

BENEFIT SUMMARY

This “Benefit Summary,” which is part of the *Evidence of Coverage (EOC)*, is a summary of answers to the most frequently asked questions about benefits. This summary does not fully describe benefits, limitations, or exclusions. To see complete explanations of what is covered for each benefit, including exclusions and limitations, and for additional benefits that are not included in this summary, please refer to the “Schedule of Benefits,” “General Exclusions,” and “Reductions” sections of the EOC.

Calendar Year Deductible	
Individual	\$1,000 per Calendar Year
(Note: Deductible does not apply to Out-of-Pocket Maximum.)	
Medical Out-of-Pocket Maximum Expenses	
Individual	\$5,000 per Calendar Year
Preventive Care Services	You Pay
Routine preventive physical exam (includes well-baby and well-child)	\$0
Scheduled prenatal care and first postpartum visit	\$0
Immunizations	\$0
Preventive tests	\$0
Diabetic self-management training and education office visits	\$0
Outpatient Services	You Pay
Primary care visit (includes routine OB/GYN visits and medical office visits, routine hearing exams, health education Services, and diabetic outpatient self-management training and education, including medical nutrition therapy).	20% Coinsurance after Deductible
Specialty care visit (includes diabetic outpatient self-management training and education, including medical nutrition therapy and health education Services).	20% Coinsurance after Deductible
TMJ therapy	20% Coinsurance after Deductible
Routine eye exam	\$0
Injections provided in the Nurse Treatment area	\$10 Copay after Deductible
Urgent Care visit	20% Coinsurance after Deductible
Emergency department visit	20% Coinsurance after Deductible
Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy	20% Coinsurance after Deductible
Respiratory therapy	20% Coinsurance after Deductible
Inpatient Hospital Services	You Pay
Room and board, surgery, anesthesia, X-ray, imaging, laboratory, and drugs	20% Coinsurance after Deductible
Ambulance Services	You Pay
Per transport	20% Coinsurance after Deductible
Chemical Dependency Services	You Pay
Outpatient Services	20% Coinsurance after Deductible
Inpatient hospital Services	20% Coinsurance after Deductible
Residential Services	20% Coinsurance after Deductible
Day treatment Services	20% Coinsurance after Deductible
Dialysis Services	You Pay
Outpatient dialysis	20% Coinsurance after Deductible

Home dialysis	\$0
Hearing Services	You Pay
Hearing exams	20% Coinsurance after Deductible
Hearing aid allowance of up to \$4,211 (total for both ears combined) every 48 months per Member. You are responsible for any amount by which price exceeds the allowance.	20% Coinsurance
Home Health Services	You Pay
Home health (up to 60 visits per Calendar Year)	20% Coinsurance after Deductible
Hospice Services	You Pay
Palliative and comfort care (limited to one inpatient respite care admission of up to five consecutive days in a 30-day period)	\$0
Mental Health Services	You Pay
Outpatient Services	20% Coinsurance after Deductible
Intensive outpatient Services	20% Coinsurance after Deductible
Inpatient hospital Services	20% Coinsurance after Deductible
Residential Services	20% Coinsurance after Deductible
Outpatient Durable Medical Equipment (DME), External Prosthetic Devices, and Orthotic Devices	You Pay
Outpatient Durable Medical Equipment (DME), External Prosthetic Devices, and Orthotic Devices	20% Coinsurance
Enteral pump, formulas, and supplies; CADD (continuous ambulatory drug delivery) pumps; ocular prosthesis for children age 12 or younger; osteogenic bone stimulators; osteogenic spine stimulators; and ventilators	\$0
Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures	You Pay
Laboratory, X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
Prescription Medication	You Pay
Generic drugs, supplies, or supplements	\$5 up to a 30-day supply and does not apply to the Out-of-Pocket Maximum.
Brand-name drugs, supplies, or supplements	\$50 or 50% (whichever is less) up to a 30-day supply and does not apply to the Out-of-Pocket Maximum.
Generic drugs, supplies, or supplements from our Mail-Delivery Pharmacy	\$10 up to a 90-day supply and does not apply to the Out-of-Pocket Maximum.
Brand-name drugs, supplies, or supplements from our Mail-Delivery Pharmacy	\$100 or 50% (whichever is less) up to a 90-day supply and does not apply to the Out-of-Pocket Maximum.
Certain self-administered IV drugs, fluids, additives, and nutrients including the supplies and equipment required for their administration	\$0
Elemental enteral formula and supplements for treatment of metabolic disorder including PKU	\$0
Medical foods and formulas	\$0
Oral chemotherapy medications used for the treatment of cancer	\$0
Post-surgical immunosuppressive drugs after covered transplant Services	\$0

Reconstructive Surgery Services	You Pay
Inpatient hospital Services	20% Coinsurance after Deductible
Outpatient surgery Services	20% Coinsurance after Deductible
Rehabilitative Therapy Services	You Pay
Outpatient physical, speech, and occupational therapies (up to 20 visits per Calendar Year)	20% Coinsurance after Deductible
Multidisciplinary rehabilitation (up to a combined total of 60 days per condition per Calendar Year for inpatient and outpatient rehabilitation)	
Inpatient multidisciplinary rehabilitation	20% Coinsurance after Deductible
Outpatient multidisciplinary rehabilitation	20% Coinsurance after Deductible
Skilled Nursing Facility Services	You Pay
Inpatient skilled nursing Services (up to 60 days per Calendar Year)	20% Coinsurance after Deductible
Transplant Services	You Pay
Inpatient hospital Services	20% Coinsurance after Deductible
Vision Hardware Optical and Therapy Services	You Pay
Allowance for standard lenses is: \$96 for single vision, \$134 for bifocal, or \$180 for trifocal, depending on vision needs; and up to and not exceeding \$96 for frames. Standard lenses and frames are only provided once every 12 months.	Any amount by which price exceeds allowance.
Vision therapy – orthoptics or eye exercises (up to 6 visits per Calendar Year)	\$0
Dependent Limiting Age	Limiting Age
General	19

This is not a contract. This “Benefit Summary” does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. Members may not be enrolled in and receive benefits from other private, public, or government sponsored health insurance plans while receiving benefits from Healthy KidsConnect plans, although some exceptions may apply. For more details on your benefit coverage, please refer to your *Evidence of Coverage* or call Membership Services. In the case of conflict between this “Benefit Summary” and the *Evidence of Coverage*, the *Evidence of Coverage* will prevail.

Benefits are subject to approval by the Oregon Health Authority.

All plans are offered and underwritten by:

Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah Street, Suite 100
Portland, OR 97232-2009

State of Oregon



Healthy KidsConnect Plan

Medical Benefits

Evidence of Coverage

This *Evidence of Coverage* is effective January 1, 2012 through December 31, 2012



Healthy KidsConnect
Office of Private Health Partnerships (OPHP)
250 Church Street SE, Suite 200
Salem, OR 97301
Salem (503) 378-8631
Toll Free 1-888-260-4555

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Introduction

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

Term of this EOC

This *EOC* is effective for the period stated on the cover page, unless amended. The Healthy KidsConnect benefits administrator can tell you whether this *EOC* is still in effect.

About Kaiser Permanente

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

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

- “Referrals to Non-Participating Providers and Non-Participating Facilities” in the “How to Obtain Services” section.
- “Emergency Room Services.”
- “Ambulance Services” in the “Schedule of Benefits” section.

For more information, see the “How to Obtain Services” section or contact Membership Services. If you would like additional information about your benefits, please call Membership Services or you may also e-mail us by registering at **kp.org**.

Definitions

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

Brand-name Medication means prescription medication that has a patent and is marketed and sold by only one source or is listed in widely accepted references as a Brand-name Medication based on manufacturer and price.

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

Charges means the following:

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

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

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

Copayment means the defined dollar amount that you must pay when you receive covered medical Services.

Cosmetic means Services and supplies that are applied to normal structures of the body primarily for the purposes of improving or changing appearance or enhancing self-esteem.

Creditable Coverage. Prior health care coverage as defined in 42 U.S.C. 300gg as amended. Creditable Coverage includes most types of group and non-group health coverage.

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

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness and/or Injury and is appropriate for use in your home.

Eligibility means the requirements that you must meet in order to qualify for and remain in the Healthy KidsConnect Program. ***See the "When coverage begins" and "When coverage ends" definitions.***

Emergency Medical Condition. A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.

- Serious dysfunction of any bodily organ or part.

Emergency Services. All of the following with respect to an Emergency Medical Condition:

- A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, including ancillary Services routinely available to the emergency department to evaluate the Emergency Medical Condition.
- Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act requires to Stabilize the patient.

“Emergency Services” does not include any Services you receive after your condition is clinically stable. (“Clinically stable” means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during your discharge or transfer from the Hospital.)

Evidence of Coverage (EOC). This *Evidence of Coverage* document provided to the Member that specifies and describes benefits and conditions of coverage.

External Prosthetic Devices. External prosthetic devices are rigid or semi-rigid external devices required to replace all or any part of a body organ or extremity.

Exclusions means specified conditions or circumstances, listed in this Plan, for which we pay no benefits. Exclusions may apply to Services that are Medically Necessary.

Generic Medication means a Prescription Medication that is an equivalent medication to the Brand-name Medication, is marketed and sold by more than one source, and is listed in widely accepted references as a Generic Medication based on manufacturer and price. Equivalent medication means the Food and Drug Administration (FDA) ensures that the generic has the same effectiveness as the Brand-name Medication.

Group. The Healthy KidsConnect Program.

Healthy KidsConnect Program means the Healthy Kids Program of the Office of Private Health Partnerships (OPHP), 250 Church Street SE, Suite 200, Salem, OR 97301. Telephone Salem (503) 378-8631, Toll Free 1-888-260-4555.

Home Health Agency. A “home health agency” is an agency that: (i) meets any legal licensing required by the state or other locality in which it is located; or (ii) qualifies as a participating Home Health Agency under Medicare; and (iii) specializes in giving Skilled Nursing Facility care Services and other therapeutic Services, such as physical therapy, in the patient’s home (or to a place of temporary or permanent residence used as your home).

Home Health Services means Services that a licensed Home Health Agency provides to a homebound patient.

