KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

A nonprofit health maintenance organization

2026 Evidence of Coverage

PEBB Classic Plan -

Important Notice Under Federal Health Care Reform

Kaiser Foundation Health Plan of Washington ("KFHPWA") recommends each Enrollee choose a Network Personal Physician. This decision is important since the designated Network Personal Physician provides or arranges for most of the Enrollee's health care. The Enrollee has the right to designate any Network Personal Physician who participates in one of the KFHPWA networks and who is available to accept the Enrollee or the Enrollee's family members. For information on how to select a Network Personal Physician, and for a list of the participating Network Personal Physicians, please call Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, 1888-901-4636.

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

The Enrollee does not need Preauthorization from KFHPWA or from any other person (including a Network Personal Physician) to access obstetrical or gynecological care from a health care professional in the KFHPWA network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Preauthorization for certain services, following a pre-approved treatment plan, or procedures for obtaining Preauthorization. For a list of participating health care professionals who specialize in obstetrics or gynecology, please call the Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, 1888-901-4636.

Women's health and cancer rights
If the Enrollee is receiving benefits for a covered mastectomy and elects breast reconstruction in connection with the mastectomy, the Enrollee will also receive coverage for:

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

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

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

Discussing treatment alternatives
While Kaiser Permanente doesn't cover every kind of treatment or procedure (no health plan does), we don't have any financial incentives or penalties that might encourage doctors or other clinicians to withhold Medically Necessary services or to keep them from discussing recognized medical alternatives with you. The only financial incentives we ever use are rewards for medical groups and hospitals that meet quality care measures (such as cancer screenings) and patient satisfaction targets.

Important resources
Visit **kp.org/wa/important-resources** to learn about coverage documents, other plan documents, and preventive care schedules. You can also read about our quality program and ratings on hospital care and safety, learn about women's health and cancer rights, and read important health plan and pharmacy disclosures.

Case management for chronic conditions
Registered nurses certified in case management offer phone-based support managing chronic asthma, diabetes, high blood pressure, cholesterol, or heart disease. Call 1-866-656-4183.

Complex case management
A specially trained nurse — in partnership with your personal care doctor — can help members who need or want help managing multiple chronic conditions, medications, and providers. Call 1-866-656-4183.

For More Information

KFHPWA will provide the information regarding the types of plans offered by KFHPWA to Enrollees on request. Please call Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, 1888-901-4636. For the deaf and hearing-impaired use Washington state's relay line at 800-833-6388 or 711 for benefits questions.

Table of Contents

Table of Contents **4**
I. Introduction **7**
II. How Covered Services Work **7**
A. Accessing Care. 7
B. Administration of the EOC. 11
C. Assignment. 11
D. Confidentiality 11
E. Modification of the EOC. 11
F. Nondiscrimination. 11
G. Preauthorization. 11
H. Recommended Treatment. 11
I. Second Opinions. 12
J. Unusual Circumstances. 12
K. Utilization Management. 12
III. Financial Responsibilities **12**
A. Premium. 12
B. Financial Responsibilities for Covered Services. 12
C. Financial Responsibilities for Non-Covered Services. 13
IV. Benefits Details **14**
Annual Deductible 14
Prescription Drug Deductible 14
Coinsurance 14
Lifetime Maximum 14
Medical Out-of-pocket Limit 14
Prescription Drug Out-of-pocket Limit 14
Pre-existing Condition Waiting Period 14
Preauthorization 14
Acupuncture 15
Allergy Services 15
Ambulance 15
Cancer Screening and Diagnostic Services 16
Circumcision 16
Clinical Trials 16
Dental Services and Dental Anesthesia 17
Devices, Equipment and Supplies (for home use) 18
Diabetic Education, Equipment and Pharmacy Supplies 18
Dialysis (Home and Outpatient) 19
Drugs – Outpatient Prescription 20
Emergency Services 24
Gender Health Services 25
Hearing Examinations and Hearing Aids 25
Home Health Care 26
Hospice 27

Hospital - Inpatient and Outpatient 27
Infertility (including sterility) 28
Infusion Therapy 29
Laboratory and Radiology 29
Manipulative Therapy 30
Massage Therapy 30
Maternity and Pregnancy 30
Mental Health and Wellness 31
Naturopathy 32
Newborn Services 32
Nutritional Counseling 33
Nutritional Therapy 33
Obesity Related Surgical Services 34
On the Job Injuries or Illnesses 34
Oncology 34
Optical (vision) 35
Oral Surgery 35
Outpatient Services 36
Plastic and Reconstructive Surgery 36
Podiatry 37
Preventive Services 37
Rehabilitation and Habilitative Care (occupational, physical and speech therapy, pulmonary and cardiac rehabilitation) and Neurodevelopmental Therapy 38
Reproductive Health 39
Sexual Dysfunction 40
Skilled Nursing Facility 40
Sterilization 41
Substance Use Disorder 41
Telehealth Services 43
Temporomandibular Joint (TMJ) 44
Tobacco Cessation 44
Transplants 44
Urgent Care 45

V. General Exclusions 46

VI. Eligibility, Enrollment and Termination – For Employees, Continuation Coverage and Retired Employees of a Former Employer Group 47

A. Eligibility. 48
B. Enrollment for subscribers and dependents. 49
C. Medicare Eligibility and Enrollment. 51
D. When Medical Coverage Begins. 52
E. Making changes 53
F. When medical coverage ends 58
G. General provisions for eligibility and enrollment 61
H. Appeal rights 62
I. Relationship to law and regulations 62

VII. Eligibility, Enrollment and Termination – For a Retiree or Survivor 62
A. Eligibility for subscribers and dependents 62
B. Enrollment for subscribers and dependents 64
C. Medicare eligibility and enrollment 67
D. When medical coverage begins 67
E. Making changes 68
F. When medical coverage ends 74
G. General provisions for eligibility and enrollment 75
H. Appeal rights 76
I. Relationship to law and regulations 76
J. PEBB customer service 76
VIII. Grievances 76
IX. Appeals 77
X. Claims 78
XI. Coordination of Benefits 79
Definitions. 79
Order of Benefit Determination Rules. 81
Effect on the Benefits of this Plan. 82
Right to Receive and Release Needed Information. 82
Facility of Payment. 83
Right of Recovery. 83
Effect of Medicare. 83
XII. Subrogation and Reimbursement Rights 83
XIII. Definitions 85

I. Introduction

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

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

Contact Kaiser Permanente Member Services at 206-630-4636 or toll-free 1888-901-4636 for the deaf and hearing-impaired use Washington state's relay line at 800-833-6388 or 711 for benefits questions.

Healthy Resources
You have access to these value-added programs and resources at no cost, unless otherwise noted below. You can register online at **kp.org/register** or on the Kaiser Permanente mobile app. You'll need your medical record number, which you can find on your Kaiser Permanente ID card.

- **Sign up for healthy lifestyle programs.** With our online wellness programs, you'll get advice, encouragement, and tools to help you create positive changes in your life. Our programs can help you lose weight, eat healthier, quit smoking, reduce stress, manage ongoing conditions like diabetes or depression. Start with a Total Health Assessment, a simple online survey to give you a complete look at your health. You can also share and discuss the results with your doctor. Visit **kp.org/healthylifestyles**.
- **Get a wellness coach.** If you need a little extra support, we offer Wellness Coaching by Phone. You'll work one-on-one with your personal coach to make a plan to help you reach your health goals. Visit **kp.org/wellnesscoach**.
- **Join health classes.** You can sign up for health classes and support groups. Classes vary at each location, and some may require a fee. Visit **kp.org/classes**.
- **Self-care.** Manage stress, improve your mood, sleep better, and more with the help of wellness apps, available to adult members. Visit **kp.org/selfcareapps**.
- **Health guides.** Stay informed on popular health subjects or discover something new through our healthy living guides. Visit **kp.org/livehealthy**.

The programs and resources described above are not covered under your health plan benefits and are not subject to the terms set forth in this EOC or other plan documents. Programs and resources are provided by third-party entities and may be discontinued at any time. If you would like additional information about these programs and resources, call Member Services.

II. How Covered Services Work

A. Accessing Care.

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

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

A listing of Core Network Personal Physicians, specialists, women's health care providers and KFHPWA-designated Specialists is available by contacting Member Services or accessing the KFHPWA website at

www.kp.org/wa. Information available online includes each physician's location, education, credentials, and specialties. KFHPWA also utilizes Health Care Benefit Managers for certain services. To see a list of Health Care Benefit Managers, go to https://healthy.kaiserpermanente.org/washington/support/forms and click on the "Evidence of coverage" link.

Receiving Care in another Kaiser Foundation Health Plan Service Area
If you are visiting in the service area of another Kaiser Permanente region, visiting member services may be available from designated providers in that region if the services would have been covered under this EOC. Visiting member services are subject to the provisions set forth in this EOC including, but not limited to, Preauthorization and cost sharing. For more information about receiving visiting member services in other Kaiser Permanente regional health plan service areas, including provider and facility locations, please call Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, 1888-901-4636. Information is also available online at https://wa.kaiserpermanente.org/html/public/services/traveling.

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

2. **Primary Care Provider Services.**
KFHPWA recommends that Enrollees select a Network Personal Physician when enrolling. One personal physician may be selected for an entire family, or a different personal physician may be selected for each family member. For information on how to select or change Network Personal Physicians, and for a list of participating personal physicians, call the Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington at 1888-901-4636 or by accessing the KFHPWA website at www.kp.org/wa. The change will be made within 24 hours of the receipt of the request if the selected physician's caseload permits. If a personal physician accepting new Enrollees is not available in your area, contact the Kaiser Permanente Member Services, who will ensure you have access to a personal physician by contacting a physician's office to request they accept new Enrollees.

   To find a personal physician, contact Member Services or access the KFHPWA website at www.kp.org/wa to view physician profiles. Online you will find information on each physician's location, education, credentials, and specialties.

   For your personal physician, choose from these specialties:
   - Family medicine
   - Adult medicine/internal medicine
   - Pediatrics/adolescent medicine (for children up to 18)

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

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

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

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

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

Specialty Care Provider Copayment.
The following providers are subject to the specialty Copayment level: allergy and immunology, anesthesiology, audiology, cardiology (pediatric and cardiovascular disease), critical care medicine, dentistry, dermatology, endocrinology, enterostomal therapy, gastroenterology, genetics, hepatology, infectious disease, massage therapy, neonatal-perinatal medicine, nephrology, neurology, nutrition, occupational medicine, occupational therapy, hematology/oncology, oncology pharmacist, ophthalmology, orthopedics, ENT/otolaryngology, pathology, pain management, physiatry (physical medicine), physical therapy, podiatry, pulmonary medicine/disease, radiology (nuclear medicine, radiation therapy), respiratory therapy, rheumatology, speech therapy, sports medicine, general surgery and urology.

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

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

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

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

Access to non-Emergency care across the Network service area: your Plan provides access to all providers in the Network, including many physicians and services at Kaiser Permanente medical facilities and Network facilities across the state. Find links to providers at kp.org/wa/directory or contact Member Services at 1888-901-4636 for assistance.

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

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

7. **Women's Health Care Direct Access Providers.**
Female Enrollees may see a general and family practitioner, physician's assistant, gynecologist, certified nurse midwife, licensed midwife, doctor of osteopathy, pediatrician, obstetrician or advance registered nurse practitioner who is unrestricted in your KFHPWA Network to provide women's health care services directly, without Preauthorization, for Medically Necessary maternity care, covered reproductive health services, preventive services (well care) and general examinations, gynecological care and follow-up visits for the above services. Women's health care services are covered as if the Enrollee's Network Personal Physician had been consulted, subject to any applicable Cost Shares. If the Enrollee's women's health care provider diagnoses a condition that requires other specialists or hospitalization, the Enrollee or her chosen provider must obtain Preauthorization in accordance with applicable KFHPWA requirements. For a list of KFHPWA providers, contact Member Services or view the Provider Directory located at www.kp.org/wa.

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

9. **Process for Medical Necessity Determination.**
Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Enrollees will be notified in writing when a determination has been made.

First Level Review:

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

Second Level (Practitioner) Review:

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

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

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

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

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

F. Nondiscrimination.
KFHPWA does not discriminate on the basis of physical or mental disabilities in its employment practices and services. KFHPWA will not refuse to enroll or terminate an Enrollee's coverage and will not deny care on the basis of age, sex, sexual orientation, gender identity, race, color, religion, national origin, citizenship or immigration status, veteran or military status, occupation or health status.

G. Preauthorization.
Refer to https://healthy.kaiserpermanente.org/washington/support/forms#preauthorizationrequirementsforms (click on "Plan services and information" then "Pre-authorization requirements"), Section IV. or call Member Services for more information regarding which services, equipment and facility types KFHPWA requires Preauthorization. All residential treatment, non-emergency inpatient hospital and non-emergency ambulance services require Preauthorization. Failure to obtain Preauthorization when required may result in denial of coverage for those services; and the Enrollee may be responsible for the cost of these non-Covered services. Enrollees may contact Member Services to request Preauthorization.

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

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

H. Recommended Treatment.
KFHPWA's medical director will determine the necessity, nature and extent of treatment to be covered in each individual case and the judgment will be made in good faith. Enrollees have the right to appeal coverage decisions (see Section VIII.). Enrollees have the right to participate in decisions regarding their health care. An Enrollee may refuse any recommended services to the extent permitted by law. Enrollees who obtain care not

recommended by KFHPWA's medical director do so with the full understanding that KFHPWA has no obligation for the cost, or liability for the outcome, of such care.

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

I. Second Opinions.

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

J. Unusual Circumstances.

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

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

K. Utilization Management.

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

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

III. Financial Responsibilities

A. Premium.

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

B. Financial Responsibilities for Covered Services.

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

1. Annual Deductible.

Covered Services may be subject to an annual Deductible. Charges subject to the annual Deductible shall be borne by the Subscriber during each year until the annual Deductible is met. Covered Services must be

received from a Network Provider at a Network Facility, unless the Enrollee has received Preauthorization or has received Emergency services.

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

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

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

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

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

IV. Benefits Details

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

Annual Deductible	**Annual Deductible without Wellness incentive:** Enrollee pays $175 per Enrollee per calendar year or $525 per Family Unit per calendar year; or **Annual Deductible with Wellness incentive:** Subscriber Enrollee pays $50 per calendar year; dependent Enrollees pay $175 per calendar year or $400 per Family Unit per calendar year
Prescription Drug Deductible	Enrollee pays $100 per Enrollee per calendar year or $300 per Family Unit per calendar year
Coinsurance	**Plan Coinsurance:** Enrollee pays nothing
Lifetime Maximum	No lifetime maximum on covered Essential Health Benefits
Medical Out-of-pocket Limit	Limited to a maximum of $2,000 per Enrollee or $4,000 per Family Unit per calendar year
	The following Out-of-pocket Expenses apply to the Out-of-pocket Limit: All Cost Shares for Covered Services **The following expenses do not apply to the Out-of-pocket Limit:** Premiums, charges for services in excess of a benefit, charges in excess of Allowed Amount, Outpatient Pharmacy Drug Deductible, Outpatient Pharmacy Copayments, and Outpatient Pharmacy coinsurance, charges for non-Covered Services
Prescription Drug Out-of-pocket Limit	Limited to a maximum of $2,000 per Enrollee or $8,000 per Family Unit per calendar year
	The following Out-of-pocket Expenses apply to the Out-of-pocket Limit: Prescription Drug Deductible, Copayments and coinsurance **The following expenses do not apply to the Out-of-pocket Limit:** Premiums, charges for services in excess of a benefit, charges in excess of Allowed Amount, charges which apply to the medical Out-of-Pocket limit, charges for non-Covered Services
Pre-existing Condition Waiting Period	No pre-existing condition waiting period
Preauthorization	Preauthorization may be required for some services. Refer to Section II. G for more information.

Acupuncture	
Acupuncture needle treatment, limited to 24 visits per calendar year without Preauthorization. Additional visits are covered with Preauthorization. No visit limit for treatment for Substance Use Disorder.	After Deductible, Enrollee pays $15 primary care provider services Copayment
Exclusions: Herbal supplements; any services not within the scope of the practitioner's licensure	

Allergy Services	
Allergy testing.	After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Allergy serum and injections. Injection rooms: Most KFHPWA owned and operated medical centers have an area where injections and vaccines are administered by nurses. For additional information on appointment requirements go to www.kp.org/wa.	After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment Administration services in a KFHPWA injection room are not subject to the office visit Copayment. All other applicable cost shares will apply.

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

Interfacility transfers are transfers from an acute care hospital bed to another facility for diagnostic evaluation or treatment and return to inpatient status.	

