function thereof. • Sales tax for devices, equipment and supplies. • Wigs or hairpieces for hair loss due to radiation or chemotherapy. <p>When provided in lieu of hospitalization, benefits will be the greater of benefits available for devices, equipment and supplies, home health or hospitalization. See Hospice for durable medical equipment provided in a hospice setting.</p> <p>Devices, equipment and supplies including repair, adjustment or replacement of appliances and equipment require Preauthorization.</p>	
<p>Exclusions: Arch supports, including custom shoe modifications or inserts and their fittings not related to the treatment of diabetes; orthopedic shoes that are not attached to an appliance; wigs/hair prosthesis (except as noted above); take-home dressings and supplies following hospitalization; supplies, dressings, appliances, devices or services not specifically listed as covered above; same as or similar equipment already in the Enrollee's possession; replacement or repair due to loss, theft, breakage from willful damage, neglect or wrongful use, or due to personal preference; structural modifications to a Enrollee's home or personal vehicle</p>	

Diabetic Education, Equipment and Pharmacy Supplies	
Diabetic education and training.	After Deductible, Enrollee pays 10% Plan Coinsurance
Diabetic equipment: Blood glucose monitors and external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters), and therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease. See Devices, Equipment and Supplies for additional information.	After Deductible, Enrollee pays 10% Plan Coinsurance
Diabetic pharmacy supplies: Insulin, lancets, lancet devices, needles, insulin syringes, insulin pens, pen needles, glucagon emergency kits, prescriptive oral agents and blood glucose test strips for a supply of 30 days or less per item. Certain brand name insulin drugs will be covered at the generic level. See Drugs – Outpatient Prescription for additional pharmacy information.	<p>Value based medications which provide significant value in treating chronic disease as determined by KFHPWA (Please contact Kaiser Permanente Member Services for a list of medications): After Deductible, Enrollee pays \$5 Copayment at KFHPWA pharmacies</p> <p>Preferred generic drugs (Tier 1): After Deductible, Enrollee pays \$20 Copayment</p> <p>Preferred brand name drugs (Tier 2): After Deductible, Enrollee pays \$40 Copayment</p>

	Non-Preferred generic and brand name drugs (Tier 3): After Deductible, Enrollee pays 50% coinsurance up to \$250 maximum per prescription
Diabetic retinal screening.	No charge; Enrollee pays nothing

Dialysis (Home and Outpatient)	
Dialysis in an outpatient or home setting is covered for Enrollees with acute kidney failure or end-stage renal disease (ESRD). Dialysis requires Preauthorization.	Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance
Injections administered by a professional in a clinical setting during dialysis.	Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance
Self-administered injectables. See Drugs – Outpatient Prescription for additional pharmacy information.	<p>Value based medications which provide significant value in treating chronic disease as determined by KFHPWA (Please contact Kaiser Permanente Member Services for a list of medications): After Deductible, Enrollee pays \$5 Copayment at KFHPWA pharmacies</p> <p>Preferred generic drugs (Tier 1): After Deductible, Enrollee pays \$20 Copayment</p> <p>Preferred brand name drugs (Tier 2): After Deductible, Enrollee pays \$40 Copayment</p> <p>Non-Preferred generic and brand name drugs (Tier 3): After Deductible, Enrollee pays 50% coinsurance up to \$250 maximum per prescription</p>

Drugs - Outpatient Prescription	
Prescription drugs, supplies and devices for a supply of 30 days or less including diabetic pharmacy supplies (insulin, lancets, lancet devices, needles, insulin syringes, insulin pens, pen needles and blood glucose test strips), mental health drugs, self-administered injectables, and routine costs for prescription medications provided in a clinical trial. “Routine costs” means items and services delivered to the Enrollee that are consistent with and typically covered by the plan or coverage for an Enrollee who is not enrolled in a clinical trial. Contraceptive drugs may be allowed up to a 12-month supply and, when available, picked up in the provider’s office. All drugs, supplies and devices must be for Covered Services. All drugs, supplies and devices must be obtained at a	<p>Value based medications which provide significant value in treating chronic disease as determined by KFHPWA (Please contact Kaiser Permanente Member Services for a list of medications): After Deductible, Enrollee pays \$5 Copayment at KFHPWA pharmacies</p> <p>Preferred generic drugs (Tier 1): After Deductible, Enrollee pays \$20 Copayment</p> <p>Preferred brand name drugs (Tier 2): After Deductible, Enrollee pays \$40 Copayment</p> <p>Non-Preferred generic and brand name drugs</p>

<p>KFHPWA-designated pharmacy except for drugs dispensed for Emergency services or for Emergency services obtained outside of the KFHPWA Service Area, including out-of-the-country. Information regarding KFHPWA-designated pharmacies is reflected in the KFHPWA Provider Directory or can be obtained by contacting Kaiser Permanente Member Services.</p> <p>Prescription drug Cost Shares are payable at the time of delivery. Certain brand name insulin drugs are covered at the generic drug Cost Share. Preferred contraceptive drugs as recommended by the U.S. Preventive Services Task Force (USPSTF) are covered as Preventive Services.</p> <p>Enrollees may be eligible to receive an emergency fill for certain prescription drugs filled outside of KFHPWA's business hours or when KFHPWA cannot reach the prescriber for consultation. For emergency fills, Enrollees pay the prescription drug Cost Share for each 7 day supply or less, or the minimum packaging size available at the time the emergency fill is dispensed. A list of prescription drugs eligible for emergency fills is available on the pharmacy website at www.kp.org/wa/formulary. Enrollees can request an emergency fill by calling 1-855-505-8107.</p> <p>Certain drugs are subject to Preauthorization as shown in the Preferred drug list (formulary) available at www.kp.org/wa/formulary.</p>	<p>(Tier 3): After Deductible, Enrollee pays 50% coinsurance up to \$250 maximum per prescription</p>
<p>Injections administered by a professional in a clinical setting.</p>	<p>After Deductible, Enrollee pays 10% Plan Coinsurance</p>
<p>Growth Hormones</p>	<p>Preferred generic drugs (Tier 1): After Deductible, Enrollee pays \$20 Copayment</p> <p>Preferred brand name drugs (Tier 2): After Deductible, Enrollee pays \$40 Copayment</p> <p>Non-Preferred generic and brand name drugs (Tier 3): After Deductible, Enrollee pays 50% coinsurance up to \$250 maximum per prescription</p>
<p>Over-the-counter drugs not included under Preventive Care.</p>	<p>Not covered; Enrollee pays 100% of all charges</p>
<p>Mail order drugs dispensed through the KFHPWA-designated mail order service</p>	<p>Enrollee pays the prescription drug Cost Share for each 90 day supply or less</p> <p>Value based medications which provide significant value in treating chronic disease as determined by KFHPWA (Please contact Kaiser Permanente Member Services for a list of medications): After Deductible, Enrollee pays \$10 Copayment up to a 90-day supply</p>

	<p>Preferred generic drugs (Tier 1): After Deductible, Enrollee pays \$40 Copayment up to a 90-day supply</p> <p>Preferred brand name drugs (Tier 2): After Deductible, Enrollee pays \$80 Copayment up to a 90-day supply</p> <p>Non-Preferred generic and brand name drugs (Tier 3): After Deductible, Enrollee pays 50% coinsurance up to \$750 maximum per prescription up to a 90-day supply</p>
<p>The KFHPWA Preferred drug list is a list of prescription drugs, supplies, and devices considered to have acceptable efficacy, safety and cost-effectiveness. The Preferred drug list is maintained by a committee consisting of a group of physicians, pharmacists and a consumer representative who review the scientific evidence of these products and determine the Preferred and Non-Preferred status as well as utilization management requirements. Preferred drugs generally have better scientific evidence for safety and effectiveness and are more affordable than Non-Preferred drugs. The preferred drug list is available at www.kp.org/wa/formulary, or upon request from Member Services.</p> <p>Enrollees may request a coverage determination by contacting Member Services. Coverage determination reviews may include requests to cover non-preferred drugs, obtain Preauthorization for a specific drug, or exceptions to other utilization management requirements, such as quantity limits.</p> <p>Prescription drugs are drugs which have been approved by the Food and Drug Administration (FDA) and which can, under federal or state law, be dispensed only pursuant to a prescription order. These drugs, including off-label use of FDA-approved drugs (provided that such use is documented to be effective in one of the standard reference compendia; a majority of well-designed clinical trials published in peer-reviewed medical literature document improved efficacy or safety of the agent over standard therapies, or over placebo if no standard therapies exist; or by the federal secretary of Health and Human Services) are covered. "Standard reference compendia" means the American Hospital Formulary Service – Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia – Drug Information, or other authoritative compendia as identified from time to time by the federal secretary of Health and Human Services. "Peer-reviewed medical literature" means scientific studies printed in health care journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.</p> <p>Generic drugs are dispensed whenever available. A generic drug is a drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. Brand name drugs are dispensed if there is not a generic equivalent. In the event the Enrollee elects to purchase a brand-name drug instead of the generic equivalent (if available), the Enrollee is responsible for paying the difference in cost in addition to the prescription drug Cost Share.</p> <p>Drug coverage is subject to utilization management that includes Preauthorization, step therapy (when an Enrollee tries a certain medication before receiving coverage for a similar, but non-Preferred medication), limits on drug quantity or days supply and prevention of overutilization, underutilization, therapeutic duplication, drug-drug interactions, incorrect drug dosage, drug-allergy contraindications and clinical abuse/misuse of drugs. If an Enrollee has a new prescription for a chronic condition, the Enrollee may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity. The Enrollee pays one-half of the Copayment if a supply of 15 days or less of the prescription is filled. There is no prorated Copayment if 16-30 days supply of the prescription is filled. The Enrollee is charged 1.5 times the Copayment for a supply of more than 30 days.</p>	

Specialty drugs are high-cost drugs prescribed by a physician that requires close supervision and monitoring for serious and/or complex conditions, such as rheumatoid arthritis, hepatitis or multiple sclerosis. Specialty drugs must be obtained through KFHPWA's preferred specialty pharmacy vendor and/or network of specialty pharmacies and are covered at the appropriate cost share above. For a list of specialty drugs or more information about KFHPWA's specialty pharmacy network, please go to the KFHPWA website at www.kp.org/wa/formulary or contact Member Services at 206-630-0107 or toll-free at 1-866-648-1928.

The Enrollee's Right to Safe and Effective Pharmacy Services: State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee Enrollees' right to know what drugs are covered and the coverage limitations. Enrollees who would like more information about the drug coverage policies, or have a question or concern about their pharmacy benefit, may contact KFHPWA at 206-630-0107 or toll-free 1-866-648-1928 or by accessing the KFHPWA website at www.kp.org/wa/formulary.

Enrollees who would like to know more about their rights under the law, or think any services received while enrolled may not conform to the terms of the EOC, may contact the Washington State Office of Insurance Commissioner at toll-free 1-800-562-6900. Enrollees who have a concern about the pharmacists or pharmacies serving them may call the Washington State Department of Health at toll-free 1-800-525-0127.