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

Hospice means a program designed to provide comfort and supportive Services to terminally ill patients and their families.

Hospital means a facility that provides diagnostic and treatment Services for inpatient surgical and medical care of persons who are injured or ill. It must be licensed under applicable

laws as a general Hospital. Its Services must be under the supervision of a staff of physicians and must include 24-hour-a-day nursing service by registered nurses. Facilities that are primarily for rest, the aged or convalescence homes are not considered Hospitals and neither are facilities operated by the state or federal government. Any Hospital listed in the *Medical Directory* for our Service Area. Participating Hospitals are subject to change.

Illness means a physical Illness or mental Illness. Physical Illness is a disease or bodily disorder. Mental Illness is an Axis 1 diagnosis listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except those specifically excluded in the “General Exclusions” *section*.

Injury means a personal bodily Injury to you caused directly and independently of all other causes by external, violent, and accidental means.

In-Network means only the covered Services that you receive from Participating Providers.

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

Managed Care Plan means the Healthy KidsConnect Managed Care Plan.

Medical Directory. The *Medical Directory* lists primary care and specialty care Participating Providers; includes addresses, maps, and telephone numbers for Participating Medical Offices and other Participating Facilities; and provides general information about getting care at Kaiser Permanente. After you enroll, you will receive a flyer that explains how you may either download an electronic copy of the *Medical Directory* or request that the *Medical Directory* be mailed to you.

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

Medically Necessary or Medical Necessity means health care Services or supplies that a Participating Physician, exercising prudent clinical judgment, would provide to you for the purpose of preventing, evaluating, diagnosing, or treating an Illness, or Injury, disease, or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Illness, Injury, or disease;
- not primarily for the convenience of you, your physician, or other Participating Provider; and
- not more costly than an alternative Service or sequence of Services, or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Illness, Injury, or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of Participating Physicians practicing in relevant clinical areas, and any other relevant factors.

Member. A person who is eligible and enrolled under this *EOC*. This *EOC* sometimes refers to a Member as “you.”

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

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

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

Obesity means a condition in which a person has a body mass index of at least 30.0 kg/m² but less than 40.0 kg/m².

Orthotic Devices. Orthotic devices are rigid or semi-rigid external devices (other than casts) required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

Out-of-Network means covered Services that you receive from Providers or Non-Participating Providers that have no contract with us to serve the Healthy KidsConnect Program.

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

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

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

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

Participating Pharmacy means any Pharmacy owned operated by Kaiser Permanente and is listed in the *Medical Directory* within our Service Area. Participating Pharmacies are subject to change.

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

Participating Provider means a Participating Provider that has a contract with us to serve the Healthy KidsConnect Program.

Participating Skilled Nursing Facility. A facility that provides inpatient skilled nursing Services, rehabilitation Services, or other related health Services and is licensed by the state of Oregon and approved by Company. The facility’s primary business must be the provision of

24-hour-a-day licensed skilled nursing care. The term “Participating Skilled Nursing Facility” does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily custodial care, including training in routines of daily living. A “Participating Skilled Nursing Facility” may also be a unit or section within another facility (for example, a Participating Hospital) as long as it continues to meet the definition above.

Pharmacist means an individual licensed to dispense Prescription Medication and counsel a patient about how the medication works and its possible adverse effects.

Pharmacy means any licensed outlet in which Prescription Medications are regularly compounded and dispensed.

Plan means our Healthy KidsConnect Medical Benefits Plan, Dental Benefits Plan, Vision Benefits Plan, and administrative procedures (such as procedures for claims submission, grievances, appeals, external review, and third party liability), all as described in this Group’s *EOC*.

Post-Stabilization Care. The Services you receive after your treating physician determines that your Emergency Medical Condition is clinically stable.

Preauthorization means a determination by us prior to provision of Services that we will provide coverage for the Services.

Prescription Medication means medications and biologicals that relate directly to the treatment of an Injury, Illness, stroke, or surgery and that can legally be dispensed only with a Prescription Order. By law, they must bear the legend: “Caution – federal law prohibits dispensing without prescription.” For purposes of the outpatient Prescription Medication benefit, Prescription Medications also include covered insulin and diabetic supplies, Self-injectable Medications, and compound medications. We require a Prescription Order for insulin and diabetic supplies.

Prescription Order means a written prescription or oral request for Prescription Medications issued by a Participating Provider or any licensed dentist who is licensed to prescribe medications.

Professional Provider means any of the following, for Medically Necessary Services, which are within the scope of the Professional Provider’s state license or registry:

- A physician (doctor of medicine or osteopathy);
- podiatrist;
- dentist (doctor of medical dentistry, doctor of dental surgery, or denturist);
- Pharmacist;
- psychologist;
- Oregon-registered clinical social worker;
- certified nurse practitioner;
- registered nurse or licensed practical nurse, but only for Services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those Services for which nurses customarily bill a patient;
- physician assistant; or
- registered physical, occupational, or speech, therapist.

The term Professional Provider does not include any other class of provider not named previously, and no medical benefit of the Plan will be paid for their Services. For certain providers, coverage may exist under the *Dental Benefits* or *Vision Benefits* of the Plan.

Provider or Health Care Provider means a Professional Provider, or a facility, agency, supplier, or program that provides health care Services.

Reconstructive means Services, procedures, and surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

Residential/Partial Hospitalization/Day Care means care in a Residential facility, Hospital or other facility which provides an organized full-day or part-day program of treatment and is licensed or approved for the particular level of care for which reimbursement is being sought by the Oregon Office of Alcohol and Drug Abuse Programs or by the Oregon Mental Health Division (or the equivalent agencies, if the Services are provided outside Oregon).

Self-injectable Medications means outpatient injectable Prescription Medications intended for self-administration and approved by us for self-injection.

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

Services mean health care diagnosis, treatments, procedures, equipment, medications, or devices. Services include supplies to support a Service.

Skilled Nursing Facility means a facility licensed under applicable laws to provide inpatient care under the supervision of a medical staff or a medical director. It must provide continuous 24-hour-a-day licensed nursing Service supervised by registered nurses.

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

Spell of Illness means the duration of a particular Illness that lasts for a period of consecutive days beginning with the first day not part of a previous Illness on which you are admitted to a Hospital, and ending at the close of the first 60-day period thereafter during which you have neither been a Hospital inpatient nor been confined in any other type of facility.

Stabilize. To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver the infant (including the placenta).

Supplies mean consumable goods to support health care Services.

Transplant means a procedure or a series of procedures by which an organ or tissue is either: removed from the body of one person (called a donor) and implanted in the body of another person (called a recipient), or removed from and replaced in the same person's body (called a self-donor). In treatment of cancer, the term "Transplant" includes any chemotherapy and related course of treatment, which the Transplant supports.

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

Usual and Customary Fee. The lower of (1) the actual fee the Provider, facility, or vendor charged for the Service, or (2) the 80th percentile of fees for the same or similar Service in the geographic area where the Service was received according to the most current survey data published by FAIR Health Inc. or another national service designated by Company.

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

When coverage begins means:

- The first of the month after we have received your completed enrollment materials from the Healthy KidsConnect Program.
- From birth or placement for adoption, in the case of a newborn or adoptee enrolled in accordance with the requirements of the Healthy KidsConnect Program.

When coverage ends is when you have:

- Become age 19 (except as provided under portability).
- Become eligible or entitled to Medicare.
- Become eligible for Medicaid/Oregon Health Plan (OHP).
- Not paid your premiums.
- Moved out of state.
- Moved out of our Service Area.
- Otherwise fail to satisfy the Eligibility requirements of the Healthy KidsConnect Program.

How to Obtain Services

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

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

Using Your Identification Card

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

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

Getting Assistance

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

Most Participating Facilities have an administrative office staffed with representatives who can provide assistance if you need help obtaining Services. Membership Services representatives are also available to assist you Monday through Friday (except holidays), from 8 a.m. to 6 p.m.

Portland area.....[503-813-2000]

All other areas [1-800-813-2000]

TTY for the hearing and speech impaired [1-800-735-2900]

Language interpretation services [1-800-324-8010]

You may also e-mail us by registering on our website at **kp.org**.

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

Our Advice Nurses

If you are unsure whether you need to be seen by a physician or where to go for Services, or if you would like to discuss a medical concern, call one of our advice nurses. During regular office hours, call the advice number at a Participating Medical Office near you. Telephone numbers and office hours are listed by facility in the *Medical Directory* and online at **kp.org**.

On evenings, weekends, and holidays, call one of the following numbers:

Portland area..... [503-813-2000]

All other areas [1-800-813-2000]

(You may call at any time to discuss urgent concerns.)

TTY for the hearing and speech impaired [1-800-735-2900]

Language interpretation services [1-800-324-8010]

You may also use the Member section of our website, **kp.org**, to send *nonurgent* questions to an advice nurse or Pharmacist.

Your Primary Care Participating Provider

Your primary care Participating Provider plays an important role in coordinating your health care needs, including Participating Hospital stays and referrals to Specialists. We encourage you to choose a primary care Participating Provider.

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

To learn how to choose your primary care Participating Provider, please call Membership Services or visit **kp.org**. You may change your primary care Participating Provider by calling Membership Services. The change will be effective the first day of the following month.

Appointments for Routine Services

If you need to make a routine care appointment, please refer to the *Medical Directory* for appointment telephone numbers, or go to **kp.org** to request an appointment online. Routine appointments are for medical needs that are not urgent, such as checkups and follow-up visits that can wait more than a day or two. Try to make your routine care appointments as far in advance as possible. For information about getting other types of care, refer to the “Emergency Room Services” section.

Prior and Concurrent Authorization and Utilization Review

Some Services are subject to Utilization Review based on Utilization Review criteria developed by the Medical Group and/or other organizations utilized by Medical Group and approved by Company and may require prior or concurrent authorization in order to be covered. Your Participating Provider will request this authorization when necessary. The following are examples of Services that require prior or concurrent authorization:

- Breast reduction surgery.
- Drug formulary exceptions.
- Durable Medical Equipment.