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

Circumcision	
Circumcision.	(No charge if provided within 60 days of birth) **Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Hospital - Outpatient:** After Deductible, Enrollee pays $150 Copayment **Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment

Clinical Trials	
Notwithstanding any other provision of this document, the Plan provides benefits for Routine Patient Costs of qualified individuals in approved clinical trials, to the extent benefits for these costs are required by federal and state law. Routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. Clinical trials are a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. “Life threatening condition” means any	**Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Hospital - Outpatient:** After Deductible, Enrollee pays $150 Copayment **Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment

disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.	
Exclusions: Routine patient costs do not include: (i) the investigational item, device, or service, itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis	

Dental Services and Dental Anesthesia	
Dental services including accidental injury to natural teeth. Dental Services (i.e., examination, evaluation and treatment) necessitated by accidental injury to sound natural teeth. Evaluation and a written treatment plan must be completed within 30 days from the date of injury. Treatment must be completed within the treatment plan time frames.	**Accidental injury:** **Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Hospital - Outpatient:** After Deductible, Enrollee pays $150 Copayment **Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment **Other dental services:** Not covered, Enrollee pays 100% of all charges
Dental services (evaluation and treatment) in preparation for treatment including but not limited to: chemotherapy, radiation therapy, and organ transplants. Dental problems such as infections requiring emergency treatment outside of standard business hours are covered as Emergency Services.	**Hospital – Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Hospital – Outpatient:** After Deductible, Enrollee pays $150 Copayment **Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
General anesthesia services and related facility charges for dental procedures for Enrollees who are under 7 years of age or are physically or developmentally disabled or have a Medical Condition where the Enrollee's health would be put at risk if the dental procedure were performed in a dentist's office.	**Hospital – Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Hospital – Outpatient:** After Deductible, Enrollee pays $150 Copayment
Exclusions: Injuries caused by biting or chewing; malocclusion as a result from an accidental injury; reconstructive surgery to the jaw in preparation for dental implants, dental implants, orthodontia; treatment not completed within the written treatment plan time frame, unless treatment is delayed due to a medical condition and the treatment plan is modified; any other dental service not specifically listed as covered	

Devices, Equipment and Supplies (for home use)	
Durable medical equipment: Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and is used in the Enrollee's home. Equipment must be ordered or prescribed by a Network Provider. • Examples of covered durable medical equipment includes hospital beds, wheelchairs, walkers, crutches, canes, blood glucose monitors, external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters), oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks), and therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease. KFHPWA will determine if equipment is made available on a rental or purchase basis. • Orthopedic appliances: Items attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function. • Ostomy supplies: Supplies for the removal of bodily secretions or waste through an artificial opening. • Post-mastectomy bras/forms, limited to 2 every 6 months. Replacements within this 6-month period are covered when Medically Necessary due to a change in the Enrollee's condition. • Prosthetic devices: Items which replace all or part of an external body part, or function thereof. • Sales tax for devices, equipment and supplies. • Wigs or hairpieces for hair loss due to radiation or chemotherapy. When provided in lieu of hospitalization, benefits will be the greater of benefits available for devices, equipment and supplies, home health or hospitalization. See Hospice for durable medical equipment provided in a hospice setting.	Enrollee pays 20% coinsurance Covered wigs or hairpieces limited to $100 lifetime maximum Annual Deductible does not apply to strip-based blood glucose monitors, test strips, lancets or control solutions.
Exclusions: Arch supports, including custom shoe modifications or inserts and their fittings not related to the treatment of diabetes; orthopedic shoes that are not attached to an appliance; wigs/hair prosthesis (except as noted above); take-home dressings and supplies following hospitalization; supplies, dressings, appliances, devices or services not specifically listed as covered above; same as or similar equipment already in the Enrollee's possession; replacement or repair due to loss, theft, breakage from willful damage, neglect or wrongful use, or due to personal preference; structural modifications to an Enrollee's home or personal vehicle	

Diabetic Education, Equipment and Pharmacy Supplies	
Diabetic education and training.	After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Diabetic equipment: Blood glucose monitors and external	Enrollee pays 20% coinsurance

insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters), and therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease. See Devices, Equipment and Supplies for additional information.	Annual Deductible does not apply to strip-based blood glucose monitors, test strips, lancets or control solutions.
Diabetic pharmacy supplies: Insulin, lancets, lancet devices, needles, insulin syringes, disposable insulin pens, pen needles, glucagon emergency kits, prescriptive oral agents and blood glucose test strips for a supply of 30 days or less per item. Certain brand name insulin drugs will be covered at the generic level. See Drugs – Outpatient Prescription for additional pharmacy information.	**Value based medications** which provide significant value in treating chronic disease as determined by KFHPWA (Please contact Kaiser Permanente Member Services for a list of medications)**:** Enrollee pays $5 Copayment **Preferred generic drugs (Tier 1):** Enrollee pays $20 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** After Prescription Drug Deductible, Enrollee pays $40 Copayment per 30-days up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** After Prescription Drug Deductible, Enrollee pays 50% coinsurance up to $250 maximum per 30-days up to a 90-day supply Annual Deductible does not apply to strip-based blood glucose monitors, test strips, lancets or control solutions. Note: An Enrollee will not pay more than $35, not subject to the Deductible, for a 30-day supply of insulin to comply with state law requirements. Any cost sharing paid will apply toward the annual Deductible.
Diabetic retinal screening.	No charge; Enrollee pays nothing

Dialysis (Home and Outpatient)	
Dialysis in an outpatient or home setting is covered for Enrollees with acute kidney failure or end-stage renal disease (ESRD). If you do not choose to enroll in Original Medicare Part B, applicable cost shares on this plan will apply. **Important things to know:** • The cost of dialysis can be • substantial. We recommend calling Member Services to find in-network providers. • If you have end-stage renal disease (ESRD), you may be eligible for Original Medicare Part B. If you are eligible, this will reduce your costs substantially. Enrollment in Original Medicare Part B is optional. • Original Medicare Part B has a waiting period, generally	**Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment

the first 90 days after dialysis starts. Original Medicare Part B doesn't start covering any of your costs until after that waiting period. • As soon as you are enrolled in Original Medicare Part B, we will directly reimburse you for your Original Medicare Part B premiums, should you opt in to this benefit. We will continue to reimburse your Original Medicare Part B premiums for as long as you are enrolled in this plan, eligible for and enrolled in Original Medicare Part B due to ESRD.	
If you choose to enroll in Original Medicare Part B, Medicare may assist with your Enrollee cost shares. Dialysis in an outpatient or home setting is covered for Enrollees with end-stage renal disease (ESRD). Coordination of Benefits rules apply. If you do not choose to enroll in Original Medicare Part B, applicable cost shares on this plan will apply.	**Medicare eligible charges:** No charge, Enrollee pays nothing
Injections administered by a Network Provider in a clinical setting during dialysis.	**Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Self-administered injectables. See Drugs – Outpatient Prescription for additional pharmacy information.	**Value based medications** which provide significant value in treating chronic disease **as determined by KFHPWA** (Please contact Kaiser Permanente Member Services for a list of medications)**:** Enrollee pays $5 Copayment **Preferred generic drugs (Tier 1):** Enrollee pays $20 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** After Prescription Drug Deductible, Enrollee pays $40 Copayment per 30-days up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** After Prescription Drug Deductible, Enrollee pays 50% coinsurance up to $250 maximum per 30-days up to a 90-day supply

Drugs – Outpatient Prescription	
Prescription drugs, supplies and devices for a supply of 30 days or less including diabetic pharmacy supplies (insulin, lancets, lancet devices, needles, insulin syringes, disposable insulin pens, pen needles and blood glucose test strips), mental health and wellness drugs, self-administered injectables, medications for the treatment arising from sexual assault, prescription hormone therapy drugs (excluding	**Value based medications** which provide significant value in treating chronic disease **as determined by KFHPWA** (Please contact Kaiser Permanente Member Services for a list of medications)**:** Enrollee pays $5 Copayment **Preferred generic drugs (Tier 1):** Enrollee pays

glucagon-like peptide-1 or glucagon-like peptide-1 agonists such as Ozempic and Wegovy) which are able to be safely stored at room temperature without refrigeration may be allowed up to a 12-month supply, and routine costs for prescription medications provided in a clinical trial. "Routine costs" means items and services delivered to the Enrollee that are consistent with and typically covered by the plan or coverage for an Enrollee who is not enrolled in a clinical trial. All drugs, supplies and devices must be for Covered Services. Pre-exposure Prophylaxis (PrEP) services are covered under the Preventive Services section. For a list of PrEP medications, refer to the formulary at www.kp.org/wa/formulary and choose the "Preventive medication and preferred contraceptives" link. All drugs, supplies and devices must be obtained at a KFHPWA-designated pharmacy except for drugs dispensed for Emergency services or for Emergency services obtained outside of the KFHPWA Service Area, including out-of-the-country. Information regarding KFHPWA-designated pharmacies is reflected in the KFHPWA Provider Directory or can be obtained by contacting Kaiser Permanente Member Services. Prescription drug Cost Shares are payable at the time of delivery. Certain brand name insulin drugs are covered at the generic drug Cost Share. Enrollees may be eligible to receive an emergency fill for certain prescription drugs filled outside of KFHPWA's business hours or when KFHPWA cannot reach the prescriber for consultation. For emergency fills, Enrollees pay the prescription drug Cost Share for each 7-day supply or less, or the minimum packaging size available at the time the emergency fill is dispensed. A list of prescription drugs eligible for emergency fills is available on the pharmacy website at www.kp.org/wa/formulary. Enrollees can request an emergency fill by calling 1-855-505-8107. Certain drugs are subject to Preauthorization as shown in the Preferred drug list (formulary) available at www.kp.org/wa/formulary. For outpatient prescription drugs and/or items that are covered under the Drugs – Outpatient Prescription section and obtained at a pharmacy owned and operated by KFHPWA, an Enrollee may be able to use approved manufacturer coupons as payment for the Cost Sharing that an Enrollee owes, as allowed under KFHPWA's coupon program. An Enrollee will owe any additional amount if the coupon does not cover the entire amount of the Cost Sharing for the Enrollee's prescription. When an Enrollee uses an approved coupon for payment of their Cost Sharing, the coupon amount and any additional payment that they make will accumulate to their	$20 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** After Prescription Drug Deductible, Enrollee pays $40 Copayment per 30-days up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** After Prescription Drug Deductible, Enrollee pays 50% coinsurance up to $250 maximum per 30-days up to a 90-day supply Annual Deductible does not apply to strip-based blood glucose monitors, test strips, lancets or control solutions. Note: An Enrollee will not pay more than $35, not subject to the Deductible, for a 30-day supply of each prescription for the following medications: insulin, and at least one inhaled corticosteroid, and at least one inhaled corticosteroid combination and at least one 2 pack of epinephrine autoinjectors to comply with state law requirements. Any cost sharing paid will apply toward the annual Deductible. Please refer to the formulary for additional information. One regimen of human immunodeficiency virus postexposure prophylaxis: Enrollee pays nothing

Deductible and Out-of-Pocket Limit. More information is available regarding the Kaiser Permanente coupon program rules and limitations at www.kp.org/rxcoupons.	
Injections administered by a Network Provider in a clinical setting. Injection rooms: Most KFHPWA owned and operated medical centers have an area where injections and vaccines are administered by nurses. For additional information on appointment requirements go to www.kp.org/wa.	After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment Administration services in a KFHPWA injection room are not subject to the office visit Copayment. All other applicable cost shares will apply.
Growth Hormones.	**Preferred generic drugs (Tier 1):** Enrollee pays $20 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** After Prescription Drug Deductible, Enrollee pays $40 Copayment per 30-days up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** After Prescription Drug Deductible, Enrollee pays 50% coinsurance up to $250 maximum per 30-days up to a 90-day supply
Over-the-counter drugs not included under Preventive Care or Reproductive Health.	Not covered; Enrollee pays 100% of all charges
Mail order drugs dispensed through the KFHPWA-designated mail order service.	Enrollee pays the prescription drug Cost Share for each 90-day supply or less **Value based medications** which provide significant value in treating chronic disease **as determined by KFHPWA** (Please contact Kaiser Permanente Member Services for a list of medications)**:** Enrollee pays $10 Copayment **Preferred generic drugs (Tier 1):** Enrollee pays $40 Copayment **Preferred brand name drugs (Tier 2):** After Prescription Drug Deductible, Enrollee pays $80 Copayment **Non-Preferred generic and brand name drugs (Tier 3):** After Prescription Drug Deductible, Enrollee pays 50% coinsurance up to $750 maximum Annual Deductible does not apply to strip-based blood glucose monitors, test strips, lancets or control solutions. Note: An Enrollee will not pay more than $35, not

	subject to the Deductible, for a 30-day supply of each prescription for the following medications: insulin, and at least one inhaled corticosteroid, and at least one inhaled corticosteroid combination, and at least one 2 pack of epinephrine autoinjectors to comply with state law requirements. Any cost-sharing paid will apply to the annual Deductible. Please refer to the formulary for additional information.

The KFHPWA Preferred drug list is a list of prescription drugs, supplies, and devices considered to have acceptable efficacy, safety and cost-effectiveness. The Preferred drug list is maintained by a committee consisting of a group of physicians, pharmacists and a consumer representative who review the scientific evidence of these products and determine the Preferred and Non-Preferred status as well as utilization management requirements. Preferred drugs generally have better scientific evidence for safety and effectiveness and are more affordable than Non-Preferred drugs. The preferred drug list is available at www.kp.org/wa/formulary, or upon request from Member Services.

For a refill of a prescription previously covered by KFHPWA as non-transition benefit for a medically stable Enrollee that KFHPWA deems medically necessary for serious mental illness, KFHPWA will not require substitution of a non-preferred with a preferred non-interchangeable drug in the therapeutic class mid-plan year and will not increase cost-sharing obligation mid-plan year for the drug.

An Enrollee, an Enrollee's designee, or a prescribing physician may request a coverage exception to gain access to clinically appropriate drugs if the drug is not otherwise covered by contacting Member Services. Coverage determination reviews may include requests to cover non-preferred drugs, obtain Preauthorization for a specific drug, or exceptions to other utilization management requirements, such as quantity limits.

KFHPWA will provide a determination and notification of the determination no later than 72 hours of the request after receipt of information sufficient to make a decision. The prescribing physician must submit an oral or written statement regarding the need for the non-Preferred drug, and a list of all of the preferred drugs which have been ineffective for the Enrollee.

Expedited or Urgent Reviews: An Enrollee, an Enrollee's designee, or a prescribing physician may request an expedited review for coverage for non-covered drugs when a delay caused by using the standard review process will seriously jeopardize the Enrollee's life, health or ability to regain maximum function or will subject to the Enrollee to severe pain that cannot be managed adequately without the requested drug. KFHPWA or the IRO will provide a determination and notification of the determination no later than 24 hours from the receipt of the request after receipt of information sufficient to make a decision.

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

Generic drugs are dispensed whenever available. A generic drug is a drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. Brand name drugs are

dispensed if there is not a generic equivalent. In the event the Enrollee or prescribing provider elects a brand-name drug instead of the generic equivalent (if available), the Enrollee is responsible for paying the difference in cost in addition to the brand-name prescription drug Cost Share, which does not apply to the Out-of-pocket Limit. The difference in cost between the brand and generic drug can be waived when Medical Necessity has been determined. Enrollee will never pay more than the actual cost of the prescription.

Drug coverage is subject to utilization management that includes Preauthorization, step therapy (when an Enrollee tries a certain medication before receiving coverage for a similar, but non-Preferred medication), limits on drug quantity or days supply and prevention of overutilization, underutilization, therapeutic duplication, drug-drug interactions, incorrect drug dosage, drug-allergy contraindications and clinical abuse/misuse of drugs. If an Enrollee has a new prescription for a chronic condition, the Enrollee may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity. Please contact Member Services for more information.

Specialty drugs are high-cost drugs prescribed by a physician that may require close supervision and monitoring for serious and/or complex medication therapy. Specialty drugs must be obtained through KFHPWA's preferred specialty pharmacy vendor and/or network of specialty pharmacies and are covered at the appropriate cost share above. For a list of specialty drugs or more information about KFHPWA's specialty pharmacy network, please go to the KFHPWA website at www.kp.org/wa/formulary or contact Member Services at 206-630-4636 or toll-free at 1888-901-4636.

The Enrollee's Right to Safe and Effective Pharmacy Services: State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee Enrollees' right to know what drugs are covered and the coverage limitations. Enrollees who would like more information about the drug coverage policies, or have a question or concern about their pharmacy benefit, may contact KFHPWA at 206-630-4636 or toll-free 1888-901-4636 or by accessing the KFHPWA website at www.kp.org/wa/formulary.