Prescription Drug Coverage and Medicare: This benefit, for purposes of Creditable Coverage, is actuarially equal to or greater than the Medicare Part D prescription drug benefit. Enrollees who are also eligible for Medicare Part D can remain covered and will not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D plan at a later date; however, the Enrollee could be subject to payment of higher Part D premiums if the Enrollee subsequently has a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan. An Enrollee who discontinues coverage must meet eligibility requirements in order to re-enroll.

Exclusions: Over-the-counter drugs, supplies and devices not requiring a prescription under state law or regulations, including most prescription vitamins, except as recommended by the U.S. Preventive Services Task Force (USPSTF); drugs and injections for anticipated illness while traveling; drugs and injections for cosmetic purposes; replacement of lost or stolen drugs or devices; administration of excluded drugs and injectables; drugs used in the treatment of sexual dysfunction disorders; compounds which include a non-FDA approved drug; growth hormones for idiopathic short stature without growth hormone deficiency; prescription drugs/products available over-the-counter or have an over-the-counter alternative that is determined to be therapeutically interchangeable

Emergency Services	
<p>Emergency services at a Network Facility or non-Network Facility. See Section XII. for a definition of Emergency.</p> <p>Emergency services include professional services, treatment and supplies, facility costs, outpatient charges for patient observation and medical screening exams required to stabilize a patient.</p> <p>Enrollees must notify KFHPWA by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible.</p> <p>If an Enrollee is admitted as an inpatient directly from an emergency department, any Emergency services Copayment is waived. Coverage is subject to the hospital services Cost Share.</p>	<p>Network Facility: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Non-Network Facility: After Deductible, Enrollee pays 10% Plan Coinsurance</p>

<p>If an Enrollee is hospitalized in a non-Network Facility, KFHPWA reserves the right to require transfer of the Enrollee to a Network Facility upon consultation between a Network Provider and the attending physician. If the Enrollee refuses to transfer to a Network Facility or does not notify KFHPWA within 24 hours following admission, all further costs incurred during the hospitalization are the responsibility of the Enrollee.</p> <p>Follow-up care which is a direct result of the Emergency must be received from a Network Provider, unless Preauthorization is obtained for such follow-up care from a non-Network Provider.</p>	
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Hearing Examinations and Hearing Aids	
<p>Routine hearing exams and hearing exams for hearing loss and evaluation and diagnostic testing for cochlear implants are covered only when provided at KFHPWA-approved facilities.</p> <p>Cochlear implants or Bone Anchored Hearing Aids (BAHA) when in accordance with KFHPWA clinical criteria.</p> <p>Covered services for cochlear implants and BAHA include implant surgery, pre-implant testing, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance</p>
<p>Hearing aids including fitting, follow-up care and repairs.</p>	<p>Enrollee pays nothing, limited to an Allowance of \$800 maximum during any consecutive 36 month period</p> <p>Note: This benefit is separate from the benefits of the Health Savings Account (HSA) Qualified Health Plan and not subject to the annual Deductible</p> <p>After Allowance: Not covered; Enrollee pays 100% of all charges</p>
<p>Exclusions: Programs or treatments for hearing loss or hearing care including, but not limited to, surgically implanted hearing aids and the surgery and services necessary to implant them other than for cochlear implants; hearing screening tests required under Preventive Services; replacement costs of hearing aids due to loss, breakage or theft, unless at the time of such replacement the Enrollee is eligible under the benefit Allowance; repairs; replacement parts; replacement batteries; maintenance costs</p>	

Home Health Care	
<p>Home health care when the following criteria are met:</p> <ul style="list-style-type: none"> • Except for patients receiving palliative care services, the Enrollee must be unable to leave home due to a health problem or illness. Unwillingness to travel and/or arrange 	<p>After Deductible, Enrollee pays 10% Plan Coinsurance</p>

<p>for transportation does not constitute inability to leave the home.</p> <ul style="list-style-type: none"> • The Enrollee requires intermittent skilled home health care, as described below. • KFHPWA’s medical director determines that such services are Medically Necessary and are most appropriately rendered in the Enrollee’s home. <p>Covered Services for home health care may include the following when rendered pursuant to a KFHPWA-approved home health care plan of treatment: nursing care; restorative physical, occupational, respiratory and speech therapy; durable medical equipment; medical social worker and limited home health aide services.</p> <p>Home health services are covered on an intermittent basis in the Enrollee’s home. “Intermittent” means care that is to be rendered because of a medically predictable recurring need for skilled home health care. “Skilled home health care” means reasonable and necessary care for the treatment of an illness or injury which requires the skill of a nurse or therapist, based on the complexity of the service and the condition of the patient and which is performed directly by an appropriately licensed professional provider.</p> <p>Home health care requires Preauthorization.</p>	
<p>Exclusions: Private duty nursing; housekeeping or meal services; any care provided by or for a family member; any other services rendered in the home which do not meet the definition of skilled home health care above</p>	

<p>Hospice</p>	
<p>Hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to an Enrollee and any family members who are caring for the Enrollee, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of the Enrollee and their family during the final stages of illness. In order to qualify for hospice care, the Enrollee’s provider must certify that the Enrollee is terminally ill and is eligible for hospice services.</p> <p>Inpatient Hospice Services. For short-term care, inpatient hospice services are covered with Preauthorization.</p> <p>Respite care is covered to provide continuous care of the Enrollee and allow temporary relief to family members from the duties of caring for the Enrollee for a maximum of 5 consecutive days per 3 month period of hospice care.</p>	<p>After Deductible, Enrollee pays 10% Plan Coinsurance</p>

<p>Other covered hospice services, when billed by a licensed hospice program, may include the following:</p> <ul style="list-style-type: none"> • Inpatient and outpatient services and supplies for injury and illness. • Semi-private room and board, except when a private room is determined to be necessary. • Durable medical equipment when billed by a licensed hospice care program. <p>Hospice care requires Preauthorization.</p>	
<p>Exclusions: Private duty nursing, financial or legal counseling services; meal services; any services provided by family members</p>	

Hospital - Inpatient and Outpatient	
<p>The following inpatient medical and surgical services are covered:</p> <ul style="list-style-type: none"> • Room and board, including private room when prescribed, and general nursing services. • Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy services). • Drugs and medications administered during confinement. • Medical implants. • Acute chemical withdrawal (detoxification). <p>Outpatient hospital includes ambulatory surgical centers.</p> <p>Alternative care arrangements may be covered as a cost-effective alternative in lieu of otherwise covered Medically Necessary hospitalization or other Medically Necessary institutional care with the consent of the Enrollee and recommendation from the attending physician or licensed health care provider. Alternative care arrangements in lieu of covered hospital or other institutional care must be determined to be appropriate and Medically Necessary based upon the Enrollee's Medical Condition. Such care is covered to the same extent the replaced Hospital Care is covered. Alternative care arrangements require Preauthorization.</p> <p>Enrollees receiving the following nonscheduled services are required to notify KFHPWA by way of the Hospital notification line within 24 hours following any admission, or as soon thereafter as medically possible: acute chemical withdrawal (detoxification) services, Emergency psychiatric services, Emergency services, labor and delivery and inpatient admissions needed for treatment of Urgent Conditions that cannot reasonably be delayed until Preauthorization can be obtained.</p> <p>Coverage for Emergency services in a non-Network Facility</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p>

and subsequent transfer to a Network Facility is set forth in Emergency Services.	
Non-Emergency hospital services require Preauthorization.	
Exclusions: Take home drugs, dressings and supplies following hospitalization; internally implanted insulin pumps, artificial larynx and any other implantable device that have not been approved by KFHPWA's medical director	

Infertility (including sterility)	
General counseling and one consultation visit to diagnose infertility conditions.	Not covered; Enrollee pays 100% of all charges
Specific diagnostic services, treatment and prescription drugs.	Not covered; Enrollee pays 100% of all charges
Exclusions: Diagnostic testing and medical treatment of sterility and infertility regardless of origin or cause; all charges and related services for donor materials; all forms of artificial intervention for any reason including artificial insemination and in-vitro fertilization; prognostic (predictive) genetic testing for the detection of congenital and heritable disorders; surrogacy	

Infusion Therapy	
Medically Necessary infusion therapy includes, but is not limited to: <ul style="list-style-type: none"> • Antibiotics. • Hydration. • Chemotherapy. • Pain management. 	After Deductible, Enrollee pays 10% Plan Coinsurance
Associated infused medications.	After Deductible, Enrollee pays 10% Plan Coinsurance

Laboratory and Radiology	
Nuclear medicine, radiology, ultrasound and laboratory services, including high end radiology imaging services such as CAT scan, MRI and PET which are subject to Preauthorization except when associated with Emergency services or inpatient services. Please contact Enrollee Services for any questions regarding these services.	After Deductible, Enrollee pays 10% Plan Coinsurance
Services received as part of an emergency visit are covered as Emergency Services.	
Preventive laboratory and radiology services are covered in accordance with the well care schedule established by KFHPWA and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in Kaiser Permanente medical centers, at www.kp.org/wa , or upon	

request from Member Services.	
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Manipulative Therapy	
Manipulative therapy of the spine and extremities when in accordance with KFHPWA clinical criteria, limited to a total of 10 visits per calendar year without Preauthorization. Additional visits are covered with Preauthorization.	After Deductible, Enrollee pays 10% Plan Coinsurance
Exclusions: Supportive care rendered primarily to maintain the level of correction already achieved; care rendered primarily for the convenience of the Enrollee; care rendered on a non-acute, asymptomatic basis; charges for any other services that do not meet KFHPWA clinical criteria as Medically Necessary	

Maternity and Pregnancy	
<p>Maternity care and pregnancy services, including care for complications of pregnancy, in utero treatment for the fetus, prenatal testing for the detection of congenital and heritable disorders when Medically Necessary and prenatal and postpartum care are covered for all female Enrollees including dependent daughters. Preventive services related to preconception, prenatal and postpartum care are covered as Preventive Services including breastfeeding support, supplies and counseling for each birth when Medically Necessary as determined by KFHPWA’s medical director and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy.</p> <p>Delivery and associated Hospital Care, including home births and birthing centers. Home births are considered outpatient services.</p> <p>Enrollees must notify KFHPWA by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. The Enrollee’s physician, in consultation with the Enrollee, will determine the Enrollee’s length of inpatient stay following delivery.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance</p>
<p>Termination of pregnancy.</p> <p>Non-Emergency inpatient hospital services require Preauthorization.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance</p>
Exclusions: Birthing tubs; genetic testing of non-Enrollees; fetal ultrasound in the absence of medical indications	

