



KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

A nonprofit health maintenance organization

2025 Benefits Booklet – LEOFF 1

Important Notice Under Federal Health Care Reform

Kaiser Foundation Health Plan of Washington (“KFHPWA”) recommends each Member choose a Network Personal Physician. This decision is important since the designated Network Personal Physician provides or arranges for most of the Member’s health care. The Member has the right to designate any Network Personal Physician who participates in one of the KFHPWA networks and who is available to accept the Member or the Member’s family members. For information on how to select a Network Personal Physician, and for a list of the participating Network Personal Physicians, please call Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

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

The Member does not need Preauthorization from KFHPWA or from any other person (including a Network Personal Physician) to access obstetrical or gynecological care from a health care professional in the KFHPWA network who specializes in obstetrics or gynecology. 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) 630-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

For More Information

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

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I. Introduction

This booklet includes information about medical benefits available under the King County Deputy Sheriff's SmartCare Connect Group Health Plan ("Plan") to eligible staff and their family members and serves as the Benefits Booklet for medical, pharmacy and optical benefits.

II. Medical Plan

King County's Group Health Plan is designed to provide health benefits for King County Deputy Sheriff's employees and their eligible family members. Questions about eligibility for health coverage can be answered by King County.

This document describes the health benefits offered under the Plan. The health benefits are administered by Kaiser Foundation Health Plan Washington (KFHPWA). If you have questions regarding your coverage or how benefits have been paid, KFHPWA encourages you to contact Kaiser Permanente Member Services at 206-630-4636 or toll free 888-901-4636.

Please take the time to become familiar with the benefits that the Plan offers. Many terms used in this booklet have specific meanings that are defined in the Definitions section.

III. Eligibility, Enrollment and Termination

An Employee becomes eligible to enroll in coverage if the Employee is a member of the Law Enforcement Officer, Fire Fighter pension plan One (LEOFF-I) and officially retired from King County in his or her capacity as a Deputy Sheriff. Please reach out to King County Benefits, Payroll and Retirement Operations team for more information on whether you meet the eligibility requirements for LEOFF-1 coverage.

IV. How Covered Services Work

KFHPWA is contracted by King County to perform health plan administrative services and to arrange for the delivery of health care services only and does not assume any financial risk or obligation with respect to claims.

Read This Benefits Booklet Carefully

This Benefits Booklet is a statement of benefits, exclusions and other provisions of the Plan.

A full description of benefits, exclusions, limits and Out-of-Pocket Expenses can be found in the Benefits Details section and the General Exclusions. These sections must be considered together to fully understand the benefits available under the Plan. Words with special meaning are capitalized and defined in the Definitions section.

A. Accessing Care.

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

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

Benefits under this Benefits Booklet 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 Benefits Booklet 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. Information available online includes each physician's location, education, credentials,

and specialties. KFHPWA also utilizes Health Care Benefit Managers for certain services. To see a list of Health Care Benefit Managers, go to <https://healthy.kaiserpermanente.org/washington/support/forms> and click on the “Evidence of coverage” link.

Receiving Care in another Kaiser Foundation Health Plan Service Area

If you are visiting in the service area of another Kaiser Permanente region, visiting member services may be available from designated providers in that region if the services would have been covered under this Benefits Booklet. Visiting member services are subject to the provisions set forth in this Benefits Booklet including, but not limited to, Preauthorization and cost sharing. For more information about receiving visiting member services in other Kaiser Permanente regional health plan service areas, including provider and facility locations, please call Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636. Information is also available online at www.wa.kaiserpermanente.org/html/public/services/traveling.

2. Primary Care Provider Services.

KFHPWA recommends that Members 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) 630-4636 in the Seattle area, or toll-free in Washington at 1-888-901-4636 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 Members 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 Members.

To find a personal physician, call Member Services or access the KFHPWA website at www.kp.org/wa to view physician profiles. Information available online includes each physician’s location, education, credentials, and specialties.

For your personal physician, choose from these specialties:

- Family medicine
- Adult medicine/internal medicine
- Pediatrics/adolescent medicine (for children up to 18)

Be sure to check that the physician you are considering is accepting new patients.

If your choice does not feel right after a few visits, you can change your personal physician at any time, for any reason. If you don’t choose a physician when you first become a KFHPWA member, we will match you with a physician to make sure you have one assigned to you if you get sick or injured.

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

3. Specialty Care Provider Services.

Unless otherwise indicated, 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, chiropractic/manipulative therapy, dermatology, gastroenterology, general surgery, hospice, mental health and wellness, nephrology,

neurology, obstetrics and gynecology, occupational medicine, oncology/hematology, ophthalmology, optometry, orthopedics, otolaryngology (ear, nose and throat), physical therapy, smoking cessation, speech/language and learning services, substance use disorder and urology.

4. Hospital Services.

Non-Emergency inpatient hospital services require Preauthorization. Refer to the Benefits Details section for more information about hospital services.

5. Emergency Services.

Emergency services at a Network Facility or non-Network Facility are covered. Members 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 the Benefits Details section for more information about Emergency services.

Members are covered for Emergency care and Medically Necessary urgent care anywhere in the world. If you think you are experiencing an emergency, go immediately to the nearest emergency care facility or call 911. Go to the closest urgent care center for an illness or injury that requires prompt medical attention but is not an emergency. Examples include, but are not limited to minor injuries, wounds, and cuts needing stitches; minor breathing issues; minor stomach pain. If you are unsure whether urgent care is your best option, call the consulting nurse helpline for advice at 1-800-297-6877 or 206-630-2244.

If you need Emergency care while traveling and are admitted to a non-network hospital, you or a family member must notify us within 24 hours after care begins, or as soon as is reasonably possible. Call the notification line listed on the back of your KFHPWA Member ID card to help make sure your claim is accepted. Keep receipts and other paperwork from non-network care. You'll need to submit them with any claims for reimbursement after returning from travel.

Access to non-Emergency care across the Network service area: your Plan provides access to all providers in the Network, including many physicians and services at Kaiser Permanente medical facilities and Network facilities across the state. Find links to providers at kp.org/wa/directory or contact Member Services at 1-888-901-4636 for assistance.

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 the Benefits Details section for more information about urgent care.

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

7. Women's Health Care Direct Access Providers.

Female Members 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 within your KFHPWA Network 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 Member's Network Personal Physician had been consulted, subject to any applicable Cost Shares. If the Member's women's health care provider diagnoses a condition that requires other specialists or hospitalization, the Member or her chosen provider must obtain Preauthorization in accordance with applicable KFHPWA requirements.

8. Travel Advisory Service.

Our Travel Advisory Service offers recommendations tailored to your travel outside the United States. Nurses certified in travel health will advise you on any vaccines or medications you need based on your destination, activities, and medical history. The consultation is not a covered benefit and there is a fee for a KFHPWA Member using the service for the first time. Travel-related vaccinations and medications are usually not covered. Visit kp.org/wa/travel-service for more details.

9. Process for Medical Necessity Determination.

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

First Level Review:

First level reviews are performed or overseen by appropriate clinical staff using KFHPWA approved clinical review criteria. Data sources for the review include, but are not limited to, referral forms, admission request forms, the Member's medical record, and consultation with the qualified health professionals and multidisciplinary health care team members. 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 Member or legal surrogate may be contacted for information. Coordination of care interventions are initiated as they are identified. The reviewer consults with the health care team 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 health care team 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 Benefits Booklet.

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

C. Assignment.

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

D. Confidentiality.

KFHPWA is required by federal and state law to maintain the privacy of Member 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 Members and is available in Kaiser Permanente medical centers, at www.kp.org/wa, or upon request from Member Services.

E. Modification of the Plan.

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

F. 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 Member's coverage and will not deny care on the basis of age, sex, sexual orientation, gender identity, race, color, religion, national origin, citizenship or immigration status, veteran or military status, occupation or health status.

G. Preauthorization.

Refer to <https://healthy.kaiserpermanente.org/washington/support/forms#preauthorizationrequirementsforms>, the Benefits Details section or call Member Services for more information regarding which services, prescriptions, equipment and facility types KFHPWA requires Preauthorization. All residential treatment, non-emergency inpatient hospital and non-emergency ambulance services require Preauthorization. Failure to obtain Preauthorization when required may result in denial of coverage for those services; and the Member may be responsible for the cost of these non-Covered services. Members may contact Member Services to request Preauthorization.

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

- For electronic standard requests – within three calendar days, excluding holidays
 - If insufficient information has been provided, a request for additional information will be made within one calendar day.
- For electronic expedited prior authorization requests – within one calendar day
 - If insufficient information has been provided, a request for additional information will be made within one calendar day.
- For nonelectronic standard requests – within five calendar days
 - If insufficient information has been provided, a request for additional information will be made within five calendar days.
- For nonelectronic expedited requests – within two calendar days
 - If insufficient information has been provided, a request for additional information will be made within one calendar day.

H. 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. Members have the right to appeal coverage decisions (see Appeals section). Members have the right to participate in decisions regarding their health care. A Member may refuse any recommended services to the extent permitted by law. Members who obtain care not recommended by KFHPWA's medical director do so with the full understanding that KFHPWA has no obligation for the cost, or liability for the outcome, of such care.

New and emerging medical technologies are evaluated on an ongoing basis by the following committees – the Interregional New Technologies Committee, Medical Technology Assessment Committee, Medical Policy Committee, and Pharmacy and Therapeutics Committee. These physician evaluators consider the new technology's benefits, whether it has been proven safe and effective, and under what conditions its use would be appropriate. The recommendations of these committees inform what is covered on KFHPWA health plans.

I. Second Opinions.

The Member may access a second opinion from a Network Provider regarding a medical diagnosis or treatment plan. The Member 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 Member's Plan; 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 Member 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 Plan.

J. 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.

K. Utilization Management.

“Case Management” means a care management plan developed for a Member whose diagnosis requires timely coordination. All benefits, including travel and lodging, are limited to Covered Services that are Medically Necessary and set forth in the Plan. KFHPWA may review a Member'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 Member except in the case of an intentional misrepresentation of a material fact by the patient, Member, 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.

V. Financial Responsibilities

A. Financial Responsibilities for Covered Services.

The employee is liable for the following Cost Shares when services are received by the employee 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.

Covered Services may be subject to an annual Deductible. Charges subject to the annual Deductible shall be borne by the employee during each year until the annual Deductible is met. Covered Services must be received from a Network Provider at a Network Facility, unless the Member has received Preauthorization or has received Emergency services.

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

Individual Annual Deductible Carryover. Under this Benefits Booklet, charges from the last 3 months of the prior year which were applied toward the individual annual Deductible will also apply to the current year individual annual Deductible. The individual annual Deductible carryover will apply only when expenses incurred have been paid in full. The Family Unit Deductible does not carry over into the next year.

2. Plan Coinsurance.

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

3. Copayments.

Members 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.