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

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

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

Emergency Services	
Emergency services at a Network Facility or non-Network Facility. See Section XII. For a definition of Emergency.	**Network Facility:** After Deductible, Enrollee pays $250 Copayment

Emergency services include professional services, treatment and supplies, facility costs, outpatient charges for patient observation, medical screening exams required to stabilize a patient and post stabilization treatment. Enrollees must notify KFHPWA by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. If an Enrollee is admitted as an inpatient directly from an emergency department, any Emergency services Copayment is waived. Coverage is subject to the applicable hospital services Cost Share. If an Enrollee is hospitalized in a non-Network Facility, KFHPWA reserves the right to require transfer of the Enrollee to a Network Facility upon consultation between a Network Provider and the attending physician. If the Enrollee refuses to transfer to a Network Facility or does not notify KFHPWA within 24 hours following admission, all further costs incurred during the hospitalization are the responsibility of the Enrollee. Follow-up care which is a direct result of the Emergency must be received from a Network Provider, unless Preauthorization is obtained for such follow-up care from a non-Network Provider.	**Non-Network Facility:** After Deductible, Enrollee pays $250 Copayment

Gender Health Services	
Medically Necessary medical and surgical services for gender affirmation. Certain procedures are subject to age limits, please see our clinical criteria https://wa-provider.kaiserpermanente.org/static/pdf/hosting/clinical/criteria/pdf/gender_reassignment_surgery.pdf for details. Prescription drugs are covered the same as for any other condition (see Drugs – Outpatient Prescription for coverage). Counseling services are covered the same as for any other condition (see Mental Health and Wellness for coverage).	**Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Hospital - Outpatient:** After Deductible, Enrollee pays $150 Copayment **Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Exclusions: Cosmetic services and surgery not related to gender affirming treatment (i.e., face lift or calf implants); complications of non-Covered Services	

Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation are covered only when provided at KFHPWA-approved facilities. Cochlear implants when in accordance with KFHPWA clinical criteria.	**Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Hospital - Outpatient:** After Deductible, Enrollee

Covered services for initial cochlear implants include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries). Replacement devices and associated supplies – see Devices, Equipment and Supplies Section.	pays $150 Copayment **Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Hearing aids, bone conduction hearing devices, and Bone Anchored Hearing System (BAHS) for hearing loss.	Enrollee pays nothing, limited to an allowance of one device per ear during any consecutive 36-month period After allowance: Not covered; Enrollee pays 100% of all charges
Initial assessment, fitting, adjustments, auditory training and ear molds as necessary to maintain optimal fit.	**Outpatient Services:** Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Exclusions: Except as described above, programs or treatments for hearing loss or hearing care including, but not limited to, externally worn hearing or surgically implanted hearing aids and the surgery and services necessary to implant them; hearing screening tests required under Preventive Services; replacement costs of hearing aids due to loss, breakage or theft, unless at the time of such replacement the Enrollee is eligible under the Allowance and benefit period; hearing aid repairs; replacement parts; replacement batteries; maintenance costs	

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

therapist, based on the complexity of the service and the condition of the patient and which is performed directly by an appropriately licensed professional provider.	
Exclusions: Private Duty Nursing; housekeeping or meal services; any care provided by or for a family member; any other services rendered in the home which do not meet the definition of skilled home health care above	

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

Hospital - Inpatient and Outpatient	
The following inpatient medical and surgical services are covered: • Room and board, including private room when prescribed, and general nursing services. • Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy	**Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Hospital - Outpatient:** After Deductible, Enrollee pays $150 Copayment

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

Infertility (including sterility)	
General counseling and one consultation visit to diagnose infertility conditions.	After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment

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

Infusion Therapy	
Administration of Medically Necessary infusion therapy in an outpatient setting.	After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Administration of Medically Necessary infusion therapy in the home setting. To receive benefits for the administration of select infusion medications in the home setting, the drugs must be obtained through KFHPWA's preferred specialty pharmacy and administered by a provider we identify. For a list of these specialty drugs or for more information about KFHPWA's specialty pharmacy network, please go to the KFHPWA website at www.kp.org/wa/formulary or contact Member Services.	No charge; Enrollee pays nothing
Associated infused medications include, but are not limited to: • Antibiotics. • Hydration. • Chemotherapy. • Pain management.	After Deductible, Enrollee pays nothing

Laboratory and Radiology	
Nuclear medicine, radiology, ultrasound and laboratory services. Services received as part of an emergency visit are covered as Emergency Services. Preventive laboratory and radiology services are covered in accordance with the well care schedule established by KFHPWA and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in Kaiser Permanente medical centers, at www.kp.org/wa, or upon request from Member Services.	After Deductible, Enrollee pays nothing **Urine Drug Screening:** Enrollee pays nothing. Limited to 2 tests per calendar year. Benefits are applied in the order claims are received and processed. After allowance: After Deductible, Enrollee pays nothing **Breast exams:** After Deductible, Member pays nothing for diagnostic imagery following a breast cancer diagnosis (Includes diagnostic mammography, digital breast tomosynthesis/3D mammography, breast magnetic resonance imaging (MRI), or breast ultrasound) **Breast Exams:** Enrollee pays nothing for screenings that precede a breast cancer diagnosis (Includes

	diagnostic mammography, digital breast tomosynthesis/3D mammography, breast magnetic resonance imaging (MRI), or breast ultrasound)
CAT scan, MRI and PET which are subject to Preauthorization except when associated with Emergency services or inpatient services. Please contact Member Services for any questions regarding these services.	After Deductible, Enrollee pays $30 Copayment

Manipulative Therapy	
Manipulative therapy of the spine and extremities when in accordance with KFHPWA clinical criteria, limited to a total of 24 visits per calendar year. Preauthorization is not required. Rehabilitation services, such as massage or physical therapy, provided with manipulations are covered under the Massage Therapy or Rehabilitation and Habilitative Care (occupational, physical and speech therapy, pulmonary and cardiac rehabilitation) and Neurodevelopmental Therapy section.	After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Exclusions: Supportive care rendered primarily to maintain the level of correction already achieved; care rendered primarily for the convenience of the Enrollee; care rendered on a non-acute, asymptomatic basis; charges for any other services that do not meet KFHPWA clinical criteria as Medically Necessary	

Massage Therapy	
Visits with licensed massage therapists to restore function immediately following illness, injury or surgery, limited to a combined total of 24 visits per calendar year without Preauthorization. Outpatient services require a prescription or order from a physician that reflects a written plan of care to restore function.	After Deductible, Enrollee pays $30 specialty care provider services Copayment
Exclusions: Recreational; life-enhancing, relaxation or services designed to relieve or soothe symptoms of a disease or disorder without effecting a cure (palliative therapy); massage therapists preventive services; any services not within the scope of the practitioner's licensure	

Maternity and Pregnancy	
Pregnancy care and services, including care for complications of pregnancy, in utero treatment for the fetus, prenatal testing for the detection of congenital and heritable disorders when Medically Necessary and prenatal and postpartum care are covered for all Enrollees including eligible Dependents. Preventive services related to preconception, prenatal and	**Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Hospital - Outpatient:** After Deductible, Enrollee pays $150 Copayment

postpartum care are covered as Preventive Services including breastfeeding support, supplies and counseling for each birth when Medically Necessary as determined by KFHPWA's medical director and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy. Delivery and associated Hospital Care, including home births and birthing centers. Home births are considered outpatient services. Enrollees must notify KFHPWA by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. The Enrollee's provider, in consultation with the Enrollee, will determine the Enrollee's length of inpatient stay following delivery. Donor human milk will be covered during the inpatient hospital stay when Medically Necessary, provided through a milk bank and ordered by a licensed Provider or board-certified lactation consultant.	**Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Termination of pregnancy.	**Hospital - Inpatient:** Enrollee pays nothing **Hospital - Outpatient:** Enrollee pays nothing **Outpatient Services:** Enrollee pays nothing
Exclusions: Birthing tubs; genetic testing of non-Enrollees; fetal ultrasound not considered Medically Necessary	

Mental Health and Wellness	
Mental health and wellness services provided at the most clinically appropriate and Medically Necessary level of mental health care intervention as determined by KFHPWA's medical director. Treatment may utilize psychiatric, psychological and/or psychotherapy services to achieve these objectives. Mental health and wellness services including medical management and prescriptions are covered the same as for any other condition. Applied behavioral analysis (ABA) therapy, limited to outpatient treatment of an autism spectrum disorder or, has a developmental disability for which there is evidence that ABA therapy is effective. Services for any involuntary court-ordered treatment program shall be covered only if determined to be Medically Necessary by KFHPWA's medical director. Services provided under involuntary commitment statutes are covered. If an Enrollee is admitted as an inpatient directly from an	**Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Hospital - Outpatient:** After Deductible, Enrollee pays $150 Copayment **Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment **Group Visits:** No charge; Enrollee pays nothing

emergency department, any Emergency services Copayment is waived. Coverage is subject to the hospital services Cost Share. Coverage for services incurred at non-Network Facilities shall exclude any charges that would otherwise be excluded for hospitalization within a Network Facility. Enrollees must notify KFHPWA by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Mental health and wellness services rendered to treat mental disorders are covered. Mental Disorders means mental disorders covered in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except as otherwise excluded under Sections IV. or V. Mental Health and Wellness Services means Medically Necessary outpatient services, Residential Treatment, partial hospitalization program, and inpatient services provided by a licensed facility or licensed providers, including advanced practice psychiatric nurses, mental health and wellness counselors, marriage and family therapists, and social workers, except as otherwise excluded under Sections IV. or V. Non-Emergency inpatient hospital services, including Residential Treatment, require Preauthorization. Outpatient specialty services, including partial hospitalization programs, rTMS, ECT, and Esketamine require Preauthorization. Routine outpatient therapy and psychiatry services with contracted network providers do not require Preauthorization.	
Exclusions: Specialty treatment programs such as "behavior modification programs" not considered Medically Necessary; relationship counseling or phase of life problems (Z code only diagnoses); wilderness therapy; aversion therapy	

Naturopathy	
Naturopathy. Limited to 3 visits per medical diagnosis per calendar year without Preauthorization. Additional visits are covered with Preauthorization. Laboratory and radiology services are covered only when obtained through a Network Facility.	After Deductible, Enrollee pays $15 primary care provider services Copayment
Exclusions: Herbal supplements; nutritional supplements; any services not within the scope of the practitioner's licensure	

Newborn Services	
Newborn services are covered the same as for any other condition. Any Cost Share for newborn services is separate	**Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per

from that of the mother. Preventive services for newborns are covered under Preventive Services. When an Enrollee gives birth, the newborn is entitled to the benefits set forth in the EOC from birth through 3 weeks of age. After 3 weeks of age, no benefits are available unless the newborn child qualifies as a Dependent and is enrolled. See Section VI. for enrollment information.	admission During the baby's initial hospital stay while the birth mother and baby are both confined, any applicable Deductible and Copayment for the newborn are waived **Hospital - Outpatient:** After Deductible, Enrollee pays $150 Copayment **Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment

Nutritional Counseling	
Nutritional counseling. Services related to a healthy diet to prevent obesity are covered as Preventive Services. See Preventive Services for additional information.	After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Exclusions: Nutritional supplements; weight control self-help programs or memberships, such as Weight Watchers, Jenny Craig, or other such programs	

Nutritional Therapy	
Medical formula necessary for the treatment of phenylketonuria (PKU), specified inborn errors of metabolism, or other metabolic disorders.	After Deductible, Enrollee pays nothing
Enteral therapy is covered when Medical Necessity criteria are met and when given through a PEG, J tube, or orally or for an eosinophilic gastrointestinal disorder. Necessary equipment and supplies for the administration of enteral therapy are covered as Devices, Equipment and Supplies.	After Deductible, Enrollee pays 20% coinsurance
Parenteral therapy (total parenteral nutrition) Necessary equipment and supplies for the administration of parenteral therapy are covered as Devices, Equipment and Supplies.	After Deductible, Enrollee pays nothing
Exclusions: Any other dietary formulas or medical foods; oral nutritional supplements that do not meet Medical Necessity criteria or are not related to the treatment of inborn errors of metabolism; special diets; prepared foods/meals	

Obesity Related Surgical Services	
Bariatric surgery is covered when KFHPWA criteria are met. Services related to obesity screening and counseling are covered as Preventive Services.	**Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Hospital - Outpatient:** After Deductible, Enrollee pays $150 Copayment **Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Exclusions: Obesity treatment and treatment for morbid obesity for any reason including any medical services, drugs, supplies, regardless of co-morbidities, except as described above; specialty treatment programs such as weight control self-help programs or memberships, such as Weight Watchers, Jenny Craig or other such programs; medications and related physician visits for medication monitoring	

On the Job Injuries or Illnesses	
On the job injuries or illnesses.	**Office of Worker's Compensation Programs (OWCP) or similar Federal or State agency pays through a third-party settlement:** Not covered; Enrollee pays 100% of all charges **After the third-party settlement maximum is paid:** **Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Hospital - Outpatient:** After Deductible, Enrollee pays $150 Copayment **Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Exclusions: Confinement, treatment or service that results from an illness or injury arising out of or in the course of any employment for wage or profit including injuries, illnesses or conditions incurred as a result of self-employment; Services needed because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or OWCP or a similar agency pays through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws	

Oncology	
Radiation therapy, chemotherapy, oral chemotherapy. See Infusion Therapy for infused medications.	**Radiation Therapy and Chemotherapy:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment

	Oral Chemotherapy Drugs: **Value based medications** which provide significant value in treating chronic disease as determined by KFHPWA (Please contact Kaiser Permanente Member Services for a list of medications)**:** Enrollee pays $5 Copayment **Preferred generic drugs (Tier 1):** Enrollee pays $20 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** After Prescription Drug Deductible, Enrollee pays $40 Copayment per 30-days up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** After Prescription Drug Deductible, Enrollee pays 50% up to $250 maximum per 30-days up to a 90-day supply

Optical (vision)	
Routine eye examinations and refractions.	**Routine Exams:** Not covered; Enrollee pays 100% of all charges
Eye and contact lens examinations for eye pathology and to monitor Medical Conditions, as often as Medically Necessary.	**Exams for Eye Pathology:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Contact lenses or framed lenses for eye pathology when Medically Necessary. One contact lens per diseased eye in lieu of an intraocular lens is covered following cataract surgery provided the Enrollee has been continuously covered by KFHPWA since such surgery. In the event an Enrollee's age or medical condition prevents the Enrollee from having an intraocular lens or contact lens, framed lenses are available. When Medically Necessary for eye pathology, one replacement lens per diseased eye, including following cataract surgery (in lieu of an intraocular lens) is covered once every 12-months.	**Frames and Lenses:** Not covered; Enrollee pays 100% of all charges **Contact Lenses or Framed Lenses for Eye Pathology:** After Deductible, Enrollee pays nothing
Exclusions: Routine eye examinations and refractions; contact lenses, contact lens evaluations, fittings and examinations not related to eye pathology; fees related to the lens fitting of non-network issued frames; orthoptic therapy (i.e., eye training); evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures	

Oral Surgery	
Reduction of a fracture or dislocation of the jaw or facial	**Hospital - Inpatient:** After Deductible, Enrollee

bones; excision of tumors or non-dental cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth; and incision of salivary glands and ducts. KFHPWA's medical director will determine whether the care or treatment required is within the category of Oral Surgery or Dental Services.	pays $150 Copayment per day up to $750 per admission **Hospital - Outpatient:** After Deductible, Enrollee pays $150 Copayment **Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Exclusions: Care or repair of teeth or dental structures of any type; tooth extractions or impacted teeth; services related to malocclusion; services to correct the misalignment or malposition of teeth; any other services to the mouth, facial bones or teeth which are not medical in nature	

Outpatient Services	
Covered outpatient medical and surgical services in a provider's office, including chronic disease management and treatment arising from sexual assault. See Preventive Services for additional information related to chronic disease management. Office visits include visits provided in a clinic, outpatient hospital or ambulatory surgical center (ASC). All other services performed in the office, not billed as an office visit, or that are not related to the actual visit (separate surgical services or laboratory/radiology fees billed in conjunction with the office visit, for example) are not considered an office visit. See Hospital - Inpatient and Outpatient for outpatient hospital surgical services, including ambulatory surgical centers.	After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment

Plastic and Reconstructive Surgery	
Plastic and reconstructive services: • Correction of a congenital disease or congenital anomaly. • Correction of a Medical Condition following an injury or resulting from surgery which has produced a major effect on the Enrollee's appearance, when in the opinion of KFHPWA's medical director such services can reasonably be expected to correct the condition. • Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed. Enrollees are covered for all stages of reconstruction on the non-diseased breast to produce a symmetrical appearance. Complications of covered mastectomy services, including lymphedemas, are covered.	**Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Hospital - Outpatient:** After Deductible, Enrollee pays $150 Copayment **Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment

Exclusions: Cosmetic services including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services

Podiatry	
Medically Necessary foot care. Routine foot care covered for the prevention of complications associated with a medical condition, when approved by KFHPWA's medical director.	After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Exclusions: Any routine foot care that is not Medically Necessary	

Preventive Services	
Preventive services in accordance with the well care schedule established by KFHPWA. The well care schedule is available in Kaiser Permanente medical centers, at www.kp.org/wa, or upon request from Member Services. Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force (USPSTF). Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians. Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines. Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices. Flu vaccines are also covered when provided by a non-Network Provider. Preventive services include, but are not limited to, well adult and well child physical examinations; immunizations and vaccinations; preferred over-the-counter drugs as recommended by the USPSTF when obtained with a prescription; preventive services related to preconception, prenatal and postpartum care; routine mammography screening; routine prostate screening; colorectal cancer screening for Enrollees who are age 45 or older or who are under age 45 and at high risk; obesity screening/counseling; healthy diet; and physical activity counseling; depression screening in adults, including maternal depression, Pre-Exposure Prophylaxis (PrEP), including laboratory services and office visits, for Enrollees at high risk for HIV infection, screening for physical, mental, sexual, and reproductive health care needs arising from a sexual assault.	No charge; Enrollee pays nothing

Preventive care for chronic disease management includes treatment plans with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, quality of care measurement and results, and education and tools for patient self-management support. In the event preventive, wellness or chronic care management services are not available from a Network Provider, non-network providers may provide these services without Cost Share when Preauthorized. Services provided during a preventive services visit, including laboratory services, which are not in accordance with the KFHPWA well care schedule are subject to Cost Shares. Eye refractions are not included under preventive services.	
Exclusions: Those parts of an examination and associated reports and immunizations that are not deemed Medically Necessary by KFHPWA for early detection of disease; all other diagnostic services not otherwise stated above	