Mental Health	
<p>Mental health services provided at the most clinically appropriate and Medically Necessary level of mental health care intervention as determined by KFHPWA's medical director. Treatment may utilize psychiatric, psychological and/or psychotherapy services to achieve these objectives.</p> <p>Mental health services including medical management and prescriptions are covered the same as for any other condition.</p> <p>Applied behavioral analysis (ABA) therapy, limited to outpatient treatment of an autism spectrum disorder as diagnosed and prescribed by a neurologist, pediatric neurologist, developmental pediatrician, psychologist or psychiatrist experienced in the diagnosis and treatment of autism. Documented diagnostic assessments, individualized treatment plans and progress evaluations are required.</p> <p>Services for any involuntary court-ordered treatment program shall be covered only if determined to be Medically Necessary by KFHPWA's medical director. Services provided under involuntary commitment statutes are covered.</p> <p>If an Enrollee is admitted as an inpatient directly from an emergency department, any Emergency services Copayment is waived. Coverage is subject to the hospital services Cost Share. Coverage for services incurred at non-Network Facilities shall exclude any charges that would otherwise be excluded for hospitalization within a Network Facility. Enrollees must notify KFHPWA by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible.</p> <p>Mental health services rendered to treat mental disorders are covered. Mental Disorders means mental disorders covered in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except as otherwise excluded under Sections IV. or V. Mental Health Services means Medically Necessary outpatient services, Residential Treatment, partial hospitalization program, and inpatient services provided by a licensed facility or licensed providers, including advanced practice psychiatric nurses, mental health counselors, marriage and family therapists, and social workers, except as otherwise excluded under Sections IV. or V.</p> <p>Inpatient mental health services, Residential Treatment and partial hospitalization programs must be provided at a hospital or facility that KFHPWA has approved specifically for the treatment of mental disorders. Chemical dependency services are covered subject to the Chemical Dependency services benefit.</p> <p>Non-Emergency inpatient hospital services, including</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Group Sessions: After Deductible, No charge; Enrollee pays nothing</p>

Residential Treatment and partial hospitalization programs, require Preauthorization.	
<p>Exclusions: Academic or career counseling; personal growth or relationship enhancement; assessment and treatment services that are primarily vocational and academic; court-ordered or forensic treatment, including reports and summaries, not considered Medically Necessary; work or school ordered assessment and treatment not considered Medically Necessary; counseling for overeating not considered Medically Necessary; specialty treatment programs such as “behavior modification programs” not considered Medically Necessary; relationship counseling or phase of life problems (V code only diagnoses); custodial care</p>	

Naturopathy	
Naturopathy, including related laboratory and radiology services are covered only when obtained through a Network Facility.	After Deductible, Enrollee pays 10% Plan Coinsurance
<p>Exclusions: Herbal supplements; nutritional supplements; any services not within the scope of the practitioner’s licensure</p>	

Newborn Services	
<p>Newborn services are covered the same as for any other condition. Any Cost Share for newborn services is separate from that of the mother.</p> <p>Preventive services for newborns are covered under Preventive Services.</p> <p>See Section VI.A.3. for information about temporary coverage for newborns.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>During the baby’s initial hospital stay while the birth mother and baby are both confined, any applicable Deductible and coinsurance for the newborn are waived</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance</p>

Nutritional Counseling	
<p>Nutritional counseling.</p> <p>Services related to a healthy diet to prevent obesity are covered as Preventive Services.</p>	After Deductible, Enrollee pays 10% Plan Coinsurance
<p>Exclusions: Nutritional supplements; weight control self-help programs or memberships, such as Weight Watchers, Jenny Craig, or other such programs</p>	

Nutritional Therapy	
Medical foods and formula necessary for the treatment of phenylketonuria (PKU), specified inborn errors of metabolism, or other metabolic disorders.	After Deductible, Enrollee pays 10% Plan Coinsurance
<p>Enteral therapy (elemental formulas) for malabsorption and an eosinophilic gastrointestinal disorder.</p> <p>Necessary equipment and supplies for the administration of enteral therapy are covered as Devices, Equipment and Supplies.</p>	After Deductible, Enrollee pays 10% Plan Coinsurance
<p>Parenteral therapy (total parenteral nutrition).</p> <p>Necessary equipment and supplies for the administration of parenteral therapy are covered as Devices, Equipment and Supplies.</p>	After Deductible, Enrollee pays nothing
Exclusions: Any other dietary formulas or medical foods; oral nutritional supplements not related to the treatment of inborn errors of metabolism; special diets; prepared foods/meals	

Obesity Related Surgical Services	
<p>Bariatric surgery is covered when Group Health criteria are met.</p> <p>Bariatric surgery related services require Preauthorization.</p> <p>Services related to obesity screening and counseling are covered as Preventive Services.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance</p>
Exclusions: Obesity treatment and treatment for morbid obesity for any reason including any medical services, drugs, supplies regardless of co-morbidities, except as described above; specialty treatment programs such as weight control self-help programs or memberships, such as Weight Watchers, Jenny Craig or other such programs; medications and related physician visits for medication monitoring	

On the Job Injuries or Illnesses	
On the job injuries or illnesses.	<p>Office of Worker's Compensation Programs (OWCP) or similar Federal or State agency pays through a third party settlement: Not covered; Enrollee pays 100% of all charges</p> <p>After the third party settlement maximum is paid:</p> <p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee</p>

	pays 10% Plan Coinsurance Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance
Exclusions: Confinement, treatment or service that results from an illness or injury arising out of or in the course of any employment for wage or profit including injuries, illnesses or conditions incurred as a result of self-employment; Services needed because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws	

Oncology	
Radiation therapy, chemotherapy, oral chemotherapy. See Infusion Therapy for infused medications.	Radiation Therapy and Chemotherapy: After Deductible, Enrollee pays 10% Plan Coinsurance Oral Chemotherapy Drugs: Preferred generic drugs (Tier 1): After Deductible, Enrollee pays \$20 Copayment Preferred brand name drugs (Tier 2): After Deductible, Enrollee pays \$40 Copayment Non-Preferred generic and brand name drugs (Tier 3): After Deductible, Enrollee pays 50% coinsurance up to \$250 maximum per prescription

Optical (vision)	
Routine eye examinations and refractions, limited to once every 12 months. Eye and contact lens examinations for eye pathology and to monitor Medical Conditions, as often as Medically Necessary.	Routine Exams: After Deductible, Enrollee pays 10% Plan Coinsurance Exams for Eye Pathology: After Deductible, Enrollee pays 10% Plan Coinsurance
Enrollees age 19 and over: Eyeglass frames, lenses (any type), lens options such as tinting, or prescription contact lenses, contact lens evaluations and examinations associated with their fitting. The benefit period begins on the date services are first obtained. The Allowance may be used toward the following in any combination: <ul style="list-style-type: none"> • Eyeglass frames • Eyeglass lenses (any type) including tinting and coating • Corrective industrial (safety) lenses • Sunglass lenses and frames when prescribed by an eye care provider for eye protection or light sensitivity • Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation 	Frames and Lenses: No charge; Enrollee pays nothing, limited to an Allowance of \$150 every 24 months After Allowance: Not covered; Enrollee pays 100% of all charges Note: This benefit is separate from the benefits of the Health Savings Account (HSA) Qualified Health Plan and not subject to the annual Deductible

<p>examinations</p> <ul style="list-style-type: none"> • Replacement frames, for any reason, including loss or breakage • Replacement contact lenses • Replacement eyeglass lenses <p>Contact lenses or framed lenses for eye pathology when Medically Necessary.</p> <p>One contact lens per diseased eye in lieu of an intraocular lens is covered following cataract surgery provided the Enrollee has been continuously covered by KFHPWA since such surgery. In the event an Enrollee's age or medical condition prevents the Enrollee from having an intraocular lens or contact lens, framed lenses are available. Replacement of lenses for eye pathology, including following cataract surgery, is covered only once within a 12-month period and only when needed due to a change in the Enrollee's prescription. Replacement for loss or breakage is subject to the frames and lenses benefit.</p> <p>Enrollees to age 19: Eyeglass frames, lenses (any type), lens options such as tinting, or prescription contact lenses, contact lens evaluations and examinations associated with their fitting. The benefit period begins on January 1 and continues through the end of the calendar year. The benefit may be used toward contact lenses (in lieu of eyeglasses) or 1 eyeglass frame and pair of lenses.</p> <ul style="list-style-type: none"> • Eyeglass frames • Eyeglass lenses (any type) including tinting and coating • Corrective industrial (safety) lenses • Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation examinations <p>Contact lenses or framed lenses for eye pathology when Medically Necessary.</p> <p>One contact lens per diseased eye in lieu of an intraocular lens is covered following cataract surgery provided the Enrollee has been continuously covered by KFHPWA since such surgery. In the event an Enrollee's age or medical condition prevents the Enrollee from having an intraocular lens or contact lens, framed lenses are available. Replacement of lenses for eye pathology, including following cataract surgery, is covered only once within a 12 month period and only when needed due to a change in the Enrollee's prescription. Replacement for loss or breakage is subject to the frames and lenses benefit.</p>	<p>Contact Lenses or Framed Lenses for Eye Pathology: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Frames and Lenses (in lieu of contact lenses): No charge; Enrollee pays nothing for 1 set of frames and lenses per calendar year</p> <p>Contact lenses (in lieu of eyeglasses): Enrollee pays 50% coinsurance</p> <p>After benefit is exhausted: Not covered; Enrollee pays 100% of all charges</p> <p>Contact Lenses or Framed Lenses for Eye Pathology: After Deductible, Enrollee pays 10% Plan Coinsurance</p>
<p>Exclusions: Orthoptic therapy (i.e. eye training); evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures</p>	

Oral Surgery	
<p>Reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or non-dental cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth; and incision of salivary glands and ducts.</p> <p>KFHPWA's medical director will determine whether the care or treatment required is within the category of Oral Surgery or Dental Services.</p> <p>Oral surgery requires Preauthorization.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance</p>
<p>Exclusions: Care or repair of teeth or dental structures of any type; tooth extractions or impacted teeth; services related to malocclusion; services to correct the misalignment or malposition of teeth; any other services to the mouth, facial bones or teeth which are not medical in nature</p>	

Outpatient Services	
<p>Covered outpatient medical and surgical services in a provider's office, including chronic disease management. See Preventive Services for additional information related to chronic disease management.</p> <p>See Hospital - Inpatient and Outpatient for outpatient hospital medical and surgical services, including ambulatory surgical centers.</p>	<p>After Deductible, Enrollee pays 10% Plan Coinsurance</p>

Plastic and Reconstructive Surgery	
<p>Plastic and reconstructive services:</p> <ul style="list-style-type: none"> • Correction of a congenital disease or congenital anomaly. • Correction of a Medical Condition following an injury or resulting from surgery which has produced a major effect on the Enrollee's appearance, when in the opinion of KFHPWA's medical director such services can reasonably be expected to correct the condition. • Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed. Enrollees are covered for all stages of reconstruction on the non-diseased breast produce a symmetrical appearance. Complications of covered mastectomy services, including lymphedemas, are covered. <p>Plastic and reconstructive surgery requires Preauthorization.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance</p>
<p>Exclusions: Cosmetic services including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services</p>	

Podiatry	
<p>Medically Necessary foot care.</p> <p>Routine foot care covered when such care is directly related to the treatment of diabetes and, when approved by KFHPWA's medical director, other clinical conditions that affect sensation and circulation to the feet.</p>	After Deductible, Enrollee pays 10% Plan Coinsurance
Exclusions: All other routine foot care	