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

B. Financial Responsibilities for Non-Covered Services.

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

VI. Benefits Details

Benefits are subject to all provisions of the Plan. Members are entitled only to receive benefits and services that are Medically Necessary and clinically appropriate for the treatment of a Medical Condition as determined by KFHPWA's medical director and as described herein. All Covered Services are subject to case management and utilization management.

Annual Deductible	Member pays \$0 per Member per calendar year or \$0 per Family Unit per calendar year
Coinsurance	Plan Coinsurance: Member pays nothing
Lifetime Maximum	No lifetime maximum on covered Essential Health Benefits
Out-of-pocket Limit	Limited to a maximum of \$1,000 per Member or \$2,000 per Family Unit per calendar year
	The following Out-of-pocket Expenses apply to the Out-of-pocket Limit: All Cost Shares for Covered Services The following expenses do not apply to the Out-of-pocket Limit: Premiums, charges for services in excess of a benefit, charges in excess of Allowed Amount, charges for non-Covered Services
Pre-existing Condition Waiting Period	No pre-existing condition waiting period
Preauthorization	Preauthorization may be required for some services. Refer to Section IV.G for more Information.

Acupuncture	
Acupuncture needle treatment. Limited to 8 visits per medical diagnosis per calendar year without Preauthorization. No visit limit for treatment for Substance Use Disorder.	Member pays \$20 Copayment
Exclusions: Herbal supplements; any services not within the scope of the practitioner's licensure	

Allergy Services	
Allergy testing.	Member pays \$20 Copayment
Allergy serum and injections. Injection rooms: Most KFHPWA owned and operated medical centers have an area where injections and vaccines are administered by nurses. For additional information on appointment requirements go to www.kp.org/wa.	Administered in a Pharmacy or Injection room setting: No charge; Member pays nothing All other settings: Member pays \$20 Copayment

Ambulance	
Emergency ambulance service is covered only when: • Transport is to the nearest facility, including behavioral health emergency services providers, that can treat your condition. • Any other type of transport would put your health or safety at risk. • The service is from a licensed ambulance. • The ambulance transports you to a location where you receive covered services. Emergency air or sea medical transportation is covered only when: • The above requirements for ambulance service are met, and • Geographic restraints prevent ground Emergency transportation to the nearest facility that can treat your condition, or ground Emergency transportation would put your health or safety at risk.	Member pays 20% ambulance coinsurance
Non-Emergency ground or air interfacility transfer to or from a Network Facility where you receive covered services when Preauthorized by KFHPWA. Contact Member Services for Preauthorization.	Member pays 20% ambulance coinsurance Hospital-to-hospital ground transfers: No charge; Member 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; Member pays nothing
Diagnostic laboratory and diagnostic services for cancer. See Diagnostic Laboratory and Radiology Services for additional information. Preventive laboratory/radiology services are covered as Preventive Services.	No charge; Member pays nothing

Circumcision	
Circumcision.	Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment Outpatient Services: Member pays \$20 Copayment Within 60 days of birth, Member pays nothing

Clinical Trials	
Notwithstanding any other provision of this document, the Plan provides benefits for Routine Patient Costs of qualified individuals in approved clinical trials, to the extent benefits for these costs are required by federal and state law. Routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. Clinical trials are a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. "Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.	Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment Outpatient Services: Member pays \$20 Copayment
Exclusions: Routine patient costs do not include: (i) the investigational item, device, or service, itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis	

Dental Services and Dental Anesthesia	
Dental services (i.e., examination, evaluation and treatment) including accidental injury to natural teeth. Repair of accidental injury to sound, natural teeth are covered when provided by a licensed dentist within 12 months of the date of injury. The treatment timeframe may be extended for children under 14 who are covered at the time of the accident and meet the coverage criteria. Dental services (evaluation and treatment) in preparation for treatment including but not limited to chemotherapy, radiation therapy, and organ transplants. Dental problems such as infections requiring emergency treatment outside of standard business hours are covered as Emergency Services.	Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment Outpatient Services: Member pays \$20 Copayment
General anesthesia services and related facility charges for dental procedures for Members who are under 7 years of age, or are physically or developmentally disabled or have a Medical Condition where the Member's health would be put at risk if the dental procedure were performed in a dentist's office.	Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment
Exclusions: Dentist's or oral surgeon's fees; dental care, surgery, services and appliances, including: injuries caused by biting or chewing, reconstructive surgery to the jaw in preparation for dental implants, dental implants, periodontal surgery; any other dental service not specifically listed as covered	

Devices, Equipment and Supplies (for home use)	
Durable medical equipment: Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and is used in the Member's home. Equipment must be ordered or prescribed by a Network Provider. • Examples of covered durable medical equipment include: hospital beds; wheelchairs; walkers; crutches; canes; blood glucose monitors; external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters); oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks) 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	Member pays 20% coinsurance

or assisting in restoration or improvement of its function. • 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 Member'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. 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.	
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; take-home dressings and supplies following hospitalization; supplies, dressings, appliances, devices or services not specifically listed as covered above; same as or similar equipment already in the Member's possession; replacement or repair due to loss, theft, breakage from willful damage, neglect or wrongful use, or due to personal preference; structural modifications to a Member's home or personal vehicle	

Diabetic Education, Equipment and Pharmacy Supplies	
Diabetic education and training.	Member pays \$20 Copayment
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.	Member pays 20% coinsurance
Diabetic pharmacy supplies: Insulin, lancets, lancet devices, needles, insulin syringes, disposable insulin pens, pen needles, glucagon emergency kits, prescriptive oral agents and blood glucose test strips for a supply of 30 days or less per item. Certain brand name insulin drugs will be covered at the generic level. See Drugs – Outpatient Prescription for additional pharmacy information.	Preferred generic drugs (Tier 1): Member pays \$10 Copayment per 30-days up to a 90-day supply Preferred brand name drugs (Tier 2): Member pays \$20 Copayment per 30-days up to a 90-day supply Non- Preferred generic and brand name drugs (Tier 3): Member pays \$30 Copayment per 30-days up to a 90-day supply
Diabetic retinal screening.	No charge; Member pays nothing

Dialysis (Home and Outpatient)	
Dialysis in an outpatient or home setting is covered for Members with acute kidney failure or end-stage renal disease	Outpatient Services: Member pays \$20 Copayment

(ESRD). If you do not choose to enroll in Original Medicare Part B, applicable cost shares on your plan will apply. Important things to know: • The cost of dialysis can be substantial. We recommend calling Member Services to find Network providers. • If you have end-stage renal disease (ESRD), you may be eligible for Original Medicare Part B. If you are eligible, this will reduce your costs substantially. Enrollment in Original Medicare Part B is optional. • Original Medicare Part B has a waiting period, generally the first 90 days after dialysis starts. Original Medicare Part B doesn't start covering any of your costs until after that waiting period. • As soon as you are enrolled in Original Medicare Part B, we will directly reimburse you for your Original Medicare Part B premiums. We will continue to reimburse your Original Medicare Part B premiums for as long as you are enrolled in this plan, eligible for and enrolled in Original Medicare Part B due to ESRD.	
If you chose to enroll in Original Medicare Part B, Medicare may assist with you Member cost shares. Dialysis in an outpatient or home setting is covered for Members with end-stage renal disease (ESRD). Coordination of Benefits rules apply. If you do not choose to enroll in Original Medicare Part B, applicable cost shares on your plan will apply.	Medicare eligible charges, No charge Member pays nothing
Injections administered by a Network Provider in a clinical setting during dialysis.	Outpatient Services: Member pays \$20 Copayment
Self-administered injectables. See Drugs – Outpatient Prescription for additional pharmacy information.	Preferred generic drugs (Tier 1): Member pays \$10 Copayment per 30-days up to a 90-day supply Preferred brand name drugs (Tier 2): Member pays \$20 Copayment per 30-days up to a 90-day supply Non-Preferred generic and brand name drugs (Tier 3): Member pays \$30 Copayment per 30-days up to a 90-day supply
Drugs - Outpatient Prescription	
Prescription drugs, supplies and devices for a supply of 30 days or less including diabetic pharmacy supplies (insulin,	Preferred generic drugs (Tier 1): Member pays \$10 Copayment per 30-days up to a 90-day supply

lancets, lancet devices, needles, insulin syringes, disposable insulin pens, pen needles and blood glucose test strips), mental health and wellness drugs, self-administered injectables, and routine costs for prescription medications provided in a clinical trial. “Routine costs” means items and services delivered to the Member that are consistent with and typically covered by the plan or coverage for a Member who is not enrolled in a clinical trial. All drugs, supplies and devices must be for Covered Services.

Pre-exposure Prophylaxis (PrEP) services are covered under the Preventive Services section. For a list of PrEP medications, refer to the formulary at www.kp.org/wa/formulary and choose the “Preventive medication and preferred contraceptives” link. All drugs, supplies and devices must be obtained at a KFHPWA-designated pharmacy except for drugs dispensed for Emergency services or for Emergency services obtained outside of the KFHPWA Service Area including out of the country. Information regarding KFHPWA-designated pharmacies is reflected in the KFHPWA Provider Directory or can be obtained by contacting Kaiser Permanente Member Services.

Prescription drug Cost Shares are payable at the time of delivery. Certain brand name insulin drugs are covered at the generic drug Cost Share.

Members may be eligible to receive an emergency fill for certain prescription drugs filled outside of KFHPWA’s business hours or when KFHPWA cannot reach the prescriber for consultation. For emergency fills, Members pay the prescription drug Cost Share for each 7-day supply or less, or the minimum packaging size available at the time the emergency fill is dispensed. A list of prescription drugs eligible for emergency fills is available on the pharmacy website at www.kp.org/wa/formulary. Members can request an emergency fill by calling 1-855-505-8107.

Certain drugs are subject to Preauthorization as shown in the Preferred drug list (formulary) available at www.kp.org/wa/formulary.

For outpatient prescription drugs and/or items that are covered under the Drugs – Outpatient Prescription section and obtained at a pharmacy owned and operated by KFHPWA, a Member may be able to use approved manufacturer coupons as payment for the Cost Sharing that a Member owes, as allowed under KFHPWA’s coupon program. A Member will owe any additional amount if the coupon does not cover the entire amount of the Cost Sharing for the Member’s prescription. When a Member uses an approved coupon for payment of their Cost Sharing, the coupon amount and any additional payment that you make will accumulate to their Out-of-Pocket Limit. More information is available regarding the Kaiser Permanente coupon program rules and limitations

Preferred brand name drugs (Tier 2): Member pays \$20 Copayment per 30-days up to a 90-day supply

Non- Preferred generic and brand name drugs (Tier 3): Member pays \$30 Copayment per 30-days up to a 90-day supply

Note: A Member will not pay more than \$35, not subject to the Deductible, for a 30-day supply of each prescription for the following medications: insulin, and at least one inhaled corticosteroid, and at least one inhaled corticosteroid combination and at least one 2 pack of epinephrine autoinjectors . Any cost sharing paid will apply toward the annual Deductible. Please refer to the formulary for additional information.