Rehabilitation and Habilitative Care (occupational, physical and speech therapy, pulmonary and cardiac rehabilitation) and Neurodevelopmental Therapy	
Rehabilitation services to restore function following illness, injury or surgery, limited to the following restorative therapies: occupational therapy, physical therapy, and speech therapy. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery. Outpatient services require a prescription or order from a physician that reflects a written plan of care to restore function and must be provided by a rehabilitation team that may include a physician, nurse, physical therapist, occupational therapist, or speech therapist. Preauthorization is not required. Habilitative care, includes Medically Necessary services or devices designed to help an Enrollee keep, learn, or improve skills and functioning for daily living. Services may include: occupational therapy, physical therapy, speech therapy when prescribed by a physician. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Limited to a combined total of 60 inpatient days and 60 outpatient visits per calendar year for all Rehabilitation, Habilitative care, and cardiac and pulmonary rehabilitation services.	**Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Outpatient Services:** After Deductible, Enrollee pays $30 specialty care provider services Copayment Group visits (occupational, physical, speech therapy or learning services): After Deductible, Enrollee pays one half of the office visit Copayment

Neurodevelopmental therapy to restore or improve function including maintenance in cases where significant deterioration in the Enrollee's condition would result without the services, limited to the following therapies: occupational therapy, physical therapy and speech therapy. There is no visit limit for Neurodevelopmental therapy. Services with mental health diagnoses are covered with no limit.	
Cardiac rehabilitation is covered when clinical criteria are met. Preauthorization is required after initial limit. Limited to a combined total of 60 inpatient days and 60 outpatient visits per calendar year for all Rehabilitation, Habilitative care, cardiac and pulmonary rehabilitation services.	**Outpatient Services:** After Deductible, Enrollee pays $30 specialty care provider services Copayment
Pulmonary rehabilitation is covered when clinical criteria are met. Preauthorization is required after initial visit. Limited to a combined total of 60 inpatient days and 60 outpatient visits per calendar year for all Rehabilitation, Habilitative care, cardiac and pulmonary rehabilitation services.	**Outpatient Services:** After Deductible, Enrollee pays $30 specialty care provider services Copayment
Exclusions: Specialty treatment programs; inpatient Residential Treatment services; specialty rehabilitation programs including "behavior modification programs"; recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs	

Reproductive Health	
Medically Necessary medical and surgical services for reproductive health, including consultations, examinations, procedures and devices, including device insertion and removal. See Maternity and Pregnancy for pregnancy care and termination of pregnancy services. Reproductive health is the care necessary to support the reproductive system and the ability to reproduce. Reproductive health includes contraception, cancer and disease screenings, termination of pregnancy, maternity, prenatal and postpartum care.	**Hospital - Inpatient:** No charge; Enrollee pays nothing **Hospital - Outpatient:** No charge; Enrollee pays nothing **Outpatient Services:** No charge; Enrollee pays nothing
All methods for Medically Necessary FDA-approved generic (including over-the-counter) contraceptive drugs, devices and	No charge; Enrollee pays nothing

products. Condoms are limited to 120 per 90-day supply, additional condoms available upon request. Contraceptive drugs may be allowed up to a 12-month supply and, when available, picked up in the provider's office. Note: Over-the-counter contraceptives can be purchased at any KFHPWA-designated pharmacy. Designated pharmacies may submit the claim. If self-payment is made at a non-KFHWA-designated pharmacy, a reimbursement claim may be made by utilizing the Member Reimbursement Drug Claim Form which can be obtained in the "Forms & Publications" section on www.kp.org/wa or by calling Member Services. To request an exception for quantity limits on condoms, members may submit a request online at www.KP.org/wa/formulary or by contacting Member Services.	

Sexual Dysfunction	
Sexual dysfunction diagnosis and medical treatment services.	After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Penile prosthesis, when impotence is caused by a covered medical condition, as a direct result of a covered surgery, or a result of an injury to the genitalia or spinal cord, and when other accepted treatment has been unsuccessful.	Enrollee pays 20% coinsurance
Exclusions: Prescription drugs for treatment of sexual dysfunction; devices, equipment and supplies for the treatment of sexual dysfunction; penile prosthesis when not Medically Necessary; All other devices, equipment and supplies for the treatment of sexual dysfunction not specifically listed as covered	

Skilled Nursing Facility	
Skilled nursing care in a skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending physician, limited to a total of 150 days per calendar year. Care may include room and board; general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by a skilled nursing facility; and short-term restorative occupational therapy, physical therapy and speech therapy.	After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission
Exclusions: Personal comfort items such as telephone and television; rest cures; domiciliary or Convalescent Care	

Sterilization	
FDA-approved female sterilization procedures, services and supplies. See Preventive Services for additional information.	**Hospital - Inpatient:** No charge; Enrollee pays nothing **Hospital - Outpatient:** No charge; Enrollee pays nothing **Outpatient Services:** No charge; Enrollee pays nothing
Vasectomy.	**Hospital - Inpatient:** No charge; Enrollee pays nothing **Hospital - Outpatient:** No charge; Enrollee pays nothing **Outpatient Services:** No charge; Enrollee pays nothing
Exclusions: Procedures and services to reverse a sterilization	

Substance Use Disorder	
Substance use disorder services including inpatient Residential Treatment; diagnostic evaluation and education; organized individual and group counseling; and/or prescription drugs unless excluded under Sections IV. or V. Substance use disorder means a substance-related or addictive disorder listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). For the purposes of this section, the definition of Medically Necessary shall be expanded to include those services necessary to treat a substance use disorder condition that is having a clinically significant impact on an Enrollee's emotional, social, medical and/or occupational functioning. Substance use disorder services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57), a psychologist (licensed under RCW 18.83), a substance use disorder treatment program licensed for the service being provided by the Washington State Department of Social and Health Services (pursuant to RCW 70.96A), a master's level therapist (licensed under RCW 18.225.090), an advance practice psychiatric nurse (licensed under RCW 18.79) or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located. The severity of symptoms designates the appropriate level of care and should be determined through a thorough assessment	**Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Hospital - Outpatient:** After Deductible, Enrollee pays $150 Copayment **Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment **Group Visits:** No charge; Enrollee pays nothing

completed by a licensed provider who recommends treatment based on medical necessity criteria. Court-ordered substance use disorder treatment shall be covered only if determined to be Medically Necessary. Preauthorization is required for outpatient specialty, intensive outpatient, and partial hospitalization services. Preauthorization is not required for inpatient or residential substance use disorder treatment services provided in-state. Enrollee is given no less than two days of treatment, excluding weekends and holidays in a behavioral health agency that provides inpatient or residential substance use disorder treatment prior to conducting a medical necessity review for continued care, initial length of authorized care will be no less than 14 days, subsequent authorization will be no less than 7 days. Enrollee or facility must notify KFHPWA within 24 hours of admission, or as soon as possible. Enrollee may request prior authorization for Residential Treatment and non-Emergency inpatient hospital services. Enrollee may contact Member Services to request Preauthorization.	
Withdrawal Management Services for Alcoholism and Substance Use Disorder. Withdrawal management services means the management of symptoms and complications of alcohol and/or substance withdrawal. The severity of symptoms designates the appropriate level of care and should be determined through a thorough assessment completed by a licensed provider who recommends treatment based on medical necessity criteria. Outpatient withdrawal management services means the symptoms resulting from abstinence are of mild/moderate severity and withdrawal from alcohol and/or other drugs can be managed with medication at an outpatient level of care by an appropriately licensed clinician. Preauthorization is required for outpatient withdrawal management services. Coverage for inpatient withdrawal management services is provided without Preauthorization. If an Enrollee is admitted as an inpatient directly from an emergency department, any Emergency services Copayment is waived. Coverage is subject to the hospital services Cost Share. Enrollees must notify KFHPWA by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Enrollee is given no less than two days of treatment, excluding weekends and holidays, in a behavioral health agency that provides inpatient or residential substance abuse treatment; and no less than three days in a behavioral health	**Emergency Services Network Facility:** After Deductible, Enrollee pays $250 Copayment **Emergency Services Non-Network Facility:** After Deductible, Enrollee pays $250 Copayment **Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission

agency that provides withdrawal management services prior to conducting a medical necessity review for continued care. Enrollee or facility must notify KFHPWA within 24 hours of admission, or as soon as possible. Enrollees may request preauthorization for Residential Treatment and non-Emergency inpatient hospital services by contacting Member Services. KFHPWA reserves the right to require transfer of the Enrollee to a Network Facility/program upon consultation between a Network Provider and the attending physician. If the Enrollee refuses transfer to a Network Facility/program, all further costs incurred during the hospitalization are the responsibility of the Enrollee.	
Exclusions: Wilderness therapy or aversion therapy; facilities and treatment programs which are not certified by the Department of Social Health Services	

Telehealth Services	
Telemedicine Services provided by the use of real time interactive audio and video communications between the patient at the originating site and a Network provider at another location. Audio-only communication requires an Established Relationship. Store and forward technology means sending an Enrollee's medical information from an originating site to the Provider at a distant site for later review. The Provider follows up with a medical diagnosis for the Enrollee and helps manage their care. Services must meet the following requirements: • Be a Covered Service under this EOC. • The originating site is qualified to provide the service. • If the service is provided through store and forward technology, there must be an associated office visit between the Enrollee and the referring provider • Is medically necessary	Enrollee pays $10 Copayment
Virtual Care – Telephone and Online Services (E-Visits, Care Chat or E-consults) Scheduled telephone visits with a Network Provider are covered. Online (E-Visits, Care Chat, E-consults): An Enrollee logs into the secure Enrollee site at www.kp.org/wa and completes a questionnaire. A KFHPWA medical provider reviews the questionnaire and provides a treatment plan for select conditions, including prescriptions. Online visits are not available to Enrollees during in-person visits at a KFHPWA	No charge; Enrollee pays nothing

facility or pharmacy. More information is available at https://wa.kaiserpermanente.org/html/public/services/e-visit. **Virtual Care –** A healthcare service provided via online technology, telephonic, or secure messaging transmission of Enrollee-initiated care from a remote location with a provider that is diagnostic- and treatment focused. The Enrollee is NOT located at a healthcare site. Examples of online technology include the use of a computer, tablet or smartphone. An example of a remote location includes the Enrollee's home or work; a nonclinical location. Services are allowed for commercial members.	
Exclusions: Fax and e-mail; telehealth services with non-contracted providers; telehealth services in states where prohibited by law; all other services not listed above	

Temporomandibular Joint (TMJ)	
Medical and surgical services and related hospital charges for the treatment of temporomandibular joint (TMJ) disorders including: • Medically Necessary orthognathic procedures for the treatment of severe TMJ disorders which have failed non-surgical intervention. • Radiology services. • TMJ specialist services. • Fitting/adjustment of splints.	After Deductible, Enrollee pays 50% coinsurance
TMJ appliances. See Devices, Equipment and Supplies for additional information.	Enrollee pays 50% coinsurance
Exclusions: Treatment for cosmetic purposes; bite blocks; dental services including orthodontic therapy and braces for any condition; any orthognathic (jaw) surgery in the absence of a diagnosis of TMJ or severe obstructive sleep apnea; hospitalizations related to these exclusions	

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

Transplants	
Transplant services, including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, liver transplants, and bone marrow and stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy.	**Hospital - Inpatient:** After Deductible, Enrollee pays $150 Copayment per day up to $750 per admission **Hospital - Outpatient:** After Deductible, Enrollee

Services are limited to the following: • Inpatient and outpatient medical expenses for evaluation testing to determine recipient candidacy, donor matching tests, hospital charges, procurement center fees, professional fees, travel costs for a surgical team and excision fees. Donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees. • Follow-up services for specialty visits • Rehospitalization • Maintenance medications during an inpatient stay **Organ Transplant Recipient:** All services and supplies related to the organ transplant, including transportation to and from KFHPWA Facilities (beyond the distance the Enrollee would normally be required to travel for most hospital services), are covered in accordance with the transplant benefit language, provided the Enrollee is accepted into the treating facility's transplant program and continues to follow that program's prescribed protocol. **Organ Transplant Donor:** The costs related to organ removal, as well as the cost of treating complications directly resulting from surgery, are covered, provided the organ recipient is an Enrollee under this Agreement, and provided the donor is not eligible for coverage under any other health care plan or government-funded program. Donor search costs for up to 15 searches only for allogeneic bone marrow transplants. Transplant services must be provided through locally and nationally contracted or approved transplant centers. All transplant services require Preauthorization. Contact Member Services for Preauthorization.	pays $150 Copayment **Outpatient Services:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment
Exclusions: Donor costs to the extent that they are reimbursable by the organ donor's insurance; living expenses except as covered under Section II.K. Utilization Management; transportation expenses except as covered above; costs for searches for non-allogeneic bone marrow donors	

Urgent Care	
Inside the KFHPWA Service Area, urgent care is covered at a Kaiser Permanente medical center, Kaiser Permanente urgent care center or Network Provider's office. Outside the KFHPWA Service Area, urgent care is covered at any medical facility. See Section XII. for a definition of Urgent Condition.	**Network Emergency Department:** After Deductible, Enrollee pays $250 Copayment **Network Urgent Care Center:** After Deductible, Enrollee pays $15 primary care provider services Copayment or $30 specialty care provider services Copayment **Network Provider's Office:** After Deductible, Enrollee pays $15 primary care provider services

	Copayment or $30 specialty care provider services Copayment **Non-Network Provider:** After Deductible, Enrollee pays $250 Copayment

V. General Exclusions

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

1. Benefits and related services, supplies and drugs that are not Medically Necessary for the treatment of an illness, injury, or physical disability, that are not specifically listed as covered in the EOC, except as required by federal or state law.

2. **Services Related to Non-Covered Services:** When a service is not covered, all services related to the non-covered service (except for the specific exceptions described below) are also excluded from coverage. Enrollees who have received a non-covered service, such as bariatric surgery, and develop an acute medical complication (such as band slippage, leak or infection) as a result, shall have coverage for Medically Necessary intervention to stabilize the acute medical complication. Coverage does not include complications that occur during or immediately following a non-covered service. Additional surgeries or other medical services in addition to Medically Necessary intervention to resolve acute medical complications resulting from non-covered services shall not be covered.

3. Services or supplies for which no charge is made, or for which a charge would not have been made if the Enrollee had no health care coverage or for which the Enrollee is not liable; services provided by a family member, or self-care.

4. Convalescent Care.

5. Services to the extent benefits are "available" to the Enrollee as defined herein under the terms of any vehicle, homeowner's, property or other insurance policy, except for individual or group health insurance, pursuant to medical coverage, medical "no fault" coverage, personal injury protection coverage or similar medical coverage contained in said policy. For the purpose of this exclusion, benefits shall be deemed to be "available" to the Enrollee if the Enrollee receives benefits under the policy either as a named insured or as an insured individual under the policy definition of insured.

6. Services or care needed for injuries or conditions resulting from active or reserve military service, whether such injuries or conditions result from war or otherwise. This exclusion will not apply to conditions or injuries resulting from previous military service unless the condition has been determined by the U.S. Secretary of Veterans Affairs to be a condition or injury incurred during a period of active duty. Further, this exclusion will not be interpreted to interfere with or preclude coordination of benefits under Tri-Care.

7. Services provided by government agencies, except as required by federal or state law.

8. Services covered by the national health plan of any other country.

9. Experimental or investigational services.

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

   a. A service is considered experimental or investigational for an Enrollee's condition if any of the following statements apply to it at the time the service is or will be provided to the Enrollee:

1) The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted.
2) The service is the subject of a current new drug or new device application on file with the FDA.
3) The service is the trialed agent or for delivery or measurement of the trialed agent provided as part of a qualifying Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial.
4) The service is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy as among its objectives.
5) The service is under continued scientific testing and research concerning the safety, toxicity or efficacy of services.
6) The service is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity or efficacy.
7) The prevailing opinion among experts, as expressed in the published authoritative medical or scientific literature, is that (1) the use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity or efficacy of the service.

b. The following sources of information will be exclusively relied upon to determine whether a service is experimental or investigational:
1) The Enrollee's medical records.
2) The written protocol(s) or other document(s) pursuant to which the service has been or will be provided.
3) Any consent document(s) the Enrollee or Enrollee's representative has executed or will be asked to execute, to receive the service.
4) The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body.
5) The published authoritative medical or scientific literature regarding the service, as applied to the Enrollee's illness or injury.
6) Regulations, records, applications and any other documents or actions issued by, filed with or taken by, the FDA or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

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

10. Hypnotherapy and all services related to hypnotherapy.

11. Directed umbilical cord blood donations.

12. Prognostic (predictive) genetic testing and related services, unless specifically provided in Section IV. Testing for non- Enrollees.

13. Autopsy and associated expenses.

14. Over-the-counter items such as hearing aids unless specifically listed as covered in Section IV.

15. Academic/career counseling, counseling for overeating, work/school ordered assessments, relationship counseling, custodial care

16. Court-ordered or forensic treatment, including reports and summaries, not considered Medically Necessary.

VI. Eligibility, Enrollment and Termination – For Employees, Continuation Coverage and Retired Employees of a Former Employer Group

In these sections, "health plan" is used to refer to a plan offering medical, dental, vision, or any combination of these coverages, developed by the Public Employees Benefits Board (PEBB) and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

A. Eligibility.

1. Eligible Employees.

The employee's state agency will inform the employee in writing whether they are eligible for PEBB benefits upon employment and whenever their eligibility status changes. The written notice will include information about the employee's right to appeal eligibility and enrollment decisions.

An employee of an employer group (such as a county, city, port, water district, etc.) that contracts with HCA for PEBB benefits should contact their payroll or benefits office for eligibility criteria.

Employees have the right to appeal eligibility and enrollment decisions. Information about appeals can be found under "**Appeal** Rights".