Preventive Services	
<p>Preventive services in accordance with the well care schedule established by KFHPWA. The well care schedule is available in Kaiser Permanente medical centers, at www.kp.org/wa, or upon request from Member Services.</p> <p>Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force (USPSTF).</p> <p>Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians.</p> <p>Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines.</p> <p>Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices. Flu vaccines are covered up to the Allowed Amount when provided by a non-network provider.</p> <p>Preventive services include, but are not limited to, well adult and well child physical examinations; immunizations and vaccinations; female sterilization; preferred over-the-counter drugs as recommended by the USPSTF when obtained with a prescription; pap smears; preventive services related to preconception, prenatal and postpartum care; routine mammography screening; routine prostate screening; colorectal cancer screening for Enrollees who are age 50 or older or who are under age 50 and at high risk; obesity screening/counseling; healthy diet; and physical activity counseling; depression screening in adults, including maternal depression.</p> <p>Preventive care for chronic disease management includes treatment plans with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, quality of care measurement and results, and education and tools for patient</p>	No charge; Enrollee pays nothing

<p>self-management support. In the event preventive, wellness or chronic care management services are not available from a Network Provider, non-network providers may provide these services without Cost Share when Preauthorized.</p> <p>Services provided during a preventive services visit, including laboratory services, which are not in accordance with the KFHPWA well care schedule are subject to Cost Shares. Eye refractions are not included under preventive services.</p>	
<p>Exclusions: Those parts of an examination and associated reports and immunizations that are not deemed Medically Necessary by KFHPWA for early detection of disease; all other diagnostic services not otherwise stated above</p>	

<p>Rehabilitation and Habilitative Care (massage, occupational, physical and speech therapy, pulmonary and cardiac rehabilitation) and Neurodevelopmental Therapy</p>	
<p>Rehabilitation services to restore function following illness, injury or surgery, limited to the following restorative therapies: occupational therapy, physical therapy, massage therapy and speech therapy. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery.</p> <p>Outpatient services require a prescription or order from a physician that reflects a written plan of care to restore function and must be provided by a rehabilitation team that may include a physician, nurse, physical therapist, occupational therapist, massage therapist or speech therapist. Preauthorization is not required.</p> <p>Habilitative care includes Medically Necessary services or devices designed to help an Enrollee keep, learn, or improve skills and functioning for daily living. Services may include occupational therapy, physical therapy, speech therapy when prescribed by a physician. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.</p> <p>Limited to a combined total of 60 inpatient days and 60 outpatient visits per calendar year for all Rehabilitation, Habilitative care, and cardiac and pulmonary rehabilitation services.</p> <p>Neurodevelopmental therapy to restore or improve function including maintenance in cases where significant deterioration in the Enrollee's condition would result without the services, limited to the following therapies: occupational therapy, physical therapy and speech therapy. There is no</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance</p>

<p>visit limit for Neurodevelopmental therapy.</p> <p>Services with mental health diagnoses are covered with no limit.</p> <p>Non-Emergency inpatient hospital services require Preauthorization.</p>	
<p>Exclusions: Specialty treatment programs; inpatient Residential Treatment services; specialty rehabilitation programs including “behavior modification programs”; recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs</p>	

Reproductive Health	
<p>Medically Necessary medical and surgical services for reproductive health, including consultations, examinations, procedures and devices, including device insertion and removal.</p> <p>See Maternity and Pregnancy for termination of pregnancy services</p> <p>Reproductive health is the care necessary to support the reproductive system and the ability to reproduce. Reproductive health includes contraception, cancer and disease screenings, termination of pregnancy, maternity, prenatal and postpartum care.</p> <p>Note: Effective January 1, 2020, vasectomies are required to be subject to the minimum Deductible amount in order to meet state law requirements (\$1,400 individual/\$2,800 family). All other services are subject to the entire Annual Deductible. The minimum Deductible amount may increase as determined by federal law. Enrollees will receive notification of any changes to the minimum Deductible amount.</p>	<p>Hospital - Inpatient: No charge; Enrollee pays nothing</p> <p>Hospital - Outpatient: No charge; Enrollee pays nothing</p> <p>Outpatient Services: No charge; Enrollee pays nothing</p>
<p>All methods for Medically Necessary FDA-approved generic (over-the-counter) contraceptive drugs, devices and products. Condoms are limited to 120 per 90-day supply.</p> <p>Contraceptive drugs may be allowed up to a 12-month supply and, when available, picked up in the provider’s office.</p> <p>Note: Effective January 1, 2020, vasectomies are required to be subject to the minimum Deductible amount in order to meet state law requirements (\$1,400 individual/\$2,800 family). All other services are subject to the entire Annual Deductible. The minimum Deductible amount may increase as determined by federal law. Enrollees will receive notification of any changes to the minimum Deductible amount.</p>	<p>No charge; Enrollee pays nothing</p>

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Sexual Dysfunction	
Sexual dysfunction diagnosis and medical treatment services.	After Deductible, Enrollee pays 10% Plan Coinsurance
Penile prosthesis when impotence is caused by a covered Medical Condition as a direct result of a covered surgery, or a result of an injury to the genitalia or spinal cord, and when other accepted treatment has been unsuccessful.	After Deductible, Enrollee pays 10% Plan Coinsurance
Exclusions: Prescription drugs for treatment of sexual dysfunction; devices, equipment and supplies for the treatment of sexual dysfunction; penile prosthesis when not medically necessary; All other devices, equipment and supplies for the treatment of sexual dysfunction not specifically listed as covered	

Skilled Nursing Facility	
Skilled nursing care in a skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending physician, limited to a total of 150 days per calendar year. Care may include room and board; general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by a skilled nursing facility; and short-term restorative occupational therapy, physical therapy and speech therapy. Skilled nursing care in a skilled nursing facility requires Preauthorization.	After Deductible, Enrollee pays 10% Plan Coinsurance
Exclusions: Personal comfort items such as telephone and television; rest cures; domiciliary or Convalescent Care	

Sterilization	
FDA-approved female sterilization procedures, services and supplies. See Preventive Services for additional information. Non-Emergency inpatient hospital services require Preauthorization.	Hospital - Inpatient: No charge; Enrollee pays nothing Hospital - Outpatient: No charge; Enrollee pays nothing Outpatient Services: No charge; Enrollee pays nothing
Vasectomy. Non-Emergency inpatient hospital services require Preauthorization.	Hospital - Inpatient: No charge; Enrollee pays nothing Hospital - Outpatient: No charge; Enrollee pays nothing

<p>Note: Effective January 1, 2020, vasectomies are required to be subject to the minimum Deductible amount in order to meet state law requirements (\$1,400 individual/\$2,800 family). All other services are subject to the entire Annual Deductible. The minimum Deductible amount may increase as determined by federal law. Enrollees will receive notification of any changes to the minimum Deductible amount.</p>	<p>Outpatient Services: No charge; Enrollee pays nothing</p>
<p>Exclusions: Procedures and services to reverse a sterilization</p>	

<p>Telehealth Services</p>	
<p>Telemedicine</p> <p>Services provided by the use of real time interactive audio and video communications between the patient at the originating site and a Network provider at another location. Store and forward technology means sending an Enrollee’s medical information from an originating site to the Provider at a distant site for later review. The Provider follows up with a medical diagnosis for the Enrollee and helps manage their care. Services must meet the following requirements:</p> <ul style="list-style-type: none"> • Be a Covered Service under this EOC. • The originating site is qualified to provide the service. • If the service is provided through store and forward technology, there must be an associated office visit between the Enrollee and the referring provider • Is medically necessary 	<p>Hospital - Outpatient: After Deductible, Enrollee pays nothing</p> <p>Outpatient Services: After Deductible, Enrollee pays nothing</p>
<p>Telephone Services and Online (E-Visits)</p> <p>Scheduled telephone visits with a Network Provider are covered.</p> <p>Online (E-Visits): A Member logs into the secure Member site at www.kp.org/wa and completes a questionnaire. A KFHPWA medical provider reviews the questionnaire and provides a treatment plan for select conditions, including prescriptions. Online visits are not available to Enrollees during in-person visits at a KFHPWA facility or pharmacy. More information is available at https://wa.kaiserpermanente.org/html/public/services/e-visit.</p>	<p>After Deductible, Enrollee pays nothing</p>
<p>Exclusions: Fax and e-mail; telehealth services with non-contracted providers; telehealth services in states where prohibited by law; all other services not listed above</p>	

Temporomandibular Joint (TMJ)	
<p>Medical and surgical services and related hospital charges for the treatment of temporomandibular joint (TMJ) disorders including:</p> <ul style="list-style-type: none"> • Orthognathic surgery for the treatment of TMJ disorders. • Radiology services. • TMJ specialist services. • Fitting/adjustment of splints. <p>Non-Emergency inpatient hospital services require Preauthorization.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays 50% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays 50% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 50% Plan Coinsurance</p>
<p>TMJ appliances. See Devices, Equipment and Supplies for additional information.</p>	<p>After Deductible, Enrollee pays 50% coinsurance</p>
<p>Exclusions: Treatment for cosmetic purposes; bite blocks; dental services including orthodontic therapy and braces for any condition; any orthognathic (jaw) surgery in the absence of a diagnosis of TMJ, severe obstructive sleep apnea; hospitalizations related to these exclusions</p>	

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

Transgender Services	
<p>Medically and surgical services for gender reassignment.</p> <p>Prescription drugs are covered the same as for any other condition (see Drugs – Outpatient Prescription for coverage).</p> <p>Counseling services are covered the same as for any other condition (see Mental Health for coverage).</p> <p>Non-Emergency inpatient hospital services require Preauthorization.</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance</p>
<p>Exclusions: Cosmetic services including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services</p>	

Transplants	
<p>Transplant services, including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, liver transplants, and bone marrow and stem cell support (obtained from allogeneic or autologous peripheral</p>	<p>Hospital - Inpatient: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Hospital - Outpatient: After Deductible, Enrollee</p>

<p>blood or marrow) with associated high dose chemotherapy.</p> <p>Services are limited to the following:</p> <ul style="list-style-type: none"> • Inpatient and outpatient medical expenses for evaluation testing to determine recipient candidacy, donor matching tests, hospital charges, procurement center fees, professional fees, travel costs for a surgical team and excision fees. Donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees. • Follow-up services for specialty visits • Rehospitalization • Maintenance medications during an inpatient stay <p>Organ Transplant Recipient: All services and supplies related to the organ transplant, including transportation to and from KFHPWA Facilities (beyond the distance the Enrollee would normally be required to travel for most hospital services), are covered in accordance with the transplant benefit language, provided the Enrollee is accepted into the treating facility's transplant program and continues to follow that program's prescribed protocol.</p> <p>Organ Transplant Donor: The costs related to organ removal, as well as the cost of treating complications directly resulting from surgery, are covered, provided the organ recipient is an Enrollee under this Agreement, and provided the donor is not eligible for coverage under any other health care plan or government-funded program.</p> <p>Donor search costs for up to 15 searches only for allogeneic bone marrow transplants.</p> <p>Transplant services require Preauthorization.</p>	<p>pays 10% Plan Coinsurance</p> <p>Outpatient Services: After Deductible, Enrollee pays 10% Plan Coinsurance</p>
<p>Exclusions: Donor costs to the extent that they are reimbursable by the organ donor's insurance; living expenses; transportation expenses except as covered above; costs for searches for non-allogeneic bone marrow donors</p>	

