The Honorable Robert S. Lasnik

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

ANDREA SCHMITT; ELIZABETH MOHONDRO; and O.L. by and through her parents, J.L. and K.L., each on their own behalf, and on behalf of all similarly situated individuals, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN OF WASHINGTON; KAISER FOUNDATION HEALTH PLAN OF WASHINGTON OPTIONS, INC.; KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST; and KAISER FOUNDATION HEALTH PLAN, INC., Defendants.	NO. 2:17-cv-01611-RSL **FOURTH AMENDED COMPLAINT (CLASS ACTION)**

I. INTRODUCTION

1. An estimated 48 million Americans have a hearing loss that measurably interferes with their ability to understand speech. The vast majority of those people take no action – indeed, most are likely unaware that they have a deficit. Others, though, experience a reduction in their ability to undertake important daily activities, and seek

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to remedy that situation through an evaluation for, and fitting of, hearing aids and/or other treatment.

2. Hearing aids improve health and life for many people. People who wear hearing aids do so because they find that otherwise, they are significantly limited in their ability to work, participate in daily activities or to engage socially. They are rarely, if ever, sought unnecessarily because hearing aids are not comfortable, affordable, or stylish. Indeed, they are highly stigmatized as associated with old age and disability. Virtually everyone who obtains professionally prescribed and fitted hearing aids is a person with a disability within the meaning of the Affordable Care Act's Section 1557, which incorporates, through Section 504, the definitions of disability found in the Americans with Disabilities Act as amended in 2008.

3. Health policies issued by defendants Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of Washington Options, Inc., Kaiser Foundation Health Plan of the Northwest, and Kaiser Foundation Health Plan, Inc. ("Kaiser") specifically exclude coverage for all treatment associated with hearing loss (*i.e.,* hearing aids, examinations and associated services) except for cochlear implants. (Hereinafter the "Hearing Loss Exclusion" or "Exclusion"). Plaintiffs initially alleged that the Exclusion violates Section 1557 of the Affordable Care Act, which bars health insurers from discriminating on the basis of disability. This Court granted defendants' motion to dismiss without leave to amend, reasoning that the Exclusion is not discriminatory because it applies both to people whose hearing loss would qualify as a disability and to people without a hearing disability.

4. The Ninth Circuit reversed and remanded the case with a directive that plaintiffs be allowed to amend to show "that the [E]xclusion is likely to predominately affect disabled persons," *Schmitt v. Kaiser,* 965 F.3d 945, 959, n. 8 (9th Cir. 2020), and that

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coverage for cochlear implants fails to meet the needs of most people with hearing loss. *Id.* at 959. For reasons set forth in this Amended Complaint, plaintiffs allege that virtually all people who wear professionally prescribed hearing aids are "disabled" under the pertinent federal definition, and that very few of those individuals with disabling hearing loss can have their needs met by treatment with cochlear implants.

5. Since this case was originally filed, the Washington Legislature has passed its own broad anti-discrimination statute that applies to health care plan design, RCW 48.43.0128. This statute prohibits all non-grandfathered health plans from discriminating on the basis of "present or predicted disability," or "health condition," in the design of benefits. *Id.* In 2020, the provision was expanded from individual and small group plans to all "non-grandfathered" health plans, with an effective date of June 11, 2020. *Id.* The statute is an additional "term" of the Kaiser's health plans in Washington. *See* RCW 48.18.510. Accordingly, plaintiffs plead an additional Breach of Contract claim due to Kaiser's ongoing violation of RCW 48.43.0128.

II. PARTIES

6. ***Andrea Schmitt***. Plaintiff Andrea Schmitt is diagnosed with disabling hearing loss. Schmitt is insured under a Kaiser Foundation Health Plan of Washington insured health plan that was issued and delivered in King County, Washington. Schmitt's health coverage is through her employment at Columbia Legal Services, which is headquartered in Seattle, Washington.

7. ***Elizabeth Mohundro.*** Plaintiff Elizabeth Mohundro is diagnosed with disabling hearing loss. Mohundro was insured under a Kaiser Foundation Health Plan of Washington Options Inc. health plan that was issued and delivered in King County Washington. Mohundro's coverage was through her employment at World Association for Children and Parents (WACAP), a nonprofit international adoption and child

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assistance agency headquartered in Renton, Washington. On April 1, 2019, WACAP merged with another agency named Holt International Children's Services. As a result of the merger, her health coverage was changed from Kaiser to Providence Health Plan.

8. ***O.L. by and through her parents J.L. and K.L.*** Plaintiff O.L. is a twelve-year old child with disabling hearing loss. O.L. is insured in a Kaiser Foundation Health Plan of Washington Options, Inc. health plan issued and delivered in Seattle, Washington through her mother's employment at Richmark Label, a Seattle label manufacturer.

9. ***Kaiser.*** Defendants Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of Washington Options, Inc. and Kaiser Foundation Health Plan of the Northwest are health care service carriers that do business in the state of Washington. Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options do business in King County, Washington. Based on information and belief, all three are wholly-owned subsidiaries of Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. For the purpose of this Complaint, all are referred to as a single defendant, "Kaiser."

III. JURISDICTION AND VENUE

10. This action arises under the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA") § 1557, 42 U.S.C. § 18116.

11. Jurisdiction of this Court also arises pursuant to 28 U.S.C. §§ 1331, 1343. Jurisdiction for Plaintiffs' breach of contract claim arises under 28 U.S.C. § 1367.

12. Venue is proper under 28 U.S.C. § 1391(b)(1) and (2), because, *inter alia*, a defendant resides or may be found in this district and a substantial part of the events giving rise to the claims occurred in King County, Washington.

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IV. NATURE OF THE CASE

13. Plaintiffs seek to end Kaiser's standard discriminatory practice of generally excluding benefits for treatment of hearing loss, except for cochlear implants. Specifically, when this lawsuit was filed, Kaiser's insured health plans in Washington contain the following benefit exclusion:

Hearing Examinations and Hearing Aids	**Preferred Provider Network**	**Out of Network**
Hearing aids including hearing aid examinations.	Not covered; ***Member pays 100%*** of all charges	Not covered; ***Member pays 100%*** of all charges
Exclusions: ***Programs or treatments for hearing loss*** or hearing care including, but not limited to, externally worn hearing aids or surgically implanted hearing aids and the surgery and services necessary to implant them other than for cochlear implants; hearing screening tests including but not limited to non-cochlear hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them other than for cochlear implants; hearing screening tests required under Preventive Services.		

See Dkt. No. 18, pp. 29 of 66 (emphasis in original and added). (In this Complaint, the condition is referred hereafter to as "Hearing Loss" and Kaiser's exclusion as the "Hearing Loss Exclusion.") Kaiser excludes benefits for Hearing Loss even when the treatment is medically necessary to treat qualified individuals with disabilities such as the named Plaintiffs. Kaiser applies its Hearing Loss Exclusion even though it covers the same benefits for other health conditions, including coverage of outpatient office visits and durable medical equipment or prosthetic devices.

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14. In Kaiser's 2020 health plan issued to Plaintiff Schmitt, the Exclusion is worded differently but has essentially the same effect:[1]

Hearing Examinations and Hearing Aids	**Preferred Provider Network**	**Out of Network**
Hearing exams for hearing loss and evaluation and diagnostic testing for cochlear implants. Cochlear implants or Bone Anchor Hearing Aids (BAHA) when in accordance with KFHPWAO clinical criteria. Covered services for cochlear implants and BAHA include implant surgery, pre-implant testing, post implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable and batteries).	**Hospital – Inpatient:** After Deductible, Member pays 10% of Plan Coinsurance **Hospital – Outpatient:** After Deductible, Member pays 10% of Plan Coinsurance **Outpatient Services:** Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits All other services including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit:	**Hospital – Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Hospital – Outpatient:** After Deductible, Member pays 50% of Plan Coinsurance

[1] The key difference is that in the 2020 Kaiser plan, Kaiser now covers Bone Anchored Hearing Aids ("BAHAs") in addition to cochlear implants. *See* ***Appendix A***, p. 28.

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	Office visits: Member pays $10 Copayment for primary care Provide office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services, After Deductible, Member pays 10% Plan Coinsurance	
Hearing aids including hearing aid examinations	Not covered; Member pays 100% of all charges	Not covered; Member pays 100% of all charges
Exclusions: Hearing care, routine hearing examinations, programs or treatments for hearing loss including but not limited to, externally worn hearing aids or surgically implanted hearing aids, and the surgery and services necessary to implant them except as described above, and hearing screening tests required under Preventive Services.		

See ***Appendix A,*** pp. 28-29. Kaiser excludes benefits for Hearing Loss even when the treatment is medically necessary to treat qualified individuals with disabilities such as the named Plaintiffs. Kaiser applies its Hearing Loss Exclusion even though it covers the same benefits for other health conditions, including coverage of outpatient office visits and durable medical equipment or prosthetic devices.

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15. By excluding coverage of all treatment for hearing loss (except for cochlear implants and, according to the 2020 Kaiser Plan, BAHAs), Kaiser engages in illegal disability discrimination. The Affordable Care Act prohibits discrimination on the basis of disability by covered entities, including health insurers like Kaiser. *See* 42 U.S.C. § 18116. Specifically, Section 1557 provides that "an individual shall not, on the ground prohibited under … Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) be excluded from participation in, ***denied the benefits of*** or be subjected to discrimination under ***any health program*** or activity…." 42 U.S.C. § 18116(a) (emphasis added).

16. Kaiser is a covered "health program or activity" that must comply with the Affordable Care Act's § 1557.

17. Kaiser violates § 1557 and engages in illegal discrimination on the basis of disability by designing its health plans to include the Hearing Loss Exclusion.

18. Kaiser's Hearing Loss Exclusion was an intentional, deliberate act. It was done without evaluating the service for efficacy, medical necessity or whether it is experimental or investigational, as Kaiser does with other excluded services.

19. This lawsuit seeks remedies under the Affordable Care Act arising out of Kaiser's failure to comply with § 1557. It seeks a court order declaring Kaiser's Hearing Loss Exclusion void and unenforceable, enjoining Kaiser from continuing to apply the Exclusion and requiring corrective notice to all Kaiser insureds concerning its required coverage of Hearing Loss. It also seeks damages stemming from Kaiser's deliberate discriminatory exclusion of medically necessary care that, but for the application of its Exclusion, would otherwise be covered.

20. Kaiser's Hearing Loss Exclusion also violates Washington's "mini-Section 1557," RCW 48.43.0128. The Washington statute prohibits Kaiser from applying in its non-grandfathered health plans any benefit design that discriminates on the basis of

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disability or health condition. *Id.* This state law enters into the Kaiser contracts of insurance and eliminates all non-conforming terms, such as the Hearing Loss Exclusion. RCW 48.18.510.

21. This lawsuit also alleges that Kaiser breached its contract with Plaintiffs and the proposed class when it failed to modify its non-grandfathered health plans, including those in which Plaintiffs are enrolled, to comply with RCW 48.43.0128, by eliminating the Hearing Loss Exclusion.

V. CLASS ALLEGATIONS

22. ***Definition of Class***. The class consists of all individuals who:

> (1) have been, are or will be insured under a health insurance plan that has been, is or will be delivered, issued for delivery, or renewed by (a) Kaiser; (b) any affiliate of Kaiser; (c) predecessors or successors in interest of any of the foregoing; and (d) all subsidiaries or parent entities of any of the foregoing, at any time on or after October 30, 2014 and excluding Medicare Advantage plans; and
>
> (2) have required, require or will require treatment for Hearing Loss other than treatment associated with cochlear implants, or treatment associated with Bone Anchored Hearing Aids (BAHAs) after Kaiser began to provide coverage for BAHAs.

23. ***Size of Class***. The class of Kaiser insureds who have required, require or will require treatment for Hearing Loss, excluding treatment associated with cochlear implants and for BAHAs, after Kaiser began providing such coverage, is so numerous that joinder of all members is impracticable.

24. ***Class Representatives Schmitt, Mohundro and O.L.*** At all relevant times, named plaintiffs Schmitt, Mohundro and O.L. were enrollees in a Kaiser insured health plan in the State of Washington. Plaintiffs Schmitt and O.L. remain enrolled in a Kaiser insured health plan. All have disabling Hearing Loss that requires treatment other than

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with cochlear implants or BAHAs. All are "qualified individuals with a disability" under the Affordable Care Act and Section 504 of the Rehabilitation Act. All require outpatient office visits (such as to licensed audiologists) and durable medical equipment and/or prosthetic devices (such as hearing aids) to treat their Hearing Loss. Consistent with the written language of the policy, Kaiser confirmed to each Plaintiff that they had no coverage for all benefits for Hearing Loss (except that related to cochlear implants) including coverage of hearing aids and outpatient office visits to the audiologist because of Kaiser's Hearing Loss Exclusion. Nonetheless, Plaintiffs Mohundro and O.L. presented claims for treatment for hearing loss to Kaiser, which were denied by Kaiser under the Hearing Loss Exclusion. Plaintiffs' claims are typical of the claims of the other members of the class. Plaintiffs Schmitt, Mohundro and O.L., by and through her parents J.L. and K.L. will fairly and adequately represent the interests of the class.

25. ***Common Questions of Law and Fact***. This action requires a determination of whether Kaiser's Hearing Loss Exclusion violates the requirements of the Affordable Care Act's § 1557 and discriminates against Plaintiffs on the basis of their disability, Hearing Loss. Adjudication of this issue will in turn determine whether Kaiser may be enjoined from enforcing the Hearing Loss Exclusion, and found liable under the Affordable Care Act for injunctive relief, classwide damages and other relief. This action further requires a determination of whether Kaiser's Hearing Loss Exclusion violates the requirements of RCW 48.43.0128 and discriminates against Plaintiffs on the basis of their disability. Finally, this action requires a determination of whether Kaiser breached its contracts with Plaintiffs and the class by designing and applying a written exclusion that is rendered void and unenforceable by RCW 48.18.200(2), RCW 48.43.0128, and other Washington law.