- Hospice and Home Health Services.
- Inpatient Hospital Services.
- Inpatient and residential Chemical Dependency Services.
- Inpatient and residential mental health Services.
- Non-emergency medical transportation.
- Open MRI.
- Plastic surgery.
- Referrals for Non-Participating Provider Services.
- Rehabilitative therapy Services.
- Routine foot Services.
- Skilled Nursing Facility Services.
- Transplant Services.

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

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

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Participating Providers, Participating Facilities, Non-Participating Providers, and Non-Participating Facilities anywhere in the world.

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

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

Emergency Services are available from Participating Hospital emergency departments 24 hours a day, seven days a week. Contact Membership Services or see our *Medical Directory* for locations of these emergency departments.

Referrals

Referrals to Participating Providers and Participating Facilities

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

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

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

Referrals to Non-Participating Providers and Non-Participating Facilities

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

Participating Providers and Participating Facilities Contracts

Participating Providers and Participating Facilities may be paid in various ways, including salary, per diem rates, case rates, fee-for-service, incentive payments, and capitation payments. Capitation payments are based on a total number of Members (on a per-Member per-month basis), regardless of the amount of Services provided. The Company may directly or indirectly make capitation payments to Participating Providers and Participating Facilities only for the professional Services they deliver, and not for Services provided by other physicians, Hospitals, or facilities. Call Membership Services if you would like to learn more about the ways Participating Providers and Participating Facilities are paid to provide or arrange medical and Hospital Services for Members.

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

Provider Whose Contract Terminates

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

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

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

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

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

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

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

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

- The 45th day after the birth; or
- As long as you continue under an active course of treatment, but not later than the 120th day from the date we notify you about the contract termination.

Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas

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

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

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

Visiting Member Services and your out-of-pocket costs may be different from the Services and Deductible, Copayments, and Coinsurance that apply inside our Service Area.

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

What You Pay

Questions Regarding Benefits and Coverage

This Plan contains information about the benefits specific to the Healthy KidsConnect Program. Please be sure to read carefully for the terms, conditions, provisions, limitations, and Exclusions of this Plan.

Deductible

For each Calendar Year, most covered Services are subject to the Deductible amount shown in the “Benefit Summary.” The “Benefit Summary” indicates which Services are subject to the Deductible. If we must bill you, an accounting fee of \$10 or more may be added to offset handling costs.

For Services that are subject to the Deductible, you must pay Charges for the Services when you receive them, until you meet your Deductible. Once your Member Deductible is satisfied, no further Member Deductible will be due for the remainder of the year. The Member Deductible

amount is shown in the “Benefit Summary.”

After you meet the Deductible, you pay the applicable Copayments and Coinsurance for covered Services for the remainder of the Calendar Year until you meet your Out-of-Pocket Maximum (see “Out-of-Pocket Maximum” in this “What You Pay” section).

For each Calendar Year, the following amounts count toward your Deductible:

- Charges you pay for covered Services you receive in that Calendar Year and that are subject to the Deductible.

Copayments and Coinsurance

The Copayment or Coinsurance for each covered Service is shown in the “Benefit Summary.” Copayments or Coinsurance are due when you receive the Service.

Medical Out-of-Pocket Maximum Expenses

Out-of-Pocket Maximum

There is a maximum to the total dollar amount of Copayments and Coinsurance that you must pay for certain covered Services that you receive within the same Calendar Year under this *EOC*. This Out-of-Pocket Maximum shown in the “Benefit Summary” is per Calendar Year for a Member or for Multi-child. Copayments and Coinsurance that count toward the Out-of-Pocket Maximum are for those Services that are subject to the Deductible. The following amounts do not count toward the Out-of-Pocket Maximum and you will continue to be responsible for these amounts even after the Out-of-Pocket Maximum is satisfied:

- Payments toward the Deductible.
- Payments for Services that are not covered under this *EOC*.
- Payments that you make because we already covered the benefit maximum amount or the maximum number of days or visits for a Service.
- Payments for Services under the Student Out-of-Area Coverage.
- Copayments and Coinsurance for Services that are not subject to the Deductible.

Membership Services can provide you with the amount you have paid toward your Out-of-Pocket Maximum.

Schedule of Benefits

To receive benefits, you must be enrolled with us for Managed Care Plan. Listed below are your medical benefits, limitations, and exclusions that apply to specific benefits:

Alternative Services (Acupuncture, Chiropractic, and Naturopathic Care)

We cover these alternative Services subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company when you receive a referral from a Participating Provider. We cover the following Services described under this “Alternative Services (Acupuncture, Chiropractic, and Naturopathic Care)” section when provided by designated Participating Providers and only when they are provided as outpatient Services in the provider’s office.

Acupuncture therapy, care received from chiropractors, and/or naturopathic care may be approved for Services within the scope of the Participating Provider’s license. Eligible Participating Providers of acupuncture are doctors of medicine or osteopathy or registered acupuncturists.

Exclusions: Nutritional supplements are not covered. Diagnoses, which are considered Plan Exclusions such as Obesity, smoking cessation, are ineligible for coverage.

Ambulance Services

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

- A Participating Provider determines that your condition requires the use of medical Services that only a licensed ambulance can provide.
- A Participating Provider determines that the use of all other means of transportation, whether or not available, would endanger your health.
- The ambulance transports you to or from a location where you receive covered Services.
- Certified air ambulance transportation will be covered if it is Medically Necessary.
- In-Network benefits apply to Out-of-Network ambulance Services.

Ambulance Services Exclusions

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

Biofeedback Therapy

Covered expenses for biofeedback therapy Services are limited to physical therapy for musculoskeletal problems without psychological complications or as an adjunct to mental health therapy.

Chemotherapy

Covered expenses include radium, radio isotopic, and X-ray therapy; treatment planning and simulation; professional Services for administration and supervision; and treatments including

the therapist, facility, and equipment Charges provided by Participating Providers and Participating Facilities.

Dialysis Services

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

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

We cover treatment at outpatient dialysis facilities. You pay the Copayment or Coinsurance shown in the “Benefit Summary” under “Dialysis Services.”

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

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

Disease Management Program

If you have been diagnosed with select chronic disease condition(s), we can provide you with disease management programs. Those eligible for disease management are identified using a combination of methods, and referral, or you may self-enroll. The program addresses asthma, diabetes, overweight or Obesity, high-risk maternity, and smoking cessation.

Durable Medical Equipment, Supplies, and Appliances

We cover the following Medically Necessary supplies and appliances when required by standard treatment practices for the treatment of an Injury, Illness, stroke, or surgery:

- Blood or blood plasma.
- Casts, trusses, limb or back braces, and crutches.
- Colostomy.
- Mastectomy supplies.
- Medically Necessary PKU formulas.
- Nonprescription elemental enteral formula for home use when ordered by a Participating Provider long as:
 - The formula is Medically Necessary for the treatment of severe intestinal malabsorption; and
 - the formula comprises the sole or an essential source of your nutrition.
- Nutritional supplies and medical assessment equipment necessary to diagnose, monitor and control disorders of inborn metabolic disorders.
- One contact lens for each eye undergoing cataract surgery.

- Prosthetic Devices, artificial limbs, artificial eyes and Orthotic Devices.
- Maxillofacial Prosthetic Devices that are Medically Necessary for the restoration and management of head and facial structures that cannot be replaced by living tissue, are defective due to disease, trauma, or developmental deformity to control or eliminate infection and pain and restore facial configuration and function.
- Rental (not to exceed the reasonable purchase price if the item can be purchased) of a wheelchair, hospital-type bed, oxygen, or other Durable Medical Equipment unique to medical care or treatment.

Covered Durable Medical Equipment must be Medically Necessary and may not serve solely as a comfort or convenience item. The following items are not Durable Medical Equipment and, therefore, are not covered:

- Deluxe equipment with mechanical or electrical features such as motor-driven wheelchairs and chair lifts;
- environmental controls or environmental enhancements such as air conditioners, humidifiers, air filters; and
- portable whirlpool pumps.

Emergency Room Services

If you receive Services for an Emergency Medical Condition, you are responsible for the emergency room Coinsurance after Deductible

We will cover Emergency Services from an Out-of-Network provider if a prudent layperson possessing an average knowledge of health and medicine, would reasonably believe that the time required to go to an In-Network provider would place your health; or the health of your fetus, in the case of a pregnant woman, in serious jeopardy.

Hearing Exam

We cover exams to determine the need for hearing correction. In addition, we cover visits to determine the appropriate hearing aid model, visits to verify that the hearing aid conforms to the prescription and visits for fitting, counseling, adjustment, cleaning, and inspection.

Hearing Aids

Every 48 months, we provide a maximum allowance, as shown in the “Benefit Summary,” toward the price of a hearing aid or aids prescribed by a Participating Provider. The allowance will be adjusted on January 1 of each Calendar Year to reflect any increase since January 1 of the previous year according to the Consumer Price Index (CPI) for medical care. You do not have to use the allowance for both ears at the same time.

The date we cover a hearing aid is the date on which you are fitted for the hearing aid. Therefore, if you are fitted for a hearing aid while you are covered under this *EOC*, and if we would otherwise cover the hearing aid, we will provide the allowance even if you do not receive the hearing aid until after you are no longer covered under this *EOC*. Also, the allowance can be

used only at the initial point of sale. If you do not use all of your allowance at the initial point of sale, you cannot use it later.

We select the vendor that supplies the covered hearing aid. Covered hearing aids are any nondisposable, wearable electronic instrument or device worn on the person for the purpose of amplifying sound and assisting in the process of hearing, including an ear mold, part, attachment, or accessory, if necessary, and are limited to one of the following digital models: (i) in-the-ear; (ii) behind-the-ear; (iii) on-the-body (Body Aid Model); or (iv) canal/CIC aids.

Hearing Aid Services Exclusions

- Bone anchored hearing aids.
- Hearing aids that were fitted before you were covered under this *EOC*.
- Internally implanted hearing aids.
- Repair of hearing aids beyond the warranty period.
- Replacement of lost or broken hearing aids, if you have exhausted (used up) your allowance.
- Replacement parts and batteries.

Home or Office Visits

A visit means that a Participating Provider actually examined you. Covered Services include physician consultations in addition to second opinion surgery consultations.