One regimen of human immunodeficiency virus postexposure prophylaxis: Member pays nothing

at kp.org/rxcoupons .	
Injections administered by a Network Provider in a clinical setting, including injections necessary for travel. Injection rooms: Most KFHPWA owned and operated medical centers have an area where injections and vaccines are administered by nurses. For additional information on appointment requirements go to www.kp.org/wa.	Administered in a Pharmacy or Injection room setting: No charge; Member pays nothing All other settings: Member pays \$20 Copayment
Over-the-counter drugs not included under Preventive Care or Reproductive Health.	Not covered; Member pays 100% of all charges
Mail order drugs dispensed through the KFHPWA-designated mail order service.	Member pays two times the prescription drug Cost Share for each 90 day supply or less. If the supply is 30 days or less, Member pays the prescription drug Cost Share. Note: A Member will not pay more than \$35, not subject to the Deductible, for a 30-day supply of each prescription for the following medications: insulin, and at least one inhaled corticosteroid, and at least one inhaled corticosteroid combination and at least one 2 pack of epinephrine autoinjectors . Any cost sharing paid will apply toward the annual Deductible. Please refer to the formulary for additional information.
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. For a refill of a prescription previously covered by KFHPWA as non-transition benefit for a medically stable member that KFHPWA deems medically necessary for serious mental illness, KFHPWA will not require substitution of a non-preferred with a preferred non-interchangeable drug in the therapeutic class mid-plan year and will not increase cost-sharing obligation mid-plan year for the drug. A Member, a Member's designee, or a prescribing physician may request a coverage exception to gain access to clinically appropriate drugs if the drug is not otherwise covered by contacting Member Services. Coverage determination reviews may include requests to cover non-preferred drugs, obtain Preauthorization for a specific drug, or exceptions to other utilization management requirements, such as quantity limits. KFHPWA will provide a determination and notification of the determination no later than 72 hours of the request after receipt of information sufficient to make a decision. The prescribing physician must submit an oral or written statement regarding the need for the non-Preferred drug, and a list of all of the preferred drugs which have been ineffective for the Member. Expedited or Urgent Reviews: A Member, a Member's designee, or a prescribing physician may request an expedited review for coverage for non-covered drugs when a delay caused by using the standard review process will seriously jeopardize the Member's life, health or ability to regain maximum function or will subject to the Member to severe	

pain that cannot be managed adequately without the requested drug. KFHPWA or the IRO will provide a determination and notification of the determination no later than 24 hours from the receipt of the request after receipt of information sufficient to make a decision.

Prescription drugs are drugs which have been approved by the Food and Drug Administration (FDA) and which can, under federal or state law, be dispensed only pursuant to a prescription order. These drugs, including off-label use of FDA-approved drugs (provided that such use is documented to be effective in one of the standard reference compendia; a majority of well-designed clinical trials published in peer-reviewed medical literature document improved efficacy or safety of the agent over standard therapies, or over placebo if no standard therapies exist; or by the federal secretary of Health and Human Services) are covered. "Standard reference compendia" means the American Hospital Formulary Service – Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia – Drug Information, or other authoritative compendia as identified from time to time by the federal secretary of Health and Human Services. "Peer-reviewed medical literature" means scientific studies printed in health care journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

Generic drugs are dispensed whenever available. A generic drug is a drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. Brand name drugs are dispensed if there is not a generic equivalent. In the event the Member elects to purchase a brand-name drug instead of the generic equivalent (if available), the Member is responsible for paying the difference in cost in addition to the brand-name prescription drug Cost Share, which does not apply to the Out-of-pocket Limit. Member will never pay more than the actual cost of the prescription.

Drug coverage is subject to utilization management that includes Preauthorization, step therapy (when a Member tries a certain medication before receiving coverage for a similar, but non-Preferred medication), limits on drug quantity or 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 a Member has a new prescription for a chronic condition, the Member may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity. Please contact Member Services for more information.

Specialty drugs are high-cost drugs prescribed by a physician that 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. 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 206-630-4636 or toll-free at 1-888-901-4636.

The Member's Right to Safe and Effective Pharmacy Services: State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee Members' right to know what drugs are covered and the coverage limitations. Members who would like more information about the drug coverage policies, or have a question or concern about their pharmacy benefit, may contact KFHPWA at 206-630-4636 or toll-free 1-888-901-4636 or by accessing the KFHPWA website at www.kp.org/wa.

Members who have a concern about the pharmacists or pharmacies serving them may call the Washington State Department of Health at toll-free 1-800-525-0127.

Prescription Drug Coverage and Medicare: This benefit, for purposes of Creditable Coverage, is actuarially equal to or greater than the Medicare Part D prescription drug benefit. Members who are also eligible for Medicare Part D can remain covered and will not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D plan at a later date; however, the Member could be subject to payment of higher Part D premiums if the Member subsequently has a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan. A Member 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 for anticipated illness while traveling; drugs and injections for cosmetic purposes; replacement of lost, stolen, or damaged drugs or devices; administration of excluded drugs and injectables; drugs used in the treatment of sexual dysfunction disorders; compounds which include a non-FDA approved drug; growth hormones for idiopathic short stature without growth hormone deficiency; prescription drugs/products available over-the-counter or have an over-the-counter alternative that is determined to be therapeutically interchangeable

Emergency Services	
Emergency services at a Network Facility or non-Network Facility. See the Definitions section for a definition of Emergency. Emergency services include professional services, treatment and supplies, facility costs, outpatient charges for patient observation, medical screening exams required to stabilize a patient, and post stabilization treatment. Members must notify KFHPWA by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. If a Member is admitted as an inpatient directly from an emergency department, any Emergency services Copayment is waived. Coverage is subject to the applicable hospital services Cost Shares. If a Member is hospitalized in a non-Network Facility, KFHPWA reserves the right to require transfer of the Member to a Network Facility upon consultation between a Network Provider and the attending physician. If the Member refuses to transfer to a Network Facility or does not notify KFHPWA within 24 hours following admission, all further costs incurred during the hospitalization are the responsibility of the Member. Follow-up care which is a direct result of the Emergency must be received from a Network Provider, unless Preauthorization is obtained for such follow-up care from a non-Network Provider.	Network Facility: Member pays \$100 Copayment Non-Network Facility: Member pays \$100 Copayment

Fertility (including sterility)	
General counseling and diagnostic services. Fertility services require Preauthorization.	Member pays \$20 Copayment
Specific diagnostic services, treatment related to conception by artificial insemination, in vitro fertilization, and assisted reproduction, including Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT). Services	Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20

include egg freezing and storage regardless of infertility diagnosis. Fertility drugs are covered in accordance with criteria established by KFHPWA. Fertility services require Preauthorization. Important! Egg freezing and tissue storage – know before you decide: Per IRS guidance, fertility preservation will be treated as a taxable benefit. If you choose this option, be aware that the cost of the procedure and subsequent storage will be added as taxable wages to your W-2. We recommend you consult with a tax advisor to determine how this might impact your specific circumstances.	Copayment Outpatient Services: Member pays \$20 Copayment Fertility treatments and services (including egg freezing and storage) are limited to a lifetime maximum of \$25,000 Fertility Drugs: Member pays 20% Coinsurance Fertility drugs are limited to a lifetime maximum of \$5,000
Exclusions: All charges and related services for donor materials; prognostic (predictive) genetic testing for the detection of congenital and heritable disorders; cryopreservation services not listed above; surrogacy	

Gender Health Services	
Coverage criteria are based on the Standards of Care published by the World Professional Association for Transgender Health. All gender health services must meet the prior approval requirements and are covered subject to the applicable inpatient and outpatient cost shares. Certain procedures are subject to age limits, please see our clinical criteria https://wa-provider.kaiserpermanente.org/static/pdf/hosting/clinical/criteria/pdf/gender_reassignment_surgery.pdf for details. Surgical services may include, but aren't limited to, mastectomy, hysterectomy, salpingo-oophorectomy, colectomy, metoidioplasty, colovaginoplasty, orchiectomy, penectomy, clitoroplasty and labiaplasty. Covered services may include hair removal or hair grafts, facial reconstruction or other gender-affirming procedures. Hormone therapy for gender dysphoria is covered subject to the applicable prescription drug cost share. Voice therapy may be covered. Counseling services for gender dysphoria are covered subject to the applicable outpatient services cost share.	Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment Outpatient Services: Member pays \$20 Copayment
Exclusions: Services that are not consistent with WPATH standards of care are excluded.	

Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation are covered only when provided at KFHPWA-approved facilities. Cochlear implants or Bone Anchored Hearing System (BAHS) when in accordance with KFHPWA clinical criteria. Covered services for initial cochlear implants and BAHS include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries). Replacement devices and associated supplies – see Devices, Equipment and Supplies Section.	Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment Outpatient Services: Member pays \$20 Copayment
Hearing aids including hearing aid examinations.	Not covered; Member pays 100% of all charges
Exclusions: Except as described above, programs or treatments for hearing loss or hearing care including, but not limited to, externally worn hearing or surgically implanted hearing aids and the surgery and services necessary to implant them; hearing screening tests required under Preventive Services	

Home Health Care	
Home health care when the following criteria are met: • Except for patients receiving palliative care services, the Member must be unable to leave home due to their health problem or illness. Unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home. • The Member requires intermittent skilled home health care, as described below. • KFHPWA's medical director determines that such services are Medically Necessary and are most appropriately rendered in the Member's home. Covered Services for home health care may include the following when rendered pursuant to a KFHPWA-approved home health care plan of treatment: nursing care; restorative physical, occupational, respiratory and speech therapy; durable medical equipment; medical social worker and limited home health aide services. Home health services are covered on an intermittent basis in the Member's home. "Intermittent" means care that is to be rendered because of a medically predictable recurring need for skilled home health care. "Skilled home health care" means reasonable and necessary care for the treatment of an illness or injury which requires the skill of a nurse or therapist, based on the complexity of the service and the condition of the patient and which is performed directly by an	No charge; Member pays nothing

appropriately licensed professional provider.	
Exclusions: Private Duty Nursing; housekeeping or meal services; any care provided by or for a family member; any other services rendered in the home which do not meet the definition of skilled home health care above	

Hospice	
Hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a Member and any family members who are caring for the member, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of the Member and their family during the final stages of illness. In order to qualify for hospice care, the Member's provider must certify that the Member is terminally ill and is eligible for hospice services. Inpatient Hospice Services. For short-term care, inpatient hospice services are covered with Preauthorization. Respite care is covered to provide continuous care of the Member and allow temporary relief to family members from the duties of caring for the Member for a maximum of 5 consecutive days per 3-month period of hospice care. Other covered hospice services may include the following: • Inpatient and outpatient services and supplies for injury and illness. • Semi-private room and board, except when a private room is determined to be necessary. • Durable medical equipment when billed by a licensed hospice care program.	No charge; Member pays nothing
Exclusions: Private Duty Nursing, financial or legal counseling services; meal services; any services provided by family members	