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26. ***Kaiser Has Acted on Grounds Generally Applicable to the Class.*** Kaiser, by imposing a uniform exclusion of all coverage for Hearing Loss except for cochlear implants and BAHAs, after Kaiser began providing such coverage, has acted on grounds generally applicable to the class, rendering declaratory relief appropriate respecting the whole class. Certification is therefore proper under FRCP 23(b)(2).

27. ***Questions of Law and Fact Common to the Class Predominate Over Individual Issues.*** The claims of the individual class members are more efficiently adjudicated on a classwide basis. Any interest that individual members of the class may have in individually controlling the prosecution of separate actions is outweighed by the efficiency of the class action mechanism. Upon information and belief, there has been no class action suit filed against these defendants for the relief requested in this action. This action can be most efficiently prosecuted as a class action in the Western District of Washington, where several of the Kaiser defendants have their principal place of business, do business, and where the disputed health insurance plans were issued. Plaintiffs also reside in the Western District of Washington. Issues as to Kaiser's conduct in applying standard policies and practices towards all members of the class predominate over questions, if any, unique to members of the class. Certification is therefore additionally proper under FRCP 23(b)(3).

28. ***Class Counsel***. Plaintiffs have retained experienced and competent class counsel.

VI. FACTUAL BACKGROUND

A. Kaiser's Hearing Loss Exclusion Predominately Affects Disabled Persons

1. Hearing Aids Under Washington Law

29. Washington state law defines "hearing instrument," as "any wearable prosthetic instrument or device designed for or represented as aiding, improving,

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compensating for, or correcting defective human hearing and any parts, attachments, or accessories of such an instrument or device," RCW 18.35.010(12). "Hearing instruments" are different from volume-amplifying "assistive listening systems," RCW 18.35.010(1). Hearing aids are "hearing instruments" within the meaning of Washington law.

30. The fitting and dispensing of hearing instruments is limited by law to licensed audiologists and licensed hearing-aid specialists. RCW 18.35.020. Audiologists must have doctoral-level education and experience, https://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/Audiologist/LicenseRequirements (last visited 10/9/20) Hearing-aid specialists must have two years of college-level education plus supervised experience, RCW 18.35.040, and pass a state-mandated examination, RCW 18.35.070. Both licensed audiologists and hearing-aid specialists are defined as "hearing health care professionals." RCW 18.35.010(11).

31. For purposes of this Complaint, "hearing instrument" and "hearing aid" are used interchangeably to mean devices prescribed by hearing health-care professionals, and do not include self-prescribed and self-fitted products such as Personal Sound Amplification Products (PSAPs) or over-the-counter products marketed as "hearing aids."

2. **The Definition of Disability Under Federal and State Law**

32. For purposes of § 1557, disability" is defined and construed according to Section 504 of the Rehabilitation Act, which, in turn "incorporates the definition of disability in the Americans with Disabilities Act (ADA), as amended." 45 C.F.R. § 92.102(c).

33. The Americans with Disabilities Act, 42 U.S.C. § 12101 *et seq.*, as amended in 2008, defines "disability" as "a physical or mental impairment that substantially limits one or more major life activities ***of such individual,***" 42 U.S.C. § 12102(1)(A) (emphasis

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added), a singular and specific reference to activities actually undertaken by the individual in question.

34. "Major life activities" include, among other things, "hearing, communicating and working." 42 U.S.C. § 12102(2)(A).

35. The presence of a disability is to be assessed "without regard to the ameliorative effects of mitigating measures such as … hearing aids or cochlear implants." 42 U.S.C. § 12102(4)(E)(i)(I). The question in assessing a hearing disability under the ADA is not what the person can do with hearing aids, but rather, what the person ***cannot do without*** hearing aids.

36. The applicable regulations state that the term "substantially limits" is to be construed "broadly," is not meant to be a "demanding standard," 29 C.F.R. § 1630.2(j)(1)(i).

37. The definition of "disability" under Washington law is broader than the ADA definition. *See* RCW 49.60.040(7)(a) ("Disability means the presence of a sensory, mental or physical impairment that: (i) [i]s medically cognizable or diagnosable; or (ii) [e]xists as a record or history; or (iii) [i]s perceived to exist whether or not it exists in fact.").

38. Under Washington law, a diagnosis with hearing loss is a "disability" because it is a physiological disorder or condition that affects the body systems listed in RCW 49.60.040(7)(c)(i). *See Taylor v. Burlington N. R.R. Holdings, Inc.*, 193 Wn.2d 611, 617, 444 P.3d 606 (2019).

39. Under both the federal and Washington definitions of "disability," Plaintiffs Schmitt, Mohundro and O.L. are "disabled" due to their hearing loss.

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3. Hearing and Hearing Loss

40. Hearing involves a complex process by which sound waves are converted to vibrations that are transmitted through the eardrum to the middle-ear bones, then to the fluid-filled cochlea in the inner ear. The cochlea contains tiny hair cells that respond to specific frequencies and emit microscopic electrical impulses to the auditory nerve, from which the brain decodes the sound. https://www.asha.org/public/hearing/How-We-Hear/ (last visited 10/13/20). Hearing loss is the result of damage to one or more of those components. https://www.asha.org/public/hearing/Types-of-Hearing-Loss/. (last visited 10/13/20).

41. A common preliminary screening for hearing loss is a pure-tone test, in which subjects are presented with tones at different frequencies (pitches), measured in Hertzes (Hz), at increasing volume, measured in decibels (dB). The subjects are asked to indicate when they hear those tones. The threshold loudness at which a tone becomes audible is recorded on an audiogram. https://www.asha.org/public/hearing/audiogram/ (last visited 10/13/20).

42. The critical metric from an audiogram is the average decibel threshold in the frequencies involving speech, which are the frequencies of 500, 1,000, 2,000 and 4,000 cycles per second, measured in Hertzes (Hz).

43. The generally accepted standard for normal hearing is a threshold of 25 dB. If the tones must be louder than 25dB to be audible, the subject has worse-than-normal hearing. An average decibel threshold greater than 25 dB in the speech frequencies is generally considered the point at which "hearing loss begins to impair communication in daily life," Lin, et al., *Hearing Loss Prevalence in the United States,* Archives of Internal Medicine Vol. 14, No. 20 at pp. 1831-32, Nov. 14 (2011). https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1106004 (last visited 10/13/20). Extrapolating from actual audiograms of a large and randomly selected population, Lin

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et al. estimate that 48 million Americans age 12 and over have impairing hearing loss in at least one ear. The prevalence of hearing loss, and particularly sensorineural hearing loss ("SNHL"), is age-related, increasing from relatively small numbers in the 12-19 age band (approximately 100,000 people nationally) to 5.7 million people age 60-69. *Id.*

44. Based on information and belief, the proposed class includes few if any individuals over the age of 65, since most, if not all, of Washington insured Kaiser enrollees lose their private Kaiser coverage when they become eligible for Medicare, even if they transfer to a Kaiser Medicare Advantage plan.

45. There are varying degrees of hearing loss, ranging from mild to profound. An individual with a speech-frequency average decibel threshold of 25-40 dB is classified as having a mild loss, and may have some difficulty hearing softly voiced sounds. A person with a moderate loss (40-70dB) will have difficulty understanding speech at normal levels, a person with a severe loss (70-90dB) will hear almost no speech and a person with a profound loss (greater then 90dB) will hear almost nothing. https://www.cdc.gov/ncbddd/hearingloss/types.html (last visited 10/13/20).

46. Most people significantly underestimate their own degree of hearing loss because they have no way of knowing what they are not hearing, unless informed by others. Based on self-reports from large-sample interviews, the U.S. Census Bureau estimates that just under 9.2 million Americans under age 65 self-reported having "serious" difficulty hearing, including 3.6 million adults who self-report as being deaf. https://www.census.gov/content/dam/Census/library/publications/2018/demo/p70-152.pdf (last visited 10/13/20) (explanatory text at p.7 and charts on pp. 21 (adults) and 31 (children)).

47. The most common form of hearing loss is sensorineural hearing loss ("SNHL"), in which the inner-ear hair cells are damaged. https://www.asha.org/

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public/hearing/Sensorineural-Hearing-Loss/ (last visited 10/13/20). That damage is generally not correctible through surgery or medication, and can be mitigated only through hearing aids or, in extreme cases, cochlear implants. *See* https://www.hearingloss.org/hearing-help/hearing-loss-basics/types-causes-and-treatment/ (last visited 10/13/20). Schmitt, Mohundro and O.L. have SNHL.

48. Conductive hearing loss occurs when damage to the outer or middle ear prevents sound from reaching the inner ear. https://www.asha.org/public/hearing/Conductive-Hearing-Loss/ (last visited 10/13/20). Conductive hearing loss can sometimes be corrected surgically, or can be addressed with a bone-anchored hearing aid (BAHA), which bypasses the damaged middle-ear structures and transmits sound directly to the cochlea and the hair cells. https://www.hopkinsmedicine.org/otolaryngology/specialty_areas/hearing/hearing-aids/baha.html (last visited 10/13/20).

49. Some people are diagnosed with both SNHL and conductive hearing loss. *See* https://www.healthyhearing.com/help/hearing-loss/types (last visited 10/13/20).

4. **Hearing Aids**

50. Even people who acknowledge having "serious" hearing difficulties resist hearing aids, particularly people under 65. According to the Census Bureau, only 2.354 million people under 65 – about 25% of the 9.2 million people who self-report serious hearing difficulties – have used hearing aids. https://www.census.gov/content/dam/Census/library/publications/2018/demo/p70-152.pdf, (last visited 10/13/20) (pp. 21 (children) and 31 (adults)).

51. The Hearing Industry Association, the trade group for hearing-aid manufacturers and distributors, conducts an annual survey of its members that asks, among other things, why people do or do not purchase hearing aids. The most recent

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survey indicates that in addition to cost concerns, people avoid hearing aids because they consider hearing aids uncomfortable, unattractive and embarrassing, and because they believe their hearing is adequate. https://www.audiologyonline.com/articles/20q-understanding-today-s-consumers-26648, (last visited 10/13/20) (20Q Consumer Insights, item #4).

52. People who believe their hearing is adequate for their purposes, even if their hearing is in fact impaired, have made a determination that their own major life activities are not substantially limited by their hearing loss. They are therefore not people with disabilities within the meaning of the Section 504 and ACA irrespective of their actual degree of hearing loss. Conversely, virtually all people who seek or obtain hearing aids do so because they have experienced limitations in their own life activities, such as hearing, communicating, learning or working, which experiences make them people with disabilities under Section 504 and ACA.

53. The needs of hearing disabled persons differ from the needs of persons whose hearing is merely impaired. Those who are disabled by their hearing loss experience its impact on their work, health and/or other daily activities of living. They seek treatment from hearing health care professionals to ameliorate their disabling condition.

54. Conversely, those whose hearing is impaired, but does not interfere with their major life activities, do not generally seek formal treatment from medical professionals, and rarely, if ever, seek hearing instruments.

55. Self-described and self-fitted hearing products not recommended by a hearing health care professional would fall within Kaiser's exclusion for devices or treatment that is not "medically necessary," which includes treatment provided (1) "primarily for the convenience of the patient," (2) in the most appropriate level of

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service or supply which can be safely provided to the Member, (3) are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not be omitted without adversely affecting the Member's condition. Dkt. No. 18-1, p. 63 of 66; *See* ***Appendix A***, pp. 75-76

56. Thus, based upon the above data, and information and belief, if any non-disabled enrollees with hearing loss seek coverage of hearing examinations and/or hearing aids, and they meet Kaiser's medical necessity standards but are still subject to denial of their claims under Kaiser's Hearing Loss Exclusion, the number of those enrollees is extremely small, if they exist at all.

57. Excluding coverage for hearing aids and hearing treatment exclusively or almost exclusively affects people with disabling hearing loss as defined by both Section 504, Section 1557 of ACA and RCW 48.43.0128.

58. Based upon the above information and information and belief, Kaiser's Hearing Loss Exclusion is rarely, if ever, applied to medically necessary claims submitted by non-disabled Kaiser enrollees. On information and belief, the internal records of Kaiser's denial of claim under the Hearing Loss Exclusion will show that most, if not all, individuals denied are disabled for the reasons set forth herein.

59. Even if the Hearing Loss Exclusion is applied to claims submitted by non-disabled enrollees, Kaiser designed the Exclusion intentionally to deny services to insureds with disabling hearing loss.

60. Given Kaiser's existing Medical Necessity definition which prohibits coverage that is not consistent with general medical standards, the only purpose of the Hearing Loss Exclusion is to eliminate coverage of medically necessary hearing treatment and equipment, *e.g.*, the precise coverage needed by those disabled by hearing loss.

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61. The design of the Hearing Loss Exclusion, uniquely and specifically targeted at insureds with disabling hearing loss, was an intentional decision made by Kaiser to ensure that the treatment needed by disabled insureds that would not be denied under the medical necessity requirement, would nonetheless be excluded.

62. The cost of hearing evaluations and hearing aids is relatively inexpensive when compared to other treatment, including cochlear implants and BAHAs. The average cost for hearing aids and associated services, including diagnosis, fitting and adjustments, is less than $2,400 per hearing aid. https://www.hearingtracker.com/how-much-do-hearing-aids-cost (last visited 10/19/20). Cochlear implant costs, including the device and the surgery, range from $50,000 to $100,000, depending on the hospital where the implantation is performed and the features of the particular implant. https://health.costhelper.com/cochlear-implant.html (last visited 10/19/20). The average cost of the surgery for a BAHA, and the sound processor is between $15,000-$25,000. https://www.healthyhearing.com/help/hearing-aids/bone-anchored (last visited 10/19/20).