Home Health Services

We cover Medically Necessary Home Health Services. Providers who deliver Home Health Care must be registered or licensed practical nurses; physical, occupational, speech, or respiratory therapists; or licensed social workers. We cover Home Health Services only if all of the following are true:

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

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

- "Dialysis Services."
- "Durable Medical Equipment, Supplies, and Appliances."

Home Health Services Limitations

- The “Benefit Summary” shows a visit maximum for Home Health Services. This visit maximum will be exhausted (used up) for a Calendar Year when the number of visits that we covered during the Calendar Year under this *EOC* adds up to the visit maximum.
- This Plan covers rehabilitative therapy Services that a Participating Provider delivers to a patient who is not confined in a Hospital. Rehabilitative therapy Services are physical, occupational, speech, or respiratory therapy Services necessary to restore or improve lost function caused by Injury, Illness, stroke, or surgery. In order for us to cover the therapy, it must be part of a written plan of treatment that a Participating Provider prescribes. Home Health Services provided by a licensed social worker are paid according to the Home Health Services benefit. This Plan covers Participating Provider Services rendered by an Oregon-registered clinical social worker upon the written referral of a physician or psychologist Participating Provider.

Home Health Services Exclusions

- “Meals on Wheels” or similar food Services.
- Nonmedical, custodial, homemaker or housekeeping type Services except by home health aides as ordered in the approved plan of treatment.
- Nutritional guidance.
- Private duty or continuous nursing Services.
- Services designed to maintain optimal health in the absence of symptoms.
- Services not included in an approved plan of treatment.
- Services of a person who normally lives in the home or who is a member of the family.
- Services that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. These Services are excluded even if we would cover the Services if they were provided by a qualified medical professional in a Hospital or Skilled Nursing Facility.
- Supportive environmental materials such as handrails, ramps, telephones, air conditioners, and similar appliances and devices.

Home Infusion Therapy Services

We cover home infusion therapy Services as described in this section that a Participating Provider orders and determines to be Medically Necessary, that an accredited home infusion therapy agency provides, and that the therapy regimen requires.

Home infusion therapy Services are limited to the following:

- Aerosolized pentamidine.
- Blood product administration.
- Enteral nutrition (under certain circumstances).
- Hydration therapy.
- Intravenous medication therapy.

- Intravenous/subcutaneous pain management.
- SynchroMed pump management therapy.
- Terbutaline infusion therapy.
- Total parenteral nutrition.

Covered expenses include only the following Medically Necessary Services:

- Ancillary medical supplies.
- Collection, analysis, and reporting of the results of laboratory testing Services required to monitor response to therapy.
- Durable Medical Equipment.
- Nursing Services associated with:
 - Administrative therapy.
 - Emergency Services.
 - Patient and/or alternative care giver training.
- Visits necessary to monitor intravenous therapy regimen.
- Solutions, medications, and pharmaceutical additives.

Hospice Services

Definitions

The following definitions apply only to this “Hospice Services” section:

- Terminally ill means your condition has reached a point where recovery can no longer be expected and you are facing imminent death within six months or less as diagnosed by a Medical Group physician.
- Approved Hospice is a private or public hospice agency or organization approved by Medicare or accredited by the Joint Commission on Accreditation of Hospitals and is approved by Kaiser Foundation Hospitals as a Participating Provider.
- Homebound means that your condition is such that there exists a normal inability to leave home. If you do leave home, the absences must be infrequent, or short duration and mainly for the reason of receiving medical Services.
- Home health aide is an employee of a Hospice agency approved by Kaiser Foundation Hospitals who provides intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist.
- Hospice treatment plan is a written plan of care established and periodically reviewed by your Medical Group physician. Your Medical Group physician must certify in the plan that you are terminally ill. The plan must describe the Services for Medically Necessary or palliative care to be provided by the approved Hospice.
- Palliative care is care primarily for the relief or control of distressing symptoms, not cure.
- The Services meet Utilization Review by Company using criteria developed by Medical Group and approved by Company.

Palliative Hospice Care

We cover palliative Hospice care as described in this section when provided by a Medicare or state-certified Hospice care provider and approved by Kaiser Foundation Hospital. A Hospice care program is a coordinated program for home and inpatient care, available 24 hours a day. It uses an interdisciplinary team of personnel to provide palliative and supportive Services to a patient-family unit experiencing a life threatening disease with a limited prognosis. The Services include acute, respite, and home care to meet the physical, psychological, and special needs of a patient-family unit during the final stages of Illness and dying.

Palliative Hospice care means medical Services provided by a Hospice care program that alleviates symptoms or affords temporary relief of pain but are not intended to affect a cure. If you elect palliative Hospice care, then you are not eligible for any other Services for active treatment of the terminal Illness.

In order to qualify for palliative Hospice care, your Medical Group physician must certify that you are terminally ill with a life expectancy of six months or less if the Illness runs its normal course.

- Palliative Hospice care is limited to the following Services:
 - Routine home care.
 - Continuous home care.
 - Inpatient respite care.
 - Inpatient Hospice care.

Additionally, covered Services for palliative Hospice care include the following when provided under any of the Services listed on the previous section:

We cover the following Hospice Services:

- Counseling and bereavement Services for up to one year.
- Durable Medical Equipment (DME).
- Home health aide and Homemaker Services.
- Medical social Services.
- Medical supplies and appliances.
- Participating Provider Services.
- Rehabilitative therapy Services for purposes of symptom control or to enable you to maintain activities of daily living.
- Services of volunteers.
- Short-term inpatient Services including respite care and care for pain control and acute and chronic symptom management. Inpatient respite care is limited to no more than five consecutive days in a 30-day period.
- Skilled nursing Services, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers.

We will not pay for the following Hospice Services:

- Care that is not palliative.
- More than one visit of any one kind of rehabilitation on any one day.
- Deluxe equipment with mechanical or electrical features such as motor-driven wheelchairs and chair lifts.
- Environmental controls or environmental enhancements such as air conditioners, humidifiers, air filters and portable whirlpool pumps.
- Food services, such as “Meals on Wheels.”
- Homemaker or housekeeping services, except those that home health aids provide as ordered in the Hospice treatment plan.
- Legal and financial counseling services.
- Normal necessities of living, including but not limited to food, clothing, and household supplies.
- Recreational or educational therapy; self-help or training.
- Rehabilitative care provided in your home and covered under the Home Health Services benefit.
- Services provided to other than the terminally ill patient.
- Services that your family or volunteer workers provide.
- Services in excess of the benefit limitations.
- Services not included in the Hospice treatment plan or not specifically set forth in a Hospice benefit.
- Services provided more than six months after the initial date of covered Hospice care, unless specifically approved by us.
- Supportive environmental materials, including but not limited to hand rails, ramps, air conditioners and telephones.
- Treatment of psychotic or psychoneurotic conditions.

Hospital Services

We cover the following Services when you are admitted as an inpatient in a Participating Hospital in our Service Area. A Participating Provider must authorize hospitalization and it must be Medically Necessary for acute care and Services for Injury, Illness, stroke, or surgery. All clinical decisions regarding length of stay in a health care facility, transfer between levels of care and follow-up care are the decision of the treating Participating Provider in consultation with you and subject to Medical Necessity as defined by us.

Covered Services consist of the following:

- Anesthesia.
- Blood, blood products, and their administration.
- Chemotherapy and radiation therapy Services.

- Dialysis Services (this benefit is subject to the benefit limitations described under “Dialysis Services” in this “Schedule of Benefits” section).
- Drugs and radioactive materials used for therapeutic purposes, except for the types of drugs excluded under the “Prescription Drugs, Supplies, and Supplements Limitations” in the “Prescription Medication Benefit” section.
- Durable Medical Equipment and medical supplies.
- Emergency detoxification.
- General and special nursing care.
- Internally implanted devices except for internally implanted insulin pumps, artificial hearts, and artificial larynx which are not covered.
- Interrupted pregnancy surgery when performed in an inpatient setting.
- Laboratory, X-rays and other imaging, and special diagnostic procedures.
- Maternity Hospital care for mother and baby. We will not limit the length of a maternity Hospital stay for a mother and baby to less than 48 hours for vaginal delivery and 96 hours for a cesarean section delivery. The length of inpatient stay is determined by an attending Participating Provider, in consultation with the mother. Our policy complies with the federal Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA).
- Medical foods and formulas if Medically Necessary.
- Medical social Services and discharge planning.
- Obstetrical care and delivery (including cesarean section).
- Operating and recovery rooms.
- Orthognathic surgery for treatment of cleft palate diagnosed at birth or cleft lip diagnosed at birth.
- Participating Provider’s Services, including consultation and treatment by Specialists.
- Prescription drugs, including injections.
- Rehabilitative therapy Services such as physical, occupational and speech therapy and multidisciplinary rehabilitation Services, subject to the benefit limitations described under the “Inpatient Rehabilitation Hospital Services” section.
- Respiratory therapy.
- Room and board, including a private room if Medically Necessary.
- Specialized care and critical care units.
- Temporomandibular joint (TMJ) surgery for the treatment of TMJ disorders subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

Number of Inpatient Hospital Days Covered

We will provide Services for unlimited days of inpatient Hospital care for most conditions. Inpatient Services for some conditions may be limited to a lesser number of days. If Services under this Plan change while you are in a Participating Hospital, we will determine what the

covered Services are according to the Services in effect when the stay began. The same rule applies to stays in other kinds of medical Participating Facilities.

Pre-Admission Testing

We cover Services for necessary pre-admission testing.

Inpatient Hospital Services

We cover inpatient Hospital Services, including intensive care, coronary care, and inpatient Hospital Services for mental illness or chemical dependency.

Outpatient Hospital Services

We cover Medically Necessary outpatient Hospital Services, including, but not limited to:

- Outpatient surgery.
- Outpatient rehabilitative Hospital care.
- Emergency room.

Imaging and Invasive Diagnostic Services

We cover imaging Services, such as MRI and CT scans, and diagnostic procedures that require entry into the body cavity, such as angiograms and endoscopy, when they are Medically Necessary.

- X-ray/radium therapy, chemotherapy.
- Diagnostic X-ray and laboratory for accident, illness, and pre-admission testing.
- Imaging and invasive diagnostic.