2. Continuation coverage eligibility

The PEBB Program determines whether subscribers are eligible for PEBB Continuation Coverage (COBRA or Unpaid Leave) upon receipt of their election to enroll. If the subscriber requests to enroll and is not eligible, the PEBB Program will notify them of their right to appeal. Information about appeals can be found under "**Appeal Rights**".

3. Retired employee of a former employer group eligibility

The PEBB Program determines whether a retired employee, retired school employee, or an eligible survivor of a former employer group is eligible to self-pay coverage in PEBB Continuation Coverage (Employer Group Ended Participation) upon receipt of their election to enroll. If the retired employee, retired school employee, or the survivor requests to enroll and is not eligible, the PEBB Program will notify them of their right to appeal. Information about appeals can be found under "Appeal rights."

4. Eligible Dependents.

The following are eligible as dependents:

1. Legal spouse.
2. State-registered domestic partner and substantially equivalent legal unions from jurisdictions as defined in Washington State statute. Individuals in a state-registered domestic partnership are treated the same as a legal spouse except when in conflict with federal law.
3. Children. Children are eligible through the last day of the month in which their 26th birthday occurred regardless of marital status, student status, or eligibility for coverage under another plan. It also includes children age 26 or older with a disability as described below in "Children of any age with a developmental or physical disability.". Children are defined as the subscriber's:
    a. **Children based on establishment of a parent-child relationship**, as described in Washington State statutes, except when parental rights have been terminated.
    b. **Children of the subscriber's spouse**, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death.
    c. **Children for whom the subscriber has assumed a legal obligation** for total or partial support in anticipation of adoption of the child.
    d. **Children of the subscriber's state-registered domestic partner**, based on the state-registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death.

e. **Children specified in a court order or divorce decree** for whom the subscriber has a legal obligation to provide support or health care coverage.

f. **Extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner.** The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include foster children unless the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption.

g. **Children of any age with a developmental or physical disability** that renders them incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the age of 26. The following requirements apply to a dependent child with a disability:

- The subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26.
- The subscriber must notify the PEBB Program in writing, when the child is no longer eligible under this subsection.
- A child with a developmental or physical disability who becomes self-supporting is not eligible as of the last day of the month in which they become capable of self-support.
- A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility under this subsection if they later become incapable of self-support.
- The PEBB Program with input from the medical plan will periodically verify the eligibility of a dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday. Verification will require renewed proof of disability and dependence from the subscriber.

B. Enrollment for subscribers and dependents.

1. For all Subscribers and Dependents

- To enroll at any time other than during the initial enrollment period, see "Making changes."
- Any Dependents enrolled in PEBB medical will be enrolled in the same medical plan as the Subscriber. Exceptions may apply if there are both Medicare and non-Medicare enrollees on the same account.

2. Employee enrollment

An employee must reside in the Service Area. An Employee's dependent must also reside in the service area, except for temporary residency outside the Service Area for purposes of attending school, court-ordered coverage for Dependents or other unique family arrangements, when approved in advance by KFHPWA. KFHPWA has the right to verify eligibility.

An employee must use Benefits 24/7, the PEBB Program's online enrollment system, or submit a *PEBB Employee Enrollment/Change* or *PEBB Employee Enrollment/Change (for Medical Only Groups)* form and any supporting documents to their employing agency when they become newly eligible or regain eligibility for PEBB benefits. The online enrollment must be completed or the form must be received no later than 31 days after the date the employee becomes eligible or regains eligibility.

If the employee does not enroll online or return the form by the deadline, the employee will be enrolled in Uniform Medical Plan Classic, and a tobacco use premium surcharge will be incurred. Consequently, dependents cannot be enrolled until the PEBB Program's next annual open enrollment or when a qualifying event occurs that creates a special open enrollment for enrolling a dependent.

3. Waiving medical enrollment

An eligible employee may waive enrollment in PEBB medical if they are enrolled in other employer-based group medical, a TRICARE plan, or Medicare Part A and Part B. They may not waive enrollment in PEBB medical if they are enrolled in PEBB retiree insurance coverage. The PEBB Program will automatically defer their enrollment or automatically disenroll them from PEBB retiree insurance coverage when they become eligible for the employer contribution toward PEBB benefits.

If an employee waives enrollment in PEBB medical, the employee cannot enroll eligible dependents. For information on when an eligible employee may waive medical plan enrollment after their initial enrollment period, or to enroll after having waived, see "Making changes."

4. Continuation coverage and retired employees of a former employer group enrollment

A subscriber enrolling in PEBB Continuation Coverage (COBRA or Unpaid Leave) or PEBB Continuation Coverage (Employer Group Ended Participation) may enroll by use Benefits 24/7 or submitting the applicable *PEBB Continuation Coverage Election/Change* form and any supporting documents to the PEBB Program.

For PEBB Continuation Coverage (COBRA or Unpaid Leave), the online enrollment must be completed or the PEBB Program must receive the election form no later than 60 days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the *PEBB Continuation Coverage Election Notice* sent by the PEBB Program, whichever is later. For PEBB Continuation Coverage (Employer Group Ended Participation), the online enrollment must be completed or the PEBB Program must receive the required form no later than 60 days after the employer group's date of termination.

Premiums and applicable premium surcharges associated with continuing PEBB medical must be made directly to HCA. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends as described above. For more information, see "Options for continuing PEBB medical coverage" and the *PEBB Continuation Coverage Election Notice* sent by the PEBB Program.

Note: Enrollment in the Kaiser Permanente WA Medicare Advantage with part D plan may not be retroactive. If a subscriber is eligible for and elects this plan and the online enrollment or the required forms are received by the PEBB Program after the date PEBB health plan coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a transitional Kaiser Permanente WA plan during the gap month(s) prior to when the Kaiser Permanente WA Medicare Advantage with Part D plan begins.

5. Dependent enrollment

To enroll an eligible dependent, the employee must include the dependent's information online using Benefits 24/7 or on the applicable enrollment form and provide the required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled in PEBB health plan coverage if the PEBB Program or the employing agency is unable to verify their eligibility within the PEBB Program enrollment timelines.

6. National Medical Support Notice (NMSN).

When a National Medical Support Notice (NMSN) requires a subscriber to provide health plan coverage for a dependent child the following provisions apply:

The subscriber may enroll their dependent child and request changes to their health plan coverage as described under "Changes to health plan coverage or enrollment are allows as directed by the NMSN" below.

- **An employee** must use Benefits 24/7 or submit the required form(s) to their employing agency.
- **Any other subscriber** must use Benefits 24/7 or submit the required form(s) to the PEBB Program.

If the subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN, the employing agency or the PEBB Program may make enrollment or health plan coverage changes according

to "Changes to health plan coverage or enrollment are allowed as directed by the NMSN" below, upon request of:

- The child's other parent; or
- Child support enforcement program.

Changes to health plan coverage or enrollment are allowed as directed by the NMSN:

a. The dependent will be enrolled under the subscriber's health plan coverage as directed by the NMSN.

b. An employee who has waived PEBB medical will be enrolled in medical as directed by the NMSN, in order to enroll the dependent.

c. The subscriber's selected health plan will be changed if directed by the NMSN.

d. If the dependent is already enrolled under another PEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN.

e. If the dependent is enrolled in both PEBB medical and School Employee Benefits Board (SEBB) medical as a dependent and there is NMSN in place, enrollment will be in accordance with the NMSN.

f. If the subscriber is eligible for and elects Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or other continuation coverage, the NMSN will be enforced and the dependent must be covered in accordance with the NMSN.

Changes to health plan coverage or enrollment as described in subsection a. through c. will begin the first day of the month following receipt of the NMSN. If the NMSN is received on the first day of the month, the change to health plan coverage or enrollment begins on that day.

A dependent will be removed from the subscriber's health plan coverage as described in d. the last day of the month the NMSN is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

When a NMSN requires a spouse, former spouse, or other individual to provide health plan coverage for a dependent who is already enrolled in the subscriber's PEBB coverage, and that health plan coverage is in fact provided, the dependent may be removed from the subscriber's PEBB health plan coverage prospectively.

7. Dual enrollment

A subscriber and their dependents may each be enrolled in only one PEBB medical plan.

An employee or their dependent who is eligible to enroll in both the PEBB Program and the School Employees Benefits Board (SEBB) Program is limited to a single enrollment in either the PEBB or SEBB Program.

For example:

- A child who is an eligible dependent under two parents enrolled in PEBB Program benefits may be enrolled as a dependent under both parents but is limited to a single enrollment in PEBB medical.
- A child who is an eligible dependent of an employee in the PEBB Program and a school employee in the SEBB Program may only be enrolled as a dependent under one parent in either the PEBB or SEBB Program.

C. Medicare Eligibility and Enrollment.

1. Employee and dependent

If an employee or their dependent becomes eligible for Medicare, they should contact the Social Security Administration to ask about the advantages of immediate or deferred Medicare enrollment.

An employee or their dependent are deemed eligible for Medicare when they have the option to receive Part A Medicare benefits. An employee that chooses to enroll in Medicare Part A is no longer eligible to contribute to a health savings account. If an employee continues to do so, they will be liable for any tax

penalties resulting from contributions made when they are no longer eligible. If an employee or their dependent chooses to enroll in Medicare Part A, Medicare regulations and guidelines will determine whether Medicare is the primary or secondary payer.

An employee or their dependent who is enrolled in Medicare may remain enrolled in PEBB medical. However, an employee may choose to waive their PEBB medical if they are enrolled in Medicare Part A and Part B or remove their dependent from their PEBB medical and choose Medicare as their primary insurer. If an employee does so, neither the employee nor their dependent can enroll in PEBB medical except during the annual open enrollment or when a specific life event creates a special open enrollment.

In most situations, an employee and their dependent can elect to defer Medicare Part B enrollment without a penalty while enrolled in PEBB medical. When the employee terminates employment, the employee and the dependent can enroll in Medicare Part B during a Special Enrollment Period. If Medicare eligibility is due to disability, the employee or their dependent must contact the Social Security Administration about deferring enrollment in Medicare Part B.

Upon retirement, Medicare will become the primary insurance payer, and the PEBB medical plan will become secondary. See "***PEBB retiree insurance coverage***."

2. Continuation coverage subscriber, a retired employee of a former employer group, or their dependent

If a continuation coverage subscriber, a retired employee of a former employer group, or their dependent becomes eligible for Medicare when they are turning age 65 but not getting Social Security benefits, federal regulations allow a seven month initial enrollment period to enroll in Medicare. If they do not enroll within three months before the month they turn age 65, enrollment in Medicare may be delayed. If enrollment in Medicare does not occur when the subscriber or their dependent is first eligible, a late enrollment penalty may apply.

D. When Medical Coverage Begins.

1. Employees and dependents

For a newly eligible employee and their eligible dependents, medical coverage begins the first day of the month following the date the employee becomes eligible. If the employee becomes eligible on the first working day of the month, then coverage begins on that date.

If the eligible employee is a faculty member hired on a quarter-to-quarter or semester-to-semester basis, medical coverage begins the first day of the month following the beginning of the second consecutive quarter or semester. If the first day of the second consecutive quarter or semester is the first working day of the month, medical coverage begins on that day.

For an employee regaining eligibility, including following a period of leave or after being between periods of leave described in PEBB Program rules, and their eligible dependents, medical coverage begins the first day of the month the employee is in pay status eight or mor hours. If the employee is a returning faculty member regaining eligibility no later than the 12th month after the month in which they lost eligibility for the employer contribution toward PEBB benefits, medical coverage begins the first day of the month in which the quarter or semester begins.

Note: When an employee who is called to active duty in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act (USERRA) loses eligibility for the employer contribution toward PEBB benefits, they regain eligibility for the employer contribution toward PEBB benefits the day they return from active duty. Medical coverage begins the first day of the month in which the employee returns from active duty.

2. Continuation coverage subscriber and dependents

For a continuation coverage subscriber and their eligible dependents enrolling when newly eligible due to a qualifying event, medical coverage begins the first day of the month following the day they lost eligibility for PEBB medical.

3. Retired employees of a former employer group and dependents

For a retired employee of a former employer group and their eligible dependents enrolling when newly eligible, medical coverage begins the first day of the month following the day they lost eligibility for PEBB retiree insurance coverage.

4. All Subscribers and dependents

For a subscriber or their eligible dependents enrolling during the PEBB Program's annual open enrollment, medical coverage begins January 1 of the following year.

For a subscriber or their eligible dependents enrolling during a special open enrollment, medical coverage begins the first day of the month following the event date or the date the online enrollment election using Benefits 24/7 or the required form is received, whichever is later. If that day is the first of the month, medical coverage begins on that day.

If the special open enrollment is due to the **birth or adoption of a child**, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, medical coverage will begin as follows:

- **For an employee**, medical coverage will begin the first day of the month in which the event occurs.
- **For a newly born child**, medical coverage will begin the date of birth.
- **For a newly adopted child**, medical coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier.
- **For a spouse or state registered domestic partner** of a subscriber, medical coverage will begin the first day of the month in which the event occurs.

If the special open enrollment is due to the enrollment of an **extended dependent, or a dependent child with a disability**, medical coverage will begin on the first day of the month following the event date or eligibility certification, whichever is later.

E. Making changes

1. Removing a dependent who is no longer eligible

A subscriber must provide notice to remove a dependent who is no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a dependent ceasing to be eligible as a dependent child as described under "Dependent eligibility." The notice must be received within 60 days of the last day of the month the dependent no longer meets the eligibility criteria.

- **An employee** must provide notice online using Benefits 24/7 or by submitting a written request to their employing agency.
- **Any other subscriber** must provide notice online using Benefits 24/7 or by submitting a written request to the PEBB Program.

Consequences for not submitting notice within the required 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue PEBB medical under one of the continuation coverage options described in "Options for continuing PEBB medical coverage."
- The subscriber may be billed for claims paid by the medical plan for services that were rendered after the dependent lost eligibility.
- The subscriber may not be able to recover subscriber-paid insurance premiums for the dependent that lost eligibility.
- The subscriber may be responsible for premiums paid by the state for the dependent's medical plan coverage after the dependent lost eligibility.

2. Voluntary termination for continuation coverage subscribers or retired employees of a former employer group

A continuation coverage subscriber or a retired employee of a former employer group may voluntarily terminate enrollment in a medical plan at any time by submitting a request online using Benefits 24/7 or in writing to the PEBB Program. Enrollment in the medical plan will be terminated the last day of the month in which the request was received online or by the PEBB Program, or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, medical plan enrollment will be terminated on the last day of the previous month.

3. Making changes during annual open enrollment and special open enrollment

A subscriber may make certain changes to their enrollment during the annual open enrollment or when a specific life event creates a special open enrollment period.

4. Annual Open Enrollment changes.

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

- Change their medical plan
- Waive their medical plan enrollment
- Enroll after waiving medical plan enrollment
- Enroll or remove eligible dependents

An employee must submit the election change online using Benefits 24/7 or submit the required *PEBB Employee Enrollment/Change* form and any supporting documents to their employing agency. The change must be completed online or the forms received, no later than the last day of the annual open enrollment period.

Any other subscriber may make the following changes to their enrollment during the PEBB Program's annual open enrollment period:

- Enroll in or terminate enrollment in a medical plan
- Enroll or remove eligible dependents
- Change their medical plan

They must submit the election change online using Benefits 24/7 or submit the required *PEBB Continuation Coverage* Election/Change form (as appropriate) and any supporting documents to the PEBB Program. The change must be completed online, or the forms received, no later than the last day of the annual open enrollment period.

The change will be effective January 1 of the following year, except when a subscriber chooses to terminate enrollment or remove an eligible dependent, then the change will be effective on December 31.

5. Special Open Enrollment changes.

A subscriber may change their enrollment outside of the annual open enrollment if a qualifying event creates a special open enrollment period. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, their dependent, or both.

A special open enrollment event must be other than an employee gaining initial eligibility or regaining eligibility for PEBB benefits.

A special open enrollment may allow a subscriber to make the following changes:

- Enroll in or change their medical plan
- Waive their medical plan enrollment

- Enroll after waiving medical plan enrollment
- Enroll or remove eligible dependents

To request a special open enrollment:

- **An employee** must make the change online using Benefits 24/7 or submit the required *PEBB Employee Enrollment/Change* form and any supporting documents to their employing agency.
- **Any other subscriber** must make the change online using Benefits 24/7 or submit the required *PEBB Continuation Coverage) Election/* form (as appropriate) and any supporting documents to the PEBB Program.

The change must be completed online, or the forms must be received, no later than 60 days after the event that creates the special open enrollment. In many instances, the date the change is received online or the date the form is received affects the effective date of the change in enrollment. Submitting the requested change sooner may avoid a delay in the enrollment or change. In addition, the PEBB Program or the employing agency will require the subscriber to provide proof of a dependent's eligibility, evidence of the event that created the special open enrollment, or both.