<p>Urgent Care</p>	
<p>Inside the KFHPWA Service Area, urgent care is covered at a Kaiser Permanente medical center, Kaiser Permanente urgent care center or Network Provider's office.</p> <p>Outside the KFHPWA Service Area, urgent care is covered at any medical facility.</p> <p>See Section XII. for a definition of Urgent Condition.</p>	<p>Network Emergency Department: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Network Urgent Care Center: After Deductible, Enrollee pays 10% Plan Coinsurance</p> <p>Network Provider's Office: After Deductible, Enrollee 10% Plan Coinsurance</p> <p>Outside the KFHPWA Service Area: After Deductible, Enrollee pays 10% Plan Coinsurance</p>

V. General Exclusions

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

1. Benefits and related services, supplies and drugs that are not Medically Necessary for the treatment of an illness, injury, or physical disability, that are not specifically listed as covered in the EOC, except as required by federal or state law.
2. **Services Related to Non-Covered Services:** When a service is not covered, all services related to the non-covered service (except for the specific exceptions described below) are also excluded from coverage. Enrollees who have received a non-covered service, such as bariatric surgery, and develop an acute medical complication (such as band slippage, leak or infection) as a result, shall have coverage for Medically Necessary intervention to resolve the acute medical complication. Coverage does not include complications that occur during or immediately following a non-covered service. Additional surgeries or other medical services in addition to Medically Necessary intervention to resolve acute medical complications resulting from non-covered services shall not be covered.
3. Services or supplies for which no charge is made, or for which a charge would not have been made if the Enrollee had no health care coverage or for which the Enrollee is not liable; services provided by a family member, or self-care.
4. Convalescent Care.
5. Services to the extent benefits are “available” to the Enrollee as defined herein under the terms of any vehicle, homeowner’s, property or other insurance policy, except for individual or group health insurance, pursuant to medical coverage, medical “no fault” coverage, personal injury protection coverage or similar medical coverage contained in said policy. For the purpose of this exclusion, benefits shall be deemed to be “available” to the Enrollee if the Enrollee receives benefits under the policy either as a named insured or as an insured individual under the policy definition of insured.
6. Services or care needed for injuries or conditions resulting from active or reserve military service, whether such injuries or conditions result from war or otherwise. This exclusion will not apply to conditions or injuries resulting from previous military service unless the condition has been determined by the U.S. Secretary of Veterans Affairs to be a condition or injury incurred during a period of active duty. Further, this exclusion will not be interpreted to interfere with or preclude coordination of benefits under Tri-Care.
7. Services provided by government agencies, except as required by federal or state law.
8. Services covered by the national health plan of any other country.
9. Experimental or investigational services.

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

- a. A service is considered experimental or investigational for an Enrollee’s condition if any of the following statements apply to it at the time the service is or will be provided to the Enrollee:
 - 1) The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration (“FDA”) and such approval has not been granted.
 - 2) The service is the subject of a current new drug or new device application on file with the FDA.
 - 3) The service is the trialed agent or for delivery or measurement of the trialed agent provided as part of a qualifying Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial.
 - 4) The service is provided pursuant to a written protocol or other document that lists an evaluation of the service’s safety, toxicity or efficacy as among its objectives.

- 5) The service is under continued scientific testing and research concerning the safety, toxicity or efficacy of services.
 - 6) The service is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity or efficacy.
 - 7) The prevailing opinion among experts, as expressed in the published authoritative medical or scientific literature, is that (1) the use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity or efficacy of the service.
- b. The following sources of information will be exclusively relied upon to determine whether a service is experimental or investigational:
- 1) The Enrollee's medical records.
 - 2) The written protocol(s) or other document(s) pursuant to which the service has been or will be provided.
 - 3) Any consent document(s) the Enrollee or Enrollee's representative has executed or will be asked to execute, to receive the service.
 - 4) The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body.
 - 5) The published authoritative medical or scientific literature regarding the service, as applied to the Enrollee's illness or injury.
 - 6) Regulations, records, applications and any other documents or actions issued by, filed with or taken by, the FDA or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

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

10. Hypnotherapy and all services related to hypnotherapy.
11. Directed umbilical cord blood donations.
12. Prognostic (predictive) genetic testing and related services, unless specifically provided in Section IV. Testing for non- Enrollees.
13. Autopsy and associated expenses.

VI. Eligibility, Enrollment and Termination

Note: If a Subscriber enrolls any eligible Dependent(s), the family level annual Deductible must be met before any benefits will be provided and the family level Out-of-pocket Maximum will apply.

A. Eligibility.

1. Eligibility and Enrollment for Retirees and Survivors.

In these sections we may refer to retirees and survivors as “Subscribers” or “Enrollees.” The term “retiree” or “retiring employee” as used in these sections includes elected and full-time appointed officials of the legislative and executive branch of state government eligible to continue enrollment in PEBB retiree insurance coverage.

The Public Employee’s Benefits Board (PEBB) Program determines if a retiring employee is eligible to enroll in PEBB retiree insurance coverage upon receipt of a completed *Retiree Coverage Election* form. If the retiring employee does not have substantive eligibility or does not meet the procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify the retiring employee of their right to an appeal. Information about appealing a decision made by the PEBB Program can be found in subsection H.

The PEBB Program will determine if a Dependent is eligible to enroll or continue enrollment in PEBB retiree insurance coverage as a survivor upon receipt of a completed *Retiree Coverage Election* form. If the survivor does not meet the eligibility and procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify the survivor of their right to an appeal. Information about appealing a decision made by the PEBB Program can be found in subsection H.

Retirees, survivors, and their enrolled Dependents, are required to enroll in Medicare Part A and Part B if entitled. Enrollees who are entitled to Medicare must enroll and maintain enrollment in Medicare Part A and Part B. This is a condition of their enrollment in a PEBB retiree health plan. Enrollees must provide a copy of their Medicare card or entitlement letter from the Social Security Administration with Medicare Part A and Part B dates to the PEBB Program as proof of enrollment in Medicare. If an Enrollee is not entitled to either Medicare Part A or Part B on their 65th birthday, the Enrollee must provide the PEBB Program with a copy of the denial letter from the Social Security Administration. The only exception to this rule is for employees who retired on or before July 1, 1991.

2. Eligible Dependents.

To be enrolled in a medical plan, a Dependent must be eligible and the Subscriber must follow the procedural requirements described in the “Enrollment” section in [Section C](#).

The following are eligible as Dependents:

- a. Legal spouse.
- b. State-registered domestic partner, as defined in state statute and substantially equivalent legal unions from other jurisdictions as defined in state statute.
- c. Children. Children are eligible through the last day of the month in which their 26th birthday occurred except as described in subsection 7 of this section. Children are defined as the Subscriber’s:
 - 1) Children as defined in state statutes that establish a parent-child relationship, except when parental rights have been terminated;
 - 2) Children of the Subscriber’s spouse, based on the spouse’s establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild’s relationship to a Subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;
 - 3) Children for whom the Subscriber has assumed a legal obligation for total or partial support in anticipation of the child;

- 4) Children of the Subscriber's state-registered domestic partner, based on the state-registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the Subscriber (and eligibility as a dependent) ends on the same date the Subscriber's legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death;
- 5) Children specified in a court order or divorce decree for whom the Subscriber has a legal obligation to provide support or health care coverage.
- 6) Extended dependent in the legal custody or legal guardianship of the Subscriber, the Subscriber's spouse, or Subscriber's state-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include a foster child unless the Subscriber, the Subscriber's spouse, or the Subscriber's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and
- 7) Children of any age with a developmental or physical disability that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the age 26. The following requirements apply to dependents with a disability:
 - The Subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26.
 - The Subscriber must agree to notify the PEBB Program in writing no later than 60 days after the date that the child is no longer eligible under this subsection.
 - A child with a developmental or physical disability who becomes self-supporting is not eligible as of the last day of the month in which they become capable of self-support.
 - A child with a developmental or physical handicap age 26 and older who becomes capable of self-support does not regain eligibility under this subsection if they later become incapable of self-support.
 - The PEBB Program with input from the medical plan will periodically verify the eligibility of a Dependent child with a disability, but no more frequently than annually after the two-year period following the child's 26th birthday, which may require renewed proof from the Subscriber.

ALERT! Notify the PEBB Program at 1-800-200-1004 as soon as possible of changes in Dependent status. You may be required to pay for service received by ineligible Dependents.

d. Parents of the Subscriber.

- 1) Parents covered under PEBB medical before July 1, 1990, may continue enrollment on a self-pay basis as long as:
 - The parent maintains continuous enrollment in PEBB medical;
 - The parent qualifies under the Internal Revenue Code as a Dependent of the Subscriber;
 - The Subscriber continues enrollment in PEBB insurance coverage; and
 - The parent is not covered by any other group medical plan.
- 2) Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the Subscriber. Parents may not enroll additional Dependents to their PEBB insurance coverage.

3. Temporary Coverage for Newborns

When an Enrollee gives birth, the newborn is entitled to the benefits set forth in the Benefits Booklet from birth through 3 weeks of age. All provisions, limitations and exclusions will apply except Subsections F. and G. After 3 weeks of age, no benefits are available unless the newborn child qualifies as a Dependent and is enrolled.

B. Deferring Enrollment in PEBB Retiree Health Plan.

Retiring employees and Dependents becoming eligible as a survivor who want to defer enrollment must submit a *Retiree Coverage Election form* to the PEBB Program. If a retiree or survivor defers enrollment in a PEBB health plan, they also defer enrollment for all eligible Dependents, except as described below. Retiring

employees and Dependents becoming eligible as a survivor that do not enroll in a PEBB health plan are only eligible to enroll later if they have deferred enrollment as identified below:

- Beginning January 1, 2001, enrollment in a PEBB health plan may be deferred when the Subscriber is enrolled in employer-based group medical insurance as an employee or such medical insurance continued under COBRA coverage or continuation coverage.
- Beginning January 1, 2001, enrollment in a PEBB health plan may be deferred when the Subscriber is enrolled as a retiree or the Dependent of a retiree in a federal retiree medical plan.
- Beginning January 1, 2006, enrollment in A PEBB health plan may be deferred when the Subscriber is enrolled in Medicare Parts A and B and a Medicaid program that includes payment of medical and hospital benefits. You may cover eligible Dependents who are not enrolled in Medicaid coverage that includes payment of medical and hospital benefits.
- Beginning January 1, 2014, Subscribers who are not eligible for Part A and Part B of Medicare may defer enrollment in a PEBB health plan when the Subscriber is enrolled in coverage through a health care exchange developed under the Affordable Care Act.
- Beginning July 17, 2018, enrollment in a PEBB health plan may be deferred when the Subscriber is enrolled as a retiree or the Dependent of a retiree in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

To defer enrollment in a PEBB health plan, the retiree or survivor must submit a *Retiree Coverage Election* form to the PEBB Program. The form must be received within the required enrollment time limits. **Exception:** A retiree may defer enrollment in a PEBB health plan during the period of time they are enrolled as a Dependent in a medical plan sponsored by PEBB, a Washington state school district, a Washington state educational service district, or a Washington State charter school including such coverage under COBRA or continuation coverage. They do not need to submit a *Retiree Coverage Election* form.