Inpatient Rehabilitation Hospital Services

We limit covered Services for rehabilitative care for inpatient care in a Participating Hospital that has a specialized department for providing such Services. These Services are available only as long as you require the full rehabilitative team approach and Services on an inpatient basis. The “Benefit Summary” shows a day maximum per condition per Calendar Year for rehabilitative Services that a Participating Provider delivers to you when not confined in a Hospital. Rehabilitative Services are physical, occupational, or speech, therapy necessary to restore or improve lost function caused by Injury, illness, stroke, or surgery. In order for this Plan to cover these types of Services and therapies, they must be Medically Necessary and part of a written treatment plan that a Participating Provider prescribes. In order to be a covered Service, inpatient rehabilitative Services must be preauthorized and be part of a Participating Provider’s formal written program to improve and restore lost function following Injury, illness, stroke, or surgery, and it must be consistent with the condition that is under treatment.

Mastectomy Services

This Plan covers surgery, reconstruction, prosthesis, and treatment of physical complications of all stages of mastectomy. This benefit applies while enrolled in Healthy KidsConnect

coverage regardless of whether or not you were covered by us at the time of any previous treatment.

If you received Services in connection with a mastectomy following breast cancer and, in consultation with the Participating Provider, choose to have breast reconstruction while enrolled in this Plan, we will provide Services for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas. Reconstruction Services are subject to the same provisions as any other Service provided under this Plan (e.g., Coinsurance and Out-of-Pocket Maximum). This benefit is limited to surgery related to breast reconstruction following a mastectomy necessary because of Injury, Illness, stroke, or surgery.

Mastectomy Services Limitations

Breast reconstruction is limited to surgery following a mastectomy that is necessary due to Injury, Illness, stroke, or surgery.

Maternity Care

Pregnancy care, childbirth, termination of pregnancy, and related conditions are covered. We will not limit benefits for the mother and her newborn's length of inpatient stay to less than 48 hours for a normal delivery and 96 hours for a cesarean section. However, the Participating Provider in consultation with the mother may decide on an early discharge. Such discharges do not need to be preauthorized.

Maxillofacial Prosthetic Services

Coverage is limited to the least costly clinically appropriate treatment as determined by a Participating Provider. We cover maxillofacial prosthetic devices if they are necessary for restoration and management of head and facial structures and that cannot be replaced with living tissue and that are defective because of disease, trauma or birth, and developmental deformities when such restoration and management are performed for the purpose of:

- Controlling or eliminating infection.
- Controlling or eliminating pain.
- Restoring facial configuration or functions such as speech, swallowing or chewing but not including Cosmetic procedures rendered to improve on the normal range of conditions.

Mental Health and Chemical Dependency Services

We will cover mental health and chemical dependency Services under this Plan the same as Illness. We cover mental health and chemical dependency Services that are Residential care (care in a licensed Residential facility, Hospital, or other facility which provides an organized full-day or part-day program of treatment).

Definitions

The following definitions apply to treatment of mental health conditions and chemical dependency conditions:

Chemical dependency conditions are substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Chemical dependency is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with your social, psychological, or physical adjustment to common problems. Chemical dependency does not include addiction to or dependency on tobacco, tobacco products, or foods.

Mental health conditions are mental disorders 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 this Plan. Mental disorders that accompany an excluded diagnosis are covered.

Mental health and chemical dependency Services are Medically Necessary outpatient, Residential, Partial Hospital, or inpatient Services provided by an approved licensed facility or licensed professionals who meet our credentialing requirements. Our mental health and chemical dependency benefit Services do not cover Skilled Nursing Facility Services (unless the Services are provided by a licensed behavioral health provider for a covered diagnosis), Home Health Services, or court ordered Services (unless the Services are determined by us to be Medically Necessary).

Preauthorization

The Preauthorization procedures described in this Plan should be followed for treatment of chemical dependency conditions and/or mental health conditions.

Mental Health Services Exclusions and Limitation

- Educational programs for drinking drivers.
- Voluntary mutual support groups, such as Alcoholics Anonymous.
- Family education or support groups.
- Mental health Services, including evaluations and psychological testing, on court order or as a condition of parole or probation, unless Medically Necessary. Court-ordered sex offender treatment programs are excluded regardless of whether they are Medically Necessary.
- Psychological testing for ability, aptitude, intelligence, or interest.
- Mental health Services for the following disorders listed by their diagnostic codes as set out in the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition), published by the American Psychiatric Association:
 - (Mental retardation) codes 317, 318.0, 318.1, 318.2, and 319.
 - (Learning disorders) codes 315.00, 315.1, 315.2, and 315.9.
 - (Paraphilias) codes 302.2, 302.4, 302.81, 302.82, 302.83, 302.84, 302.89, and 302.9.
 - (Gender identity disorders in adults) 302.6, 302.85, and 302.9 (This Exclusion does not apply to anyone 18 years of age or younger).

- (Life transition problems referred to as “V” codes) codes V15.81 through V62.81 and V62.83 through V71.09. This Exclusion does not apply to anyone 5 years of age or younger for code V61.20 (parent-child relational problems) or code V61.21 (neglect, physical abuse, or sexual abuse of child).
- Mental health Services for substance related disorders.
- In home mental health Services, unless all of the following are true:
 - You are substantially confined to your home (or a friend’s or relative’s home), or the care is provided in lieu of Medically Necessary hospitalization.
 - Your Participating Provider determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home.
 - You receive prior authorization from Company in accordance with Utilization Review criteria developed by Medical Group and approved by Company.

Newborn Nursery Services

We cover routine nursery Services of a newborn infant while the mother is confined in a Participating Hospital and receiving maternity Services under this Plan. However, we cover professional Services for well-baby care under the well-baby Services benefit. This Plan does not provide coverage for pediatric standby Services for vaginal delivery. Please Note: We cover an ill or injured newborn under the other medical provisions of this Plan.

Outpatient Diabetic Self-Management

This Plan covers Services used in outpatient diabetic self-management programs when they are provided by a Participating Provider or by a credentialed or accredited diabetic education program for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes. For the purposes of this benefit, a Participating Provider means a licensed physician, registered nurse, nurse practitioner, certified diabetes educator, or licensed dietician with demonstrated expertise in diabetes. We will cover one outpatient diabetic self-management program of assessment and training after diagnosis, including up to three hours per year of assessment and training when there is a material change of condition. Diabetic medication and supplies that are not included in the outpatient diabetic self-management program are covered under the Prescription Medication benefit under this Plan. Diabetic insulin and supplies are covered under the Prescription Medication benefit.

Outpatient Rehabilitation Services

This Plan covers all outpatient rehabilitative Services that a Participating Provider delivers to a Member who is not confined in a Hospital. Rehabilitative Services are physical, occupational, or speech therapy Services necessary to restore or improve lost function caused by Injury, Illness, stroke, or surgery. In order for us to cover the therapy, it must be part of a written plan of treatment that a Participating Provider prescribes. Covered Services exclude the following:

- More than one session of any one kind of rehabilitation on any one day.
- Rehabilitative care provided in your home is covered under the Home Health Services benefit.

- Recreational or educational therapy.
- Self-help or training.
- Treatment of psychotic or psychoneurotic conditions.

Outpatient Rehabilitation Services Exclusions

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

Preventive Care Services

Routine Physical Examinations

We cover the following physical examinations and related laboratory tests and X-ray examinations (as long as a third party is not liable for these charges) for adults age 18: Routine periodic health appraisals, routine physical examinations, and physical examinations required for school and/or to participate in athletics.

- Age 18 – Once
- Age 3-6, one examination per Calendar Year.
- Age 7-18, one examination every two Calendar Years.

Preventive care Services include:

- Services recommended by, and rated A or B by, U.S. Preventive Services Task Force.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC.
- Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
- Preventive care and screenings for women supported by HRSA.

We cover these preventive care Services at the Copayment or Coinsurance shown in your “Benefit Summary.” Services received for an existing Illness, Injury, or condition during a preventive care examination, may be subject to the applicable Deductible, Copayment, or Coinsurance.

Covered preventive care Services include, but are not limited to:

- Bone densitometry.
- Breast examination
- Chlamydia test.
- Cholesterol tests (all types).
- Fasting glucose test.
- Fecal occult test.
- Flexible sigmoidoscopy.
- Immunizations.

- Mammography.
- Pap smear tests.
- Prenatal visits and first postpartum visit.
- Routine preventive physical exam (adult, well-child, and well-baby).
- Screening prostate-specific antigen (PSA) test (not including monitoring or ultrasensitive tests).

If you would like additional information about covered preventive care Services, call Membership Services. Information is also available online at **kp.org**.

Colorectal Screenings

We cover the following Services for colorectal cancer screening for any individual at high risk:

- One fecal occult blood test each Calendar Year plus one flexible sigmoidoscopy every five years;
- one colonoscopy every ten years; or
- one double contrast barium enema every five years.

Those that are at high risk for colorectal cancer for the purpose of this Plan are:

- Individuals who have a family history of colorectal cancer; or
- a prior occurrence of cancer or precursor neoplastic; polyps; or a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, chronic disease, or ulcerative colitis.

PKU Testing

We cover one PKU test to detect the presence of Phenylketonuria (PKU).

If the test detects the presence of PKU, we cover the formulas determined to be Medically Necessary for the treatment of PKU. We cover necessary formulas for treatment under the “Durable Medical Equipment, Supplies, and Appliances” in the “Schedule of Benefits” section.

Professional Provider Services

Services received from certain Professional Providers must meet specific criteria as described below.

- Dentist (doctor of medical dentistry or doctor of dental surgery). This medical benefit covers treatment of accidental Injury to natural teeth or fractured jaw rendered within 12 months after the Injury, or for surgery that does not involve repair, removal or replacement of teeth, gums or supporting tissue. The Injury must be one that occurred while you are a Member under this Plan. You have additional dental coverage under the *Dental Benefits Evidence of Coverage* portion of this Plan.
- Oregon-registered clinical social worker. This Plan covers Services rendered upon the written referral of a Participating Provider.
- RN or LPN. This Plan covers Services rendered upon the written referral of a Participating Physician if nurses customarily provide the Services to Members.