Exceptions:

If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify their employing agency or the PEBB Program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required forms must be received no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

A continuation coverage subscriber or a retired employee of a former employer group:

- Has six months from the date of their or their dependent's enrollment in Medicare Part B to change their enrollment to a PEBB Medicare Supplement Plan. The change must be made online using Benefits 24/7, or the PEBB Program must receive the required form(s) no later than six months after the enrollment in Medicare Part B for either the subscriber or their dependent.
- Has seven months to enroll in a Medicare Advantage Prescription Drug (MAPD) plan or Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP) that begins three months before they or their dependent first enrolled in both Medicare Part A and Part B and ends three months after the month of Medicare eligibility. They may also enroll themselves or their dependent in a MAPD plan or UMP Classic Medicare with Part D (PDP) before their last day of the Medicare Part B initial enrollment period. The change must be made online using Benefits 24/7, or the forms must be received by the PEBB Program, no later than the last day of the month prior to the month the continuation coverage subscriber or their dependent enrolls in the MAPD plan or UMP Classic Medicare with Part D (PDP).
- Has three months to enroll in a MAPD plan, Medicare Supplement plan, or the UMP Classic Medicare with Part D (PDP) if eligible, after they or their dependent gain, lose, or have a change in low-income subsidy (LIS) eligibility, or notification of such a change, whichever is later. The change must be made online using Benefits 24/7 or the forms must be received by the PEBB Program, no later than three months after they or their dependent gain, lose, or have a change in LIS eligibility, or notification of such a change, whichever is later.

6. Special open enrollment events that allow for a change in health plans

A subscriber may not change their health plan during a special open enrollment if their state-registered domestic partner or state-registered domestic partner's child is not a tax dependent.

Any of the following events may create a special open enrollment:

- Subscriber gains a new dependent due to:

    - Marriage or registering a state-registered domestic partnership.
    - Birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
    - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber has a change in residence and their current medical plan is no longer available , the subscriber must select a new medical plan. If the subscriber does not elect a new medical plan as required, they will be enrolled in a PEBB medical plan designated by the director of HCA or their designee.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber or their dependent enrolls in coverage under Medicare, or the subscriber or their dependent loses eligibility for coverage under Medicare or enrolls in or terminates enrollment in a Medicare Advantage-Prescription Drug or a Part D plan. If the subscriber's current medical plan becomes unavailable due to the subscriber or their dependents enrollment in Medicare, the subscriber must select a new medical plan.
- Subscriber or their dependent gains, loses or has a change in low-income subsidy eligibility.
- Subscriber or their dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA).
- Subscriber or their dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent. The subscriber may not change their health plan election because the subscriber or dependent's physician stops participation with the subscriber's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but not limit its consideration to the following:
    - Active cancer treatment, such as chemotherapy or radiation therapy
    - Treatment following a recent organ transplant
    - A scheduled surgery
    - Recent major surgery still within the postoperative period
    - Treatment for a high-risk pregnancy

- The PEBB Program determines that there has been a substantial decrease in the providers available under a PEBB medical plan.

Note: The plan cannot guarantee that any physician, hospital, or other provider will be available or remain under contract with the plan. An enrollee may not change medical plans simply because their provider or health care facility discontinues participation with this medical plan until the PEBB Program's next annual open enrollment or when another qualifying event creates a special open enrollment for changing health plans, unless the PEBB Program determines that a continuity of care issue exists or there has been a substantial decrease in the providers available under the plan.

7. Special open enrollment events that allow adding or removing a dependent

Any of the following events may create a special open enrollment:

- Subscriber gains a new dependent due to:
  - Marriage or registering a state-registered domestic partnership.
  - Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption.
  - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber's dependent enrolls in Medicare or loses eligibility for Medicare.
- Subscriber or their dependent enrolled in a Medicare Advantage Prescription Drug plan, Medicare Supplement plan, or the Uniform Medical Plan classic Medicare with Part D (PDP) who gains, loses, or has a change to their low-income subsidy eligibility.

8. Special open enrollment events that allow waiving medical enrollment and enrolling after waiving

An employee may waive PEBB medical during a special open enrollment if they are enrolled in other employer-based group medical, a TRICARE plan, or Medicare Part A and Part B. An employee may not waive enrollment in PEBB medical if they are enrolled in PEBB retiree insurance coverage. Their enrollment in PEBB retiree insurance coverage will be automatically deferred or automatically disenrolled by the PEBB Program.

Any of the following events may create a special open enrollment:

- Employee gains a new dependent due to:
  - Marriage or registering a state-registered domestic partnership.
  - Birth, adoption, or when the employee has assumed a legal obligation for total or partial support in anticipation of adoption.
  - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Employee or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the HIPAA.
- Employee has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group medical.
- Employee's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group medical. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Employee or their dependent has a change in enrollment under an employer-based group medical plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and the change in residence resulted in the dependent losing their health insurance.
- A court order requires the employee or any other individual to provide a health plan for an eligible dependent of the employee (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Employee or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the employee or their dependent loses eligibility for coverage under Medicaid or CHIP. **Note:** An employee may only return from having waived PEBB medical for the events described in this paragraph. An employee may not waive their PEBB medical for the events described in this paragraph.
- Employee or their dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Employee or their dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan.
- Employee becomes eligible and enrolls in Medicare or loses eligibility for Medicare.

F. When medical coverage ends

1. Termination dates

Medical coverage ends on the following dates:

- On the last day of the month when any enrollee ceases to be eligible.
- On the date a medical plan terminates due to a change in contracted service area or when the group policy ends. If that should occur, the subscriber will have the opportunity to enroll in another PEBB medical plan.
- **For an employee** and their dependents, on the last day of the month the employment relationship is terminated. The employment relationship is considered terminated:
    - On the date specified in an employee's letter of resignation.
    - On the date specified in any contract or hire letter.
    - On the effective date of an employer-initiated termination notice.

Note: If the employing agency deducted the employee's premium for PEBB insurance coverage after the employee was no longer eligible for the employer contribution, medical coverage ends the last day of the month that employee premiums were deducted.

- **For a continuation coverage subscriber or a retired employee of a former employer group** who submits a request to terminate medical coverage, enrollment in medical coverage will be terminated the last day of the month in which the request was received online using Benefits 24/7 or by the PEBB Program, or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, medical coverage will be terminated on the last day of the previous month.

A subscriber will be responsible for payment of any services received after the date medical coverage ends as described above.

2. Final premium payments

Premium payments and applicable premium surcharges are not prorated during any month, for any reason, even if an enrollee dies or asks to terminate their medical plan before the end of the month.

If the monthly premium or applicable premium surcharges remain unpaid for 30 days the account will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premiums or applicable premium surcharges become delinquent to pay the unpaid premium balance and applicable premium surcharges. If the subscriber's premium balance or applicable premium surcharges remain unpaid for 60 days from the original due date, the subscriber's medical coverage (including enrolled dependents) will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges were paid.

3. If an enrollee is hospitalized

An enrollee who is receiving covered services in a hospital on the date medical coverage ends will continue to be eligible for covered services while an inpatient for the condition which the enrollee was hospitalized, until one of the following events occur:

- According to this plan's clinical criteria, it is no longer medically necessary for the enrollee to be an inpatient at the facility.
- The remaining benefits available for the hospitalization are exhausted, regardless of whether a new calendar year begins.
- The enrollee becomes covered under another agreement with a group health plan that provides benefits for the hospitalization.
- The enrollee becomes enrolled under an agreement with another carrier that provides benefits for the hospitalization.

This provision will not apply if the enrollee is covered under another agreement that provides benefits for the hospitalization at the time medical coverage ends, except as set forth in this section, or if the enrollee is

eligible for PEBB Continuation Coverage as described in "Options for continuing PEBB medical coverage."

4. Options for continuing PEBB medical coverage

When medical coverage ends, the subscriber and their dependents covered by this medical plan may be eligible to continue PEBB medical coverage during temporary or permanent loss of eligibility.

There are three options the subscriber and their dependents may qualify for when coverage ends.

- PEBB Continuation Coverage (COBRA)
- PEBB Continuation Coverage (Unpaid Leave)
- PEBB retiree insurance coverage

A subscriber also has the right to convert to individual medical insurance coverage with the plan when continuation of group medical insurance coverage is no longer possible.

(a) PEBB Continuation Coverage

The PEBB Program administers the following continuation coverage options to temporarily extend group insurance coverage when the enrollee's PEBB medical plan coverage ends due to a qualifying event:

- **PEBB Continuation Coverage (COBRA)** includes eligibility and administrative requirements under federal COBRA laws and regulations. Some enrollees who are not qualified beneficiaries under federal COBRA, may also qualify for PEBB Continuation Coverage (COBRA).
- **PEBB Continuation Coverage (Unpaid Leave)** is an option created by the PEBB Program with wider eligibility criteria and qualifying event types than COBRA.

An enrollee who qualifies for both types of PEBB Continuation Coverage (COBRA and Unpaid Leave) may enroll in only one of these options. See "Continuation coverage enrollment" and the *PEBB Continuation Coverage Election Notice* sent by the PEBB Program.

Premium payments for PEBB Continuation Coverage

If a subscriber enrolls in continuation coverage, the subscriber is responsible for timely payment of premiums and applicable premium surcharges.

(b) PEBB retiree insurance coverage

The following are eligible to continue enrollment or defer enrollment in PEBB retiree insurance coverage if they meet procedural and substantive eligibility requirements:

- Retiring employee
- Retiring school employee
- Eligible elected or full-time appointed official of the legislative or executive branch of state government leaving public office
- Dependent becoming eligible as a survivor
- Retiree or survivor enrolled in PEBB retiree insurance coverage

For details, see the *PEBB Retiree Enrollment Guide*.

5. Family and Medical Leave Act of 1993

An employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward PEBB benefits in accordance with the federal FMLA.

The employing agency determines if the employee is eligible for leave and the duration of the leave under FMLA. The employee must continue to pay their monthly premium contribution and applicable premium surcharges during this period.

If an employee exhausts the period of leave approved under FMLA, they may continue PEBB insurance coverage by self-paying the monthly premium and applicable premium surcharges set by HCA, with no contribution from the employing agency. See "Options for continuing PEBB medical coverage."

6. Paid Family and Medical Leave Act

An employee on approved leave under the Washington State Paid Family and Medical Leave (PFML) Program may continue to receive the employer contribution toward PEBB benefits.

The Employment Security Department determines if the employee is eligible for leave under PFML. The employee must continue to pay their monthly premium contribution and applicable premium surcharges during this period.

If an employee exhausts the period of leave approved under PFML, they may continue PEBB insurance coverage by self-paying the monthly premium and applicable premium surcharges set by HCA, with no contribution from the employing agency. See "Options for continuing PEBB medical coverage."

7. Conversion of coverage

An enrollee (including a dependent of a subscriber terminated for cause) has the right to switch from PEBB group medical to an individual conversion plan offered by this plan when they are no longer eligible to continue the PEBB group medical plan and are not eligible for Medicare or covered under another group insurance coverage that provides benefits for hospital or medical care.

An enrollee must apply for conversion coverage and pay the first month's premium no later than 31 days after their PEBB group medical plan ends or within 31 days from the date the notice of termination of coverage is received, whichever is later. The conversion coverage will become effective immediately following termination of coverage under the PEBB group medical plan.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage, and eligibility requirements of this conversion plan differ from those of the enrollee's current group medical plan. To receive detailed information on conversion options under this medical plan, call us at (206) 630-4636 in the Seattle area, or toll-free in Washington, 1888-901-4636.

G. General provisions for eligibility and enrollment

1. Payment of premiums during a labor dispute

Any employee or dependent whose monthly premiums are paid in full or in part by the employing agency may pay premiums directly to HCA if the employee's compensation is suspended or terminated directly or indirectly because of a strike, lockout, or any other labor dispute, for a period not to exceed six months.

When the employee's compensation is suspended or terminated, HCA will notify the employee immediately, by mail at the last address of record, that the employee may pay premiums as they become due.

If coverage is no longer available to the employee under this certificate of coverage, then the employee may be eligible to purchase an individual medical plan from this plan consistent with premium rates filed with the Washington State Office of the Insurance Commissioner.

2. Termination for just cause

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

An eligible dependent may have coverage terminated by HCA for the following reasons:

- Failure to comply with the PEBB Program's procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB Program
- Knowingly providing false information

- Failure to pay the monthly premium and applicable premium surcharges when due
- Misconduct. Examples of such termination include, but are not limited to the following:
    - Fraud, intentional misrepresentation or withholding of information the subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium
    - Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan, or other HCA-contracted vendor providing PEBB insurance coverage on behalf of HCA, its employees, or other persons

The PEBB Program will enroll an employee and their eligible dependents in another PEBB medical plan upon termination from this plan.

H. Appeal rights

Any current or former employee of a state agency or their dependent may appeal a decision made by the state agency regarding PEBB eligibility, enrollment, or premium surcharges to the state agency.

Any current or former employee of an employer group, such as a county, city, port, water district, etc., that contracts with HCA for PEBB benefits, or their dependent may appeal a decision made by an employer group regarding PEBB eligibility, enrollment, or premium surcharges to the employer group.

Any enrollee may appeal a decision made by the PEBB Program regarding PEBB eligibility, enrollment, premium payments, or premium surcharges to the PEBB Appeals Unit.

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

Learn more at hca.wa.gov/pebb-appeals.

I. Relationship to law and regulations

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

VII. Eligibility, Enrollment and Termination – For a Retiree or Survivor

In these sections, the term "retiree" or "retiring employee" includes a retiring employee from a Public Employees Benefits Board (PEBB) employing agency or employer group, and an elected or full-time appointed official of the legislative and executive branch of state government. The term "retiree" or "retiring school employee" includes a retiring school employee from a School Employees Benefits Board (SEBB) organization or employer group. Additionally, "health plan" is used to refer to a plan offering medical, dental, vision, or any combination of these coverages developed by PEBB and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

A. Eligibility for subscribers and dependents

1. Retiree eligibility

The PEBB Program determines if a retiring employee or retiring school employee is eligible to enroll in PEBB retiree insurance coverage upon receipt of their election to enroll. If the retiring employee or retiring school employee does not have substantive eligibility or does not meet the procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to appeal eligibility decisions. Information about appeals can be found under "Appeal rights."

2. Survivor eligibility

The PEBB Program determines whether a dependent is eligible to enroll or continue enrollment in PEBB retiree insurance coverage as a survivor. If an election to enroll is required, eligibility will be determined

upon receipt of *their election to enroll.* If the survivor does not meet the eligibility and procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to appeal. Information about appeals can be found under "Appeal rights*."*

3. Dependent eligibility

The following are eligible dependents:

- Legal spouse
- State-registered domestic partner and substantially equivalent legal unions from jurisdictions as defined in Washington State statute. Individuals in a state-registered domestic partnership are treated the same as a legal spouse except when in conflict with federal law.
- Children, through the last day of the month in which their 26th birthday occurred regardless of marital status, student status, or eligibility for coverage under another plan. It also includes children age 26 or older with a disability as described below in "Children of any age with a developmental or physical disability." Children are defined as the subscriber's:
    - **Children based on establishment of a parent-child relationship**, as described in Washington State statutes, except when parental rights have been terminated.
    - **Children of the subscriber's spouse**, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death.
    - **Children for whom the subscriber has assumed a legal obligation** for total or partial support in anticipation of adoption of the child.
    - **Children of the subscriber's state-registered domestic partner,** based on the state-registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death.
    - **Children specified in a court order or divorce decree** for whom the subscriber has a legal obligation to provide support or health care coverage.
    - **Extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner.** The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include foster children unless the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption.
    - **Children of any age with a developmental or physical disability** that renders them incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance, provided such condition occurs before the age of 26. The following requirements apply to a dependent child with a disability:
        a) The subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26.
        b) The subscriber must notify the PEBB Program in writing when the child is no longer eligible under this subsection.
        c) A child with a developmental or physical disability who becomes self-supporting is not eligible as of the last day of the month in which they become capable of self-support.
        d) A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility if they later become incapable of self-support.

e) The PEBB Program, with input from the medical plan, will periodically verify the eligibility of a dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday. Verification will require renewed proof of disability and dependence from the subscriber.

A retiree, a survivor, or their enrolled dependents are required to enroll in Medicare Part A and Part B if eligible. This is a requirement for enrollment in a PEBB retiree health plan. A subscriber must provide a copy of their or their dependent's Medicare card or Medicare benefit verification letter with Medicare Part A and Part B effective dates by uploading it online using Benefits 24/7, the PEBB Program's online enrollment system, or providing it to the PEBB Program. If a subscriber or their dependent is not enrolled in either Medicare Part A or Part B on their 65th birthday, the subscriber must upload or provide the PEBB Program with a copy of the denial letter from the Social Security Administration. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

B. Enrollment for subscribers and dependents

1. Deferring enrollment

A retiring employee, a retiring school employee, or a dependent becoming eligible as a survivor may defer (postpone) enrollment in PEBB retiree insurance coverage if they meet the substantive eligibility requirements to enroll and also meet the procedural requirement by electing to defer enrollment using Benefits 24/7 or by submitting a *PEBB Retiree Election Form (form A)* to the PEBB Program within the enrollment timelines.

If a retiring employee, a retiring school employee, or a dependent becoming eligible as a survivor chooses to defer enrollment in PEBB medical, enrollment in PEBB dental and PEBB vision will also be deferred. Deferring enrollment in PEBB retiree insurance coverage will also defer enrollment for all eligible dependents, except as described below.