If a retiree or a survivor defers enrollment in PEBB medical plan, enrollment must also be deferred for PEBB dental.

Enrollees can enroll in only one PEBB medical plan even if eligibility criteria is met under two or more Subscribers.

Note: PEBB retiree health plan enrollment is deferred if a retiree or a survivor becomes newly eligible for PEBB benefits as a new employee and enrolls in a PEBB health plan.

C. Enrollment

1. How to Enroll.

Retiring employees and Dependents becoming eligible as a survivor must submit a *Retiree Coverage Elections/Change* form along with any other required forms to the PEBB Program to enroll in PEBB retiree insurance coverage. The form(s) must be received within the required enrollment time limits listed under “When Medical Coverage Begins.”

Survivors of emergency service personnel killed in the line of duty must submit a *Retiree Coverage Election* form along with any other required forms to the PEBB Program. The completed form(s) must be received no later than 180 days after the later of:

- The date on the letter from the Department of Retirement Systems or the Board for Volunteer Firefighters and Reserve Officers that informs the survivor that they are determined to be an eligible survivor; or
- The date of the emergency service worker’s death; or
- The last day the survivor was covered under a health plan through the emergency service worker’s employer or COBRA coverage from the emergency service worker’s employer.

A retiree or a survivor who requests to voluntarily terminate their enrollment in a PEBB health plan must do so in writing to the PEBB Program. Once coverage is terminated, a retiree or a survivor may not enroll again in the future unless they reestablish eligibility for PEBB insurance coverage by becoming newly

eligible. Retirees or survivors who deferred coverage may later enroll in a PEBB health plan if they provide proof of continuous enrollment (see Enrollment Following Deferral section).

Retiring employees and dependents becoming eligible as a survivor who request to enroll an eligible Dependent must include the Dependent's enrollment information on the form and provide any required document(s) as proof of the Dependent's eligibility to the PEBB Program. The PEBB Program will not enroll or reenroll Dependents if the PEBB Program is unable to verify a Dependent's eligibility.

- a. Retirees and survivors may also enroll eligible Dependents during the PEBB Program's annual open enrollment (see "Annual Open Enrollment" below) or during a special open enrollment (See "Special Open Enrollment" below). The retiree or survivor must provide proof of the event that created the special open enrollment.
- b. If a retiree or a survivor elects to enroll a dependent in medical coverage, the dependent must be enrolled in the same PEBB medical as the retiree or surviving dependent.

Exception: If a retiree or a survivor selects a Kaiser Permanente Washington Medicare plan, they must also select the Kaiser Permanente Washington Classic, SoundChoice, or Value plan for non-Medicare enrollees.

ALERT! Failure to notify the PEBB Program of changes in status affecting eligibility may result in termination of coverage. You are responsible for the cost of any services received when you or your Dependent(s) were ineligible.

- c. Subscribers are required to remove Dependents within 60 days from the last day of the month when Dependents no longer meet the eligibility criteria described under "Eligible Dependents" in Section A.2. Consequences for not submitting the notice within 60 days may include, but are not limited to:
 - 1) The Dependent losing eligibility to continue health plan coverage under one of the continuation coverage options described in Section F;
 - 2) The Subscriber being billed for claims paid by the health plan for services that were rendered after the Dependent lost eligibility;
 - 3) The Subscriber being unable to recover Subscriber-paid insurance premiums for Dependents that lost their eligibility; and
 - 4) The Subscriber being responsible for premiums paid by the state for the Dependent's health plan coverage after the Dependent lost eligibility.

2. When Medical Enrollment Begins.

ALERT! Adding a new Dependent to your coverage in Section A.2, "Eligibility".

- a. For retiring employees and their Dependents enrolling no later than 60 days after the employee's employer-paid coverage, COBRA coverage, or continuation coverage ends, PEBB retiree insurance coverage begins on the first day of the month after the loss of employer-paid coverage, COBRA coverage, or continuation coverage.
- b. For an eligible elected or full-time appointed official and their dependents enrolling **no later than 60 days after the official leaves public office**, PEBB retiree insurance coverage begins the first day of the month following the date the official leaves public office.
- c. For an eligible survivor of a retiree and their dependents enrolling **no later than 60 days after the death of the retiree**, PEBB retiree insurance coverage will be continued without a gap subject to payment of premiums and any applicable premium surcharges.
- d. For an eligible survivor of an employee (not including emergency service personnel killed in the line of duty) and their dependents enrolling **no later than 60 days after the later of the date of the employee's death or the date the survivor's PEBB, school district, educational service district, or charter school coverage ends**, PEBB retiree insurance coverage begins the first day of the month following the

later of the date of the employee's death or the date the survivor's PEBB, school district, educational service district, or charter school coverage ends.

- e. For a retiree or survivor who deferred enrollment and is enrolling in a PEBB health plan **no later than 60 days after a loss of other qualifying coverage**, PEBB health plan coverage begins on the first day of the month after the loss of the other qualifying coverage.
- f. For a retiree's or survivor's Dependent enrolling during the PEBB Program's annual open enrollment, medical coverage will begin on January 1 of the following year.
- g. For a retiree's or a survivor's Dependent enrolling during a special open enrollment, medical coverage will begin the first of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment begins on that day.
- h. Exceptions:
 - 1) If the special open enrollment is due to the birth or adoption of a child, or when the Subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, medical coverage will begin as follows:
 - a. For the newly born child, medical coverage will begin from the date of birth.
 - b. For a newly adopted child, medical coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier.
 - c. For a spouse or state registered domestic partner of a Subscriber, medical coverage will begin the first day of the month in which the event occurs.
 - 2) If adding a child who becomes eligible as an extended Dependent through legal custody or legal guardianship, medical coverage will begin on the first day of the month following eligibility certification.

TIP: Retirees or survivors should notify the PEBB Program at 1-800-200-1004 of address, name, or other changes as soon as possible. This helps ensure that you receive important information about your benefits and helps us serve you better.

3. Enrollment Following Deferral.

- 1. Retirees or survivors who defer enrollment while enrolled in employer-based group medical or such coverage under COBRA coverage or continuation coverage may enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period or no later than 60 days after the date their enrollment in employer-based group medical coverage or such coverage under COBRA coverage or continuation coverage ends.
- 2. Retirees or survivors who defer enrollment **while enrolled in a federal retiree medical plan as a retiree or Dependent** will have a one-time opportunity to enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after their enrollment in a federal retiree medical plan ends.
- 3. Retirees or survivors who defer enrollment **while enrolled in Medicare Parts A and B and a Medicaid program that provides creditable coverage** may enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period or no later than 60 days after their Medicaid coverage ends or no later than the end of the calendar year when their Medicaid coverage ends if they were also enrolled in a subsidized Medicare Part D plan.
- 4. Retirees or survivors who defer enrollment **while enrolled in coverage through a health care exchange** developed under the Affordable Care Act will have a one-time opportunity to enroll or reenroll in a PEBB medical plan during the PEBB Program's annual open enrollment period or no later than 60 days after exchange coverage ends.
- 5. Retirees or survivors who defer enrollment while enrolled in CHAMPVA as a retiree or Dependent will have a one-time opportunity to enroll in a PEBB medical plan during the PEBB Program's annual

open enrollment period, or no later than 60 days after their enrollment in a CHAMPVA medical plan ends.

6. Retirees or survivors who defer enrollment while enrolled as a Dependent in a medical plan sponsored by PEBB, a Washington State school district, a Washington State educational service district, or a Washington State charter school, including coverage under COBRA or continuation coverage, may enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period or no later than 60 days after the enrollment in a medical plan sponsored by PEBB, a Washington State school district, a Washington State educational service district, or Washington State charter school ends, or such coverage under COBRA or continuation coverage ends.
7. Retirees or survivors who defer enrollment may enroll in a PEBB medical plan if they receive formal notice that the HCA has determined it is more cost-effective to enroll in PEBB medical than a medical assistance program.
8. To enroll in a PEBB medical plan, the retiree or survivor must send a *Retiree Coverage Election* form along with any other required forms and proof of continuous enrollment in one or more qualifying coverages to the PEBB Program.

Retirees and survivors should contact the PEBB Program or visit www.hca.wa.gov/pebb-retirees to get the required forms, information on premiums, and available medical plans.

4. Annual Open Enrollment.

Subscribers may make the following changes to their enrollment during the PEBB Program's annual open enrollment:

- Enroll in a medical plan following a deferral or defer their enrollment in a medical plan,
- Enroll or remove eligible Dependents, or
- Change their medical plan.

The subscriber must submit the required form(s) and any other required documents to the PEBB Program. The forms must be received no later than the last day of the annual open enrollment (usually November 30). The enrollment change will become effective January 1 of the following year.

5. Special Open Enrollment.

- a. Subscribers may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must be allowable under Internal Revenue code (IRC) and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the Subscriber, the Subscriber's Dependent, or both.

Exception: A retiree or survivor may defer or terminate enrollment in a PEBB health plan or terminate a Dependent's enrollment at any time by providing written notice to the PEBB Program.

- b. Retirees or survivors who have deferred their enrollment in a PEBB health plan may only enroll as described in the "Enrollment Following Deferral" section.
- c. To make an enrollment change, the Subscriber must submit the required form(s) to the PEBB Program. Forms must be received no later than 60 days after the event that created the special open enrollment. In addition to the required forms, the PEBB Program will require the Subscriber to provide proof of the Dependent's eligibility, proof of the event that created the special open enrollment, or both.

Exceptions: A subscriber has six months from the date of their or their dependents enrollment in Medicare Part B to change their enrollment to a PEBB Medicare Supplement Plan. The PEBB Program must receive the forms no later than six months after the enrollment in Medicare Part B for either the subscriber or the subscriber's dependent. If a Subscriber wants to enroll a newborn or child whom the Subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of

adoption, the Subscriber should notify the PEBB Program by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required enrollment/change form must be received no later than 12 months after the date of birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

- 6. When may a Subscriber change their health plan?** Any one of the following events may create a special open enrollment:
- a. Subscriber gains a new Dependent due to:
 - 1) Marriage or registering a domestic partnership;
 - 2) Birth, adoption or when the Subscriber has assumed a legal obligation for total or partial support in anticipation of adoption or
 - 3) A child becoming eligible as an extended Dependent through legal custody or legal guardianship.
 - b. Subscriber or Subscriber's Dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
 - c. Subscriber has a change in employment status that affects the Subscriber's eligibility for their employer contribution toward their employer-based group health plan;
 - d. Subscriber has a change in employment status that affects the Subscriber's eligibility for the employer contribution toward their employer-based group health plan;
 - e. Subscriber's Dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
 - f. Subscriber or Subscriber's Dependent has a change in residence that affects health plan availability. If the Subscriber moves and their current health plan is not available in the new location the Subscriber must select a new health plan;
 - g. A court order requires the Subscriber or any other individual to provide insurance coverage for an eligible Dependent of the Subscriber (a former spouse or former registered domestic partner is not an eligible Dependent);
 - h. Subscriber or a Subscriber's Dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the Subscriber or the Subscriber's Dependent loses eligibility for coverage under Medicaid or CHIP;
 - i. Subscriber or a Subscriber's Dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state (CHIP);
 - j. Subscriber or Subscriber's Dependent becomes entitled to coverage under Medicare, or the Subscriber or a Subscriber's Dependent loses eligibility for coverage under Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan. If the Subscriber's current health plan becomes unavailable due to Subscriber's or a Subscriber's Dependent's entitlement to Medicare, the Subscriber must select a new health plan;
 - k. Subscriber or a Subscriber's Dependent's current health plan becomes unavailable because the Subscriber or enrolled Dependent is no longer eligible for a health savings account (HSA);
 - l. Subscriber or a Subscriber's Dependent experiences a disruption of care that could function as a reduction in benefits for the Subscriber or the Subscriber's Dependent for a specific condition or ongoing course of treatment. The Subscriber may not change their health plan election if the Subscriber's or Dependent's physician stops participation with the Subscriber's health plan unless the PEBB Program determines that continuity of care issue exists. The PEBB Program will consider but is not limited to considering the following:

- 1) Active cancer treatment such as chemotherapy or radiation therapy for up to 90 days or until medically stable; or
- 2) Transplant within the last 12 months; or
- 3) Scheduled surgery within the next 60 days (elective procedures within the next 60 days do not qualify for continuity of care); or
- 4) Recent major surgery still within the postoperative period of up to 8 weeks; or
- 5) Third trimester of pregnancy.