- **Therapists.** This Plan covers Services of registered physical, occupational, or speech, therapists Participating Provider for rehabilitative Services. A Participating Provider must write a referral for rehabilitative therapy Services. Any Medically Necessary follow-up exams are covered according to the general medical benefits of this Plan and subject to any applicable Copayment or Coinsurance.

Participating Provider Visits in the Hospital

Covered Services include Participating Provider visits to Members during a covered Participating Hospital or Skilled Nursing Facility stay. We do not cover separately, visits relating to surgery performed during a Hospital stay because these visits are ordinarily included in the surgeon's fee. Covered expenses also include physician consultations with written reports during each Hospital stay. These benefits apply only if you are eligible for Hospital or Skilled Nursing Facility benefits.

Reconstructive Surgery Services

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

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

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

Prosthetic and Orthotic Devices are covered under and subject to the "Durable Medical Equipment, Supplies, and Appliances" section.

Skilled Nursing Facility Services

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

We cover the following:

- Room and board.
- Nursing Services.
- Medical social Services.
- Medical and biological supplies.
- Blood, blood products, and their administration.
- Dialysis Services.

- Rehabilitative therapy (this benefit is subject to the benefit limitations shown in the “Benefit Summary” under “Outpatient Rehabilitation Services”).
- Drugs prescribed by a Participating Provider as part of your plan of care in the Participating Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Participating Skilled Nursing Facility by medical personnel.

Skilled Nursing Facility Services Exclusions

Covered Services exclude routine nursing care, non-medical self-help or training, personal hygiene, or custodial care. Covered Services exclude an admission to a Skilled Nursing Facility that began before you enrolled in Healthy KidsConnect or for a stay where Services are provided principally for:

- Mental deficiency or retardation; or
- mental illness.

Special Dental Services

We cover the treatment of accidental Injury to natural teeth or a fractured jaw after you have paid any applicable Copayment or Coinsurance. To qualify for coverage, you must receive the treatment from a Participating Provider or Dentist while you are a Member under this Plan, and within 12 months after the Injury except when completion is delayed due to healing time following Medically Necessary surgery.

For purposes of this special dental Services benefit, Injury does not include accidents that occur during eating, biting, or chewing. You have additional dental coverage under the *Dental Benefits Evidence of Coverage* portion of this Plan.

Special Facility Services

This Plan includes Services provided in a special Participating Facility. A special Participating Facility is an ambulatory surgical facility, surgical center, or birthing center. Covered Services include use of the procedure room and other Services that are Medically Necessary for treatment.

Speech-Language Pathology Services

This Plan includes inpatient and outpatient speech-pathology therapy Services, when prescribed by a Participating Provider, subject to the benefit descriptions and limitation under this section.

Speech therapy Services are covered for the treatment of acute conditions or acute exacerbations of chronic conditions, which in the judgment of the Participating Provider will show significant, sustainable, objective, measurable improvement as a result of the prescribed therapy. Prescribed outpatient therapy Services must receive prior-authorization as described under “Prior and Concurrent Authorization and Utilization Review” in the “How to Obtain Services” section. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

Speech Therapy Services Limitations

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

Speech Therapy Services Exclusions

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

Surgery Services

This Plan covers surgery (operative and cutting procedures) Services, including treatment of fractures, dislocations, and burns, and includes the Services of Participating Providers (primary surgeon, assistant surgeon, the anesthesiologist, or certified anesthesiologist). It also covers surgical supplies such as sutures and sterile setups when surgery is performed in the Participating Medical Office. When more than one surgical procedure is performed through the same incision during a single operative session, we cover only the major procedure.

Temporomandibular Joint Services

Temporomandibular joint disorders (TMJ) are covered under this Plan the same as for other injuries or musculoskeletal disorders. All diagnostic and surgical procedures for TMJ Services require Preauthorization.

Therapeutic Injections

We cover therapeutic injections, such as allergy shots, when given in a Participating Provider’s office, except when comparable results can be obtained safely with home self-care or thorough oral use of a Prescription Medication. Therapeutic injection benefits apply only to administrative Charges. Medicine Charges for serum, vaccine, or mixture in connection with the therapeutic injection are not part of this benefit, but may be paid under the provisions of this Plan, subject to any applicable Copayment or Coinsurance. Vitamin and mineral injections are not covered unless Medically Necessary for treatment of a specific medical condition.

Tobacco Use Cessation Programs

Benefits are included for tobacco use cessation programs provided by a Hospital that is a Participating Facility for members age 15 years or older. Covered Services include programs recommended by a Physician that follow the United States Public Health Service guidelines for tobacco use cessation.

Transplants Services

We cover the listed Transplants under this “Transplant Services” section at National Transplant Network Facilities if you meet Utilization Review criteria developed by Medical Group and approved by Company. You pay the Deductible, Copayment, or Coinsurance you would pay if the Services were not related to a Transplant. For Services we provide (or pay for) for actual or potential donors, there is no Charge. We also cover post-surgical immunosuppressive drugs without Charge.

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

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

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

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

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

- If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for a Transplant, we will only cover Services you receive before that determination is made.
- Company, Participating Hospitals, Medical Group, and Participating Providers are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor.

- In accord with our guidelines for Services for living Transplant donors, we provide or pay for certain donation-related Services for a donor, or an individual identified by Medical Group as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered Transplant for you. Our criteria for donor Services are available by calling Membership Services.
- We may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. Your Transplant coordinator can provide information about covered expenses.

Transplant Services Exclusions

- Non-human and artificial organs and their implantation.

Vision Hardware Optical and Therapy Services

Every 12 months we provide an allowance toward the price of eyeglass lenses and a frame. The allowance is shown in the “Benefit Summary.” Coverage allowance may be applied to standard lenses (single vision, bifocal, or trifocal) and frames, and can be used only when you order the item. If you do not use all of your allowance when you order the item, you cannot use it later.

Vision Services Limitations

The “Benefit Summary” shows a visit maximum for vision therapy (orthoptics or eye exercises) Services. This visit maximum will be exhausted (used up) for a Calendar Year when the number of visits that we covered during the Calendar Year under this *EOC* adds up to the visit maximum.

Vision Services Exclusions

- Cosmetic contact lenses, unless Medically Necessary.
- Low vision aids.
- Non-prescription products (other than eyeglass frames), such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
- Professional services for fitting and follow-up care for contact lenses.
- Replacement of lost, broken, or damaged lenses or frames.

X-rays and Laboratory Tests

Medically Necessary diagnostic X-rays and laboratory tests are covered when a Participating Provider orders them. The X-rays for tests must be related to diagnosis or treatment of an Injury, Illness, stroke, or surgery.

Prescription Medication Benefit

Covered Drugs, Supplies and Supplements

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

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

Copayments and Coinsurance for Covered Drugs, Supplies, and Supplements

When you pick up a prescription at a Participating Pharmacy for one of the items listed above, you pay the Copayment or Coinsurance shown in the “Benefit Summary.” The following items require payment of a different Copayment or Coinsurance as indicated in the “Benefit Summary”:

- Medical foods and formulas necessary for the treatment of phenylketonuria (PKU), severe intestinal malabsorption, specified inborn errors of metabolism, or other metabolic disorders.
- Certain self-administered IV drugs, fluids, additives and nutrients that require specific types of parenteral-infusion (such as IV or intraspinal-infusion) for up to a 30-day supply, including the supplies and equipment required for their administration.
- Post-surgical immunosuppressive drugs after covered Transplant Services.
- Oral chemotherapy drugs for the treatment of cancer.
- Drugs, injectables, and radioactive materials used for therapeutic purposes, if they are administered to you in a Participating Medical Office or during home visits. We cover these items upon payment of the applicable visit Copayment or Coinsurance as shown in the “Benefit Summary.” If you pay a Copayment for the visit, then you will not pay additional amounts for these items. If you pay a Coinsurance for the visit, you will also pay the same Coinsurance for these items.

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

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

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

Day Supply Limit

The Participating Provider determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, the Participating Provider determines the amount of a drug, supply, or supplement that constitutes a Medically Necessary supply for you. When you pay the applicable Copayment or Coinsurance shown in the “Benefit Summary,” you will receive the prescribed supply up to the day supply limit also listed in the “Benefit Summary.” If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantity that exceeds the day supply limit, if it can be dispensed in a quantity that exceeds the day supply limit.

How to Get Covered Drugs, Supplies, or Supplements

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

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

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

About Our Drug Formulary

Our drug formulary includes the list of drugs that our Regional Formulary and Therapeutics Committee has approved for our Members. The Regional Formulary and Therapeutics Committee meets monthly and is made up of Participating Physicians, other Participating Providers, Pharmacists, and administrative staff. The Regional Formulary and Therapeutics Committee chooses drugs for the formulary based on a number of factors, including safety and effectiveness as determined from a review of the scientific literature. To see if a drug, supply, or supplement is on our drug formulary, call our Formulary Application Services Team (FAST) at [503-261-7900] or toll free at [1-888-572-7231]. If you would like a copy of our drug formulary or additional information about the formulary process, please call Membership Services. The formulary is also available online at **kp.org**. The presence of a drug on our drug formulary does not necessarily mean that your provider will prescribe it for a particular medical condition.

Drug Formulary Exception Process

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

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

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

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

Outpatient Prescription Drug, Supplies, and Supplements Limitations

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

Outpatient Prescription Drugs, Supplies, and Supplements Exclusions

- Any packaging, such as blister or bubble repackaging, other than the dispensing Pharmacy's standard packaging.
- Drugs prescribed for an indication if the U.S. Food and Drug Administration (FDA) has determined that use of that drug for that indication is contraindicated
- Drugs prescribed for an indication if the FDA has not approved the drug for that indication, except that this exclusion does not apply if the Oregon Health Resources Commission or our Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health and Human Services.
- Drugs, supplies, and supplements that are available without a prescription, even if the non-prescription item is in a different form or different strength (or both), except that this Exclusion does not apply to drugs, supplies, or supplements that our drug formulary lists for your condition.