Hospital - Inpatient and Outpatient	
The following inpatient medical and surgical services are covered: • Room and board, including private room when prescribed, and general nursing services. • Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy services). • Drugs and medications administered during confinement.	Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment

• Medical implants. • Withdrawal management services. Outpatient hospital includes ambulatory surgical centers. Outpatient services include: • Outpatient surgical care • Anesthesia and anesthesia services • Surgical dressings and supplies • Facility costs See the Outpatient Services section for provider office visits and non-surgical hospital services. Alternative care arrangements may be covered as a cost-effective alternative in lieu of otherwise covered Medically Necessary hospitalization or other Medically Necessary institutional care with the consent of the Member and recommendation from the attending physician or licensed health care provider. Alternative care arrangements in lieu of covered hospital or other institutional care must be determined to be appropriate and Medically Necessary based upon the Member's Medical Condition. Such care is covered to the same extent the replaced Hospital Care is covered. Alternative care arrangements require Preauthorization. Members receiving the following nonscheduled services are required to notify KFHPWA by way of the Hospital notification line within 24 hours following any admission, or as soon thereafter as medically possible: acute withdrawal management services, Emergency psychiatric services, Emergency services, labor and delivery and inpatient admissions needed for treatment of Urgent Conditions that cannot reasonably be delayed until Preauthorization can be obtained. Coverage for Emergency services in a non-Network Facility and subsequent transfer to a Network Facility is set forth in Emergency Services. Non-Emergency inpatient 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	

Infusion Therapy	
Administration of Medically Necessary infusion therapy in an outpatient setting.	Member pays \$20 Copayment
Administration of Medically Necessary infusion therapy in the home setting.	No charge; Member pays nothing

To receive benefits for the administration of select infusion medications in the home setting, the drugs must be obtained through KFHPWA's preferred specialty pharmacy and administered by a provider we identify. For a list of these specialty drugs or for more information about KFHPWA's specialty pharmacy network, please go to the KFHPWA website at www.kp.org/wa/formulary or contact Member Services.	
Associated infused medications include, but are not limited to: • Antibiotics. • Hydration. • Chemotherapy. • Pain management.	No charge; Member pays nothing

Laboratory and Radiology	
Nuclear medicine, radiology, ultrasound and laboratory services, including high end radiology imaging services such as CAT scan, MRI and PET which are subject to Preauthorization except when associated with Emergency services or inpatient services. Please contact Member Services for any questions regarding these services. 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.	No charge; Member pays nothing Breast Exam: Member pays nothing. (Includes diagnostic mammography, digital breast tomosynthesis/3D mammography, breast magnetic resonance imaging (MRI), or breast ultrasound) Urine Drug Screening: No charge, Member pays nothing. Limited to 2 test claims received and processed per calendar year. After Allowance: No charge; Member pays nothing

Manipulative Therapy	
Manipulative therapy of the spine and extremities, including services provided by a chiropractor, when in accordance with KFHPWA clinical criteria. Preauthorization is not required. Rehabilitation services, such as massage or physical therapy, provided with manipulations is covered under the Rehabilitation and Habilitative Care (massage, occupational, physical and speech therapy, pulmonary and cardiac rehabilitation) and Neurodevelopmental Therapy section.	Member pays \$20 Copayment
Exclusions: Supportive care rendered primarily to maintain the level of correction already achieved; care rendered primarily for the convenience of the Member; care rendered on a non-acute, asymptomatic basis; charges for any other services that do not meet KFHPWA clinical criteria as Medically Necessary	

Maternity and Pregnancy	
Pregnancy care and services, including care for complications of pregnancy, in utero treatment for the fetus, prenatal testing for the detection of congenital and heritable disorders when Medically Necessary and prenatal and postpartum care are covered for all Members including eligible Dependents. Preventive services related to preconception, prenatal and postpartum care are covered as Preventive Services including breastfeeding support, supplies and counseling for each birth when Medically Necessary as determined by KFHPWA's medical director and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy. Delivery and associated Hospital Care, including home births and birthing centers. Home births are considered outpatient services. Members must notify KFHPWA by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. The Member's provider, in consultation with the Member, will determine the Member's length of inpatient stay following delivery. Donor human milk will be covered during the inpatient hospital stay when Medically Necessary, provided through a milk bank and ordered by a licensed Provider or board-certified lactation consultant.	Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment Outpatient Services: Member pays \$20 Copayment
Termination of pregnancy.	Hospital - Inpatient: Member pays nothing Hospital - Outpatient: Member pays nothing Outpatient Services: Member pays nothing
Exclusions: Birthing tubs; genetic testing of non-Members; fetal ultrasound in the absence of medical indications	

Mental Health and Wellness	
Mental health and wellness services provided at the most clinically appropriate and Medically Necessary level of mental health care intervention as determined by KFHPWA's medical director. Treatment may utilize psychiatric, psychological and/or psychotherapy services to achieve these objectives. Mental health and wellness services including marital and family counseling (certain diagnoses only), medical management and prescriptions are covered the same as for any other condition. Applied behavioral analysis (ABA) therapy, limited to	Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment Outpatient Services: Member pays \$20 Copayment Group Visits: No charge; Member pays nothing

outpatient treatment of an autism spectrum disorder, or has a developmental disability for which there is evidence that ABA therapy is effective. 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. If a Member 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. Members must notify KFHPWA by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Mental health and wellness services rendered to treat mental disorders are covered. Mental Disorders means mental disorders covered in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except as otherwise excluded under Sections VI. or VII. Mental Health and Wellness Services means Medically Necessary outpatient services, Residential Treatment, partial hospitalization program, and inpatient services provided by a licensed facility or licensed providers, except as otherwise excluded under Sections VI. or VII. Non-Emergency inpatient hospital services, including Residential Treatment, require Preauthorization. Outpatient specialty services, including partial hospitalization programs, rTMS, ECT, and Esketamine require Preauthorization. Routine outpatient therapy and psychiatry services with contracted network providers do not require Preauthorization.	
Exclusions: Specialty treatment programs such as “behavior modification programs” not considered Medically Necessary; wilderness therapy; aversion therapy	

Naturopathy	
Naturopathy. Limited to 3 visits per medical diagnosis per calendar year without Preauthorization. Additional visits are covered with Preauthorization. Laboratory and radiology services are covered only when obtained through a Network Facility.	Member pays \$20 Copayment
Exclusions: Herbal supplements; nutritional supplements; any services not within the scope of the practitioner's	

licensure

Newborn Services	
Newborn services are covered the same as for any other condition. Any Cost Share for newborn services is separate from that of the mother. Preventive services for newborns are covered under Preventive Services. See the Eligibility, Enrollment and Termination section for information about temporary coverage for newborns.	Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment Outpatient Services: Member pays \$20 Copayment

Nutritional Counseling	
Nutritional counseling. Services related to a healthy diet to prevent obesity are covered as Preventive Services. See Preventive Services for additional information.	Member pays \$20 Copayment
Exclusions: Nutritional supplements; weight control self-help programs or memberships, such as Weight Watchers, Jenny Craig, or other such programs	

Nutritional Therapy	
Medical formula necessary for the treatment of phenylketonuria (PKU), specified inborn errors of metabolism, or other metabolic disorders	No charge; Member pays nothing
Enteral therapy is covered when Medical Necessity criteria is met and when given through a PEG, J tube or orally, or for an eosinophilic gastrointestinal disorder. Necessary equipment and supplies for the administration of enteral therapy are covered as Devices, Equipment and Supplies.	Member pays 20% coinsurance
Parenteral therapy (total parenteral nutrition). Necessary equipment and supplies for the administration of parenteral therapy are covered as Devices, Equipment and Supplies.	No charge; Member pays nothing
Exclusions: Any other dietary formulas, medical foods or oral nutritional supplements that do not meet Medical Necessity criteria or are not related to the treatment of inborn errors of metabolism; special diets; prepared foods/meals	

Obesity Related Services	
Services directly related to obesity, including bariatric surgery.	Hospital - Inpatient: Member pays \$200 Copayment per admission
Services related to obesity screening and counseling are covered as Preventive Services.	Hospital - Outpatient: Member pays \$20 Copayment
	Outpatient Services: Member pays \$20 Copayment
Exclusions: All other 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.	Hospital - Inpatient: Not covered; Member pays 100% of all charges
	Hospital - Outpatient: Not covered; Member pays 100% of all charges
	Outpatient Services: Not covered; Member pays 100% of all charges
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	

Oncology	
Radiation therapy, chemotherapy, oral chemotherapy. See Infusion Therapy for infused medications.	Radiation Therapy and Chemotherapy: Member pays \$20 Copayment
	Oral Chemotherapy Drugs: Preferred generic drugs (Tier 1): Member pays \$10 Copayment per 30-days up to a 90-day supply
	Preferred brand name drugs (Tier 2): Member pays \$20 Copayment per 30-days up to a 90-day supply
	Non-Preferred generic and brand name drugs (Tier 3): Member pays \$30 Copayment per 30-days up to a 90-day supply

Optical (vision)	
Routine eye examinations and refractions, limited to once every 12 months.	Routine Exams: Member pays \$20 Copayment

Eye and contact lens examinations for eye pathology and to monitor Medical Conditions, as often as Medically Necessary.	Exams for Eye Pathology: Member pays \$20 Copayment
Contact lenses or framed lenses for eye pathology when Medically Necessary. One contact lens per diseased eye in lieu of an intraocular lens is covered following cataract surgery provided the Member has been continuously covered by KFHPWA since such surgery. In the event a Member's age or medical condition prevents the Member from having an intraocular lens or contact lens, framed lenses are available. 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 Member's prescription.	Frames and Lenses: Not covered; Member pays 100% of all charges Contact Lenses or Framed Lenses for Eye Pathology: Member pays \$20 Copayment
Exclusions: Eyeglasses; contact lenses, contact lens evaluations, fittings and examinations not related to eye pathology; fees related to the lens fitting of non-network issued frames; orthoptic therapy (i.e., eye training); evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures	

Oral Surgery	
Reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or non-dental cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth; and incision of salivary glands and ducts. KFHPWA's medical director will determine whether the care or treatment required is within the category of Oral Surgery or Dental Services. Oral surgery requires Preauthorization.	Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment Outpatient Services: Member pays \$20 Copayment
Exclusions: Care or repair of teeth or dental structures of any type; tooth extractions or impacted teeth; services related to malocclusion; services to correct the misalignment or malposition of teeth; any other services to the mouth, facial bones or teeth which are not medical in nature	