63. In 2018, Washington's Medicaid program added coverage of hearing aids and hearing examinations for adults. *See* Washington Health Care Authority Fiscal Note for House Bill No. 1264 (2018), at https://fortress.wa.gov/FNSPublicSearch/GetPDF?packageID=47296 (last visited 10/12/20). Adding the benefit for nearly 1 million enrollees cost approximately $4 million annually, or just $0.33 per person per month. *Id.*

B. Cochlear Implants and BAHAs Do Not Serve the Needs of Most Individuals With a Hearing Disability.

64. A cochlear implant ("CI") is a mitigating measure for a limited class of people with severe to profound SNHL. A CI bypasses the damaged hair cells in the inner

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ear. A CI consists of an external microphone and processor that send electronic signals to an array of electrodes embedded in a filament that is threaded into the cochlea. Those electrodes substitute for the damaged hair cells by sending electronic impulses directly to the auditory nerve, creating a sensation of sound. https://www.mayoclinic.org/tests-procedures/cochlear-implants/about/pac-20385021 (last visited 10/13/20).

65. The implantation is done under general anesthesia, often but not always on an outpatient basis. The recipient must undertake a considerable effort at rehabilitation to enable the brain to make sense of the information received through the implant and "translate" it into recognizable sound.

66. CI is only available to people with severe to profound hearing loss who cannot be adequately treated with hearing aids. https://bulletin.entnet.org/article/cochlear-implantation-who-is-a-candidate-in-2018/ (last visited 10/13/20).

67. Using the same data as the prevalence estimate referenced in ¶44, Goman and Lin determined the national prevalence of hearing loss by severity. *See* ***Appendix B,*** Adele M. Goman, Ph.D., Frank R. Lin, M.D., Ph.D., "Prevalence of Hearing Loss by Severity in the United States," AJPH October 2016, Vol. 106, No. 10. They determined that 340,000 people age 12-59 have severe or profound losses, as do 360,000 people aged 60-69. Making the extremely conservative assumption that half of the people in the 60-69 age group are under 65, that would indicate that roughly 520,000 people under 65 would be potentially eligible for a CI, or just 5.6% of the 9.2 million people under 65 with self-reported hearing losses.

68. Cochlear-implant usage in practice is far less than the number of people who might be eligible. As of 2012, the last year for which data has been located, the National Institute on Deafness and Communication Disorders found that only 58,000 U.S. adults had cochlear implants, just over 10% of those who might be eligible.

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https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing#:~:text=One%20in%20eight%20people%20in,based%20on%20standard%20hearing%20examinations.&text=About%202%20percent%20of%20adults,adults%20aged%2055%20to%2064 (last visited 10/13/20).

69. Cochlear-implant usage in children is higher – the NIDCD reported that 38,000 children under 18 have been implanted, or 3.2% of the 1,176,000 children with self-reported hearing loss. As the NIDCD stated, implantation is more aggressive with children because of the importance of providing access to sound during the years that speech develops.

70. Based on the data, cochlear implants treat the needs of only a very small fraction of the total population of people with hearing loss. As a result, Kaiser's coverage of cochlear implants serves only a very small percentage of its enrollees with disabling Hearing Loss. The inclusion of coverage for cochlear implants does not serve the needs of hearing disabled people as a group.

71. Similarly, BAHAs meet the needs of only a tiny portion of hearing disabled enrollees. It is a treatment for conductive and mixed hearing loss, as well as unilateral SNHL. https://www.evms.edu/patient_care/specialties/ent_surgeons/services/otology/patient_education/bone_anchored_hearing_aids_baha/ (last visited 10/20/20).

72. BAHAs meet the needs of only a tiny portion of hearing disabled enrollees. Current estimates are that 75,000 Americans have received BAHAs. *Id.* There is no breakdown of BAHA recipients by age. Based on the Census Bureau estimates that over 18 million Americans of all ages self-report serious hearing loss, fewer than 1% treat that condition using BAHAs.

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73. Of the estimated 18 million Americans of all ages who self-report serious hearing loss, only 171,000 – less than 1% – are currently being treated by either CIs or BAHA hearing aids. By comparison, according to the Census Bureau, some 8.3 million Americans of all ages use hearing aids. Based on those numbers, CIs and BAHA hearing aids together account for just over 2% of treatments for hearing loss. https://www.census.gov/content/dam/Census/library/publications/2018/demo/p70-152.pdf (last visited 10/14/20) (explanatory text at p.7 and charts on pp. 21 (adults) and 31 (children)).

C. Plaintiffs' Need for Hearing Treatment

74. Plaintiff Schmitt has a significant loss in the higher frequencies, and is therefore unable to hear softly voiced consonant sounds like p, h, sh, ch, k, t, f, s and th. She hears vowel sounds at normal volume, but without hearing many of the consonants, she is unable to understand speech without her hearing aids.

75. Without her hearing aids, Schmitt is significantly limited in the major life activity of hearing. Among other things, she cannot understand her four-year-old child, hear her baby crying in the next room, have any conversations in a moving car, carry on a conversation in a noisy situation such as a busy restaurant, use the phone, hear a smoke alarm or any kind of warning beep, understand people speaking in a darkened room, use a drive-through window or go to a movie theater, live theater or concert and understand what is being said.

76. Without her hearing aids, Schmitt is significantly limited in the major life activity of working. She is an attorney with Columbia Legal Services, and works primarily with low-wage immigrants. Without hearing aids, she cannot participate in telephone conferences or remote proceedings, is extremely limited in a courtroom, cannot attend seminars or large meetings, cannot participate in group discussions,

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cannot speak Spanish to her clients either in person or over the telephone, cannot observe or participate in legislative committee hearings and cannot review audio recordings.

77. Schmitt got her first pair of hearing aids at age 16 when her mother observed that Schmitt could not hear in the car even though her friends could. Schmitt tried to participate in debate, but had great difficulty keeping up. She quit playing the violin, again because she couldn't keep up with the other students. She realized she had trouble hearing on the phone. As a result of those limitations, she got hearing aids and has used them ever since.

78. Plaintiff Mohundro works as an international adoption counselor. Like Schmitt, she has a high- and mid-frequency hearing loss that makes it difficult for her to hear consonants and understand speech.

79. Without her hearing aids, Mohundro is limited in the major life activity of hearing. She cannot understand her children's speech, cannot understand speech in a moving car or in a crowded place, and cannot tell that someone is speaking to her unless they initially attract her attention. She cannot hear warning beeps.

80. Without her hearing aids, Mohundro is limited in major life activities including her work. Much of her work is over the phone, and she cannot consistently follow conversations on the phone without her hearing aids. Without her aids, she cannot participate in group conversations or conversations in a noisy environment.

81. Mohundro got hearing aids at age 13 after failing hearing tests at school. She had considerable difficulties socially beginning in roughly fifth grade because she couldn't participate fully in conversations. Other children thought she was ignoring them when they spoke, and her friends found it annoying that they had to repeat themselves so often when speaking to her.

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82. Plaintiff O.L. has bilateral sloping moderate to severe hearing loss. Newborn hearing screenings from birth through 12 months were inconclusive, but her parents suspected that she had some hearing loss. She was diagnosed with hearing loss after undergoing a sedated procedure to evaluate her hearing at Seattle Children's Hospital when she was 14 months old. She received her first hearing aids one month later.

83. Plaintiff O.L. wears her hearing aids all day, during all activities and at home. She uses the FM system at school and receives other educational accommodations. She is enrolled at TOPS K-8 with a cohort of deaf and hard of hearing students as well as typical hearing students and attends classes where there are sign language interpreters. Although there are sign language interpreters in her classroom, Plaintiff O.L. is a beginning learner of sign language; it is not her main method of communication.

84. Plaintiff O.L. wears hearing aids full time but even with her hearing aids, she misunderstands approximately 20% of the words spoken. Without her hearing aids, she mishears approximately 40-50% of spoken words, and she can only have a conversation with people who are physically close to her and facing her while speaking. She has to work quite hard to keep up with her peers due solely to her hearing loss.

85. Without hearing aids she would not be able to participate successfully in school or other group activities because she would be unable to hear most of the communication. Loss of access to hearing aids would further impact her development, health and safety. For example, her uncorrected hearing is so limited that she cannot hear a fire alarm or talk on the telephone without hearing aids.

86. Plaintiff O.L.'s hearing aids and hearing evaluations have been repeatedly denied by Kaiser. For example, in 2019 and 2020, coverage for Plaintiff O.L.'s annual

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hearing evaluation at Seattle Children's Hospital was denied, in whole or in part, due to Kaiser's Hearing Loss Exclusion. Both Kaiser explanations of benefits in 2019 and 2020 referenced the code "071." The 2019 explanation of benefits further states the following reason for denial of coverage: "071 – THE SERVICE REPORTED IS NOT A COVERED SERVICE UNDER YOUR CONTRACT."

87. Plaintiff O.L. requires a new pair of hearing aids in 2020. Plaintiff and her parents expect Kaiser to deny coverage of the claims for her new hearing aids based upon the exclusion of coverage in their Kaiser plan.

88. All three Plaintiffs are disabled under federal and state law.

D. Class-wide Allegations

89. During the relevant time periods, Schmitt, Mohundro, O.L. and members of the class have been insured in one or more Kaiser insured plans.

90. Plaintiffs Schmitt, Mohundro, O.L., and other members of the class have been diagnosed with Hearing Loss, a physical impairment that limits a major life activity so substantially as to require medical treatment. As a result, Schmitt, Mohundro and other members of the class are "qualified individuals with a disability." *See* 28 C.F.R. § 39.103.

91. Plaintiffs Schmitt, Mohundro, O.L., and other members of the class have required, require and/or will require medical treatment for their Hearing Loss, excluding treatment with cochlear implants.

92. Kaiser is a "health program or activity" part of which receives federal financial assistance. 42 U.S.C. § 18116; 45 C.F.R. § 92.4.

93. As a result, Kaiser is a "covered entity" under the Affordable Care Act, § 1557.

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94. Kaiser provided assurances to the U.S. Department of Health and Human Services that it complies with the requirements of § 1557. *See* 45 C.F.R. § 92.5.

95. It also provided similar statements to its Washington insured enrollees, confirming that it complies with the requirements of § 1557.

96. Despite these statements and assurances, Kaiser has designed, issued and administered Washington health plans that exclude all benefits for Hearing Loss, except for cochlear implants and BAHAs, to the extent Kaiser provided such coverage. Kaiser continues to do so, to date.

97. The Kaiser health plans in which Plaintiffs were and Schmitt and O.L. presently are enrolled are "non-grandfathered health plans" as described in the Washington Insurance Code.

98. Kaiser's non-grandfathered insured health plans must comply with the requirements of RCW 48.43.0128.

99. Based upon the Hearing Loss Exclusion, Kaiser has a standard policy of denying coverage of medically necessary treatment and equipment for Schmitt, Mohundro and other members of the class, because the requested treatment and equipment would treat their diagnosed condition of Hearing Loss, and/or the treatment they seek is for "hearing treatment" and "hearing aids" such that the Exclusion is a form of intentional proxy discrimination.

100. Specifically, Kaiser designed the Hearing Loss Exclusion to target the health care needs of insureds with disabling hearing loss.

101. Non-disabled insureds rarely seek treatment for hearing loss. To the extent such insureds seek such treatment, their claims are already excluded under Kaiser's medical necessity exclusion. Only disabled insureds with hearing loss are denied medically necessary treatment for their condition under the Hearing Loss Exclusion.

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102. Kaiser does not meet the needs of disabled enrollees with hearing loss by permitting limited coverage for cochlear implants, and BAHAs, to the extent Kaiser provided such coverage. As alleged above, cochlear implants and BAHAs only serve the needs of a small percentage of Kaiser's disabled insureds with hearing loss (approximately 5% or fewer).

103. As a result of its deliberate discriminatory actions, Kaiser insureds with disabling Hearing Loss, like Schmitt, Mohundro, and O.L., do not receive coverage for medically necessary outpatient office visits to audiologists or for medically necessary hearing aids, a type of durable medical equipment or prosthetic device.

104. Kaiser excludes all coverage for outpatient office visits and durable medical equipment to treat Hearing Loss, even though it covers outpatient office visits, durable medical equipment and prosthetic devices for other medical conditions.

105. The application of Kaiser's Hearing Loss Exclusion denies individuals with disabling Hearing Loss the benefits and health coverage available to other insureds, based on their disability, Hearing Loss.

106. As a direct result, Plaintiffs Schmitt, Mohundro, O.L., and members of the class have paid out-of-pocket for medically necessary treatment for their Hearing Loss, including audiology examinations and hearing aids. Other class members have been forced to forgo needed medical treatment due to Kaiser's conduct.

107. No administrative appeal is required before this § 1557 claim may be brought. *See* 45 C.F.R. § 92.301(a); 81 Fed. Reg. 31441. In any event, such an appeal would be futile given Kaiser's clearly articulated position. *See Horan v. Kaiser Steel Ret. Plan*, 947 F.2d 1412, 1416 (9th Cir. 1991).

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VII. CLAIMS FOR RELIEF:

COUNT I – VIOLATION OF AFFORDABLE CARE ACT § 1557, 42 U.S.C. § 18116

108. Plaintiffs re-allege all paragraphs above.

109. Section 1557, 42 U.S.C. § 18116 provides that "an individual shall not, on the ground prohibited under … section 504 of the Rehabilitation Act of 1973 … be excluded from participation in, denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance…."

110. Defendants receive federal financial assistance and are therefore a "covered entity" for purposes of Section 1557.

111. Plaintiffs are "qualified persons with a disability" under both Section 504 and Section 1557.

112. Persons like Schmitt, Mohundro and O.L. who have disabling hearing loss are discriminated against by Kaiser because it applies the Hearing Loss Exclusion to deny coverage of medically necessary audiological examinations, a type of out-patient office visit, and coverage of medically necessary hearing aids, a type of durable medical equipment or prosthetic device. Under the exclusion, only or predominantly people with disabling Hearing Loss, a qualifying disability, are denied access to the benefits that they require. Out-patient office visits and durable medical equipment/prosthetic devices are covered for many other health conditions under Kaiser's policies.

113. As described above, Kaiser's Hearing Loss Exclusion treats "hearing loss" as a proxy for disabling hearing loss, since the vast majority of treatment sought by hearing-disabled enrollees is excluded and few, if any, non-disabled Kaiser enrollees are subject to the Hearing Loss Exclusion.