ALERT: If an Enrollee's provider or health care facility discontinues participation with this plan, the Enrollee may not change medical plans until the PEBB Program's next annual open enrollment or when another qualifying event occurs that creates a special open enrollment, unless the PEBB Program determines that a continuity of care issue exists. The plan cannot guarantee that any one physician, hospital, or other provider will be available or remain under contract with us.

7. When can a Subscriber enroll or remove eligible Dependents? Any one of the following events may create a special open enrollment:

- 1) Subscriber gains a new Dependent due to:
 - 1) Marriage or registering for a state domestic partnership;
 - 2) Birth, adoption or when the Subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
 - 3) A child becoming eligible as an extended Dependent through legal custody or legal guardianship.
- 2) Subscriber or Subscriber's Dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
- 3) Subscriber has a change in employment status that affect the Subscriber's eligibility for their employer contribution toward their employer-based group health plan;
- 4) Subscriber's Dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
- 5) Subscriber or Subscriber's Dependent has a change in enrollment under an employer-based group health insurance plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment;
- 6) Subscriber's Dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States;
- 7) A court order requires the Subscriber or any other individual to provide insurance coverage for an eligible Dependent of the Subscriber (A former spouse or former state-registered domestic partner is not an eligible Dependent.);
- 8) Subscriber or Subscriber's Dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the Subscriber or a Subscriber's Dependent loses eligibility for coverage under Medicaid or CHIP;
- 9) Subscriber or a Subscriber's Dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP.

D. Medicare Entitlement.

1. Medicare Part A and Medicare Part B

If an Enrollee becomes entitled to Medicare, they should contact the nearest Social Security Administration office to ask about Medicare enrollment. Unless retirement occurred before July 1, 1991, or the Enrollee is a Dependent of an employee who retired before July 1, 1991 and is enrolled in PEBB retiree insurance coverage, the Enrollee must enroll and maintain enrollment in Medicare Part A and Medicare Part B.

Medicare will become the primary insurance coverage, in most cases, and the PEBB retiree medical plan will become the secondary insurance coverage.

FOR MEDICARE RETIREES: PEBB rules do not require you to enroll in Medicare’s prescription drug coverage, Medicare Part D. You cannot have both this plan and Medicare Part D. If you sign up for Medicare Part D, you will need to select a Medicare supplement plan offered through PEBB. If you do not sign up with a PEBB Medicare supplement plan, you cannot keep your PEBB health plan coverage.

2. Medicare Part D

PEBB has determined that this Plan has prescription drug coverage that is, on average, as good as or better than the standard Medicare Part D prescription drug coverage (it is “creditable coverage”). Therefore, you cannot enroll in Medicare Part D and remain in this Plan. If you choose to enroll in Medicare Part D, you may continue your PEBB coverage only by enrolling in the PEBB-sponsored Medicare supplement plan.

FOR MEDICARE RETIREES: PEBB includes an “annual notice of creditable prescription drug coverage” in the October *For Your Benefit* newsletter sent to each retiree Subscriber. If you or your covered Dependent(s) decide to terminate this plan, you may contact the PEBB Program to request a certificate of creditable prescription drug coverage. If you do not show that you had creditable coverage, you may have to pay higher premiums Medicare Part D prescription drug coverage.

E. When Medical Coverage Ends.

TIP: If your coverage under this plan ends, you must pay the costs of any services or supplies, except when coverage is required by law.

1. Medical Plan enrollment ends on the following dates:
 - a. On the last day of the month when any enrollee ceases to be eligible.
 - b. On the date a plan terminates. If that should occur, any Enrollee losing coverage will be given the opportunity to enroll in another PEBB medical plan.
 - c. For an Enrollee who declines the opportunity or is ineligible to continue enrollment under one of the options described in the “Options for Continuing PEBB Medical Coverage” in section F., coverage ends for the Enrollee on the last day of the month in which they cease to be eligible.
 - d. The Subscriber is responsible for timely payment of premiums and applicable premium surcharges. If the monthly premium or applicable premium surcharge remain unpaid for 30 days it will be considered delinquent. A Subscriber is allowed a grace period of 30 days from the date the monthly premium or applicable premium surcharge becomes delinquent to pay the unpaid premium balance or surcharge. If the Subscriber’s premium balance or applicable premium surcharge remains unpaid for 60 days from the original due date, coverage will be terminated for the Subscriber and enrolled Dependents retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid.

A full month’s premium is charged for each calendar month of coverage. Premium payments and applicable premium surcharges become due the first of the month in which medical coverage is effective. Premium payments and applicable premium surcharges are not prorated during any month, even if an Enrollee dies or if the Subscriber requests to terminate their medical plan before the end of a month.

2. ***The Subscriber is responsible for timely payment of premiums and applicable premium surcharges, and reporting changes in eligibility or address.*** The Subscriber and their covered Dependent(s) or beneficiary is responsible for reporting changes no later than 60 days after the event, such as divorce, termination of a state-registered domestic partnership, death, or when a Dependent no longer meets the eligibility criteria described under “Eligible Dependents.”

Failure to report changes can result in loss of premiums and loss of the Subscriber and their Dependent’s right to continue coverage under one of the continuation coverage options described in the “Options for

Continuing PEBB Medical Coverage” in subsection F. To find forms, retirees and survivors can visit www.hca.wa.gov/pebb-retirees or can call the PEBB Program at 1-800-200-1004.

3. If an Enrollee or newborn eligible for benefits under Maternity is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB coverage ends and the Enrollee is not immediately covered by other health care coverage, benefits will be extended until whichever of the following occurs first:
 - The Enrollee is discharged from the hospital or from a hospital to which the Enrollee is directly transferred;
 - The Enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization;
 - The Enrollee is discharged from a skilled nursing facility or from a skilled nursing facility to which the Enrollee is directly transferred;
 - The Enrollee is covered by another health plan that will provide benefits for the services; or
 - Benefits are exhausted.

When medical plan enrollment ends, the Enrollee may be eligible for continuation coverage or conversion to other health care coverage if application is made within the time limits explained in the following sections.

TIP: If your coverage under this plan ends, you are responsible for letting your providers know when you receive services. If you do not tell your provider your enrollment has ended and they bill this Plan for services you receive, the plan will deny all claims.

F. Options for Continuing PEBB Medical Coverage.

Subscribers and their Dependents covered by this medical plan may be eligible to continue enrollment if they lose eligibility and are eligible under one of the following options for continuing coverage:

1. PEBB Continuation Coverage (COBRA)
2. PEBB retiree insurance coverage

The first option above temporarily extends group insurance coverage if certain circumstances occur that would otherwise end your or your Dependent’s PEBB medical coverage. PEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements in federal law and regulation and also includes coverage for some enrollees who are not qualified beneficiaries under federal COBRA continuation coverage.

The second option above is available only to Dependents becoming eligible as a survivor who meet eligibility and procedural requirements.

The PEBB Program administers both options. Contact the PEBB Program at 1-800-200-1004 or refer to the PEBB *Continuation of Coverage Election Notice* booklet or the *Retiree Enrollment Guide* for details.

G. Conversion of Coverage.

Enrollees (including spouses and Dependents of a Subscriber who was terminated for cause) have the right to switch from PEBB group medical coverage to an individual conversion plan offered by this plan when they are no longer eligible to continue the PEBB group medical plan, and are not eligible for Medicare or covered under another group insurance coverage that provides benefits for hospital or medical care. Enrollees must apply for conversion coverage no later than 31 days after their group medical plan ends or within 31 days from the date the notice of the termination of coverage is received, whichever is later.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage and eligibility requirements of our conversion plan differ from those of the Enrollee’s current group medical plan. To obtain detailed information on conversion options under this medical plan, call Kaiser Permanente Member Services at (206) 630-0107 in the Seattle area, or toll-free in Washington, 1-866-648-1928.

H. Termination for Just Cause

The purpose of this provision is to allow for a fair and consistent method to process the plan-designated provider's request to terminate coverage from this plan for Just Cause.

A retiree or an eligible dependent may have coverage terminated by HCA for the following reasons:

1. Failure to comply with the PEBB program's procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB program;
2. Knowingly providing false information;
3. Failure to pay the monthly premium and applicable premium surcharge when due;
4. Misconduct. If a retiree's PEBB insurance coverage is terminated for misconduct, PEBB insurance coverage will not be reinstated at a later date. Examples of such termination include, but are not limited to the following:
 - a. Fraud, intentional misrepresentation or withholding of information the subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium;
 - b. Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan, or other HCA contracted vendor providing PEBB insurance coverage on behalf of the HCA, its employees, or other persons.

If a retiree's PEBB insurance coverage is terminated by HCA for the above reasons, PEBB insurance coverage for all of the retiree's eligible dependents is also terminated.

I. Appeals Rights.

Any Enrollee may appeal a decision made by the PEBB Program regarding PEBB eligibility, enrollment, or premium payments, or premium surcharges (if applicable) to the PEBB appeals Unit.

Any Enrollee may appeal a decision regarding the administration of health plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment decisions.

J. Relationship to Law and Regulations.

Any provision of this EOC that is in conflict with any governing law or regulation of the state of Washington is hereby amended to comply with the minimum requirements of such law or regulation.

K. Customer Service.

If you have questions about your PEBB retiree eligibility and benefit information, please contact the PEBB Program at 1-800-200-1004 or visit www.hca.wa.gov/pebb-retirees. For questions about Medicare, please contact the Centers for Medicare and Medicaid Services (CMS) at 1-800-MEDICARE or go to www.medicare.gov.

VII. Grievances

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

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

Step 2: If the Enrollee is still not satisfied, they should write to Member Services at P.O. Box 34590, Seattle, WA 98124-1590, or call at 206-630-0107 or toll-free 1-866-648-1928. Most concerns are handled by phone within a few days. In some cases the Enrollee will be asked to write down their concerns and state what they think would be a fair resolution to the problem. An appropriate representative will investigate the Enrollee's

concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Member Rights and Responsibilities statement. This process can take up to 30 days to resolve after receipt of the Enrollee's written statement.