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

General Exclusions

We will not cover:

- Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control or education, such as air conditioners, humidifiers, air filters, whirlpools, heat lamps or tanning lights.
- Cosmetic Services, which means those Services that are intended primarily to change or maintain your appearance and will not result in significant improvement in physical function. This Exclusion does not apply to Services that are covered under “Reconstructive Surgery Services” in the “Schedule of Benefits” section.
- Custodial Services, including nonskilled, personal Services such as help with activities of daily living (like bathing, dressing, getting in and out of a bed or chair, moving around and using the bathroom, routine nursing care and rest cures, and hospitalization for environmental change. It may also include care that most people do themselves, like using eye drops.
- Dental Services, except as specifically provided in the “Special Dental Care” subsection in the “Schedule of Benefits” section and in the *Dental Benefits Evidence of Coverage Plan*. The dental Services excluded from the medical benefit Plan are Services to prevent, diagnose or treat disease of the teeth, gingiva, the periodontal tissue and the alveolus, including Services to repair defects, which have developed because of tooth loss, and/or to restore the ability to chew.
- Designated blood donations. Collection, processing, and storage of blood donated by donors whom you designate, and procurement and storage of cord blood is covered only when Medically Necessary for the imminent use at the time of collection for a designated recipient.
- Detained or confined Members. Services provided or arranged by criminal justice officials or institutions for detained or confined Members are limited to Services which meet the requirements of Emergency Services under this *EOC*.

- Educational programs for which drivers are referred by the judicial system, or for volunteer mutual support groups.
- Employer responsibility. We do not reimburse the employer for any Services that the law requires an employer to provide. When we cover any of these Services we may recover the Charges for the Services from the employer.
- Eye surgery. Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures.
- Family planning Services and supplies for infertility (except sterilization), artificial insemination, invitro fertilization, or to surgically to correct voluntary sterilization.
- Family Services. Services provided by a member of your immediate family.
- Genetic testing. Genetic testing and related Services are limited to genetic counseling and medically appropriate genetic testing for the purpose of diagnostic testing to determine disease and/or predisposition of disease and to develop treatment plans. Covered Services are limited to preconception and prenatal testing for detection of congenital and heritable disorders, and testing for the prediction of high-risk occurrence or reoccurrence of disease when Medically Necessary as determined by a Participating Provider, in accordance with applicable law. However, testing for family members who are not Members is always excluded.
- Hypnotherapy. All Services related to hypnotherapy.
- Immunizations for the sole purpose of travel, occupation, or residence in a foreign country.
- Inpatient Services after your termination from this Plan. The only exception occurs if you are in a Participating Hospital on the day the coverage ends. This Plan will continue to provide benefits for that hospitalization until your discharge from the Hospital.
- Instruction or training programs, except as covered under the disease management benefit. Examples of instruction or training programs excluded from coverage are:
 - Instruction to learn to self-administer medications or nutrition, except as provided in the outpatient diabetic instruction benefit;
 - self-management education courses;
 - training to control weight or provide general fitness, except under our disease management program;
 - programs that teach you how to use Durable Medical Equipment, except for prosthetics or orthotics; or
 - training how to care for your family.
- Intermediate Services. Services in an intermediate care facility are excluded.
- Massage or massage therapy.
- Nonreusable medical supplies, such as splints, slings, and wound dressing, including bandages and ace wrap bandages, are limited to those supplied and applied by a licensed Health Care Provider, while providing a covered Service. Nonreusable medical supplies that a Member purchases or obtains from another source are excluded.
- Treatment of sexual dysfunction or inadequacy or Services and supplies related to sex change procedures.

- Off-the-shelf orthopedic shoes and orthopedic inserts.
- Orthognathic surgery, which includes Services and supplies to change the position of a bone of the upper or lower jaw.
- Personal items, such as telephones, televisions, and guest meals, in a Hospital or Skilled Nursing Facility.
- Physical exercise programs, even though they may be prescribed for a specific condition.
- Private nursing Service for Hospital or Skilled Nursing Facility inpatients.
- Routine tests and screening procedures not specified by this Plan, except that routine preadmission testing is covered.
- Services you received while in the custody of any law enforcement authority or while in jail or prison.
- Services that are not Medically Necessary for the diagnosis or treatment of an Injury, Illness, stroke, or surgery.
- Skilled nursing care for mental Illness, mental deficiency, or retardation.
- Missed appointments, completion of claim forms, or completion of reports requested by us in order to process claims.
- Services for corns, calluses, removal of nails (except complete removal), and other routine foot care.
- Services for weight control or Obesity. This includes surgery and/or any other Services provided for weight control or Obesity and/or any complications arising out of or related to such Services. These Services are not covered whether or not you have other medical conditions related to or caused by overweight or Obesity, or the treatment of those conditions. However, disease management programs for overweight or Obesity are covered.
- Treatment of any condition caused by or arising out of service in the armed forces of any country or from war or insurrection.
- Services you received before the effective date of your enrollment in this Plan or after the date of your termination from this Plan.

Reductions

Hospitalization on Your Effective Date

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

Injuries or Illnesses Alleged to be Caused by Third Parties

This “Injuries or Illnesses Alleged to be Caused by Third Parties” section applies if you receive covered Services for an Injury or Illness alleged to be any of the following:

- Caused by a third party’s act or omission.

- Received on the premises of a third party.

If you obtain a settlement or judgment from or on behalf of a third party, you must pay us Charges for covered Services that you receive for the Injury or Illness, except that you do not have to pay us more than the amount you receive from or on behalf of the third party. This “Injuries or Illnesses Alleged to be Caused by Third Parties” section does not affect your obligation to make any applicable Deductible, Copayment, or Coinsurance payments for these covered Services, but we will credit any such payments toward the amount you must pay us under this paragraph.

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

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

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

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

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

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send to us all consents, releases, trust agreements, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party’s liability insurer to pay us directly. You must not take any action prejudicial to our rights.

You must place and hold in trust a portion of the proceeds of your recovery that is sufficient to satisfy our claims under this “Injuries or Illnesses Alleged to be Caused by Third Parties” section pending final resolution of the claims. You must provide us with written notice before you settle a claim or obtain a judgment against any third party based on your Injury or Illness.

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

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your Injury or Illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens

and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

No Dual Enrollment or Double Coverage

Members may not be enrolled in and receive benefits from other private, public, or government sponsored health insurance plan while receiving benefits from Healthy KidsConnect Plans. There may be three exceptions to this:

- 1) There may be brief times of transition (typically less than 30 days) when a Member of Healthy KidsConnect is changing to or from another plan such as the Oregon Medical Insurance Pool or Oregon Health Plan.
- 2) If a child with end stage renal disease who is in need of dialysis or a kidney transplant is covered by other health coverage including Medicare, Company is secondary in all cases.
- 3) Tribal members may be enrolled in a qualified tribal health plan in which case the tribal health plan is secondary to Healthy KidsConnect coverage.

Workers' Compensation or Employer's Liability

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

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

Requesting Medical Services and Benefits

Post-Service Claims—Services Already Received

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

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

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

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

You can request a claim form from Membership Services or download it from **kp.org**. When you submit the claim, please include a copy of your medical records from the Non-Participating Provider or Non-Participating Facility if you have them. If you do not submit medical records and they are deemed necessary to decide the claim, you will be notified and required to submit them.

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

You must submit a claim for a Service within 90 days after receiving that Service. If it is not reasonably possible to submit a claim within 90 days, then you must submit a claim as soon as reasonably possible, but in no case more than 15 months after receiving the Service, except in the absence of legal capacity.

We will reach a decision on the claim and pay those covered Charges within 30 calendar days from receipt unless additional information, not related to coordination of benefits, is required to make a decision. If the 30-day period must be extended, you will be notified in writing with an explanation about why.

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

If you have questions or concerns about a bill from Company, you may contact Membership Services for an explanation. If you believe the Charges are not appropriate, Membership Services will advise you on how to proceed.

Pre-Service Claims—Requesting Future Services

When you need Services, you should talk with your Participating Provider about your medical needs or your request for Services. Your Participating Provider provides Services that are Medically Necessary and appropriate. Participating Providers will use their own judgment to determine if Services are medically appropriate. Some Services are subject to approval through Utilization Review, based on Utilization Review criteria developed by Medical Group or another organization utilized by the Medical Group and approved by Company. If you seek a specific Service, you should talk with your Participating Provider. Your Participating Provider will discuss your needs and recommend the most appropriate course of treatment.

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

If you request Services that must be approved through Utilization Review, as previously described, and the Participating Provider believes they are Medically Necessary, the

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

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

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

Dispute Resolution, Complaints, Grievances, and Appeals

We want you to be satisfied with the Services you receive from Kaiser Permanente. If you have questions about Services or your coverage, please contact Membership Services.

We encourage you to discuss any questions or concerns about your care with your Participating Provider or another member of your health care team. If you are not satisfied with your Participating Provider, you may request another. Contact Membership Services for assistance. You always have the right to a second opinion from a qualified Participating Provider at the applicable Deductible, Copayment, or Coinsurance.

If you feel that additional assistance is needed, complaint and grievance procedures are available to help. All complaints and grievances are handled in a confidential manner.

Complaints

If you want to talk with someone because you are dissatisfied with the availability, delivery, or quality of our Participating Provider Services, benefits, or administrative matters, you can make an oral complaint. Examples include appointment delays or the manner of communication by staff members. If you have a concern involving a denial of future care, refer to "Your Appeal Rights" in this section. If your concern involves a claims "Grievances" denial for Services you already received, refer to "Grievances" in this section.

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

Grievances

A grievance is a written or, in the case of an expedited review, an oral request for a specific action, submitted by or on behalf of a Member.

You can file a written grievance regarding the availability, delivery, or quality of Participating Provider Services, benefits, or administrative matters. Examples include delays in hearing back from your Participating Physician's office; not receiving an appointment in a timely manner; or a disagreement with a bill from Kaiser Permanente; or disagreement with our denial of your claim for Services that you received from a Non-Participating Provider or Facility.

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

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

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

If your grievance involves a denial of urgently needed future care, we will expedite our response according to the clinical urgency of the situation, and we will send our response not later than 72 hours after we receive your written grievance.