Outpatient Services	
Covered outpatient medical and surgical services in a provider's office, including chronic disease management. See Preventive Services for additional information related to chronic disease management. Office visits include visits provided in a clinic, outpatient hospital or ambulatory surgical center (ASC). All other services performed in the office, not billed as an office visit,	Member pays \$20 Copayment

or that are not related to the actual visit (separate surgical services or laboratory/radiology fees billed in conjunction with the office visit, for example) are not considered an office visit. See Hospital - Inpatient and Outpatient for outpatient hospital surgical services, including ambulatory surgical centers.	
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Plastic and Reconstructive Surgery	
Plastic and reconstructive services: • Correction of a congenital disease or congenital anomaly. • Correction of a Medical Condition following an injury or resulting from surgery which has produced a major effect on the Member's appearance, when in the opinion of KFHPWA's medical director such services can reasonably be expected to correct the condition. • Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed. Members are covered for all stages of reconstruction on the non-diseased breast to produce a symmetrical appearance. Complications of covered mastectomy services, including lymphedemas, are covered.	Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment Outpatient Services: Member pays \$20 Copayment
Exclusions: Cosmetic services including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services	

Podiatry	
Medically Necessary foot care. Routine foot care covered when such care is directly related to the treatment of diabetes and, when approved by KFHPWA's medical director, other clinical conditions that effect sensation and circulation to the feet.	Member pays \$20 Copayment
Exclusions: All other routine foot care	

Preventive Services	
Preventive services in accordance with the well care schedule established by KFHPWA. The well care schedule is available in Kaiser Permanente medical centers, at www.kp.org/wa, or upon request from Member Services. Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force (USPSTF).	No charge; Member pays nothing

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. Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines. Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices. Flu vaccines are also covered when provided by a non-network provider. Preventive services include, but are not limited to, well adult and well child physical examinations; immunizations and vaccinations; female sterilization; pap smears; preventive services related to preconception, prenatal and postpartum care; routine mammography screening; routine prostate screening; colorectal cancer screening for Members who are age 45 or older or who are under age 45 and at high risk; obesity screening/counseling; healthy diet; and physical activity counseling; depression screening in adults, including maternal depression; Pre-Exposure Prophylaxis (PrEP), including laboratory services and office visits, for Members at high risk for HIV infection. Preventive care for chronic disease management includes treatment plans with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, quality of care measurement and results, and education and tools for patient self-management support. In the event preventive, wellness or chronic care management services are not available from a Network Provider, non-network providers may provide these services without Cost Share when Preauthorized. Services provided during a preventive services visit, including laboratory services, which are not in accordance with the KFHPWA well care schedule are subject to Cost Shares. Eye refractions are not included under preventive services.	
Exclusions: Those parts of an examination and associated reports and immunizations that are not deemed Medically Necessary by KFHPWA for early detection of disease; all other diagnostic services not otherwise stated above	

Rehabilitation and Habilitative Care (massage, occupational, physical and speech therapy, pulmonary and cardiac rehabilitation) and Neurodevelopmental Therapy	
Rehabilitation services to restore function following illness, injury or surgery, limited to the following restorative	Hospital - Inpatient: Member pays \$200 Copayment per admission

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. 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. Habilitative care, includes Medically Necessary services or devices designed to help a Member keep, learn, or improve skills and functioning for daily living. Services may include: occupational therapy, physical therapy, speech therapy is covered 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. Neurodevelopmental therapy to restore or improve function including maintenance in cases where significant deterioration in the Member's condition would result without the services, limited to the following therapies: occupational therapy, physical therapy and speech therapy. There is no visit limit for Neurodevelopmental Therapy. Limited to a combined total of 60 inpatient days and 60 outpatient visits per calendar year for all Rehabilitation, Habilitative care, cardiac and pulmonary rehabilitation services. Services with mental health diagnoses are covered with no limit.	Outpatient Services: Member pays \$20 Copayment Group Visits (occupational, physical, or speech therapy or learning services): Member pays one half of the office visit Copayment
Cardiac rehabilitation is covered when clinical criteria is met. Preauthorization is required after initial visit Limited to a combined total of 60 inpatient days and 60 outpatient visits per calendar year for all Rehabilitation, Habilitative care, cardiac and pulmonary rehabilitation services.	Outpatient Services: Member pays \$20 Copayment Group Visits: Member pays one half of the office visit Copayment

Pulmonary rehabilitation is covered when clinical criteria is met. Preauthorization is required after initial visit. Limited to a combined total of 60 inpatient days and 60 outpatient visits per calendar year for all Rehabilitation, Habilitative care, cardiac and pulmonary rehabilitation services.	Outpatient Services: Member pays \$20 Copayment Group Visits: Member pays one half of the office visit Copayment
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	

Reproductive Health	
Medically Necessary medical and surgical services for reproductive health, including consultations, examinations, procedures and devices, including device insertion and removal. See Maternity and Pregnancy for pregnancy care and termination of pregnancy services. Reproductive health is the care necessary to support the reproductive system and the ability to reproduce. Reproductive health includes contraception, cancer and disease screenings, termination of pregnancy, maternity, prenatal and postpartum care.	Hospital - Inpatient: No charge; Member pays nothing Hospital - Outpatient: No charge; Member pays nothing Outpatient Services: No charge; Member pays nothing
All methods for Medically Necessary FDA-approved (including over-the-counter) contraceptive drugs, devices and products. Condoms are limited to 120 per 90-day supply, additional condoms available upon request. Contraceptive drugs may be allowed up to a 12-month supply and, when available, picked up in the provider’s office. Note: Over-the-counter contraceptives can be purchased at any KFHPWA-designated pharmacy. Designated pharmacies may submit the claim. If self-payment is made at a non-KFHPWA-designated pharmacy, a reimbursement claim may be made by utilizing the Member Reimbursement Drug Claim Form which can be obtained in the “Forms & Publications” section on www.kp.org/wa or by calling Member Services. To request an exception for quantity limits on condoms, members may submit a request. Additional information is available online at www.KP.org/wa/formulary or by contacting Member Services.	No charge; Member pays nothing

Sexual Dysfunction	
One consultation visit to diagnose sexual dysfunction conditions.	Member pays \$20 Copayment
Specific diagnostic services, treatment and prescription drugs.	Not covered; Member pays 100% of all charges
Exclusions: Diagnostic testing and medical treatment of sexual dysfunction regardless of origin or cause; devices, equipment and supplies for the treatment of sexual dysfunction	

Skilled Nursing Facility	
Skilled nursing care in a skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending physician, limited to a total of 60 days per calendar year. Care may include room and board; general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by a skilled nursing facility; and short-term restorative occupational therapy, physical therapy and speech therapy.	No charge; Member pays nothing
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.	Hospital - Inpatient: No charge; Member pays nothing Hospital - Outpatient: No charge; Member pays nothing Outpatient Services: No charge; Member pays nothing
Vasectomy.	Hospital - Inpatient: No charge; Member pays nothing Hospital - Outpatient: No charge; Member pays nothing Outpatient Services: No charge; Member pays nothing
Exclusions: Procedures and services to reverse a sterilization	

Substance Use Disorder	
Substance use disorder services including inpatient	Hospital - Inpatient: Member pays \$200

Residential Treatment; diagnostic evaluation and education; organized individual and group counseling; and/or prescription drugs unless excluded under Sections IV. or V. Substance use disorder means a substance-related or addictive disorder listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). For the purposes of this section, the definition of Medically Necessary shall be expanded to include those services necessary to treat a substance use disorder condition that is having a clinically significant impact on a Member's emotional, social, medical and/or occupational functioning. Substance use disorder services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57), a psychologist (licensed under RCW 18.83), a substance use disorder treatment program licensed for the 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. The severity of symptoms designates the appropriate level of care and should be determined through a thorough assessment completed by a licensed provider who recommends treatment based on medical necessity criteria. Court-ordered substance use disorder treatment shall be covered only if determined to be Medically Necessary. Preauthorization is required for outpatient specialty, intensive outpatient, and partial hospitalization services. Preauthorization is required for Residential Treatment and non-Emergency inpatient hospital services provided at out-of-state facilities. Preauthorization is not required for inpatient or residential substance use disorder treatment services provided in-state. Member is given no less than two days of treatment, excluding weekends and holidays in a behavioral health agency that provides inpatient or residential substance use disorder treatment prior to conducting a medical necessity review for continued care, initial length of authorized care will be no less than 14 days, subsequent authorization will be no less than 7 days. Member or facility must notify KFHPWA within 24 hours of admission, or as soon as possible. Member may request prior authorization for Residential Treatment and non-Emergency inpatient hospital services. Members may contact Member Services to request Preauthorization.	Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment Outpatient Services: Member pays \$20 Copayment Group Visits: No charge; Member pays nothing
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Withdrawal Management Services for Alcoholism and Substance Use Disorder. Withdrawal management services means the management of symptoms and complications of alcohol and/or substance withdrawal. The severity of symptoms designates the appropriate level of care and should be determined through a thorough assessment completed by a licensed provider who recommends treatment based on medical necessity criteria. Outpatient withdrawal management services means the symptoms resulting from abstinence are of mild/moderate severity and withdrawal from alcohol and/or other drugs can be managed with medication at an outpatient level of care by an appropriately licensed clinician. Subacute withdrawal management means symptoms associated with withdrawal from alcohol and/or other drugs can be managed through medical monitoring at a 24-hour facility or other outpatient facility. Preauthorization is required for outpatient withdrawal management services and subacute withdrawal management services. "Acute withdrawal management services" mean withdrawal from alcohol and/or drugs require medical management in a hospital setting, which is needed immediately to prevent serious impairment to the Member's health. Coverage for acute withdrawal management services is provided without Preauthorization. If a Member 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. Members must notify KFHPWA by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Member is given no less than two days of treatment, excluding weekends and holidays, in a behavioral health agency that provides inpatient or residential substance abuse treatment; and no less than three days in a behavioral health agency that provides withdrawal management services prior to conducting a medical necessity review for continued care. Member or facility must notify KFHPWA within 24 hours of admission, or as soon as possible. Members may request Preauthorization for Residential Treatment and non-Emergency inpatient hospital services by contacting Member Services. KFHPWA reserves the right to require transfer of the Member to a Network Facility/program upon consultation between a Network Provider and the attending physician. If the Member refuses transfer to a Network Facility/program,	Emergency Services Network Facility: Member pays \$100 Copayment Emergency Services Non-Network Facility: Member pays \$100 Copayment Hospital - Inpatient: Member pays \$200 Copayment per admission
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all further costs incurred during the hospitalization are the responsibility of the Member.	
Exclusions: Wilderness therapy or aversion therapy; facilities and treatment programs which are not certified by the Department of Social Health Services.	