114. Also, as alleged above, only a very small percentage of disabled hearing loss enrollees receive the treatment they need in the form of cochlear implants or BAHAs.

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115. Accordingly, the Hearing Loss Exclusion is a form of proxy discrimination since the "fit" between the Hearing Loss Exclusion and disabling hearing loss is "sufficiently close" to make a discriminatory inference plausible. *See Schmitt,* 965 F.3d at 958-959.

116. The drafting and inclusion of the Hearing Loss Exclusion was an inherently intentional act. It was done for the purpose of excluding coverage for insureds with disabling hearing loss since coverage for insureds with non-disabling hearing loss would be excluded under Kaiser's medical necessity clause. Kaiser understood that the only way to exclude ***medically necessary*** services and supplies for hearing loss – services and supplies that would only be provided to disabled insureds – was to put in place the broad Hearing Loss Exclusion.

117. The design and administration of the Hearing Loss Exclusion was an intentional choice or, at the very least, the result of deliberate indifference to the effect it would have on its insureds with disabling hearing loss.

118. This discriminatory decision directly resulted in Kaiser retaining money that it would otherwise would have been required to pay to cover services and equipment for disabled insureds. Kaiser made this calculus as part of its underwriting, and decided that its desire to retain money outweighed the medically necessary needs of its insureds with disabling hearing loss.

119. By excluding coverage of all health care related to hearing loss (except for cochlear implants and in 2020 for BAHAs), Kaiser has discriminated, and continues to discriminate against Plaintiffs and the class they seek to represent, on the basis of disability, in violation of Section 1557.

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COUNT II – BREACH OF CONTRACT AND VIOLATION OF RCW 48.43.0128

120. Plaintiffs re-allege all paragraphs above.

121. All Washington health plan incorporate the relevant requirements of the Insurance Code as additional terms and conditions of the contract, rendering any non-conforming terms void. *See* RCW 48.18.200(2); *Brown v. Snohomish Cty. Physicians Corp.*, 120 Wn.2d 747, 753, 845 P.2d 334, 337 (1993); *accord UNUM Life Ins. v. Ward*, 526 U.S. 358, 376 (1999).

122. RCW 48.43.0128 forbids Kaiser's health plans from discriminating "in its benefit design or implementation of its benefit design, … against individuals because of their … present or predicted disability, … or other health conditions" or otherwise "discriminate on the basis of …. disability."

123. RCW 48.43.0128 renders Kaiser's Hearing Loss Exclusion null and void, since the Exclusion is a form of benefit design discrimination targeted at disabled individuals with hearing loss. Specifically, since the plaintiffs are disabled under Washington law, and Kaiser's health plans are subject to RCW 48.43.0128, the Hearing Loss Exclusion discriminates against Plaintiffs and violates their insurance contract since Plaintiffs' disability is a "substantial factor" in the design and administration of the exclusion of coverage. *See Fell v. Spokane Transit Auth.*, 128 Wn.2d 618, 637, 911 P.2d 1319 (1996).

124. By excluding coverage of all health care related to hearing loss, (except for cochlear implants and in 2020, BAHAs), Kaiser has discriminated, and continues to discriminate against Plaintiffs and the class they seek to represent, on the basis of disability, in violation of RCW 48.43.0128. As Kaiser's contracts must be construed and applied without the Hearing Loss Exclusion pursuant to RCW 48.43.0128 and Washington contract law, Kaiser's use of the Exclusion to deny coverage is also a breach of contract.

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VIII. DEMAND FOR RELIEF

WHEREFORE, Plaintiffs request that this Court:

1. Certify this case as a class action; designate the named Plaintiffs as class representatives; and designate SIRIANNI YOUTZ SPOONEMORE HAMBURGER, Eleanor Hamburger, Richard E. Spoonemore, and John Waldo (of counsel) as class counsel;

2. Enter judgment on behalf of the Plaintiffs and the class due to Kaiser's discrimination on the basis of disability under both Section 1557 and RCW 48.43.0128;

3. Declare that Kaiser may not apply the Hearing Loss Exclusion and/or other contract provisions, policies or practices that exclude or impermissibly limit coverage of medically necessary treatment on the basis of disability;

4. Enjoin Kaiser from applying the Hearing Loss Exclusion and/or other violations of the Affordable Care Act now and in the future;

5. Enter judgment in favor of Plaintiffs and the class for damages in an amount to be proven at trial due to Kaiser's violation of Section 1557 of the Affordable Care Act and RCW 48.43.0128 of the Washington Insurance Code, and breach of its contracts with Plaintiffs and the class;

6. Award Plaintiffs and the class their attorney fees and costs under 42 U.S.C. § 1988 and *Olympia S.S. Co. v. Centennial Ins. Co.*, 117 Wn.2d 37, 811 P.2d 673 (1991); and

7. Award such other relief as is just and proper.

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DATED: December 15, 2020.

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Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on December 15, 2020, I caused the foregoing to be electronically filed with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to the following:

- **Mark A. Bailey**
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DATED: December 15, 2020, at Seattle, Washington.

s/ Eleanor Hamburger
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APPENDIX A

KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington Options, Inc.

Small Group

Evidence of Coverage

Important Notice Under Federal Health Care Reform

Kaiser Foundation Health Plan of Washington Options, Inc. ("KFHPWAO") recommends each Member choose a personal physician. This decision is important since the designated personal physician provides or arranges for most of the Member's health care. The Member has the right to designate any personal physician who participates in KFHPWAO's Access PPO network and who is available to accept the Member or the Member's family members. For information on how to select a personal physician, and for a list of the participating personal physicians, please call Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

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

The Member does not need Preauthorization from KFHPWAO or from any other person (including a personal physician) to access obstetrical or gynecological care from a health care professional in the KFHPWAO 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. For a list of participating health care professionals who specialize in obstetrics or gynecology, please call Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

Women's health and cancer rights

If the Member is receiving benefits for a covered mastectomy and elects breast reconstruction in connection with the mastectomy, the Member 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 Member 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 her newborn earlier than 48 hours (or 96 hours as applicable). In any case, carriers may not, under federal law, require that a provider obtain authorization from the carrier for prescribing a length of stay not in excess of 48 hours (or 96 hours). Also, under federal law, a carrier may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

For More Information

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

Table of Contents

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 Options, Inc. ("KFHPWAO") and the Group. The benefits were approved by the Group who contracts with KFHPWAO 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 1-888-901-4636 for benefits questions.

II. How Covered Services Work

A. Accessing Care.

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

- Your Provider Network is KFHPWAO's Access PPO Preferred Provider Network, referred to as "PPN".
  - Standard in-network benefits apply to any Preferred Provider
  - Enhanced in-network benefits apply when a Member utilizes designated integrated providers (Kaiser Permanente Medical Centers and providers or other designated providers as identified in the Provider Directory). These providers provide services at the lowest cost share as stated in Section IV.
- Care provided by an Out-of-Network Provider. Coverage provided by an Out-of-Network Provider is limited to the Allowed Amount.
  - Out-of-Country providers are limited to Emergency services and urgent care only when provided by a provider who meets licensing and certification requirements established where the provider practices.

Benefits paid under one option will not be duplicated under the other option.

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.

In order for services to be covered at the highest benefit levels, services must be obtained from PPN Facilities or Preferred Providers, except for Emergency services. Emergency services will always be covered at the in-network (PPN) level.

A listing of Access PPO Preferred Providers is available by contacting Member Services or accessing the KFHPWAO website at www.kp.org/wa. On the website, Enhanced providers include an asterisk prior to the provider's name. For assistance searching the website for the providers providing Enhanced in-network benefits, please contact Member Services.

KFHPWA will not directly or indirectly prohibit Members 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.**
KFHPWAO recommends that Members select a personal physician. 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 personal physicians, and for a list of participating personal physicians, call Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington at 1-888-901-4636 or by accessing the KFHPWAO website at www.kp.org/wa. The change will be made within 24 hours of the receipt of the request if the selected physician's caseload permits. If a personal physician accepting new Members is not available in your area, contact Kaiser Permanente Member Services, who will ensure you have access to a personal physician by contacting a physician's office to request they accept new Members.

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

3. **Specialty Care Provider Services.**
Members may make appointments with specialists without Preauthorization, except as noted under Section IV. In the event specialty services are not available from a PPN or Preferred Provider, Preauthorization is required and services will be covered at the in-network level.

   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, oncology pharmacist, pain management, hematology/oncology, occupational medicine, occupational therapy, ophthalmology, orthopedics, ENT/otolaryngology, pathology, 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.

   KFHPWAO-designated Specialist.
Members may make an appointment with KFHPWAO-designated Specialists at facilities owned and operated by KFHPWAO without Preauthorization. To access a KFHPWAO-designated Specialist, consult your Network Personal Physician or contact Member Services for a list of KFHPWAO designated specialists, or via the Provider Directory located at www.kp.org/wa. The following specialty care areas are available from KFHPWAO-designated Specialists: allergy, audiology, cardiology, chemical dependency, chiropractic, dermatology, gastroenterology, general surgery, hospice, manipulative therapy, mental health, nephrology, neurology, obstetrics and gynecology, occupational medicine, oncology/hematology, ophthalmology, optometry, orthopedics, otolaryngology (ear, nose and throat), physical therapy, smoking cessation, speech/language and learning services and urology.

4. **Hospital Services.**
Refer to Section IV. for more information about hospital services.

5. **Emergency Services.**
Members must notify KFHPWAO 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. Refer to Section IV. for more information about Emergency services.

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

   First Level Review:

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

Second Level (Practitioner) Review:

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

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

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

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

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

F. Preauthorization.
Some Covered Services require Preauthorization as noted under Section IV. Refer to Section IV. for more information. Preauthorization requests are reviewed and approved based on Medical Necessity, eligibility and benefits. KFHPWAO will generally process Preauthorization requests and provide notification for benefits within the following timeframes:

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

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

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

H. Second Opinions.
The Member may access a second opinion regarding a medical diagnosis or treatment plan. The Member may also obtain a second opinion from an Out-of-Network Provider without Preauthorization, subject to Out-of-Network Provider Cost Shares and all other Preauthorization requirements specifically stated within Section IV. Coverage is determined by the Member's EOC; therefore, coverage for the second opinion does not imply that the services or treatments recommended will be covered. Services, drugs and devices prescribed or recommended as a result of the consultation are not covered unless included as covered under the EOC.

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

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

Under the Out-of-Network option, if Covered Services are delayed or unavailable due to unusual circumstances such as those described above, KFHPWAO shall have no liability or obligation to arrange for Covered Services.

J. Utilization Management.
All benefits are limited to Covered Services that are Medically Necessary and set forth in the EOC. KFHPWAO may review a Member's medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent or retrospective review, KFHPWAO may deny coverage if, in its determination, such services are not Medically Necessary. Such determination shall be based on established clinical criteria.

KFHPWAO will not deny coverage retroactively for services with Preauthorization and which have already been provided to the Member except in the case of an intentional misrepresentation of a material fact by the patient, Member, or provider of services; or if coverage was obtained based on inaccurate, false, or misleading information provided on the enrollment application; or for nonpayment of premiums. Benefits do not require Preauthorization, except as noted under Section IV.

III. Financial Responsibilities

A. Premium.
The Subscriber is liable for payment to the Group of his/her 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 his/her 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 calendar year until the annual Deductible is met. There is an individual annual Deductible amount for each Member and a maximum annual Deductible amount for each Family Unit. Once the annual Deductible amount is reached for a Family Unit in a calendar year, the individual annual Deductibles are also deemed reached for each Member during that same calendar year.

   Note: There are separate deductibles for the Preferred Provider Network and the Out-of-Network benefits. These deductibles accrue separately and the Member is responsible for meeting each deductible, as appropriate, prior to benefits being covered.

2. **Plan Coinsurance.**
   After the applicable annual Deductible is satisfied, Members may be required to pay Plan Coinsurance for Covered Services. Coinsurance is calculated on the Allowed Amount.

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

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

   Note: There are separate Out-of-pocket limits for the Preferred Provider Network and the Out-of-Network benefits. These Out-of-pocket limits accrue separately and the Member is responsible for meeting each Out-of-pocket limit, as appropriate.

C. Financial Responsibilities for Non-Covered Services.
The cost of non-Covered Services and supplies is the responsibility of the Member. The Subscriber is liable for payment of any fees charged for non-Covered Services provided to the Subscriber and his/her 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. Members are entitled only to receive benefits and services that are Medically Necessary and clinically appropriate for the treatment of a Medical Condition as determined by KFHPWAO's medical director and as described herein. All Covered Services are subject to case management and utilization management. "Case management" means a care management plan developed for a Member whose diagnosis requires timely coordination.

Under the Out-of-Network option, Members shall be required to pay any difference between the Out-of-Network Provider's charge for services and the Allowed Amount.