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

While we encourage you to use our complaint, grievance and appeal procedures, you have the right to seek assistance from the Consumer Protection Unit at the Oregon Insurance Division. Contact them by mail, telephone, over the internet, or by email:

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

If you filed a grievance for an adverse benefit determination as defined below, you will not have to file a separate letter of appeal. We will begin the appeal process when we are in receipt of

your grievance letter as long as we receive your letter within 185 days from the date of the initial denial notice.

Adverse Benefit Determinations

Adverse benefit decision is a denial, reduction or termination of a health care item or Service, or failure or refusal to provide or to make a payment in whole or in part for a health care item or Service that is based on:

- Denial of eligibility for or termination of enrollment in a health benefit plan;
- Rescission or cancellation of an *EOC*;
- Imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or Services;
- Determination that a health care item or Service is experimental and investigational or not Medically Necessary, effective or appropriate; or
- Determination that a course or plan of treatment is not eligible for continuity of care when a provider's contract has terminated.

Your Appeal Rights

Please read this explanation carefully. It explains your right to request a review of our adverse benefit determination.

You, or anyone you formally designate to represent you, have the right to request an appeal (reconsideration) related to a denied grievance or a denial of Service following a utilization review determination made by Kaiser (also referred to as "Company"). You must submit your appeal in writing within 185 days from the date on the initial denial notice. The process is described in the following appeal procedures. These procedures reflect the requirements of state and federal laws.

- Appeals will be acknowledged within seven days of receipt.
- You may submit written comments, documents, records or other information relating to the appeal. This includes both previously submitted information and any new information that you may choose to provide. You may also provide testimony by telephone or in writing. All information provided will be considered when the appeal review is conducted.
- You may request a copy of the complete medical necessity criteria, benefit provision, guidelines or protocol used to make a denial determination, at no cost to you, by contacting Member Relations at 503-813-4480 or Membership Services at 1-800-813-2000 and ask for Member Relations.
- If we previously requested information that we never received, it is important that we are provided that information for your appeal. Without it, we may not be able to thoroughly evaluate your appeal.
- We will fully and fairly review all available information relevant to your request without deferring to any prior decisions.
- Upon request, you may access and obtain copies of all documents relevant to the appeal.
- Appeals requiring quality review, Medical Necessity review, utilization review criteria application, or experimental service determination will be reviewed by a physician who practices in the same or similar specialty that treats the medical condition involved, who

was neither involved in a previous related review nor is a subordinate of the previous physician reviewer; or by an appeal review panel made up of individuals who were not involved in the previous related decisions.

- If we are inclined to deny your appeal and we relied upon or generated any new/additional evidence or rationale in connection with the appeal, we will provide the new/additional evidence or rationale to you, without charge, and you will be given the opportunity to respond prior to our determination.
- We will not impose fees as part of our appeal process.
- Appeals will be decided and you will be provided a written response within 30 days after we receive your appeal.
- If you are not satisfied with the decision made on your pre-Service or post-Service claim, you may have the right to take legal action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if all required internal reviews have been completed. The following departments or committees within Kaiser Foundation Health Plan of the Northwest review appeals: Medical Office Administration, Member Relations, Continuing Care Services, Regional Telephonic Medicine Center, and Patient Care Coordination.

Please submit your request for appeal to:

Kaiser Permanente
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, Oregon 97232-2099

Appeals Regarding Ongoing Care

If your appeal involves Company's decision to deny, modify, reduce, or terminate an otherwise covered Service that you are receiving through Company and Company's decision was based on a finding that the Service is no longer Medically Necessary or appropriate, we will suspend our denial of benefits during the internal appeal period and will continue providing that Service until your appeal has been decided. Our provision of benefits for Services received during the internal appeal period does not, and should not be construed to reverse our denial. If your appeal results in a denial, you may have to pay the full Charges of the continued care Services.

Expedited Appeal Procedure for Urgent Pre-Service and Urgent-Concurrent Care

If your appeal involves urgently needed future care, a request for an expedited appeal may be submitted orally or in writing. An expedited appeal will be initiated when the time frame associated with a routine appeal could seriously jeopardize your life, health, or your ability to regain maximum function, or a physician with an established clinical relationship certifies in writing and provides supporting documentation that your medical condition would subject you to severe pain that cannot be adequately managed without the care or treatment at issue. Expedited appeals will be resolved as quickly as necessary, but not later than 72 hours from the time the appeal is received. We will determine if your request meets the criteria for an expedited review. If your appeal is accepted as expedited, you or we can communicate the information necessary to process the appeal by telephone, fax, or other methods that will deliver the information quickly. If our expedited appeal decision is communicated to you orally, we will also send it in writing within three days of the decision.

You can request an expedited appeal related to a coverage denial of urgently needed future care by calling Member Relations at 503-813-4480 or faxing your request to 503-813-3985. If you are receiving urgent or concurrent care (for example, inpatient or skilled nursing facility care), you may be allowed to proceed with an expedited external review while we are conducting our internal appeal process. See the “External Review by an IRO under Oregon Law” section below for more information on external reviews.

External Review by an IRO under Oregon Law

Certain requests may be eligible for external review by an independent review organization (IRO) only after the appeal process has been exhausted within Company, unless the request qualifies for an expedited review. If you are receiving urgent or concurrent care (for example, inpatient or skilled nursing facility care), you may be allowed to proceed with an expedited external review while we are conducting our internal review process.

You may submit written comments, documents, records or other information relating to the adverse decision. This includes both previously submitted information and any new information that you may choose to provide.

You have the right to request a review by an IRO of an adverse decision that is based on one or more of the following:

- Whether a course or plan of treatment is Medically Necessary, experimental, or investigational.
- Whether a course or plan of treatment is an active course of treatment for purposes of continuity of care when a Participating Provider’s contract with us is terminated.
- Whether a course or plan of treatment is delivered in an appropriate health care setting and with the appropriate level of care.

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

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

Expedited External Review

We shall expedite the external review:

- If the adverse benefit determination concerns an admission, the availability of care, a continued stay or a health care Service for a medical condition for which the enrollee received emergency services and has not been discharged for a health care facility; or

- if a provider you have an established relationship with certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize your life, health, or ability to regain maximum function.

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

Termination of Membership

Healthy KidsConnect is required to inform you of the date your membership terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date.

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

Termination during Confinement in a Hospital

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

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

Your coverage under this provision continues until the earlier of:

- Your discharge from the Hospital or
- Your exhaustion of Hospital benefits under this *EOC*.

Termination for Cause

If you are proven to have committed one of the following acts, we may terminate your membership under this *EOC* by sending written notice, including the specific reason for termination with supporting evidence to you at least 31 days before your membership termination date:

- You abuse or threaten the safety of Company employees or of any person or property at a Participating Facility.
- You knowingly commit fraud in connection with membership, Company, or a Participating Provider. Some examples of fraud include:
 - Misrepresenting Eligibility information about you.
 - Presenting an invalid prescription or physician order for Services.

- Intentionally misusing a Company ID card (or letting someone else use your ID card to obtain Services pretending to be you).
- Giving us incorrect or incomplete material information.
- Failing to notify us of changes in family status or Medicare coverage that may affect your Eligibility or benefits.

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

If we terminate your membership for cause we will:

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

We may deduct any amounts you owe Company, Participating Providers, or Participating Facilities from any payment we make to you.

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

Termination of the *Group Agreement*

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

Termination of Certain Types of Health Benefit Plans by Us

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

Certificates of Creditable Coverage

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

Continuation of Membership

Conversion to an Individual Plan

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

Portability Plans

If you want to remain a Company Member, one option that may be available is a Kaiser Foundation Health Plan of the Northwest Portability Plan. The premium and coverage under our portability plans will differ from those under this *EOC*. You may be eligible to enroll in one of our portability plans if you no longer meet Healthy KidsConnect's Eligibility requirements. If you enroll in Group continuation coverage through State Continuation Coverage, you may be eligible to enroll in one of our portability plans when your Healthy KidsConnect continuation coverage ends. As a general rule, if you accept portability coverage at the end of coverage under this Plan, you will not qualify as a HIPAA eligible individual.

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

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

You may not convert to one of our portability plans if any of the following is true:

- You continue to be eligible for coverage under this *EOC* (not including COBRA, State Continuation Coverage, or USERRA).
- Your membership ends because *Healthy KidsConnect's Agreement* with us terminates and it is replaced by another plan within 15 days after the termination date.
- We terminated your membership under "Termination for Cause" in the "Termination of Membership" section.
- The number of days you were enrolled on an Oregon group plan is less than 180 days, or your total amount of prior Creditable Coverage is less than 18 months.
- You live in the service area of another Kaiser Foundation Health Plan or Allied Plan.
- You reside outside the state of Oregon and not within the Service Area of Company.
- You are covered under another group plan, policy, contract, or agreement providing benefits for Hospital or medical care.

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

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

If you move to another Kaiser Foundation Health Plan or Allied Plan service area, you should contact Healthy KidsConnect's benefits administrator to learn about your health care options.

Miscellaneous Provisions

Administration of *Agreement*

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

***Agreement* Binding on Members**

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

Amendment of *Agreement*

The *Agreement* between Healthy KidsConnect and Kaiser Foundation Health Plan of the Northwest will change periodically. If these changes affect this *EOC*, revised materials will be available to you.

Applications and Statements

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

Assignment

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

Attorney Fees and Expenses

In any dispute between a Member and Company or Medical Group or Kaiser Foundation Hospitals, each party will bear its own attorneys' fees and other expenses.

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC*, and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*.

Exercise of Conscience

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

Governing Law

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

Group and Members not Company Agents

Neither Healthy KidsConnect nor any Member is the agent or representative of Company.

Litigation Venue

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

No Waiver

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

Nondiscrimination

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

Notices

We will send our notices to the Member to the most recent address we have on record. The Member's parent or legal guardian is responsible for notifying us as soon as possible of any change in address.

Overpayment Recovery

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

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. Your PHI is individually identifiable information about your health, health care Services you receive, or payment for your health care. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

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

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices*, which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request. To request a copy, please call Membership Services. You can also find the notice at your local Participating Facility or on our website at **kp.org**.

Unusual Circumstances

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