Telehealth Services	
Telemedicine Services provided by the use of real-time interactive audio and video communications or store and forward technology between the patient at the originating site and a Network Provider at another location. Audio-only communication requires an Established Relationship. Store and forward technology means sending a Member's medical information from an originating site to the provider at a distant site for later review. The provider follows up with a medical diagnosis for the Member and helps manage their care. Services must meet the following requirements: • Be a Covered Service under this EOC. • The originating site is qualified to provide the service. • If the service is provided through store and forward technology, there must be an associated office visit between the Member and the referring provider. • Is Medically Necessary. Virtual Care - Telephone and Online Services (E-Visits, Care Chat or E-Consults) Scheduled telephone visits with a Network Provider are covered. Online (E-Visits, Care Chat, e-consults): A Member logs into the secure Member site at www.kp.org/wa and completes a questionnaire and provides a treatment plan for select conditions, including prescriptions. Online visits are not available to Members during in-persons visits at a KFHPWA facility or pharmacy. More information is available at https://wa.kaiserpermanente.org/html/public/services/e-visit. Virtual Care – A healthcare service provided via online technology, telephonic, or secure messaging transmission of member-initiated care from a remote location with a provider that is diagnostic- and treatment focused. The member is NOT located at a healthcare site. Examples of online technology include the use of a computer, tablet or smartphone. An example of a remote location includes the member's home or work; a nonclinical location. Services are allowed for commercial members.	No charge; Member pays nothing
Exclusions: Fax and e-mail; telehealth services with non-contracted providers; telehealth services in state where prohibited by law; all other services not listed above	

Temporomandibular Joint (TMJ)	
Medical and surgical services and related hospital charges for the treatment of temporomandibular joint (TMJ) disorders including: • Medically Necessary orthognathic procedures for the treatment of severe TMJ disorders which have failed non-surgical intervention. • Radiology services. • TMJ specialist services. • Fitting/adjustment of splints.	Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment Outpatient Services: Member pays \$20 Copayment
TMJ appliances. See Devices, Equipment and Supplies for additional information.	Member pays 20% coinsurance
Exclusions: Treatment for cosmetic purposes; bite blocks; dental services including orthodontic therapy and braces for any condition; any orthognathic (jaw) surgery in the absence of a diagnosis of TMJ, or severe obstructive sleep apnea; hospitalizations related to these exclusions	

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

Transplants	
Transplant services, including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, liver transplants, and bone marrow and stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy. Services are limited to the following: • Inpatient and outpatient medical expenses for evaluation testing to determine recipient candidacy, donor matching tests, hospital charges, procurement center fees, professional fees, travel costs for a surgical team and excision fees. Donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees. • Follow-up services for specialty visits • Rehospitalization • Maintenance medications during an inpatient stay Transplant services must be provided through locally and	Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment Outpatient Services: Member pays \$20 Copayment

nationally contracted or approved transplant centers. All transplant services require Preauthorization. Contract Member Services for Preauthorization	
Exclusions: Donor costs to the extent that they are reimbursable by the organ donor's insurance; treatment of donor complications; living expenses; expenses except as covered under Section IV.K. Utilization Management	

Uniformed Personnel	
Coverage is provided only to uniformed personnel who establish membership in the Law Enforcement Officers and Firefighters Retirement System (LEOFF) on or before September 30, 1977, and are subject to RCW 41.26.150 — Sick or Disability Benefits — Medical Services (LEOFF Plan 1 members) and is limited to treatment of occupational injuries arising out of employment as a LEOFF Plan 1 member. Occupational injuries are covered to the same extent as any other Covered Service. The Group is responsible for identifying LEOFF Plan 1 members and for providing written notification to KFHPWA at the time the employee is enrolled with KFHPWA. Benefits shall be reduced by amounts receivable by the LEOFF Plan 1 member under workers' compensation or from any other source. Coverage described below does not apply to Dependents. Covered Services for an occupational injury provided subsequent to the initial injury, including follow-up care, are covered only when provided at Network Facilities. In the event of an occupational injury which, in the opinion of the officer in charge, needs treatment that cannot be delayed, KFHPWA will bear the cost of Covered Services for Emergency treatment at a non-Network Facility and related ambulance service. Services provided in a KFHPWA-approved skilled nursing facility for occupational injuries will be covered only with Preauthorization, limited to 30 days per condition.	Emergency Services: No charge; Member pays nothing Ambulance: No charge; Member pays nothing Skilled Nursing Facility: No charge; Member pays nothing Occupational injuries received prior to enrollment or subsequent to initial injury Hospital - Inpatient: Member pays \$200 Copayment per admission Hospital - Outpatient: Member pays \$20 Copayment Outpatient Services: Member pays \$20 Copayment
Exclusions: Job-related injuries or illnesses occurring prior to the effective date	

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.	Network Emergency Department: Member pays \$100 Copayment Network Urgent Care Center: Member pays \$20 Copayment Network Provider's Office: Member pays \$20

See the Definitions section for a definition of Urgent Condition.	Copayment Non-Network Provider: Member pays \$100 Copayment
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VII. General Exclusions

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

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

- a. A service is considered experimental or investigational for a Member’s condition if any of the following statements apply to it at the time the service is or will be provided to the Member:
 - 1) The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration (“FDA”) and such approval has not been granted.

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

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

10. Hypnotherapy and all services related to hypnotherapy.
11. Directed umbilical cord blood donations.
12. Prognostic (predictive) genetic testing and related services, unless specifically provided in the Benefits Details section. Testing for non-Members.
13. Autopsy and associated expenses.
14. Over-the-counter items such as hearing aids unless specifically listed as covered in Section IV.
15. Academic/career counseling, counseling for overeating, work/school ordered assessments, relationship counseling, custodial care
16. Court-ordered or forensic treatment, including reports and summaries not considered Medically Necessary.

VIII. Grievances

Grievance means a written or verbal complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or non-provision of medical services, including

dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier. The grievance process is outlined as follows:

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

Step 2: If the Member is still not satisfied, they should call or write to Member Services at PO Box 34590, Seattle, WA 98124-1590, 206-630-4636 or toll-free 1-888-901-4636. Most concerns are handled by phone within a few days. In some cases, the Member will be asked to write down their concerns and state what they think would be a fair resolution to the problem. An appropriate representative will investigate the Member's concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Member Rights and Responsibilities statement. This process can take up to 30 days to resolve after receipt of the Member's written or verbal statement.

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

IX. Appeals

Members are entitled to appeal through the appeals process if/when coverage for an item or service is denied due to an adverse determination made by the KFHPWA medical director. The appeals process is available for a Member to seek reconsideration of an adverse benefit determination (action). Adverse benefit determination (action) means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. KFHPWA will comply with any new requirements as necessary under federal laws and regulations. Assistance is available to Members who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process. The most current information about your appeals process is available by contacting KFHPWA's Member Appeal Department at the address or telephone number below.

1. Internal Review

If the Member wishes to appeal a decision denying benefits, they must submit a request for an appeal either orally or in writing to the Member Appeals Department, specifying why they disagree with the decision. The appeal must be submitted within 180 days from the Member's receipt of a determination. KFHPWA will notify the Member of its receipt of the request within 72 hours of receiving it. Appeals should be directed to KFHPWA's Member Appeals Department, P.O. Box 34593, Seattle, WA 98124-1593, toll free 1-866-458-5479.

KFHPWA will then notify the Member of its determination within a reasonable period of time but no later than:

- Pre-service claim – 30 days after receipt of your request
- Post-service claim – 60 days after the receipt of your request.

Expedited/Urgent Internal Review

There is an expedited/urgent appeals process in place for cases which meet criteria or where the Member's provider believes that the standard 30 day appeal review process will seriously jeopardize the Member's life, health or ability to regain maximum function or subject the Member to severe pain that cannot be managed adequately without the requested care or treatment. KFHPWA will accept a treating provider's determination

that an appeal should be expedited/urgent. The Member can request an expedited/urgent appeal in writing to the above address, or by calling KFHPWA's Member Appeals Department toll free 1-866-458-5479. The Member's request for an expedited/urgent appeal will be processed as such if the definition above is met and a decision issued and communicated verbally no later than 72 hours after receipt of the request. If additional information is needed, KFHPWA will inform the Member and allow up to 48 hours for a response.

If the Member is currently receiving care that is the subject of the appeal, the health plan will continue coverage pending the outcome of the internal appeal.

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

2. External Review

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

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

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

X. Claims

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

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

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

- Immediate request situations – within 1 business day.
- Concurrent urgent requests – within 24 hours.
- Urgent care review requests – within 48 hours.
- Non-urgent preservice review requests – within 5 calendar days.
- Post-service 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. Members will be notified in writing of such extension prior to the expiration of the initial timeframe.

XI. Coordination of Benefits

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

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

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

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

A. Definitions.

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

2. 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.

3. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the Member has health care coverage under more than one plan.

When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 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 Member. This reserve must be used by the secondary plan to pay any allowable expenses not otherwise paid, that are incurred by the covered person during the claim determination period.

4. Allowable Expense. Allowable expense is a health care expense, coinsurance or copayments and without reduction for any applicable deductible, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the Member is not an allowable expense.

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

- a. 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.
 - b. If a Member is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
 - c. If a Member is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
 - d. 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.
5. 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.
 6. 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.

B. Order of Benefit Determination Rules.

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

1. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
2. Except as provided below, 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.

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 employee. 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.

3. 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.
4. Each plan determines its order of benefits using the first of the following rules that apply:
 - a. Non-Dependent or Dependent. The plan that covers the Member other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary plan and the plan that covers the Member as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Member as a Dependent, and primary to the plan covering the Member as other than a Dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the Member as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.
 - b. 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:
 - 1) 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.
 - 2) 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.
 - 3) 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.
 - c. Active employee or retired or laid-off employee. The plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same Member as a retired or laid off employee is the secondary plan. The same would

hold true if a Member is a Dependent of an active employee and that same Member is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under Section b.4.a can determine the order of benefits.

- d. COBRA or State Continuation Coverage. If a Member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the Member as an employee, member, employee or retiree or covering the Member as a Dependent of an employee, member, employee 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 a. can determine the order of benefits.
- e. Longer or shorter length of coverage. The plan that covered the Member as an employee, member, employee or retiree longer is the primary plan and the plan that covered the Member the shorter period of time is the secondary plan.
- f. 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.

C. Effect on the Benefits of this Plan.

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

D. Right to Receive and Release Needed Information.

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

E. 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.

F. 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.

G. 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 Member who is eligible for Medicare benefits, and Medicare is deemed to be the primary bill payer under Medicare secondary payer guidelines and regulations, KFHPWA will seek Medicare reimbursement for all Medicare covered services.