	Preferred Provider Network	**Out-of-Network**
Annual Deductible	Member pays $250 per Member per calendar year or $500 per Family Unit per calendar year	Member pays $500 per Member per calendar year or $1,000 per Family Unit per calendar
Coinsurance	**Plan Coinsurance:** Member pays 10% of the Allowed Amount	**Plan Coinsurance:** Member pays 50% of the Allowed Amount
Lifetime Maximum	No lifetime maximum on covered Essential Health Benefits	
Out-of-pocket Limit	Limited to a maximum of $2,500 per Member or $5,000 per Family Unit per calendar year.	Limited to a maximum of $7,500 per Member or $15,000 per Family Unit per calendar year.
	The following Out-of-pocket Expenses apply to the Out-of-pocket Limit: All Cost Shares for Covered Services **The following expenses do not apply to the Out-of-pocket Limit:** Premiums, charges for services in excess of a benefit, charges in excess of Allowed Amount, charges for non-Covered Services	**The following Out-of-pocket Expenses apply to the Out-of-pocket Limit:** All Cost Shares for Covered Services **The following expenses do not apply to the Out-of-pocket Limit:** Premiums, charges for services in excess of a benefit, charges in excess of Allowed Amount, charges for non-Covered Services
Pre-existing Condition Waiting Period	No pre-existing condition waiting period	

Acupuncture	**Preferred Provider Network**	**Out-of-Network**
Acupuncture needle treatment, limited to 12 visits per calendar year. Preauthorization is not required. No visit limit for treatment for Chemical Dependency.	Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance
Exclusions: Herbal supplements; reflexology; any services not within the scope of the practitioner's licensure		

Allergy Services	**Preferred Provider Network**	**Out-of-Network**
Allergy testing.	Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider	After Deductible, Member pays 50% Plan Coinsurance

	office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	
Allergy serum and injections.	Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance

Cancer Screening and Diagnostic Services	**Preferred Provider Network**	**Out-of-Network**
Routine cancer screening covered as Preventive Services in accordance with the well care schedule established by	No charge; Member pays nothing	After Deductible, Member pays 50% Plan

KFHPWAO 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.		Coinsurance
Diagnostic laboratory, diagnostic procedures (including colonoscopies, cardiovascular testing, pulmonary function studies, and neurology/neuromuscular procedures) and diagnostic services for cancer. See Laboratory and Radiology for additional information. Preventive laboratory/radiology services are covered as Preventive Services.	After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance

Cardiac Rehabilitation	**Preferred Provider Network**	**Out-of-Network**
Cardiac rehabilitation is covered when clinical criteria is met.	Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After	After Deductible, Member pays 50% Plan Coinsurance

	Deductible, Member pays 10% Plan Coinsurance	

Chemical Dependency	**Preferred Provider Network**	**Out-of-Network**
Chemical dependency services, including treatment provided in an outpatient or home health setting, and inpatient Residential Treatment; diagnostic evaluation and education; organized individual and group counseling; and/or prescription drugs unless excluded under Sections IV. or V.. Chemical dependency means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages, and where the user's health is substantially impaired or endangered or his/her social or economic function is substantially disrupted. For the purposes of this section, the definition of Medically Necessary shall be expanded to include those services necessary to treat a chemical dependency condition that is having a clinically significant impact on a Member's emotional, social, medical and/or occupational functioning. Chemical dependency services must be provided at an approved treatment facility or treatment program. Non-Washington State alcoholism and/or drug abuse treatment service providers must meet the equivalent licensing and certification requirements established in the state where the provider's practice is located. Contact Member Services for additional information on Non-Washington State providers. Chemical dependency services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57), a psychologist (licensed under RCW 18.83), a chemical dependency treatment program licensed for the service being provided by the Washington State Department of Social and Health Services (pursuant to RCW 70.96A), a master's level therapist (licensed under RCW 18.225.090), an advance practice psychiatric nurse (licensed under RCW 18.79). Residential Treatment and court-ordered chemical dependency treatment shall be covered only if determined to be Medically Necessary.	**Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance **Outpatient Services:** Office visits: After Deductbile, Member pays $20 Copayment for primary care provider and specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: After Deductbile, Member pays $10 Copayment for primary care provider and specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance **Group Sessions:** No	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance

	charge; Member pays nothing	
Acute chemical withdrawal (detoxification) services for alcoholism and drug abuse. "Acute chemical withdrawal" means withdrawal of alcohol and/or drugs from a Member for whom consequences of abstinence are so severe that they require medical/nursing assistance in a hospital setting, which is needed immediately to prevent serious impairment to the Member's health. Coverage for acute chemical withdrawal (detoxification) is provided without Preauthorization. Members must notify KFHPWAO by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible.	**Emergency Services:** After Deductible, Member pays 10% Plan Coinsurance **Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance	**Emergency Services:** After PPN Deductible, Member pays 10% Plan Coinsurance **Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance
Exclusions: Experimental or investigational therapies, such as wilderness therapy; facilities and treatments programs which are not certified by the Department of Social Health Services or which are not listed in the Directory of Certified Chemical Dependency Services in Washington State		

Circumcision	**Preferred Provider Network**	**Out-of-Network**
Circumcision.	**Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 10% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance

	pays 10% Plan Coinsurance	

Clinical Trials	**Preferred Provider Network**	**Out-of-Network**
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 or state law. Routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. Clinical Trials are a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. “Life threatening condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. Clinical trials require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 10% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance

	All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	
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	**Preferred Provider Network**	**Out-of-Network**
Dental services including accidental injury to natural teeth.	Not covered; Member pays 100% of all charges	Not covered; Member pays 100% of all charges
Dental services or appliances provided during medical treatment for emergent dental care, dental care which requires the extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, and oral surgery related to trauma.	**Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance **Hospital - Outpatient:** After Deductible, After Deductible, Member pays 10% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance
General anesthesia services and related facility charges for dental procedures for Members who are under 9 years of age, or are physically or developmentally disabled or have a Medical Condition where the Member's health would be put at risk if the dental procedure were performed in a dentist's office.	**Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 10% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance
Exclusions: Dentist's or oral surgeon's fees for non-emergent dental care, surgery, services and appliances, including: non-emergent treatment of accidental injury to natural teeth, reconstructive surgery to the jaw in preparation for dental implants, dental implants, orthodontic braces for any condition, periodontal surgery; any other dental service not specifically listed as covered		

Devices, Equipment and Supplies (for home use)	**Preferred Provider Network**	**Out-of-Network**
• Durable medical equipment: Equipment which can withstand repeated use, is primarily and customarily used	After Deductible, Member pays 10% Plan	After Deductible, Member pays 50% Plan

to serve a medical purpose, is useful only in the presence of an illness or injury and is used in the Member's home. Durable medical equipment includes hospital beds, wheelchairs, walkers, crutches, canes, braces and splints, blood glucose monitors, external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters), oxygen and oxygen equipment, and therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease. KFHPWAO 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. • Orthotic devices. • Ostomy supplies: Supplies for the removal of bodily secretions or waste through an artificial opening. • Post-mastectomy bras/forms, limited to 2 every 6 months. Replacements within this 6 month period are covered when Medically Necessary due to a change in the Member's condition. • Prosthetic devices: Items which replace all or part of an external body part, or function thereof. • Sales tax for devices, equipment and supplies. When provided in lieu of hospitalization, benefits will be the greater of benefits available for devices, equipment and supplies, home health or hospitalization. See Hospice for durable medical equipment provided in a hospice setting. Repair, adjustment or replacement of appliances and equipment is covered when Medically Necessary and appropriate.	Coinsurance	Coinsurance
Exclusions: Arch supports, including custom shoe modifications or inserts and their fittings not related to the treatment of diabetes; orthopedic shoes that are not attached to an appliance; wigs/hair prosthesis; take-home dressings and supplies following hospitalization; supplies, dressings, appliances, devices or services not specifically listed as covered above; same as or similar equipment already in the Member's possession; replacement or repair due to loss, theft, breakage from willful damage, neglect or wrongful use, or due to personal preference; structural modifications to a Member's home or personal vehicle		

Diabetic Education, Equipment and Pharmacy Supplies	**Preferred Provider Network**	**Out-of-Network**
Diabetic education and training.	Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and	After Deductible, Member pays 50% Plan Coinsurance

	coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	
Diabetic equipment: Blood glucose monitors and external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters), and therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease. See Devices, Equipment and Supplies for additional information.	After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance
Diabetic pharmacy supplies: Insulin, lancets, lancet devices, needles, insulin syringes, insulin pens, pen needles, glucagon emergency kits, prescriptive oral agents and blood glucose test strips for a supply of 30 days or less per item. Certain brand name insulin drugs will be covered at the generic level. See Drugs – Outpatient Prescription for additional pharmacy information.	**Preferred generic drugs (Tier 1):** Member pays $10 Copayment up to a 30-day supply **Preferred brand name drugs (Tier 2):** Member pays $20 Copayment up to a 30-day supply **Non-Preferred generic and brand name drugs (Tier 3):** Member pays 40% coinsurance up to a 30-day supply **Specialty drugs (Tier**	Not covered; Member pays 100% of all charges

	4): After Deductible, Member pays 40% coinsurance up to a 30-day supply Enhanced Benefit: **Preferred generic drugs (Tier 1):** Member pays $5 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** Member pays $15 Copayment per 30-days up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** Member pays 35% coinsurance up to a 90-day supply **Specialty drugs (Tier 4):** After Deductible, Member pays 40% coinsurance up to a 30-day supply	
Diabetic retinal screening.	No charge, Member pays nothing	After Deductible, Member pays 50% Plan Coinsurance

Dialysis (Home and Outpatient)	**Preferred Provider Network**	**Out-of-Network**
Dialysis in an outpatient or home setting is covered for Members with acute kidney failure or end-stage renal disease (ESRD).	Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical	After Deductible, Member pays 50% Plan Coinsurance

	services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	
Injections administered by a professional in a clinical setting during dialysis.	Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays 10% Plan	After Deductible, Member pays 50% Plan Coinsurance

	Coinsurance	
Self-administered injectables. See Drugs – Outpatient Prescription for additional pharmacy information.	**Preferred generic drugs (Tier 1):** Member pays $10 Copayment up to a 30-day supply **Preferred brand name drugs (Tier 2):** Member pays $20 Copayment up to a 30-day supply **Non-Preferred generic and brand name drugs (Tier 3):** Member pays 40% coinsurance up to a 30-day supply **Specialty drugs (Tier 4):** After Deductible, Member pays 40% coinsurance up to a 30-day supply Enhanced Benefit: **Preferred generic drugs (Tier 1):** Member pays $5 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** Member pays $15 Copayment per 30-days up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** Member pays 35% coinsurance up to a 90-day supply **Specialty drugs (Tier 4):** After Deductible, Member pays 40% coinsurance up to a 30-day supply	Not covered; Member pays 100% of all charges

Drugs - Outpatient Prescription	**Preferred Provider Network**	**Out-of-Network**
Prescription drugs, supplies and devices for a supply of 30	**Preferred generic**	Not covered; Member

days or less including diabetic pharmacy supplies (insulin, lancets, lancet devices, needles, insulin syringes, insulin pens, pen needles and blood glucose test strips), mental health drugs, self-administered injectables, teaching doses of self-administered injections, limited to 3 doses per medication per lifetime, and routine costs for prescription medications provided in a clinical trial. "Routine costs" means items and services delivered to the Member that are consistent with and typically covered by the plan or coverage for a Member who is not enrolled in a clinical trial. All drugs, supplies and devices must be for Covered Services. All drugs, including specialty drugs, supplies and devices must be obtained at a KFHPWAO-designated pharmacy except for drugs dispensed for Emergency services or for Emergency services obtained outside of the KFHPWAO Service Area. Information regarding KFHPWAO-designated pharmacies is reflected in the KFHPWAO 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. A list of these drugs are available at www.kp.org/wa/formulary. Members may be eligible to receive an emergency fill for certain prescription drugs filled outside of KFHPWAO's business hours or when KFHPWAO cannot reach the prescriber for consultation. For emergency fills, Members pay the prescription drug Cost Share for each 7 day supply or less, or the minimum packaging size available at the time the emergency fill is dispensed. A list of prescription drugs eligible for emergency fills is available on the pharmacy website at www.kp.org/wa/formulary. Members can request an emergency fill by calling 1-855-505-8107. Certain drugs are subject to Preauthorization as shown in the Preferred drug list (formulary) available at www.kp.org/wa/formulary. In order to obtain the enhanced benefits, Members must utilize designated pharmacies, which are reflected in the KFHPWAO Provider Directory, or can be obtained by contacting Kaiser Permanente Member Services.	**drugs (Tier 1):** Member pays $10 Copayment up to a 30-day supply **Preferred brand name drugs (Tier 2):** Member pays $20 Copayment up to a 30-day supply **Non-Preferred generic and brand name drugs (Tier 3):** Member pays 40% coinsurance up to a 30-day supply **Specialty drugs (Tier 4):** After Deductible, Member pays 40% coinsurance up to a 30-day supply Enhanced Benefit: **Preferred generic drugs (Tier 1):** Member pays $5 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** Member pays $15 Copayment per 30-days up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** Member pays 35% coinsurance up to a 90-day supply **Specialty drugs (Tier 4):** After Deductible, Member pays 40% coinsurance up to a 30-day supply	pays 100% of all charges
Injections administered by a professional in a clinical setting.	Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits All other services,	After Deductible, Member pays 50% Plan Coinsurance

	including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	
Over-the-counter drugs not included under Preventive Care or Reproductive Health.	Not covered; Member pays 100% of all charges	Not covered; Member pays 100% of all charges
Mail order drugs dispensed through the KFHPWAO-designated mail order service.	**Preferred generic drugs (Tier 1):** Member pays $5 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** Member pays $15 Copayment per 30-days up to a 90-day supply **Non-Preferred generic and brand name drugs (Tier 3):** Member pays 35% coinsurance up to a 90-day supply **Specialty (Tier 4):** After Deductible, Member pays 40% coinsurance up to a 30-day supply	Not covered; Member pays 100% of all charges
The KFHPWAO 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.		

A Member, A Member's designee, or a prescribing physician may request a coverage exception to gain access to clinically appropriate drugs if the drug is not otherwise covered by contacting Member Services. Coverage determination reviews may include requests to cover non-preferred drugs, obtain Preauthorization for a specific drug, or exceptions to other utilization management requirements, such as quantity limits. KFHPWAO will provide a determination and notification of a determination no later than 72 hours from the non-urgent request after receipt of information sufficient to make a decision. The prescribing physician must submit an oral or written statement regarding the need for the non-Preferred drug, and a list of all of the preferred drugs which have been ineffective for the Member.

Expedited or Urgent Reviews: A Member, a Member's designee, or a prescribing physician may request an expedited review for coverage for non-covered drugs when a delay caused by using the standard review process will seriously jeopardize the Member's life, health or ability to regain maximum function or will subject to the Member to severe pain that cannot be managed adequately without the requested drug. KFHPWAO 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.

Notification of Determination: If coverage is approved, KFHPWAO will notify the prescribing physician of the determination. If coverage is denied, KFHPWAO will provide notification of the adverse determination to the prescribing physician and the member.