A retiring employee, a retiring school employee, or a dependent becoming eligible as a survivor who does not enroll in PEBB retiree insurance coverage is only eligible to enroll later if they have deferred enrollment. Enrollment may be deferred as follows:

- Beginning January 1, 2001, enrollment in PEBB retiree insurance coverage may be deferred when the subscriber is enrolled in employer-based group medical insurance as an employee or the dependent of an employee, or such medical insurance continued under Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or continuation coverage.
- Beginning January 1, 2001, enrollment in PEBB retiree insurance coverage may be deferred when the subscriber is enrolled as a retiree or the dependent of a retiree in a federal retiree medical plan.
- Beginning January 1, 2006, enrollment in PEBB retiree insurance coverage may be deferred when the subscriber is enrolled in Medicare Parts A and B and a Medicaid program that provides creditable coverage. Eligible dependents who are not enrolled in Medicaid coverage that provides creditable coverage may be enrolled.
- Beginning January 1, 2014, subscribers who are not eligible for Medicare Part A and Part B may defer enrollment in PEBB retiree insurance coverage when the subscriber is enrolled in qualified health plan coverage through a health benefit exchange developed under the Affordable Care Act.
- Beginning July 17, 2018, enrollment in PEBB retiree insurance coverage may be deferred when the subscriber is enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).
- Beginning January 1, 2025, subscribers who are enrolled in Medicare may defer enrollment in PEBB retiree insurance coverage when they permanently live in a location outside of the United States.

Exception: A retiree may defer enrollment in PEBB retiree insurance coverage during the period of time they are enrolled as a dependent in a medical plan sponsored by PEBB or School Employees Benefits

Board (SEBB), including such coverage under COBRA or continuation coverage. They do not need to elect to defer enrollment online or submit a *PEBB Retiree Election Form*.

The PEBB Program will automatically defer enrollment in PEBB retiree insurance coverage:

- If a retiree or a survivor becomes eligible for the employer contribution toward PEBB or SEBB benefits.
- If a retiree or a survivor who is not on Medicare and permanently lives outside of the United States, becomes eligible for Medicare Parts A and B, and does not respond to HCA within the required timeframe.

A retiree or a survivor whose enrollment in PEBB retiree insurance coverage is deferred, may enroll as described in the section titled "Enrollment following deferral."

2. Retiree and survivor enrollment

An eligible retiree, a survivor, or their dependent can enroll in only one PEBB medical plan, even if eligibility criteria is met under two or more subscribers.

An eligible retiring employee or a retiring school employee must enroll using Benefits 24/7 or by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. The online enrollment must be completed or the forms must be received no later than 60 days after the employee's or the school employee's own employer-paid coverage, COBRA coverage, or continuation coverage ends. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible elected or full-time appointed official must enroll using Benefits 24/7 or by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. The online enrollment must be completed or the forms must be received no later than 60 days after the official leaves public office. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible survivor of a retiree who is enrolled at the time of the retiree's death will be enrolled under their own account with no gap in coverage in the same PEBB health plan coverage they were enrolled in. To make changes to their PEBB health plan coverage, they must submit a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the death of the retiree. An eligible survivor of a retiree who is not enrolled at the time of the retiree's death, must enroll by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the death of the retiree.

An eligible survivor of an employee or school employee must enroll by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the later of the date of the employee's or the school employee's death, or the date the survivor's PEBB insurance coverage or SEBB insurance coverage ends. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible employee or school employee determined to be retroactively eligible for disability retirement must enroll using Benefits 24/7 or by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms, supporting documents, and their formal determination letter to the PEBB Program. The online enrollment must be completed or the forms must be received no later than 60 days after the date on the determination letter. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible survivor of an emergency service personnel killed in the line of duty must enroll by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 180 days after the later of:

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

A retiree or a survivor who deferred enrollment and is enrolling in a PEBB retiree health plan, must enroll using Benefits 24/7 or by submitting a *PEBB Retiree Election Form (form A)* along with any other required forms and supporting documents to the PEBB Program.

A retiree or a survivor who deferred enrollment while enrolled in other qualifying coverage must also submit evidence of continuous enrollment. The online enrollment must be completed or the forms must be received no later than 60 days after a loss of other qualifying coverage.

A retiree or a survivor enrolled in Medicare whose enrollment is deferred while permanently living outside of the United States and they permanently move back to the United States, must also submit proof of enrollment in Medicare Parts A and B; evidence of continuous enrollment in qualified coverage is waived. The online enrollment must be completed or the forms must be received no later than 60 days after the date of the permanent move or the date the retiree or survivor provides notification of such move, whichever is later.

The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends. See "Enrollment following deferral" for additional information and enrollment timelines.

Note: Enrollment in the Kaiser Permanente WA Medicare Advantage with Part D plan may not be retroactive. If a subscriber is eligible for and elects this plan and the online enrollment or the required forms are received by the PEBB Program after the date PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a transitional Kaiser Permanente WA plan during the gap month(s) prior to when the Kaiser Permanente WA Medicare Advantage with Part D plan begins.

3. Dependent enrollment

To enroll an eligible dependent, the subscriber must include the dependent's information using Benefits 24/7 or on the applicable enrollment form and provide the required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled in PEBB health plan coverage if the PEBB Program is unable to verify their eligibility within the PEBB Program enrollment timelines.

Dependents who are enrolled in PEBB medical must be enrolled in the same PEBB medical plan as the retiree or survivor.

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

A retiree or a survivor may also enroll an eligible dependent during the PEBB Program's annual open enrollment or when a specific life event creates a special open enrollment. See "Making changes."

C. Medicare eligibility and enrollment

1. Medicare Part A and Part B

If a subscriber or their enrolled dependent becomes eligible for Medicare, they should contact the Social Security Administration to ask about Medicare enrollment.

Any enrollee who is eligible for Medicare must enroll and stay enrolled in Medicare Part A and Part B.

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

A subscriber must provide a copy of their or their dependent's Medicare card or Medicare benefit verification letter from the Social Security Administration with effective dates by uploading it online using Benefits 24/7 or providing it to the PEBB Program. If a subscriber or their dependent is not enrolled in either Medicare Part A or Part B on their 65th birthday, the subscriber must upload or provide a copy of the denial letter from the Social Security Administration. If this procedural requirement is not met, eligibility will end as described in the termination notice sent by the PEBB Program. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

2. Medicare Part D

The PEBB Program has determined that this medical plan has prescription drug coverage that is, on average, as good as or better than the standard Medicare Part D prescription drug coverage (it is "creditable coverage"). Therefore, a subscriber or their enrolled dependent cannot enroll in a Medicare Part D plan and stay in this medical plan.

If the subscriber terminates this medical plan, they may contact the PEBB Program to request a certificate of creditable coverage. If creditable prescription drug coverage is not maintained, Medicare Part D premiums may be higher in the future.

If a subscriber, or their enrolled dependent chooses to enroll in a stand-alone Medicare Part D plan, PEBB retiree insurance coverage may only be continued by enrolling in the PEBB-sponsored Medicare supplement plan.

D. When medical coverage begins

For an eligible retiring employee or retiring school employee and their eligible dependents, medical coverage begins the first day of the month after the retiring employee's or retiring school employee's own employer-paid coverage, COBRA coverage, or continuation coverage ends.

For an eligible employee or school employee determined to be retroactively eligible for disability retirement and their eligible dependents, medical coverage begins on the date chosen by the employee or school employee as allowed under PEBB Program rules.

For an eligible elected or full-time appointed official and their eligible dependents, medical coverage begins the first day of the month following the date the official leaves public office.

For an eligible survivor of a retiree and their eligible dependents, medical coverage will be continued without a gap, subject to payment of premiums and applicable premium surcharges. If the eligible survivor is not enrolled at the time of the retiree's death, medical coverage will begin the first day of the month following the retiree's death.

For an eligible survivor of an employee or school employee and their eligible dependents, medical coverage begins the first day of the month following the later of the date of the employee's or the school employee's

death or the date the survivor's PEBB insurance coverage or SEBB insurance coverage ends. This does not include emergency service personnel killed in the line of duty.

For an eligible survivor of an emergency service personnel killed in the line of duty and their eligible dependents, medical coverage begins on the date chosen, as allowed under PEBB Program rules.

For a retiree or a survivor who deferred enrollment and is enrolling in a PEBB retiree health plan following loss of other qualifying coverage, medical coverage for the retiree or the survivor and their eligible dependents begins the first day of the month after the loss of the other qualifying coverage. For a retiree or a survivor enrolled in Medicare whose enrollment was deferred while permanently living outside of the United States, and they permanently move back to the United States, medical coverage for the retiree or the survivor and their eligible dependents begins the first day of the month after the permanent move or the date the retiree or survivor provides notification of such move, whichever is later.

For a retiree, a survivor, or their eligible dependents enrolling during the PEBB Program's annual open enrollment, medical coverage begins January 1 of the following year.

For a retiree, a survivor, or their eligible dependents enrolling during a special open enrollment, medical coverage begins the first of the month following the event date or the date the online enrollment election using Benefits 24/7 or the required form is received, whichever is later. If that day is the first of the month, medical coverage begins on that day.

If the special open enrollment is **due to the birth or adoption of a child,** or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, medical coverage will begin as follows:

- **For a newly born child,** medical coverage will begin the date of birth;
- **For a newly adopted child,** medical coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier; or
- **For a spouse or state registered domestic partner** of a subscriber, medical coverage will begin the first day of the month in which the event occurs.

If the special open enrollment is due to the enrollment of an **extended dependent or a dependent child with a disability**, medical coverage will begin the first day of the month following the later of the event date or eligibility certification, whichever is later.

E. Making changes

1. Removing a dependent who is no longer eligible

A subscriber must provide notice to remove a dependent who is no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a dependent ceasing to be eligible as a dependent child, as described under "Dependent eligibility." The notice must be received online using Benefits 24/7 or by written request to the PEBB Program within 60 days of the last day of the month the dependent no longer meets the eligibility criteria.

Consequences for not submitting notice within the required 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue PEBB medical under one of the continuation coverage options described in "Options for continuing PEBB medical coverage."
- The subscriber may be billed for claims paid by the medical plan for services that were rendered after the dependent lost eligibility.
- The subscriber may not be able to recover subscriber-paid insurance premiums for the dependent that lost eligibility.

- The subscriber may be responsible for premiums paid by the state for the dependent's medical plan coverage after the dependent lost eligibility.

2. Voluntary termination

An enrolled retiree or survivor may voluntarily terminate enrollment in a medical plan at any time by submitting a request online using Benefits 24/7 or in writing to the PEBB Program. Enrollment in the medical plan will be terminated the last day of the month in which the request is received online or by the PEBB Program, or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, medical plan enrollment will be terminated on the last day of the previous month.

A retiree or a survivor who voluntarily terminates their enrollment in a medical plan also terminates all other health plan enrollment and enrollment for all eligible dependents. Once coverage is terminated, a retiree or a survivor may not enroll again in the future unless they reestablish eligibility for PEBB insurance coverage by becoming newly eligible.

3. Deferring enrollment

An enrolled retiree or survivor may defer enrollment in PEBB retiree insurance coverage at any time by submitting the request online using Benefits 24/7 or the *PEBB Retiree Change Form (form E)* along with any other required forms and supporting documents to the PEBB Program. Enrollment in PEBB retiree insurance coverage will be deferred effective the first of the month following the date the request is received online or by the PEBB Program. If the request is received on the first day of the month, enrollment will be deferred effective that day. A retiree or a survivor who deferred their enrollment may enroll as described in "Enrollment following deferral."

4. Enrollment following deferral

A retiree or a survivor who defers enrollment in PEBB retiree insurance coverage:

- **While enrolled in employer-based group medical or such coverage under COBRA coverage or continuation coverage** may enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after the date their enrollment in employer-based group medical coverage or such coverage under COBRA coverage or continuation coverage ends.
- **While enrolled in a federal retiree medical plan as a retiree or dependent** will have a one-time opportunity to enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after their enrollment in a federal retiree medical plan ends.
- **While enrolled in Medicare Parts A and B and a Medicaid program that provides creditable coverage** may enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after their Medicaid coverage ends, or no later than the end of the calendar year when their Medicaid coverage ends if they were also enrolled in a subsidized Medicare Part D plan.
- **While enrolled in qualified health plan coverage through a health benefit exchange** developed under the Affordable Care Act will have a one-time opportunity to enroll or reenroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after exchange coverage ends.
- **While enrolled in CHAMPVA** will have a one-time opportunity to enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after their enrollment in a CHAMPVA medical plan ends.
- **While enrolled in Medicare and permanently living outside of the United States** and who moves back permanently to the United States, may enroll in a PEBB medical plan during the PEBB

Program's annual open enrollment period, or no later than 60 days after the date of the permanent move or the date the retiree or survivor provides notification of such move, whichever is later.

- **While enrolled as a dependent** in a medical plan sponsored by PEBB or SEBB, including coverage under COBRA or continuation coverage, may enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after the enrollment in a medical plan sponsored by PEBB or SEBB ends, or such coverage under COBRA or continuation coverage ends. The evidence of continuous enrollment required to enroll as described below may include a health plan sponsored by a Washington State educational service district if enrollment was deferred prior to January 1, 2024.

Note: Enrollment in the Kaiser Permanente WA Medicare Advantage with Part D plan may not be retroactive. If a subscriber is eligible for and elects this plan and the online enrollment or the required forms are received by the PEBB Program after the date PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in a transitional Kaiser Permanente WA plan during the gap month(s) prior to when the Kaiser Permanente WA Medicare Advantage with Part D plan begins.

For a retiree or a survivor to enroll in a PEBB medical plan, the enrollment must be completed online using Benefits 24/7 or the PEBB Program must receive a *PEBB Retiree Election Form (form A)*, any other required forms and supporting documents during the timelines described in this section.

A retiree or a survivor who deferred enrollment while enrolled in other qualifying coverage, must also submit evidence of continuous enrollment in one or more qualifying coverages. A gap in coverage of 31 days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualifying coverage, and between each period of enrollment in qualifying coverages during the deferral period.

A retiree or a survivor enrolled in Medicare whose enrollment is deferred while permanently living outside of the United States, and they permanently move back to the United States, must submit proof of enrollment in Medicare Parts A and B; evidence of continuous enrollment in qualified coverage is waived while the retiree or survivor enrolled in Medicare lives outside of the United States.

A retiree or a survivor who deferred their enrollment in PEBB retiree insurance coverage as described above may also enroll in a PEBB medical plan if they receive formal notice that HCA has determined it is more cost-effective to enroll in a PEBB medical plan than a medical assistance program.

A retiree or a survivor should contact the PEBB Program or visit hca.wa.gov/pebb-retirees to get the required forms, information on premiums, and a list of available medical plans.

5. Making changes during annual open enrollment and special open enrollment

A subscriber may make certain changes to their enrollment during the annual open enrollment or when a specific life event creates a special open enrollment period.

6. Annual open enrollment changes

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

- Enroll in a medical plan following a deferral
- Defer or terminate their enrollment in a medical plan
- Enroll or remove eligible dependents
- Change their medical plan

A subscriber must submit the election change online using Benefits 24/7 or submit the required *PEBB Retiree Open Enrollment Election/Change Form (form A-OE)* along with any other required forms, and any supporting documents to the PEBB Program. The change must be completed online, or the forms must be received, no later than the last day of the annual open enrollment period. The change will be effective January 1 of the following year, except when a subscriber chooses to terminate enrollment or remove an eligible dependent, then the change will be effective on December 31.

7. Special open enrollment changes

A subscriber may change their enrollment outside of the annual open enrollment period if a qualifying event creates a special open enrollment period. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, their dependent, or both.

To make an enrollment change, the subscriber must submit the change online using Benefits 24/7 or submit the required *PEBB Retiree Change Form (form E)* along with any other required forms to the PEBB Program. The change must be completed online, or the PEBB Program must receive the forms no later than 60 days after the event that creates the special open enrollment. In many instances, the date the change is received online or the date the form is received affects the effective date of the change in enrollment. Submitting the requested change sooner may avoid a delay in the enrollment or change. In addition, the PEBB Program will require the subscriber to provide proof of the dependent's eligibility, evidence of the event that created the special open enrollment, or both.

Exceptions:

- A subscriber enrolled in PEBB retiree insurance coverage has six months from the date of their or their dependent's enrollment in Medicare Part B to change their enrollment to a PEBB Medicare Supplement Plan. The change must be made online or the PEBB Program must receive the required form(s) no later than six months after the enrollment in Medicare Part B for either the subscriber or their dependent.
- A subscriber enrolled in PEBB retiree insurance coverage has seven months to enroll in a Medicare Advantage Prescription Drug (MAPD) plan or Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP) that begins three months before they or their dependent first enrolled in both Medicare Part A and Part B and ends three months after the month of Medicare eligibility. A subscriber may also enroll themselves or their dependent in a MAPD plan or UMP Classic Medicare with Part D (PDP) before their last day of the Medicare Part B initial enrollment period. The change must be made online using Benefits 24/7 or the forms must be received by the PEBB Program no later than the last day of the month prior to the month the subscriber or their dependent enrolls in the MAPD plan or UMP Classic Medicare with Part D (PDP).
- A subscriber enrolled in PEBB retiree insurance coverage has three months to enroll in a MAPD plan, Medicare Supplement plan, or the UMP Classic Medicare with Part D (PDP), after they or their dependent gain, lose, or have a change in low-income subsidy (LIS) eligibility, or notification of such a change, whichever is later. The change must be made online using Benefits 24/7 or the forms must be received by the PEBB Program, no later than three months after they or their dependent gain, lose, or have a change in LIS eligibility, or notification of such a change, whichever is later.
- If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should complete the request online or notify the PEBB Program by submitting the required form(s) as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the request must be received online, or the required form(s) must be received no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

8. Special open enrollment events that allow for a change in health plans

A subscriber may not change their health plan during a special open enrollment if their state-registered domestic partner or state-registered domestic partner's child is not a tax dependent.