XII. Subrogation and Reimbursement Rights

The benefits under this Plan will be available to a Member for injury or illness caused by another party, subject to the exclusions and limitations of this Plan. If the Plan provides for the treatment of the injury or illness, the Plan will be subrogated to any rights that the Member may have to recover compensation or damages related to the injury or illness and the Member shall reimburse the Plan for all benefits provided, from any amounts the Member received or is entitled to receive from any source on account of such injury or illness, whether by suit, settlement or otherwise, including but not limited to:

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

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

"Injured Person" under this section means a Member covered by the Plan who sustains an injury or illness and any spouse, dependent or other person or entity that may recover on behalf of such Member, including the estate of the Member and, if the Member is a minor, the guardian or parent of the Member. When referred to in this section, "the Plan's Medical Expenses" means the expenses incurred and the value of the benefits provided by the Plan for arranging 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, the Plan shall have the right to recover the Plan'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." The Plan shall be subrogated to and may enforce all rights of the Injured Person to the full extent of the Plan'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 he or she 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 he or she chooses to pursue the claim.

The Plan'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.

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, the Plan's Medical Expenses are secondary, not primary.

The Injured Person and their agents shall cooperate fully with the Plan in its efforts to collect the Plan's Medical Expenses. This cooperation includes, but is not limited to, supplying the Plan 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 the Plan 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 the Plan's right to reimbursement or subrogation as requested by the Plan, and shall inform the Plan of any settlement or other payments relating to the Injured Person's injury. The Injured Person and their agents shall permit the Plan, at the Plan'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 the Plan's subrogation and reimbursement rights. The Injured Person shall promptly notify the Plan of any tentative settlement with a third party and shall not settle a claim without protecting the Plan's interest. The Injured Person shall provide 21 days advance notice to the Plan 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 the Plan in recovery of the Plan's Medical Expenses, and such failure prejudices KFHPWA's subrogation and/or reimbursement rights, the Injured Person shall be responsible for directly reimbursing the Plan for 100% of the Plan'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 the Plan's right of reimbursement or subrogation, the Injured Person agrees to hold such monies in trust or in a separate identifiable account until the Plan's subrogation and reimbursement rights are fully determined and that the Plan has an equitable lien over such monies to the full extent of the Plan's Medical Expenses and/or the Injured Person agrees to serve as constructive trustee over the monies to the extent of the Plan'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 the Plan's rights of subrogation or reimbursement will be personally liable to the Plan for the amounts so distributed.

XIII. Definitions

Allowance	The maximum amount payable by the Plan 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. Members shall be required to pay any difference between a non-Network Provider's charge for services and the Allowed Amount, except ground ambulance services and Emergency services. Including post stabilization and for ancillary services received from an out of network provider in a network facility. For more information about balance billing protections, please visit: https://healthy.kaiserpermanente.org/washington/support/forms and click on the "Billing forms" link.
Care Chat	Care available 24-hours a day online at www.kp.org/wa or through the KP mobile application. Chat with a Kaiser Permanente clinician to receive immediate care, treatment and prescriptions.
Consulting Nurse Service	Advice available 24-hours a day by talking on the phone with a licensed care nurse.
Convalescent Care	Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in walking, dressing, bathing, eating, preparation of special diets, and taking medication.

Copayment	The specific dollar amount a Member is required to pay at the time of service for certain Covered Services.
Cost Share	The portion of the cost of Covered Services for which the Member is liable. Cost Share includes Copayments, coinsurances and Deductibles.
Covered Services	The services for which a Member is entitled to coverage in the Plan.
Creditable Coverage	Coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, the actuarial determination measures whether the expected amount of paid claims under KFHPWA's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.
Deductible	A specific amount a Member is required to pay for certain Covered Services before benefits are payable.
Dependent	Any member of an employee's family who meets all applicable eligibility requirements, is enrolled hereunder.
Emergency	The emergent and acute onset of a medical, mental health or substance use disorder symptom or symptoms, including but not limited to severe pain or emotional distress, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily function or serious dysfunction of a bodily organ or part, or would place the Member's health, or if the Member is pregnant, the health of the unborn child, in serious jeopardy, or any other situations which would be considered an emergency under applicable federal or state law.
Essential Health Benefits	Benefits set forth under the Patient Protection and Affordable Care Act of 2010, including the categories of ambulatory patient services, Emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.
Established Relationship	Member must have had at least one in-person appointment or at least one real-time interactive appointment using both audio and visual technology within the past 3 years, with the provider providing audio only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by KFHPWA. Or the Member was referred to the provider providing audio-only telemedicine by a provider who they have had an in-person appointment within the past 3 years.
Family Unit	An employee and all their Dependents.
Hospital Care	Those Medically Necessary services generally provided by acute general hospitals for admitted patients.
KFHPWA-designated Specialist	A specialist specifically identified by KFHPWA.

Medical Condition	A disease, illness or injury.
Medically Necessary	Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Members will be notified in writing when a determination has been made. Appropriate and clinically necessary services, as determined by KFHPWA's medical director according to generally accepted principles of good medical practice, which are rendered to a Member for the diagnosis, care or treatment of a Medical Condition and which meet the standards set forth below. In order to be Medically Necessary, services and supplies must meet the following requirements: (a) are not solely for the convenience of the Member, their family 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 Member; (c) are for the diagnosis or treatment of an actual or existing Medical Condition unless being provided under KFHPWA's schedule for preventive services; (d) are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions; (e) are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the Member's condition or the quality of health services rendered; (f) as to inpatient care, could not have been provided in a provider's office, the outpatient department of a hospital or a non-residential facility without affecting the Member's condition or quality of health services rendered; (g) are not primarily for research and data accumulation; and (h) are not experimental or investigational. The length and type of the treatment program and the frequency and modality of visits covered shall be determined by KFHPWA's medical director. In addition to being medically necessary, to be covered, services and supplies must be otherwise included as a Covered Service and not excluded from coverage.
Medicare	The federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).
Member	Any enrolled employee or Dependent.
Network Facility	A facility (hospital, medical center or health care center) owned or operated by Kaiser Foundation Health Plan of Washington or otherwise designated by KFHPWA, or with whom KFHPWA has contracted to provide health care services to Members.
Network Personal Physician	A provider who is employed by Kaiser Foundation Health Plan of Washington or Washington Permanente Medical Group, P.C., or contracted with KFHPWA to provide primary care services to Members and is selected by each Member to provide or arrange for the provision of all non-emergent Covered Services, except for services set forth in the Plan which a Member can access without Preauthorization. Network Personal Physicians must be capable of and licensed to provide the majority of primary health care services required by each Member.
Network Provider	The medical staff, clinic associate staff and allied health professionals employed by Kaiser Foundation Health Plan of Washington or Washington Permanente Medical Group, P.C., and any other health care professional or provider with whom KFHPWA has contracted to provide health care services to Members, including, but not limited to physicians, podiatrists, nurses, physician assistants, social workers, optometrists, psychologists, physical therapists and other professionals engaged in the delivery of healthcare services who are licensed or certified to practice in accordance with Title 18 Revised Code of Washington.

Out-of-pocket Expenses	Those Cost Shares paid by the employee or Member for Covered Services which are applied to the Out-of-pocket Limit.
Out-of-pocket Limit	The maximum amount of Out-of-pocket Expenses incurred and paid during the calendar year for Covered Services received by the employee 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 the Benefits Details section.
Plan	The King County SmartCare Connect Group Health Plan.
Plan Administrator	King County.
Plan Coinsurance	The percentage amount the Member is required to pay for Covered Services received.
Preauthorization	An approval by KFHPWA that entitles a Member to receive Covered Services from a specified health care provider. Services shall not exceed the limits of the Preauthorization and are subject to all terms and conditions of the Plan. Members who have a complex or serious medical or psychiatric condition may receive a standing Preauthorization for specialty care provider services.
Private Duty Nursing (or 24-hour nursing care)	The hiring of a nurse by a family or Member to provide long term and/or continuous one on one care with or without oversight by a home health agency. The care may be skilled, supportive or respite in nature.
Residential Treatment	A term used to define facility-based treatment, which includes 24 hours per day, 7 days per week rehabilitation. Residential Treatment services are provided in a facility specifically licensed in the state where it practices as a residential treatment center. Residential treatment centers provide active treatment of patients in a controlled environment requiring at least weekly physician visits and offering treatment by a multi-disciplinary team of licensed professionals.
Service Area	Washington counties of Benton, Columbia, Franklin, Island, King, Kitsap, Lewis, Mason, Pierce, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman and Yakima.
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.

XIV. Plan Administration and Legal Rights

About your Benefits Booklet

The information contained in this booklet, together with your certificates of coverage, certificates of insurance, open enrollment materials, and other explanatory materials constitutes your Benefits Booklet for purposes of the Employee Retirement Income Security Act of 1974 (see “Your rights under the Employee Retirement Income Security Act of 1974”). The Benefits Booklet provides highlights of the health benefit plan, (the “Plan”), established by King County —the employer and plan sponsor.

The Benefits Booklet does not create a contract of employment.

Amendment or termination of plan

King County, the Plan sponsor, reserves the right to change, suspend or discontinue the Plan in whole or in part at any time, and doesn’t promise to continue any specific level of benefits during or after employment, including during retirement.

Authority of plan administrator

King County is the plan administrator of the Plan. King County, as plan administrator, has the sole discretionary authority to interpret the Plan and determine eligibility with respect to non-insured benefits, determine the amount of non-insured benefits payable under the Plan, make any related findings of fact, and resolve any ambiguities that may exist between the Benefits Booklet and the plan documents. All such decisions by the plan administrator will be final and binding on participants and beneficiaries to the fullest extent permitted by law.

Rights of recovery

Benefits under the medical plan are available to cover services or supplies necessary due to illness or injury for which a third party is liable because of negligent or wrongful acts or omissions, subject to the exclusions, limitations and conditions of the plans, including rights related to reimbursement and subrogation.

Reimbursement

If you receive payment as compensation for any condition or injury caused by a third party, the plan has the right to seek reimbursement for any benefits the plan may have paid or provided for that condition or injury. In some cases, the plan may reserve the right to recover the actual amount of reimbursement received; in others, the reasonable value of the reimbursement. (Check with the individual claim administrators for details.)

Notice of privacy practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Review it carefully.

The King County Group Health Plan (the “Plan”) is an employee benefits plan that provides welfare (non-pension) benefits to eligible staff members and their spouses, domestic partners and dependents. The Plan is a “group health plan” as defined by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). As such, it is a “covered entity” as defined by HIPAA, subject to the requirements of HIPAA with respect to the use and disclosure of your medical information.

King County is the “plan sponsor” of the Plan. The Plan is required by law to protect the privacy of your personal information and provide you with this Notice which explains its responsibilities and privacy practices regarding your personal information. The Plan is also required to abide by the terms of this Notice. This Notice is designed to inform you of the Plan’s privacy practices in accordance with HIPAA.

In this Notice, the term “personal information” refers to any medical or financial information that can reasonably be used to identify you and relates to your physical or mental health or condition, the provision of health care to you, or the payment for that care. Personal information may include your name, Social Security number, address, telephone number, employment, medical history, health records, claims information, or credit card number.