External Exception Review: If an exception is not authorized for a non-formulary drug, a Member, a Member's designee, or a prescribing physician may request a second level exception denial review by an external independent review. Organization (IRO) not legally affiliated with or controlled by KFHPWAO. The IRO will provide its determination to the Member, Member designee and the prescribing physician no later than 72 hours of receipt of the request after receipt of information sufficient to make a decision.

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

Generic drugs are dispensed whenever available. A generic drug is a drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. Brand name drugs are dispensed if there is not a generic equivalent. In the event the Member elects to purchase a brand-name drug instead of the generic equivalent (if available) the Member is responsible for paying the difference in cost in addition to the prescription drug Cost Share.

Drug coverage is subject to utilization management that includes step therapy (when a Member tries a certain medication before receiving coverage for a similar, but non-Preferred medication), limits on drug quantity or days supply and prevention of overutilization, underutilization, therapeutic duplication, drug-drug interactions, incorrect drug dosage, drug-allergy contraindications and clinical abuse/misuse of drugs. If a Member has a new prescription for a chronic condition, the Member may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity. The Member pays one-half of the copayment if a supply of 15 days or less of the prescription is filled. There is no prorated Copayment if 16 – 30 days supply of the prescription is

filled. The Member is charged 1.5 times the copayment for a supply of more than 30 days. Specialty drugs are high-cost drugs prescribed by a physician that requires close supervision and monitoring for serious and/or complex conditions, such as rheumatoid arthritis, hepatitis or multiple sclerosis. Specialty drugs must be obtained through KFHPWAO'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 KFHPWAO's specialty pharmacy network, please go to the KFHPWAO website at www.kp.org/wa/formulary or contact Member Services at 206-630-4636 or toll-free at 1-888-901-4636.
The Member's Right to Safe and Effective Pharmacy Services: State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee Members' right to know what drugs are covered and the coverage limitations. Members who would like more information about the drug coverage policies, or have a question or concern about their pharmacy benefit, may contact KFHPWAO at 206-630-4636 or toll-free 1-888-901-4636 or by accessing the KFHPWAO website at www.kp.org/wa. Members 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. Members who have a concern about the pharmacists or pharmacies serving them may call the Washington State Department of Health at toll-free 1-800-525-0127.
Prescription Drug Coverage and Medicare: This benefit, for purposes of Creditable Coverage, is actuarially equal to or greater than the Medicare Part D prescription drug benefit. Members who are also eligible for Medicare Part D can remain covered and will not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D plan at a later date; however, the Member could be subject to payment of higher Part D premiums if the Member subsequently has a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan. A Member who discontinues coverage must meet eligibility requirements in order to re-enroll.
Exclusions: Over-the-counter drugs, supplies and devices not requiring a prescription under state law or regulations, including most prescription vitamins, except as recommended by the U.S. Preventive Services Task Force (USPSTF); drugs and injections for anticipated illness while traveling; drugs and injections for cosmetic purposes; replacement of lost or stolen drugs or devices; administration of excluded drugs and injectables; drugs used in the treatment of sexual dysfunction disorders; compounds which include a non-FDA approved drug; growth hormones for idiopathic short stature without growth hormone deficiency; prescription drugs/products available over-the-counter or have an over-the-counter alternative that is determined to be therapeutically interchangeable

Emergency Services	**Preferred Provider Network**	**Out-of-Network**
Emergency Services. See Section XII. for a definition of Emergency. Members must notify KFHPWAO by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Emergency services include professional services, treatment and supplies, facility costs, outpatient charges for patient observation and medical screening exams required to stabilize a patient. Under the PPN option, follow-up care which is a direct result of the Emergency must be received from a Preferred Provider,	After Deductible, Member pays 10% Plan Coinsurance	After PPN Deductible, Member pays 10% Plan Coinsurance

unless Preauthorization is received. Under the Out-of-Network option, follow-up care which is a direct result of the Emergency is covered subject to the Out-of-Network Cost Shares.		
Ambulance Emergency ground or air transport to any facility, including treatment included as part of the ambulance service.	After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance
Under the Preferred Provider Network option, non-Emergency ground or air interfacility transfer to or from a Preferred Provider Network Facility when initiated by KFHPWAO. Under the Preferred Provider Network option, hospital-to-hospital ground transfers when initiated by KFHPWAO. Non-emergent air transportation requires Preauthorization.	After Deductible, Member pays 10% Plan Coinsurance **Hospital-to-hospital ground transfers:** No charge; Member pays nothing	After Deductible, Member pays 50% Plan Coinsurance

Hearing Examinations and Hearing Aids	**Preferred Provider Network**	**Out-of-Network**
Hearing exams for hearing loss and evaluation and diagnostic testing for cochlear implants. Cochlear implants or Bone Anchor Hearing Aids (BAHA) when in accordance with KFHPWAO clinical criteria. Covered services for cochlear implants and BAHA include implant surgery, pre-implant testing, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).	**Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 10% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance

	Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	
Hearing aids including hearing aid examinations.	Not covered; Member pays 100% of all charges	Not covered; Member pays 100% of all charges
Exclusions: Hearing care, routine hearing examinations, programs or treatments for hearing loss including, but not limited to, externally worn hearing aids or surgically implanted hearing aids, and the surgery and services necessary to implant them except as described above, and hearing screening tests required under Preventive Services		

Home Health Care	**Preferred Provider Network**	**Out-of-Network**
Home health care when the following criteria are met, limited to 130 visits per calendar year: • Except for patients receiving palliative care services, the Member must be unable to leave home due to his/her health problem or illness. Unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home. • The Member requires intermittent skilled home health care, as described below. • KFHPWAO's medical director determines that such services are Medically Necessary and are most appropriately rendered in the Member's home. Covered Services for home health care may include the following when rendered pursuant to a 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	After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance

the Member's home. "Intermittent" means care that is to be rendered because of a medically predictable recurring need for skilled home health care. "Skilled home health care" means reasonable and necessary care for the treatment of an illness or injury which requires the skill of a nurse or therapist, based on the complexity of the service and the condition of the patient and which is performed directly by an appropriately licensed professional provider. Under the Out-of-Network option, home health care must be prescribed by a provider and provided by a State-licensed home health agency.		
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	**Preferred Provider Network**	**Out-of-Network**
Hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a Member and any family members who are caring for the Member, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of the Member and their family during the final stages of illness. In order to qualify for hospice care, the Member's provider must certify that the Member is terminally ill and is eligible for hospice services. **Inpatient Hospice Services.** For short-term care, inpatient hospice services are covered with Preauthorization. Respite care is covered to provide continuous care of the Member and allow temporary relief to family members from the duties of caring for the Member on an inpatient or outpatient basis for a maximum of 14 days per lifetime. **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; Member pays nothing	After Deductible, Member pays 50% Plan Coinsurance
Exclusions: Private duty nursing; financial or legal counseling services; meal services; any services provided by family members		

Hospital - Inpatient and Outpatient	Preferred Provider Network	Out-of-Network
The following inpatient medical and surgical services are covered: • Room and board, including private room when prescribed, and general nursing services. • Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy services). • Drugs and medications administered during confinement. • Medical implants. • Acute chemical withdrawal (detoxification). Outpatient hospital includes ambulatory surgical centers. See the Outpatient Services section for provider office visits. Outpatient services include: • Outpatient medical and surgical care • Anesthesia and anesthesia services • Surgical dressings and supplies • Facility costs Members must notify KFHPWAO by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Alternative care arrangements may be covered as a cost-effective alternative in lieu of otherwise covered Medically Necessary hospitalization or other Medically Necessary institutional care with the consent of the Member and recommendation from the attending physician or licensed health care provider. Alternative care arrangements in lieu of covered hospital or other institutional care must be determined to be appropriate and Medically Necessary based upon the Member's Medical Condition. Such care is covered to the same extent the replaced Hospital Care is covered.	**Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 10% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance
Exclusions: Take home drugs, dressings and supplies following hospitalization; internally implanted insulin pumps, and any other implantable device that have not been approved by KFHPWAO's medical director		

Infertility (including sterility)	Preferred Provider Network	Out-of-Network
Services to diagnose infertility conditions in accordance with KFHPWA clinical criteria.	After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance
Treatment and prescription drugs.	Not covered; Member pays 100% of all charges	Not covered; Member pays 100% of all charges
Exclusions: Medical treatment of sterility and infertility regardless of origin or cause; all charges and related services		

for donor materials; all forms of artificial intervention for any reason including artificial insemination and in-vitro fertilization; prognostic (predictive) genetic testing for the detection of congenital and heritable disorders; surrogacy; and any devices, equipment and supplies related to the treatment of infertility

Infusion Therapy	**Preferred Provider Network**	**Out-of-Network**
Medically Necessary infusion therapy includes, but is not limited to: • Antibiotics. • Hydration. • Chemotherapy. • Pain management.	Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance
Associated infused medications.	After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance

Laboratory and Radiology	Preferred Provider Network	Out-of-Network
Nuclear medicine, radiology, ultrasound and laboratory services, including high end radiology imaging services such as CAT scan, MRI and PET which are subject to Preauthorization except when associated with Emergency services or inpatient services. Please contact Member Services for any questions regarding these services. Services received as part of an emergency visit are covered as Emergency Services. Preventive laboratory and radiology services are covered in accordance with the well care schedule established by KFHPWAO 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, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance

Manipulative Therapy	Preferred Provider Network	Out-of-Network
Manipulative therapy of the spine and extremities when in accordance with KFHPWAO clinical criteria, limited to a combined total of 10 visits per calendar year without Preauthorization.	Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance
Exclusions: Supportive care rendered primarily to maintain the level of correction already achieved; care rendered primarily for the convenience of the Member; care rendered on a non-acute, asymptomatic basis; charges for any other services that do not meet KFHPWAO clinical criteria as Medically Necessary		

Maternity and Pregnancy	Preferred Provider Network	Out-of-Network
Maternity care and pregnancy services, including care for complications of pregnancy, in utero treatment for the fetus,	**Hospital - Inpatient:** After Deductible,	**Hospital - Inpatient:** After Deductible,

prenatal testing for the detection of congenital and heritable disorders when Medically Necessary and prenatal and postpartum care are covered for all female members including dependent daughters. Preventive services related to preconception, prenatal and postpartum care are covered as Preventive Services including breastfeeding support, supplies and counseling for each birth when Medically Necessary as determined by KFHPWAO's medical director and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy. Delivery, care for complications of pregnancy and associated Hospital Care, including home births and Medically Necessary supplies for the home birth, and birthing centers. Home births are considered outpatient services. Members must notify KFHPWAO by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. The Member's physician, in consultation with the Member, will determine the Member's length of inpatient stay following delivery.	Member pays 10% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 10% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	Member pays 50% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance
Termination of pregnancy.	**Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance **Hospital - Outpatient:**	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Hospital - Outpatient:**

	After Deductible, Member pays 10% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance
Exclusions: Birthing tubs; genetic testing of non-Members; fetal ultrasound in the absence of medical indications		

Mental Health	**Preferred Provider Network**	**Out-of-Network**
Mental health services provided at the most clinically appropriate Medically Necessary level of mental health care	**Hospital - Inpatient:** After Deductible,	**Hospital - Inpatient:** After Deductible,

intervention as determined by KFHPWAO's medical director. Treatment may utilize psychiatric, psychological and/or psychotherapy services to achieve these objectives. Mental health services including medical management and prescriptions are covered the same as for any other condition. Behavioral treatment for a DSM category diagnosis. Eating disorder treatment provided on an inpatient or outpatient basis must be Medically Necessary and the treatment program must meet clinical criteria standards. The inpatient mental health benefit can only be used if a Member with an eating disorder also meets clinical criteria for inpatient psychiatric care. Applied behavioral analysis (ABA) therapy, limited to outpatient treatment of an autism spectrum disorder as diagnosed and prescribed by a neurologist, pediatric neurologist, developmental pediatrician, psychologist or psychiatrist experienced in the diagnosis and treatment of autism. Documented diagnostic assessments, individualized treatment plans and progress evaluations are required. Partial hospitalization is covered subject to Hospital - Outpatient Cost Shares. Services for any involuntary court-ordered treatment program shall be covered only if determined to be Medically Necessary by KFHPWAO's medical director. Services provided under involuntary commitment statutes are covered. Members must notify KFHPWAO by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Mental health services rendered to treat mental disorders are covered. Mental Disorders means mental disorders covered in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except as otherwise excluded under Sections IV. or V. Mental Health Services means Medically Necessary outpatient services, Residential Treatment, partial hospitalization program, and inpatient services provided by a licensed facility or licensed providers, including advanced practice psychiatric nurses, mental health counselors, marriage and family therapists, and social workers, except as otherwise excluded under Section IV. or V. Medically Necessary mental health services provided in an outpatient and home health setting. Mental health services are covered when Medically Necessary for treatment of parent-child relational problems for children 5 years of age or younger, neglect or abuse of a child for children five years of age or younger, bereavement	Member pays 10% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 10% Plan Coinsurance **Outpatient Services:** Office visits: After Deductbile, Member pays $20 Copayment for primary care provider and specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance **Group Sessions:** No charge; Member pays nothing Enhanced Benefit: Office visits: After Deductbile, Member pays $10 Copayment for primary care provider and specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance **Group Sessions:** No charge; Member pays nothing	Member pays 50% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance

for children five years of age or younger, and gender dysphoria unless preempted by federal law. Medically Necessary inpatient mental health services, partial hospitalization programs, and residential treatment must be provided at a hospital or facility that KFHPWAO has approved specifically for the treatment of mental disorders. Chemical dependency services are covered subject to the Chemical Dependency services benefit.		
Exclusions: Academic or career counseling; personal growth or relationship enhancement; assessment and treatment services that are primarily vocational and academic; court-ordered or forensic treatment, including reports and summaries, not considered Medically Necessary; work or school ordered assessment and treatment not considered Medically Necessary; counseling for overeating not considered Medically Necessary; specialty treatment programs such as "behavior modification programs" not considered Medically Necessary; parent-child relational problems for children six years of age and older; neglect or abuse counseling for individuals six years of age or older; bereavement counseling for individuals six years of age or older; counseling for relational or phase of life problems for individuals six years of age or older; custodial care		