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

VIII. Appeals

Enrollees are entitled to appeal through the appeals process if/when coverage for an item or service is denied due to an adverse determination made by the KFHPWA medical director. The appeals process is available for an Enrollee to seek reconsideration of an adverse benefit determination (action). Adverse benefit determination (action) means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Enrollee's eligibility to participate in a plan. KFHPWA will comply with any new requirements as necessary under federal laws and regulations. Assistance is available to Enrollees who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process. The most current information about your appeals process is available by contacting KFHPWA's Member Appeal Department at the address or telephone number below.

1. Initial Appeal

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

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

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

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

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

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

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

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

2. Next Level of Appeal

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

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

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

IX. Claims

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

If an Enrollee receives a bill for services the Enrollee believes are covered, the Enrollee must, within 90 days of the date of service, or as soon thereafter as reasonably possible, either (1) contact Member Services to make a claim or (2) pay the bill and submit a claim for reimbursement of Covered Services to KFHPWA, or (3) for out-of-country claims (Emergency care only) – submit the claim and any associated medical records, including the type of service, charges, and proof of travel to KFHPWA, P.O. Box 30766, Salt Lake City, UT 84130-0766. In no event, except in the absence of legal capacity, shall a claim be accepted later than 1 year from the date of service.

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

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

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

X. Coordination of Benefits

Note: If an Enrollee participating in a Health Savings Account has other health care coverage, the tax deductibility of Health Savings Account contributions may be affected. Please contact the Health Savings Account trustee or administrator regarding questions about requirements for Health Savings Accounts.

The coordination of benefits (COB) provision applies when an Enrollee has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits according to its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings.

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

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

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

Definitions.

- A. A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Enrollees of a Group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.
 1. Plan includes: group, individual or blanket disability insurance contracts and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
 2. Plan does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans; unless permitted by law.

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

- B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the **Enrollee** has health care coverage under more than one plan.

When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim. This means that when this plan is secondary, it must pay the amount which, when combined with what the primary plan paid, totals 100% of the allowable expense. In addition, if this plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the primary plan) and record these savings as a benefit reserve for the covered Enrollee. This reserve must be used by the secondary plan to pay any allowable expenses not otherwise paid, that are incurred by the covered person during the claim determination period.

- D. Allowable Expense. Allowable expense is a health care expense, coinsurance or copayments and without reduction for any applicable deductible, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the Enrollee 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 Enrollee is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
 3. If an Enrollee is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
 4. An expense or a portion of an expense that is not covered by any of the plans covering the person is not an allowable expense.
- E. Closed panel plan is a plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the plan, and that excludes coverage for services provided by other providers, except in cases of Emergency or referral by a panel member.
 - F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules.

When an Enrollee is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
- B. (1) Except as provided below (subsection 2), a plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both plans state that the complying plan is primary.

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

- C. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
- D. Each plan determines its order of benefits using the first of the following rules that apply:
1. Non-Dependent or Dependent. The plan that covers the Enrollee other than as a Dependent, for example as an employee, Enrollee, policyholder, Subscriber or retiree is the primary plan and the plan that covers the Enrollee 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 Enrollee as a Dependent, and primary to the plan covering the Enrollee 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 Enrollee as an employee, Enrollee, policyholder, Subscriber or retiree is the secondary plan and the other plan is the primary plan.
 2. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
 - b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;
 - ii. If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
 - iii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of a) above determine the order of benefits;
 - iv. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subsection a) above determine the order of benefits; or
 - v. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The plan covering the custodial parent, first;
 - The plan covering the spouse of the custodial parent, second;
 - The plan covering the non-custodial parent, third; and then
 - The plan covering the spouse of the non-custodial parent, last.

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

Effect on the Benefits of this Plan.

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

Right to Receive and Release Needed Information.

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

Facility of Payment.

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

Right of Recovery.

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

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

Effect of Medicare.

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

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

XI. Subrogation and Reimbursement Rights

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

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

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

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

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

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

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

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

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

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

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

If reasonable collections costs have been incurred by an attorney for the Injured Person in connection with obtaining recovery, KFHPWA will reduce the amount of reimbursement to KFHPWA by the amount of an equitable apportionment of such collection costs between KFHPWA and the Injured Person. This reduction will be made only if each of the following conditions has been met: (i) KFHPWA receives a list of the fees and associated costs before settlement and (ii) the Injured Person's attorney's actions were directly related to securing recovery for the Injured Party to the extent the provisions of this Subrogation and Reimbursement section are deemed governed by ERISA, implementation of this section shall be deemed a part of claims administration and KFHPWA shall therefore have discretion to interpret its terms.

XII. Definitions

Allowance	The maximum amount payable by KFHPWA for certain Covered Services.
Allowed Amount	The level of benefits which are payable by KFHPWA when expenses are incurred from a non-Network Provider. Expenses are considered an Allowed Amount if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies. Enrollees shall be required to pay any difference between a non-Network Provider's charge for services and the Allowed Amount, except for Emergency services.
Convalescent Care	Care furnished for the purpose of meeting non-medically necessary personal needs

	which could be provided by persons without professional skills or training, such as assistance in walking, dressing, bathing, eating, preparation of special diets, and taking medication.
Copayment	The specific dollar amount a Enrollee is required to pay at the time of service for certain Covered Services.
Cost Share	The portion of the cost of Covered Services for which the Enrollee is liable. Cost Share includes Copayments, coinsurances and Deductibles.
Covered Services	The services for which an Enrollee is entitled to coverage in the EOC.
Creditable Coverage	Coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, the actuarial determination measures whether the expected amount of paid claims under KFHPWA's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.
Deductible	A specific amount an Enrollee is required to pay for certain Covered Services before benefits are payable.
Dependent	Any member of a Subscriber's family who meets all applicable eligibility requirements, is enrolled hereunder and for whom the premium has been paid.
Emergency	The emergent and acute onset of a medical, mental health or substance use disorder symptom or symptoms, including but not limited to severe pain or emotional distress, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily function or serious dysfunction of a bodily organ or part, or would place the Enrollee's health, or if the Enrollee is pregnant, the health of the unborn child, in serious jeopardy, or any other situations which would be considered an emergency under applicable federal or state law.
Enrollee	Any enrolled Subscriber or Dependent.
Essential Health Benefits	Benefits set forth under the Patient Protection and Affordable Care Act of 2010, including the categories of ambulatory patient services, Emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.
Evidence of Coverage (EOC)	The Evidence of Coverage is a statement of benefits, exclusions and other provisions as set forth in the Group medical coverage agreement between KFHPWA and the Group.
Family Unit	A Subscriber and all their Dependents.
Group	An employer, union, welfare trust or bona-fide association which has entered into a Group medical coverage agreement with KFHPWA.
Health Savings Account (HSA)	A tax-exempt savings account established exclusively for the purpose of paying qualified medical expenses and meeting other requirements under federal law.

Health Savings Account (HSA) Qualified Health Plan	A high deductible health plan that meets regulatory requirements for use in conjunction with a Health Savings Account.
Hospital Care	Those Medically Necessary services generally provided by acute general hospitals for admitted patients.
KFHPWA-designated Specialist	A specialist specifically identified by KFHPWA.
Medical Condition	A disease, illness or injury.
Medically Necessary	Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Enrollees will be notified in writing when a determination has been made. Appropriate and clinically necessary services, as determined by KFHPWA's medical director according to generally accepted principles of good medical practice, which are rendered to an Enrollee for the diagnosis, care or treatment of a Medical Condition and which meet the standards set forth below. In order to be Medically Necessary, services and supplies must meet the following requirements: (a) are not solely for the convenience of the Enrollee, their family member or the provider of the services or supplies; (b) are the most appropriate level of service or supply which can be safely provided to the Enrollee; (c) are for the diagnosis or treatment of an actual or existing Medical Condition unless being provided under KFHPWA's schedule for preventive services; (d) are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions; (e) are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the Enrollee's condition or the quality of health services rendered; (f) as to inpatient care, could not have been provided in a provider's office, the outpatient department of a hospital or a non-residential facility without affecting the Enrollee's condition or quality of health services rendered; (g) are not primarily for research and data accumulation; and (h) are not experimental or investigational. The length and type of the treatment program and the frequency and modality of visits covered shall be determined by KFHPWA's medical director. In addition to being medically necessary, to be covered, services and supplies must be otherwise included as a Covered Service and not excluded from coverage.
Medicare	The federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).
Network Facility	A facility (hospital, medical center or health care center) owned or operated by Kaiser Foundation Health Plan of Washington or otherwise designated by KFHPWA, or with whom KFHPWA has contracted to provide health care services to Enrollees.
Network Personal Physician	A provider who is employed by Kaiser Foundation Health Plan of Washington or Washington Permanente Medical Group, P.C., or contracted with KFHPWA to provide primary care services to Enrollees and is selected by each Enrollee to provide or arrange for the provision of all non-emergent Covered Services, except for services set forth in the EOC which an Enrollee can access without Preauthorization. Network Personal Physicians must be capable of and licensed to provide the majority of primary health care services required by each Enrollee.
Network Provider	The medical staff, clinic associate staff and allied health professionals employed by

	Kaiser Foundation Health Plan of Washington or Washington Permanente Medical Group, P.C., and any other health care professional or provider with whom KFHPWA has contracted to provide health care services to Enrollees, including, but not limited to physicians, podiatrists, nurses, physician assistants, social workers, optometrists, psychologists, physical therapists and other professionals engaged in the delivery of healthcare services who are licensed or certified to practice in accordance with Title 18 Revised Code of Washington.
Out-of-pocket Expenses	Those Cost Shares paid by the Subscriber or Enrollee for Covered Services which are applied to the Out-of-pocket Limit.
Out-of-pocket Limit	The maximum amount of Out-of-pocket Expenses incurred and paid during the calendar year for Covered Services received by the Subscriber and their Dependents within the same calendar year. The Out-of-pocket Expenses which apply toward the Out-of-pocket Limit are set forth in Section IV.
Plan Coinsurance	The percentage amount the Enrollee is required to pay for Covered Services received.
Preauthorization	An approval by KFHPWA that entitles a Enrollee to receive Covered Services from a specified health care provider. Services shall not exceed the limits of the Preauthorization and are subject to all terms and conditions of the EOC. Enrollees who have a complex or serious medical or psychiatric condition may receive a standing Preauthorization for specialty care provider services.
Residential Treatment	A term used to define facility-based treatment, which includes 24 hours per day, 7 days per week rehabilitation. Residential Treatment services are provided in a facility specifically licensed in the state where it practices as a residential treatment center. Residential treatment centers provide active treatment of patients in a controlled environment requiring at least weekly physician visits and offering treatment by a multi-disciplinary team of licensed professionals.
Service Area	Washington counties of Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman and Yakima.
Subscriber	A person employed by or belonging to the Group who meets all applicable eligibility requirements, is enrolled and for whom the premium has been paid.
Urgent Condition	The sudden, unexpected onset of a Medical Condition that is of sufficient severity to require medical treatment within 24 hours of its onset.