Use and disclosure of your personal information

The following summarizes the circumstances under which and purposes for which the Plan may use or disclose your personal information:

- **For treatment.** The Plan may use or disclose your personal information for the provision, coordination or management of health care or related services. For example, if you receive your medical care at KFHPWA, information you submit through your Health Profile may be included in your KFHPWA medical record.
- **For payment.** The Plan may use or disclose your personal information for payment purposes. Payment includes activities undertaken by the Plan to obtain premiums, to determine and fulfill its responsibilities for coverage and the provision of benefits under the Plan, or to obtain or provide reimbursement for the provision of health care. For example, payment may include determining benefit eligibility and coordinating benefits with other health plans, reviewing services for medical necessity, paying a claim, performing utilization review, obtaining premiums, subrogating a claim, and collection activities.
- **For health care operations.** The Plan may use or disclose your personal information to carry out its own health care operations, including general administration of the plan. For example, the Plan may use your personal information to review and improve the care you receive, to provide disease and case management, for health plan underwriting, to administer and review a health plan, to conduct medical reviews, and to provide customer service. Health care operations may also include determining coverage policies, business planning, arranging for legal and auditing services, obtaining accreditations and licenses, referrals to a disease management program, suggesting treatment alternatives, projecting future benefit costs or auditing the accuracy of its claims processing functions.
- **To business associates.** The Plan may disclose your personal information to the Plan's business associates. Business associates are persons who, on behalf of the Plan, perform or assist in the performance of a function or activity involving the use or disclosure of personal information described in this Notice. For example, the Plan may contract with a Business Associate to provide the Plan with legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services. The Plan's business associates must agree in writing to safeguard the confidentiality of your personal information.
- **In legal proceedings.** The Plan may disclose your personal information in response to a court order and in certain cases, in response to a subpoena, discovery request, or other lawful process. Also, for law enforcement purposes when required by federal state or local law enforcement.
- **For law enforcement.** The Plan may disclose your personal information to law enforcement officials in limited circumstances for law enforcement purposes. For example, disclosures may be made to identify or locate a suspect, witness, or missing person; to report a crime; or to provide information concerning victims of crimes.
- **As required by law.** The Plan may use or disclose your personal information when it is required to do so by law.
- **For treatment alternatives or distribution of health-related benefits & services.** The Plan may use or disclose your personal information to remind you about preventive health services or to let you know about treatment alternatives, providers, settings of care, or health and wellness products or services that are available for you as a health plan participant.
- **Disclosures to the Plan Sponsor.** The Plan may disclose your health information to King County, the Plan Sponsor of the Plan, to carry out plan administration functions performed by the Plan Sponsor on behalf of the Plan. The plan documents have been amended in accordance with federal law to permit this use and disclosure.

The Plan may also disclose "summary health information", if requested by the Plan Sponsor for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. Summary health information is information (which may be personal information) from which personal identifiers (except zip code) have been removed, and which summarizes claims history, claims expense or types of claims experienced by individuals for whom the Plan sponsor has provided health benefits under the Plan.

The Plan may also disclose to the Plan Sponsor whether an individual is participating in the Plan.

The Plan **will not** disclose your personal information to the Plan Sponsor for purposes of employment-related decisions or actions, or in connection with any other benefit plan of the Plan Sponsor.

- **To conduct health oversight activities.** The Plan must agree to oversight reviews by federal and state agencies. These agencies may, by law conduct audits, perform inspections and investigations, license health care providers, health plans and health care facilities, and enforce federal and state regulations.
- **With an authorized public health authority or their agent** in the event of a serious threat to the health and safety of the public.
- **For specified government functions.** With government benefit programs, like **Medicare** and **Medicaid**, the Plan may use or disclose your personal information in order to review your eligibility and enrollment in these programs. With **armed forces personnel**, the Plan may use or disclose your personal information for military activities and to authorized **federal officials** for national security activities and intelligence purposes.
- **For workers' compensation.** The Plan may use or disclose your personal information to the workers' compensation program which provides benefits to you if you have a work-related injury or illness.
- **For research.** The Plan may use or disclose your personal information for the Plan's or another organization's research purposes provided that certain steps are taken to protect your privacy.
- **For fundraising.** The Plan may use or disclose your demographic information and other limited information such as dates and where health care was provided, to certain organizations for the purpose of contacting you to raise funds for our organization. To direct us not to contact you for this purpose, call Member Services toll free at 1-888-630-4636.
- **To "de-identify" information.** The Plan may use or disclose your personal information in order to de-identify it by removing information that could be used to identify you.
- **In case of threat to health or safety.** The Plan may use or disclose your personal information in order to avoid a serious threat to the health or safety of yourself and others.

Other uses of your medical information

Except in the situations described above, the Plan will use and share your personal information only with your written permission or authorization.

Changes to privacy practices

You have rights regarding personal information that the Plan maintains about you. You may get more information about exercising any of these rights by calling the Privacy Office at [add contact information].

- **Request restrictions:** You may request that the Plan limit the way it uses or shares your personal information outside of the Plan.
- **Confidential communication:** You may ask that the Plan contact you at a different address or phone number. The Plan will usually be able to accommodate your request. Please make your request in writing.
- **Inspect and copy:** You may request a copy of your personal information maintained by or for the Plan in a designated record set. The Plan may maintain the following records in a designated record set: enrollment, payment, claims adjudication, care management and other records that are used by the Plan, in whole or in part, to make decisions about you. Such requests must be made in writing. The Plan may charge a reasonable fee for the cost of producing and mailing the copies. In certain situations, the Plan may deny your request and tell you why your request has been denied. You have the right to ask for a review of the Plan's denial.
- **Amendments:** You may ask the Plan to correct or amend your personal information maintained by the Plan. Your request for a change to your personal information must be in writing and give a reason for your request. The Plan may deny your request, but you may respond by filing a written statement of disagreement and ask that the statement be included with health plan information.
- **Accounting of disclosures:** You may seek an accounting of certain disclosures by asking for a list of the times the Plan has shared your personal information. Your request must be in writing and give the specific information the Plan needs in order to respond to your request.
- **Notice of privacy practices:** The Plan must send a Notice of privacy practices that describes the use and disclosures of personal information by the health plan to the subscriber. You may ask general questions about this Notice by calling the Privacy Office at [add contact information].

Questions and complaints

If you have questions about this Notice or want to file a complaint about the Plan's privacy practices, including the process for breach notification, write to [add contact information]. For more information on how to file a written complaint, call the Privacy Office at [add contact information]. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. The Plan will not retaliate against you if you file a complaint about its privacy practices with the Plan or with the Department of Health and Human Services.

Changes to privacy practices

The Plan may change the terms of this Notice at any time. Any such changes will be effective for all personal information maintained by the Plan. If the Plan changes any of the privacy practices described in this Notice, the Plan will post the revised notice on [add website]. The Plan may also give you additional information about its privacy practices in other notices it provides. This Notice is effective as of January 1, 2025.

Foreign language assistance

Contact the appropriate claim administrator or the plan administrator if you would like translation services to understand your benefits.

Notice On The Women's Health And Cancer Rights Act Of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided by in a manner determined in consultation with the attending physician and the patient, 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; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided by the Plan. If you would like more information on these benefits or your rights under this federal law, please contact the Plan Administrator at [add contact information].

Notice Of Rights Under The Newborns' And Mothers' Health Protection Act Of 1996

Under federal law, group health plans and benefits such as the Plan's health benefits generally may not 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 delivery by cesarean section. However, group health plans may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans 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. In addition, a plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may under federal law be required to obtain preauthorization before going into a hospital for these services or any other type of services under group health plan coverage.

Notice of Nondiscrimination

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Kaiser Permanente does not exclude people or treat them less favorably because of race, color, national origin (including limited English proficiency and primary language), age, disability, sex, sex characteristics (including intersex traits), pregnancy (or related conditions), sex stereotypes, sexual orientation, or gender identity. We also:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, braille, audio, accessible electronic formats, other formats)
- Provide free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Member Services at **1-888-901-4636 (TTY 711)**.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, sex, sex characteristics (including intersex traits), pregnancy (or related conditions), sex stereotypes, sexual orientation, or gender identity, you can file a grievance with our Civil Rights Coordinator at P.O. Box 35191, Mail Stop: RCR-A1N-22, Seattle, WA 98124-5191 or by calling **1-888-901-4636 (TTY 711)**. You can file a grievance in person or by mail, phone, or online at kp.org/wa/feedback. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with:

- The U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F HHH Building, Washington, DC 20201; **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>
- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at **800-562-6900, 360-586-0241 (TDD)**. Complaint forms are available at <https://fortress.wa.gov/oic/online-services/cc/pub/complaintinformation.aspx>

Multi-language Interpreter Services

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-888-901-4636** (TTY **711**).

Español (Spanish): ATENCIÓN: Si habla español, tiene disponibles servicios de ayuda con el idioma sin cargo. Llame al **1-888-901-4636** (TTY **711**).

中文 (Chinese): 注意: 如果您說中文，您可以免費獲得語言援助服務。請致電 **1-888-901-4636** (TTY **711**)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu quý vị nói tiếng Việt, quý vị có thể sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí của chúng tôi. Xin gọi số **1-888-901-4636** (TTY **711**).

한국어 (Korean): 참고: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 제공해 드립니다. **1-888-901-4636**(TTY **711**)번으로 문의하십시오.

Русский (Russian): ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Звоните по номеру **1-888-901-4636** (TTY **711**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-901-4636** (TTY **711**).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, вам доступні безкоштовні послуги перекладу. Телефонуйте за номером **1-888-901-4636** (TTY **711**).

ភាសាខ្មែរ (Khmer): សូមយកចិត្តទុកដាក់: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃគឺមានសម្រាប់អ្នក។ ទូរស័ព្ទទៅលេខ **1-888-901-4636** (TTY **711**)។

日本語 (Japanese): 注意事項: 無料の日本語での言語サポートをご利用いただけます。**1-888-901-4636** (TTY **711**) まで、お電話にてご連絡ください。

አማርኛ (Amharic): ማሳሰቢያ፡ የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አገዛ አገልግሎቶች፡ በነጻ ለእርስዎ ይቀርባሉ፡ ወደ **1-888-901-4636** (TTY **711**) ይደውሉ።

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa yoo ta'e, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. **1-888-901-4636** (TTY **711**) irraatti bilbilaa.

ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। **1-888-901-4636** (TTY **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic): انتباه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، متوفرة لك، مجاناً. اتصل بالرقم **1-888-901-4636** (TTY **711**)

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-901-4636** (TTY **711**).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ແມ່ນຈະມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ໂທ **1-888-901-4636** (TTY **711**).

International Symbol for ASL (American Sign Language):



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