Naturopathy	**Preferred Provider Network**	**Out-of-Network**
Naturopathy, including related laboratory and radiology services.	Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance
Exclusions: Herbal supplements; nutritional supplements; any services not within the scope of the practitioner's licensure		

Newborn Services	**Preferred Provider Network**	**Out-of-Network**
Newborn services, including nursery services and supplies, are covered the same as for any other condition. Any Cost Share for newborn services is separate from that of the	**Hospital - Inpatient:** After Deductible, Member pays 10% Plan	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan

mother. Preventive services for newborns are covered under Preventive Services. See Section VI.A.3. for information about temporary coverage for newborns. Newborn services care covered for newly adopted children.	Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 10% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance

Nutritional Counseling	**Preferred Provider Network**	**Out-of-Network**
Nutritional counseling. Nutritional counseling is not subject	Office visits: Member	Not covered; Member

to visit limitations. Services related to a healthy diet to prevent obesity are covered as Preventive Services.	pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	pays 100% of all charges
Exclusions: Nutritional supplements; weight control self-help programs or memberships, such as Weight Watchers, Jenny Craig, or other such programs; pre and post bariatric surgery nutritional counseling		

Nutritional Therapy	**Preferred Provider Network**	**Out-of-Network**
Dietary formula for the treatment of phenylketonuria (PKU).	No charge; Member pays nothing	No charge; Member pays nothing
Enteral therapy (elemental formulas) for malabsorption and an eosinophilic gastrointestinal associated disorder. Necessary equipment and supplies for the administration of	After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance

enteral therapy are covered as Devices, Equipment and Supplies.		
Parenteral therapy (total parenteral nutrition). Necessary equipment and supplies for the administration of parenteral therapy are covered as Devices, Equipment and Supplies.	After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance
Exclusions: Any other dietary formulas or medical foods; oral nutritional supplements not related to the treatment of inborn errors of metabolism; special diets; and prepared foods/meals		

Obesity Related Services	**Preferred Provider Network**	**Out-of-Network**
Services directly related to obesity, including bariatric surgery. Services related to obesity screening and counseling are covered as Preventive Services.	**Hospital - Inpatient:** Not covered; Member pays 100% of all charges **Hospital - Outpatient:** Not covered; Member pays 100% of all charges **Outpatient Services:** Not covered; Member pays 100% of all charges	**Hospital - Inpatient:** Not covered; Member pays 100% of all charges **Hospital - Outpatient:** Not covered; Member pays 100% of all charges **Outpatient Services:** Not covered; Member pays 100% of all charges
Exclusions: Obesity treatment and treatment for morbid obesity for any reason including any medical services, drugs, supplies or any bariatric surgery (such as gastroplasty, gastric banding or intestinal bypass), 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; pre and post bariatric surgery nutritional counseling		

Oncology	**Preferred Provider Network**	**Out-of-Network**
Radiation therapy, chemotherapy, oral chemotherapy. See Infusion Therapy for infused medications.	**Oral Chemotherapy Drugs:** After Deductible, Member pays $25 Copayment per 30 days up to a 90-day supply **Radiation Therapy and Chemotherapy:** **Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance **Hospital - Outpatient:** After Deductible,	**Oral Chemotherapy Drugs:** Not covered, Member pays 100% of all charges **Radiation Therapy and Chemotherapy:** **Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance

	Member pays 10% Plan Coinsurance **Outpatient Services:** Office visits: Member pays$35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	**Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance

Optical (adult vision)	**Preferred Provider Network**	**Out-of-Network**
Members age 19 and over – routine eye examinations and refractions, limited to one per calendar year. Eye and contact lens examinations for eye pathology and to monitor Medical Conditions when Medically Necessary.	**Routine Exams:** Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits	**Routine Exams:** After Deductible, Member pays 50% Plan Coinsurance **Exams for Eye Pathology:** After Deductible, Member

	Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance **Exams for Eye Pathology:** Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit:	pays 50% Plan Coinsurance

	Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	
Members age 19 and over: Eyeglass frames, lenses (any type), lens options such as tinting, or prescription contact lenses, contact lens evaluations and examinations associated with their fitting. The benefit period begins on the date services are first obtained. The Allowance may be used toward the following in any combination: • Eyeglass frames • Eyeglass lenses (any type) including tinting and coating • Corrective industrial (safety) lenses • Sunglass lenses and frames when prescribed by an eye care provider for eye protection or light sensitivity • Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation examinations • Replacement frames, for any reason, including loss or breakage • Replacement contact lenses • Replacement eyeglass lenses Contact lenses or framed lenses for eye pathology when Medically Necessary. One contact lens per diseased eye in lieu of an intraocular lens is covered following cataract surgery provided the Member has been continuously covered by KFHPWAO since such surgery. In the event a Member's age or medical condition prevents the Member from having an intraocular lens or contact lens, framed lenses are available. Replacement of lenses for eye pathology, including following cataract surgery, is covered only once within a 12 month period and only when needed due to a change in the Member's prescription.	**Frames and Lenses:** No charge; Member pays nothing, limited to an Allowance of $100 per calendar year After Allowance: Not covered; Member pays 100% of all charges **Contact Lenses or framed lenses for Eye Pathology:** After Deductible, Member pays 10% Plan Coinsurance	**Frames and Lenses:** Allowance shared with PPN After Allowance: Not covered; Member pays 100% of all charges **Contact Lenses or framed lenses for Eye Pathology:** After Deductible, Member pays 50% Plan Coinsurance

Exclusions: Orthoptic therapy (i.e. eye training); evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures

Optical (pediatric vision)	**Preferred Provider Network**	**Out-of-Network**
Members to age 19 – routine eye examinations and refractions, limited to one per calendar year. Eye and contact lens examinations for eye pathology and to monitor Medical Conditions when Medically Necessary.	**Routine Exams:** No charge; Member pays nothing **Exams for Eye Pathology:** Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	**Routine Exams:** After Deductible, Member pays 50% Plan Coinsurance **Exams for Eye Pathology:** After Deductible, Member pays 50% Plan Coinsurance
Members to age 19 – Eyeglass frames, lenses (any type), lens	**Frames and Lenses:** No	**Frames and Lenses:**

options such as tinting, or prescription contact lenses, contact lens evaluations and examinations associated with their fitting. The benefit period begins on January 1 and continues through the end of the calendar year. The benefit may be used toward contact lenses (in lieu of eyeglasses) or 1 eyeglass frame and pair of lenses in any of the following combination: • Eyeglass frames • Eyeglass lenses (any type) including tinting and coating • Corrective industrial (safety) lenses • Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation examinations Contact lenses or framed lenses for eye pathology when Medically Necessary. Note: Disposable contact lenses are available up to a 1 year supply as prescribed by the Member's provider. One contact lens per diseased eye in lieu of an intraocular lens is covered following cataract surgery provided the Member has been continuously covered by KFHPWAO since such surgery. In the event a Member's age or medical condition prevents the Member from having an intraocular lens or contact lens, framed lenses are available. Replacement of lenses for eye pathology, including following cataract surgery, is covered only once within a 12 month period and only when needed due to a change in the Member's prescription. Replacement for loss or breakage is subject to the frames and lenses benefit.	charge; Member pays nothing for 1 set of frames and lenses (or corrective contact lenses in lieu of eyeglasses) per calendar year **Contact Lenses or framed lenses for Eye Pathology after benefit is exhausted:** After Deductible, Member pays 10% Plan Coinsurance **After benefit is exhausted and there is no eye pathology indicated:** Not covered; Member pays 100% of all charges	Benefit shared with PPN **Contact Lenses or framed lenses for Eye Pathology after benefit is exhausted:** After Deductible, Member pays 50% Plan Coinsurance **After benefit is exhausted and there is no eye pathology indicated:** Not covered; Member pays 100% of all charges
Low vision evaluation and treatment including: • One comprehensive low vision evaluation every 5 years • Visual aids and devices such as high power spectacles, magnifiers and telescopes as Medically Necessary • Four follow-up care visits for low vision services in a 5 year period Low vision services require Preauthorization.	**Outpatient Services:** Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	**Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance
Exclusions: Orthoptic therapy (i.e. eye training); evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures		

Oral Surgery	Preferred Provider Network	Out-of-Network
Reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or non-dental cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth; and incision of salivary glands and ducts. KFHPWAO's medical director will determine whether the care or treatment required is within the category of Oral Surgery or Dental Services.	**Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 10% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance
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	Preferred Provider Network	Out-of-Network
Covered outpatient medical and surgical services in a provider's office including but not limited to: blood, blood products and blood storage, services and supplies of a blood bank, chronic disease management, routine costs during clinical trials, therapeutic injections, supplies, and Medically Necessary genetic testing. 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 visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty	After Deductible, Member pays 50% Plan Coinsurance

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 medical and surgical services, including ambulatory surgical centers.	care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	

Plastic and Reconstructive Surgery	**Preferred Provider Network**	**Out-of-Network**
Plastic and reconstructive services: • Correction of a congenital disease or congenital anomaly in newborns and dependent children. • Correction of a Medical Condition following an injury or resulting from surgery which has produced a major effect on the Member's appearance, when in the opinion of KFHPWAO's medical director such services can reasonably be expected to correct the condition. • Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed. Members are covered for all stages of reconstruction on the non-diseased breast to produce a symmetrical appearance. Complications of covered mastectomy services, including lymphedemas, are covered. Reconstructive breast surgery requires Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 10% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance

	coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	
Exclusions: Cosmetic services including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services		

Podiatry	**Preferred Provider Network**	**Out-of-Network**
Medically Necessary foot care. Routine foot care covered when such care is directly related to the treatment of diabetes and other clinical conditions that effect sensation and circulation to the feet.	Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical	After Deductible, Member pays 50% Plan Coinsurance

	services: After Deductible, Member pays 10% Plan Coinsurance	
Exclusions: All other routine foot care		

Preventive Services	**Preferred Provider Network**	**Out-of-Network**
Preventive services in accordance with the well care schedule established by KFHPWAO. 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. Flu vaccines are covered up to the Allowed Amount when provided by a non-network provider. Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices. Preventive services include, but are not limited to, well adult and well child physical examinations; immunizations and vaccinations; female sterilization; preferred over-the-counter drugs as recommended by the USPSTF when obtained with a prescription; pap smears; preventive services related to preconception, prenatal and postpartum care routine mammography screening, routine prostate cancer screening, colorectal cancer screening for Members who are age 50 or older or who are under age 50 and at high risk, obesity screening/ counseling, healthy diet; and physical activity counseling; depression screening in adults, including maternal depression. 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.	No charge; Member pays nothing	After Deductible, Member pays 50% Plan Coinsurance

In the event preventive, wellness or chronic care management services are not available from a Network Provider, out-of-network providers are covered under this benefit when Preauthorized. Services provided during a preventive services visit, including laboratory services, which are not in accordance with the KFHPWAO 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 KFHPWAO for early detection of disease; all other diagnostic services not otherwise stated above		

Rehabilitation and Habilitative Care (massage, occupational, physical and speech therapy) and Neurodevelopmental Therapy	**Preferred Provider Network**	**Out-of-Network**
Rehabilitation services to restore function following illness, injury or surgery, limited to the following restorative therapies: occupational therapy, physical therapy, massage therapy and speech therapy. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery. Outpatient services require a prescription or order from a physician that reflects a written plan of care to restore function, and must be provided by a rehabilitation team that may include a physician, nurse, physical therapist, occupational therapist, massage therapist or speech therapist. Rehabilitation Care is limited to a combined total of 30 inpatient days and 25 outpatient visits per calendar year. Habilitative care includes Medically Necessary services or devices designed to help a Member keep, learn, or improve skills and functioning for daily living. Services may include: occupational therapy, physical therapy, speech therapy, aural therapy, and health care devices is covered when prescribed by a physician. . Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Habilitative care is limited to a combined total of 30 inpatient days and 25 outpatient visits per calendar year. Outpatient services include services provided by a school district that are not delivered pursuant to the Individuals with Disabilities Education Act (IDEA) or an Individual Education Plan (IEP). Treatments for cancer, pulmonary or respiratory disease, and other chronic conditions are not included under rehabilitation or habilitative care.	**Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance **Outpatient Services:** Office visits: Member pays$35 Copayment for specialty care provider office visits Group visits (occupational, physical or speech therapy): Member pays one half of the office visit Copayment. Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: (except for massage therapy) Office visits: Member pays$25 Copayment for	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance

Services with mental health diagnoses are covered with no limit. Neurodevelopmental therapy to restore or improve function including maintenance in cases where significant deterioration in the Member's condition would result without the services, limited to the following therapies: occupational therapy, physical therapy and speech therapy. There is no visit limit for neurodevelopmental therapy services. Inpatient rehabilitation services require Preauthorization.	specialty care provider office visits Group visits (occupational, physical or speech therapy): Member pays one half of the office visit Copayment. Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	
Exclusions: Specialty treatment programs; specialty rehabilitation programs including "behavior modification programs"; recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs		

Reproductive Health	**Preferred Provider Network**	**Out-of-Network**
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 termination of pregnancy services Reproductive health is the care necessary to support the reproductive system and the ability to reproduce. Reproductive health includes contraception, cancer and disease screenings, termination of pregnancy, maternity, prenatal and postpartum care.	**Hospital - Inpatient:** No charge; Member pays nothing **Hospital - Outpatient:** No charge; Member pays nothing **Outpatient Services:** Office visits: No charge; Member pays nothing Enhanced Benefit: Office visits: No charge; Member pays nothing	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance
All methods for Medically Necessary FDA-approved (over-the-counter) contraceptive drugs, devices and products. Condoms are limited to 120 per 90-day supply. Contraceptive drugs may be allowed up to a 12-month supply and, when available, picked up in the provider's office.	No charge; Member pays nothing	Not covered; Member pays 100% of all charges