Any of the following events may create a special open enrollment:

- Subscriber gains a new dependent due to:
    - Marriage or registering a state-registered domestic partnership.
    - Birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
    - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber has a change in residence and their current medical plan is no longer available, the subscriber must select a new medical plan. If the subscriber does not elect a new medical plan as required, they will be enrolled in a PEBB medical plan designated by the director of HCA or their designee.
- A court order requires the subscriber or any other individual to individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber or their dependent enrolls in coverage under Medicare, or the subscriber or their dependent loses eligibility for coverage under Medicare or enrolls in or terminates enrollment in a Medicare Advantage Prescription Drug or a Part D plan. If the subscriber's current medical plan becomes unavailable due to the subscriber or their dependents enrollment in Medicare, the subscriber must select a new medical plan.
- Subscriber or their dependent gains, loses, or has a change in low-income subsidy eligibility.
- Subscriber or their dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA).
- Subscriber or their dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent. The subscriber may not change their health plan election because the subscriber or dependent's physician stops participation with the subscriber's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but not limit its consideration to the following:
    - Active cancer treatment, such as chemotherapy or radiation therapy
    - Treatment following a recent organ transplant
    - A scheduled surgery

- Recent major surgery still within the postoperative period
- Treatment for a high-risk pregnancy

- The PEBB Program determines that there has been a substantial decrease in the providers available under a PEBB medical plan.

Note: The plan cannot guarantee that any physician, hospital, or other provider will be available or remain under contract with the plan. An enrollee may not change medical plans simply because their provider or health care facility discontinues participation with this medical plan until the PEBB Program's next annual open enrollment or when another qualifying event creates a special open enrollment for changing health plans, unless the PEBB Program determines that a continuity of care issue exists or there has been a substantial decrease in the providers available under the plan.

9. Special open enrollment events that allow adding or removing a dependent

Any of the following events may create a special open enrollment:

- Subscriber gains a new dependent due to:
  - Marriage or registering a state-registered domestic partnership.
  - Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption.
  - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP) or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber's dependent enrolls in Medicare or loses eligibility for Medicare.
- Subscriber or their dependent enrolled in a Medicare Advantage Prescription Drug plan, Medicare Supplement plan, or the Uniform Medical Plan Classic Medicare with Part D (PDP) who gains, loses, or has a change to their low-income subsidy eligibility.

F. When medical coverage ends

1. Termination dates

Medical coverage ends on the following dates:

- On the last day of the month when any enrollee ceases to be eligible.
- On the date a medical plan terminates due to a change in contracted service area or when the group policy ends. If that should occur, the subscriber will have the opportunity to enroll in another PEBB medical plan.
- On the last day of the month in which the monthly premium and applicable premium surcharges were paid.
- The first of the month following the date the election is received online using Benefits 24/7 or the required forms are received by the PEBB Program when an enrolled retiree or survivor requests to defer enrollment in PEBB retiree insurance coverage. If the election is received on the first day of the month, enrollment will be deferred effective that day.
- The last day of the month in which the request is received online using Benefits 24/7 or the PEBB Program receives a written request and all required forms requesting to voluntarily terminate enrollment in a medical plan. If a future date is specified, medical coverage terminates the last day of the month specified. If the termination request is received on the first day of the month, medical plan enrollment will be terminated on the last day of the previous month.

A subscriber will be responsible for payment of any services received after the date medical coverage ends, as described above.

2. Final premium payments

The subscriber is responsible for timely payment of premiums and applicable premium surcharges. Premium payments and applicable premium surcharges are not prorated during any month, for any reason, even if an enrollee dies or asks to terminate their medical plan before the end of the month.

An exception occurs when an enrolled retiree dies, in which case, HCA will waive the premium payment for medical, dental, vision, and any applicable premium surcharges for the retiree for the month in which the death occurred.

If the monthly premium or applicable premium surcharges remain unpaid for 30 days, it will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premium or applicable premium surcharges become delinquent to pay the unpaid premium balance or applicable premium surcharges. If the subscriber's premium balance or applicable premium surcharges remain unpaid for 60 days from the original due date, coverage will be terminated retroactive to the last day of the month for which the monthly premium and any applicable premium surcharges were paid.

3. If an enrollee is hospitalized

An enrollee who is receiving covered services in a hospital on the date medical coverage ends will continue to be eligible for covered services while an inpatient for the condition which the enrollee was hospitalized, until one of the following events occur:

- According to this plan's clinical criteria, it is no longer medically necessary for the enrollee to be an inpatient at the facility.
- The remaining benefits available for the hospitalization are exhausted, regardless of whether a new calendar year begins.

- The enrollee becomes covered under another agreement with a group health plan that provides benefits for the hospitalization.
- The enrollee becomes enrolled under an agreement with another carrier that provides benefits for the hospitalization.

This provision will not apply if the enrollee is covered under another agreement that provides benefits for the hospitalization at the time medical coverage ends, except as set forth in this section, or if the enrollee is eligible for PEBB Continuation Coverage as described in "Options for continuing PEBB medical coverage."

4. Options for continuing PEBB medical coverage

A subscriber and their dependents covered by this medical plan may be eligible to continue enrollment under PEBB Continuation Coverage (COBRA) if they lose eligibility. PEBB Continuation Coverage (COBRA) temporarily extends group insurance coverage if certain circumstances occur that would otherwise end the subscriber's or their dependent's PEBB medical coverage. PEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal COBRA laws and regulations and also includes coverage for some enrollees who are not qualified beneficiaries under federal COBRA continuation coverage. Refer to the *PEBB Continuation Coverage Election Notice* for details.

A subscriber and their dependents covered by this medical plan who lose eligibility for PEBB retiree insurance coverage when their employer group ends participation with the Health Care Authority, may be eligible to continue their enrollment under PEBB Continuation Coverage (Employer Group Ended Participation).

The PEBB Program administers these coverages. Call the PEBB Program at 1-800-200-1004 (TRS: 711) for details.

5. Options for continuing coverage under PEBB Retiree Insurance Coverage

A dependent becoming eligible as a survivor of a retiree is eligible to continue enrollment or defer enrollment in PEBB retiree insurance coverage if they meet procedural and substantive eligibility requirements. See the *PEBB Retiree Enrollment Guide* for details.

6. Conversion of coverage

An enrollee (including a dependent of a subscriber terminated for cause) has the right to switch from PEBB group medical to an individual conversion plan offered by this plan when they are no longer eligible to continue the PEBB group medical plan and are not eligible for Medicare or covered under another group insurance coverage that provides benefits for hospital or medical care.

An enrollee must apply for conversion coverage and pay the first month's premium no later than 31 days after their PEBB group medical plan ends or within 31 days from the date the notice of termination of coverage is received, whichever is later. The conversion coverage will become effective immediately following termination of coverage under the PEBB group medical plan.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage, and eligibility requirements of this conversion plan differ from those of the enrollee's current group medical plan. To receive detailed information on conversion options under this medical plan, call us at (206) 630-4636 in the Seattle area, or toll-free in Washington, 1888-901-4636.

G. General provisions for eligibility and enrollment

1. Termination for just cause

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

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

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

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

H. Appeal rights

Any enrollee may appeal a decision made by the PEBB Program regarding PEBB eligibility, enrollment, premium payments, or premium surcharges to the PEBB Appeals Unit.

Learn more at hca.wa.gov/pebb-appeals.

Fax: 360-763-4709

Mail: Health Care Authority
Attn: PEBB Appeals Unit
PO Box 45504
Olympia, WA 98504-5504

Hand deliver: Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

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

I. Relationship to law and regulations

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

J. PEBB customer service

For questions about PEBB retiree eligibility and enrollment, please call the PEBB Program at 1-800-200-1004 (TRS:711) or visit hca.wa.gov/pebb-retirees.

For questions about Medicare, please call the Centers for Medicare and Medicaid Services (CMS) at 1-800-MEDICARE or visit medicare.gov.

VIII. Grievances

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

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

Step 2: If the Enrollee is still not satisfied, they should write to Member Services at P.O. Box 34590, Seattle, WA 98124-1590, or call at 206-630-4636 or toll-free 1888-901-4636. Most concerns are handled by phone within a few days. In some cases, the Enrollee will be asked to write down their concerns and state what they think would be a fair resolution to the problem. An appropriate representative will investigate the Enrollee's concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Enrollee Rights and Responsibilities statement. This process can take up to 30 days to resolve after receipt of the Enrollee's written or verbal statement.

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

IX. Appeals

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

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

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

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

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

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

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

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

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

2. Next Level of Appeal

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

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

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

X. Claims

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

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

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

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

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

XI. Coordination of Benefits

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

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

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

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

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

Definitions.

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

   1. Plan includes: group, individual or blanket disability insurance contracts and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts,

such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans; unless permitted by law.

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

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

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

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

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

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

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

2. If an Enrollee is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

3. If an Enrollee is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

4. An expense or a portion of an expense that is not covered by any of the plans covering the person is not an allowable expense.

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

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

Order of Benefit Determination Rules.

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

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

B. (1) Except as provided below (subsection 2), a plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both plans state that the complying plan is primary.

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

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

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

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

2. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:
   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
      - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
   b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;
      ii. If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

iii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of a) above determine the order of benefits;
iv. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subsection a) above determine the order of benefits; or
v. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
- The plan covering the custodial parent, first;
- The plan covering the spouse of the custodial parent, second;
- The plan covering the non-custodial parent, third; and then
- The plan covering the spouse of the non-custodial parent, last.

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

3. Active employee or retired or laid-off employee. The plan that covers an Enrollee as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same Enrollee as a retired or laid off employee is the secondary plan. The same would hold true if an Enrollee is a Dependent of an active employee and that same Enrollee is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If an Enrollee whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the Enrollee as an employee, member, Subscriber or retiree or covering the Enrollee as a Dependent of an employee, member, Subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D.1. can determine the order of benefits.

5. Longer or shorter length of coverage. The plan that covered the Enrollee as an employee, member, Subscriber or retiree longer is the primary plan and the plan that covered the Enrollee the shorter period of time is the secondary plan.

6. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

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

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

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

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

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

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

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

XII. Subrogation and Reimbursement Rights

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

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

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

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

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

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

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

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

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

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

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

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

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

XIII. Definitions

Allowance	The maximum amount payable by KFHPWA for certain Covered Services.
Allowed Amount	The level of benefits which are payable by KFHPWA when expenses are incurred from a non-Network Provider. Expenses are considered an Allowed Amount if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies. Enrollees shall be required to pay any difference between a non-Network Provider's charge for services and the Allowed Amount, except for ground ambulance services and Emergency services, including post stabilization and for ancillary services received from an out of network provider in a network facility. For more information about balance billing protections, please visit: https://healthy.kaiserpermanente.org/washington/support/forms and click on the "Billing forms" link.
Annual Open Enrollment	A period of time defined by HCA when a Subscriber may change to another health plan offered by the PEBB Program and make certain other account changes for an effective date beginning January 1 of the following year.
Care Chat	Care available online at www.kp.org/wa or through the KP mobile application. Chat with a Kaiser Permanente clinician to receive immediate care, treatment and prescriptions.
Consulting Nurse Service	Advice available 24-hours a day by talking on the phone with a licensed care nurse.
Continuation Coverage	Temporary continuation of PEBB benefits available to Enrollees under the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), or PEBB policies.
Convalescent Care	Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in walking, dressing, bathing, eating, preparation of special diets, and taking medication.
Copayment	The specific dollar amount an Enrollee is required to pay at the time of service for certain Covered Services.
Cost Share	The portion of the cost of Covered Services for which the Enrollee is liable. Cost Share includes Copayments, coinsurances and Deductibles.
Covered Services	The services for which an Enrollee is entitled to coverage in the EOC.
Creditable Coverage	Coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, the actuarial determination measures whether the expected amount of paid claims under KFHPWA's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.
Deductible	A specific amount an Enrollee is required to pay for certain Covered Services before benefits are payable.

Dependent	Any member of a Subscriber's family who meets all applicable eligibility requirements as described in the "Dependent Eligibility" section of this EOC, is enrolled hereunder and for whom the premium has been paid.
Emergency	The emergent and acute onset of a medical, mental health or substance use disorder symptom or symptoms, including but not limited to severe pain or emotional distress, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily function or serious dysfunction of a bodily organ or part, or would place the Enrollee's health, or if the Enrollee is pregnant, the health of the unborn child, in serious jeopardy, or any other situations which would be considered an emergency under applicable federal or state law.
Employer Group	For the Public Employees Benefits Board (PEBB) Program means those counties, municipalities, political subdivisions, the Washington health benefits exchange, tribal governments, and employee organizations representing state civil service employees obtaining employee benefits through a contractual agreement with the Health Care Authority (HCA) to participate in benefit plans developed by the PEB board. For the School Employees Benefits Board (SEBB) Program means an employee organization representing school employees and a tribal school as defined in Washington state statute, obtaining school employee benefits through a contractual agreement with the Health Care Authority (HCA) to participate in benefit plans developed by the SEB board.
Employing Agency	A division, department, or separate agency of state government, including an institution of higher education; a county, municipality, or other political subdivision; and a tribal government covered by HCA statute.
Enrollee	Any enrolled Subscriber or Dependent.
Essential Health Benefits	Benefits set forth under the Patient Protection and Affordable Care Act of 2010, including the categories of ambulatory patient services, Emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.
Established Relationship	Enrollee must have had at least one in-person appointment or at least one real-time interactive appointment using both audio and visual technology within the last 3 years, with the provider providing audio only telemedicine or with a provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by KFHPWA. Or the Enrollee was referred to the provider providing audio-only telemedicine by a provider who they have had an in-person appointment within the past 3 years.
Evidence of Coverage (EOC)	The EOC is a statement of benefits, exclusions and other provisions as set forth in the Group medical coverage agreement between KFHPWA and the Group.
Family Unit	A Subscriber and all their Dependents.
Group	An employer, union, welfare trust or bona-fide association which has entered into a Group medical coverage agreement with KFHPWA.

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

	Group, P.C., and any other health care professional or provider with whom KFHPWA has contracted to provide health care services to Enrollees, including, but not limited to physicians, podiatrists, nurses, physician assistants, social workers, optometrists, psychologists, physical therapists and other professionals engaged in the delivery of healthcare services who are licensed or certified to practice in accordance with Title 18 Revised Code of Washington.
Out-of-pocket Expenses	Those Cost Shares paid by the Subscriber or Enrollee for Covered Services which are applied to the Out-of-pocket Limit.
Out-of-pocket Limit	The maximum amount of Out-of-pocket Expenses incurred and paid during the calendar year for Covered Services received by the Subscriber and their Dependents within the same calendar year. The Out-of-pocket Expenses which apply toward the Out-of-pocket Limit are set forth in Section IV.
Plan Coinsurance	The percentage amount the Enrollee is required to pay for Covered Services received.
Preauthorization	An approval by KFHPWA that entitles an Enrollee to receive Covered Services from a specified health care provider. Services shall not exceed the limits of the Preauthorization and are subject to all terms and conditions of the EOC. Enrollees who have a complex or serious medical or psychiatric condition may receive a standing Preauthorization for specialty care provider services.
Private Duty Nursing (or 24-hour nursing care)	The hiring of a nurse by a family or Member to provide long term and/or continuous one on one care with or without oversight by a home health agency. The care may be skilled, supportive or respite in nature.
Public Employees Benefits Board (PEBB)	A group of representatives, appointed by the governor, who approves insurance benefit plans for employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.
Public Employees Benefits Board (PEBB) Program	Is the HCA program that administers PEBB benefit eligibility and enrollment.
Residential Treatment	A term used to define facility-based treatment, which includes 24 hours per day, 7 days per week rehabilitation. Residential Treatment services are provided in a facility specifically licensed in the state where it practices as a residential treatment center. Residential treatment centers provide active treatment of patients in a controlled environment requiring at least weekly physician visits and offering treatment by a multi-disciplinary team of licensed professionals.
Retired Employee of a Former Employer Group	Includes a retired employee of a PEBB Employer Group and a retired school employee of a SEBB Employer Group continuing enrollment in PEBB health plan coverage after losing eligibility for PEBB retiree insurance coverage upon the Employer Group ending participation in insurance plans and contracts with the Health Care Authority (HCA).
School Employees Benefits Board (SEBB)	A group of representatives, appointed by the governor, who designs and approves insurance benefit plans for school employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.
School Employees Benefits Board (SEBB) Organization	A public school district or educational service district or charter school established under Washington state statute that is required to participate in benefit plans provided by the School Employees Benefits Board (SEBB).

School Employees Benefits Board (SEBB) Program	Is the program within HCA that administers insurance and other benefits for eligible school employees, eligible dependents, and eligible school board members.
Service Area	Washington counties of Benton, Columbia, Franklin, Island, King, Kitsap, Lewis, Mason, Pierce, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman and Yakima.
State Agency	An office, department, board, commission, institution, or other separate unit or division, however designated, of the Washington state government. It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.
Subscriber	An employee, retired employee of a former employer group, continuation coverage enrollee, retiree, or a survivor who has been determined eligible and is enrolled in this plan, and is the individual to whom the PEBB Program or KFHPWA will issue notices, requests, and premium bills on behalf of an Enrollee.
Urgent Condition	The sudden, unexpected onset of a Medical Condition that is of sufficient severity to require medical treatment within 24 hours of its onset.