Sexual Dysfunction	**Preferred Provider Network**	**Out-of-Network**
Sexual dysfunction services.	Not covered; Member pays 100% of all charges	Not covered; Member pays 100% of all charges
Exclusions: Diagnostic testing and medical treatment of sexual dysfunction regardless of origin or cause; devices, equipment and supplies for the treatment of sexual dysfunction		

Skilled Nursing Facility	**Preferred Provider Network**	**Out-of-Network**
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 combined total of 60 days per calendar year. Care may include room and board; general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by a skilled nursing facility; services provided by a licensed behavioral health provider, and short-term restorative occupational therapy, physical therapy and speech therapy. Skilled nursing care in a skilled nursing facility requires Preauthorization.	After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan Coinsurance
Exclusions: Personal comfort items such as telephone and television; rest cures; domiciliary or Convalescent Care		

Sterilization	**Preferred Provider Network**	**Out-of-Network**
FDA approved female sterilization procedures, services and supplies. See Preventive Services for additional information.	No charge; Member pays nothing	After Deductible, Member pays 50% Plan Coinsurance
Vasectomy services and supplies.	No charge; Member pays nothing	After Deductible, Member pays 50% Plan Coinsurance
Exclusions: Procedures and services to reverse a sterilization		

Telemedicine	Preferred Provider Network	Out-of-Network
Telemedicine services provided by the use of real time interactive audio and video communication or time delayed transmission of medical information between the patient at the originating site and a provider at another location for diagnosis, consultation, or treatment. Services must be provided by a provider meeting certification requirements established in the state where the provider's practice is located.	No charge; Member pays nothing	**Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance
Exclusions: Audio-only; telephone; fax and e-mail		

Temporomandibular Joint (TMJ)	Preferred Provider Network	Out-of-Network
Medical and surgical services and related hospital charges for the treatment of temporomandibular joint (TMJ) disorders including: • Orthognathic surgery for the treatment of TMJ disorders. • Radiology services. • TMJ specialist services. • Fitting/adjustment of splints. TMJ surgery requires Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 10% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance

	office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	
TMJ appliances. See Devices, Equipment and Supplies for additional information.	After Deductible, Member pays 10% Plan Coinsurance	After Deductible, Member pays 50% Plan 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, severe obstructive sleep apnea; hospitalizations related to these exclusions		

Tobacco Cessation	**Preferred Provider Network**	**Out-of-Network**
Individual/group counseling and educational materials.	No charge; Member pays nothing	After Deductible, Member pays 50% Plan Coinsurance
Approved pharmacy products. See Drugs – Outpatient Prescription for additional pharmacy information.	No charge; Member pays nothing	Not covered; Member pays 100% of all charges

Transgender Services	**Preferred Provider Network**	**Out-of-Network**
Medically Necessary medical and surgical services for gender reassignment. 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 for coverage). Transgender services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance **Hospital - Outpatient:** After Deductible, After Deductible, Member pays 10% Plan Coinsurance **Outpatient Services:** Office visits: Member	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan

	pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	Coinsurance
Exclusions: Cosmetic services including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services travel		

Transplants	**Preferred Provider Network**	**Out-of-Network**
Transplant services, including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, liver transplants, and bone marrow and stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy. Services are limited to the following:	**Hospital - Inpatient:** After Deductible, Member pays 10% Plan Coinsurance **Hospital - Outpatient:** After Deductible,	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan Coinsurance **Hospital - Outpatient:** After Deductible,

• 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. Artificial organ transplants based on an issuer's medical guidelines and manufacturer recommendation. Transplant services require Preauthorization.	Member pays 10% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% Plan Coinsurance
Exclusions: Donor costs to the extent that they are reimbursable by the organ donor's insurance; treatment of donor complications; living expenses; transportation expenses except as covered as Ambulance Services		

Urgent Care	**Preferred Provider Network**	**Out-of-Network**
Under the PPN option, urgent care is covered at a Kaiser Permanente medical center, Kaiser Permanente urgent care center or Preferred Provider's office. Under the Out-of-Network option, urgent care is covered at any medical facility. Urgent care includes provider services, facility costs and supplies. See Section XII. for a definition of Urgent Condition.	**Emergency Department:** After Deductible, Member pays 10% Plan Coinsurance **Urgent Care Center:** Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After	**Emergency Department:** After PPN Deductible, Member pays 10% Plan Coinsurance **Urgent Care Center:** After Deductible, Member pays 50% Plan Coinsurance **Provider's Office:** After Deductible, Member pays 50% Plan Coinsurance

	Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance **Provider's Office:** Office visits: Member pays $20 Copayment for primary care provider office visits or $35 Copayment for specialty care provider office visits Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $25 Copayment for specialty care provider office visits	

	Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 10% Plan Coinsurance	

Virtual Care	**Preferred Provider Network**	**Out-of-Network**
Healthcare service provided through the use of online technology, telephonic and secure messaging of member initiated care from a remote location (ex. home) with an in-network provider that is diagnostic and treatment focused. The Member is NOT located at a healthcare site.	No charge; Member pays nothing	Not covered; Member pays 100% of all charges

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. Follow-up services or complications related to non-Covered Services, except as required by federal or state law.

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

4. Convalescent Care.

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

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

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

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

9. Experimental or investigational services.

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

   a. A service is considered experimental or investigational for a Member's condition if any of the following statements apply to it at the time the service is or will be provided to the Member:
      1) The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted.
      2) The service is the subject of a current new drug or new device application on file with the FDA.
      3) The service is the trialed agent or for delivery or measurement of the trialed agent provided as part of a qualifying Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial.
      4) The service is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy as among its objectives.
      5) The service is under continued scientific testing and research concerning the safety, toxicity or efficacy of services.
      6) The service is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity or efficacy.

7) The prevailing opinion among experts, as expressed in the published authoritative medical or scientific literature, is that (1) the use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity or efficacy of the service.

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

Appeals regarding KFHPWAO denial of coverage can be submitted to the Member Appeal Department, or to KFHPWAO'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-Members.

13. Autopsy and associated expenses.

14. Job skills training for specific occupations or educational therapy.

15. Expenses for services and supplies incurred as a result of any work-related injury or illness. This includes individuals who are partners, proprietors or corporate officers who are not covered by a Workers' Compensation Act or other similar law.

VI. Eligibility, Enrollment and Termination

A. Eligibility.

In order to be accepted for enrollment and continuing coverage, individuals must meet any eligibility requirements, reside or work in the Service Area and meet all applicable requirements set forth below, 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 KFHPWAO. KFHPWAO has the right to verify eligibility.

1. Subscribers.

Bona fide employees as established and enforced by the Group shall be eligible for enrollment. Please contact the Group for more information.

2. Dependents.

The Subscriber may also enroll the following:

a. The Subscriber's legal spouse.

b. The Subscriber's state-registered domestic partner (as required by Washington State law) or if specifically included as eligible by the Group, the Subscriber's non-state registered domestic partner.

c. Children who are under the age of 26.

"Children" means the children of the Subscriber, spouse or eligible domestic partner, including adopted children, stepchildren, children for whom the Subscriber has a qualified court order to provide coverage and any other children for whom the Subscriber is the legal guardian.

Eligibility may be extended past the Dependent's limiting age as set forth above if the Dependent is totally incapable of self-sustaining employment because of a developmental or physical disability incurred prior to attainment of the limiting age, and is chiefly dependent upon the Subscriber for support and maintenance. Enrollment for such a Dependent may be continued for the duration of the continuous total incapacity, provided enrollment does not terminate for any other reason. Medical proof of incapacity and proof of financial dependency must be submitted to KFHPWAO within 31 days of the date a Dependent reaches the limiting age. Proof must also be furnished to KFHPWAO upon request, but not more frequently than annually after the 2 year period following the Dependent's attainment of the limiting age.

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

B. Application for Enrollment.
Application for enrollment must be made on an application approved by KFHPWAO. The Group is responsible for submitting completed applications to KFHPWAO.

KFHPWAO reserves the right to refuse enrollment to any person whose coverage under any medical coverage agreement issued by Kaiser Foundation Health Plan of Washington Options, Inc. or Kaiser Foundation Health Plan of Washington ("KFHPWA") has been terminated for cause.

1. Newly Eligible Subscribers.
Newly eligible Subscribers and their Dependents may apply for enrollment in writing to the Group within 31 days of becoming eligible.

2. New Dependents.
A written application for enrollment of a newly dependent person, other than a newborn or adopted child, must be made to the Group within 31 days after the dependency occurs.

A written application for enrollment of a newborn child must be made to the Group within 60 days following the date of birth when there is a change in the monthly premium payment as a result of the additional Dependent.

A written application for enrollment of an adoptive child must be made to the Group within 60 days from the day the child is placed with the Subscriber for the purpose of adoption or the Subscriber assumes total or partial financial support of the child if there is a change in the monthly premium payment as a result of the additional Dependent.

When there is no change in the monthly premium payment, it is strongly advised that the Subscriber enroll the newborn or newly adoptive child as a Dependent with the Group to avoid delays in the payment of claims.

3. Open Enrollment.
KFHPWAO will allow enrollment of Subscribers and Dependents who did not enroll when newly eligible as described above during a limited period of time specified by the Group and KFHPWAO.

4. Special Enrollment.

a. KFHPWAO will allow special enrollment for persons:
   1) Who initially declined enrollment when otherwise eligible because such persons had other health care coverage and have had such other coverage terminated due to one of the following events:
      - Cessation of employer contributions.
      - Loss of eligibility for the other coverage, except for loss of eligibility for cause.
      - Exhaustion of COBRA continuation coverage.
   2) Who initially declined enrollment when otherwise eligible because such persons had other health care coverage and who have had such other coverage exhausted because such person reached a lifetime maximum limit.

   KFHPWAO or the Group may require confirmation that when initially offered coverage such persons submitted a written statement declining because of other coverage. Application for coverage must be made within 60 days of the termination of previous coverage.

b. KFHPWAO will allow special enrollment for individuals who are eligible to be a Subscriber and his/her Dependents in the event one of the following occurs:
   1) Marriage or domestic partnership. Application for coverage must be made within 60 days of the date of marriage.
   2) Dissolution of Marriage or Termination of domestic partnership. Application for coverage must be made within 60 days of the dissolution/termination.
   3) Birth. Application for coverage for the Subscriber and Dependents other than the newborn child must be made within 60 days of the date of birth.
   4) Adoption or placement for adoption. Application for coverage for the Subscriber and Dependents other than the adopted child must be made within 60 days of the adoption or placement for adoption.
   5) Eligibility for premium assistance from Medicaid or a state Children's Health Insurance Program (CHIP), provided such person is otherwise eligible for coverage under this EOC. The request for special enrollment must be made within 60 days of the eligibility for such premium assistance.
   6) Coverage under a Medicaid or CHIP plan is terminated as a result of loss of eligibility for such coverage. Application for coverage must be made within 60 days of the date of termination under Medicaid or CHIP.
   7) A permanent change in residence, work, or living situation. Voluntary and involuntary change where the Member's health plan coverage is not offered in the new area. Application for coverage must be made within 60 days of the change in residence, work, or living situation.
   8) Loss of individual or group Health Benefit Exchange coverage due to error by the Health Benefit Exchange, the insurance carrier, or the U.S. Department of Health and Human Services. Application for coverage must be made within 60 days of the loss of coverage.
   9) Applicable federal or state law or regulation otherwise provides for special enrollment.

C. When Coverage Begins.

1. Effective Date of Enrollment.

- Enrollment for a newly eligible Subscriber and listed Dependents is effective on the date eligibility requirements are met, provided the Subscriber's application has been submitted to and approved by KFHPWAO. Please contact the Group for more information.
- Enrollment for a newly dependent person, other than a newborn or adoptive child, is effective on the first of the month following the date eligibility requirements are met. Please contact the Group for more information.
- Enrollment for newborns is effective from the date of birth.
- Enrollment for adoptive children is effective from the date that the adoptive child is placed with the Subscriber for the purpose of adoption or the Subscriber assumes total or partial financial support of the child.

2. Commencement of Benefits for Persons Hospitalized on Effective Date.
Members who are admitted to an inpatient facility prior to their enrollment will receive covered benefits beginning on their effective date, as set forth in Subsection C.1. above.

D. Eligibility for Medicare.
An individual shall be deemed eligible for Medicare when he/she has the option to receive Part A Medicare benefits. Medicare secondary payer regulations and guidelines will determine primary/secondary payer status for individuals covered by Medicare.

A Member who is enrolled in Medicare has the option of continuing coverage under this EOC while on Medicare coverage. Coverage between this EOC and Medicare will be coordinated as outlined in Section X.

E. Termination of Coverage.
The Subscriber shall be liable for payment of all charges for services and items provided to the Subscriber and all Dependents after the effective date of termination.

Termination of Specific Members.
Individual Member coverage may be terminated for any of the following reasons:

1. Loss of Eligibility. If a Member no longer meets the eligibility requirements and is not enrolled for continuation coverage as described in Subsection G. below, coverage will terminate at the end of the month during which the loss of eligibility occurs, unless otherwise specified by the Group.

2. For Cause. In the event of termination for cause, KFHPWAO reserves the right to pursue all civil remedies allowable under federal and state law for the collection of claims, losses or other damages. Coverage of a Member may be terminated upon 10 working days written notice for:
   a) Material misrepresentation, fraud or omission of information in order to obtain coverage.
   b) Permitting the use of a KFHPWAO identification card or number by another person, or using another Member's identification card or number to obtain care to which a person is not entitled.

3. Premium Payments. Nonpayment of premiums or contribution for a specific Member by the Group.

Individual Member coverage may be retroactively terminated upon 30 days written notice and only in the case of fraud or intentional misrepresentation of a material fact; or as otherwise allowed under applicable law or regulation. Notwithstanding the foregoing, KFHPWAO reserves the right to retroactively terminate coverage for nonpayment of premiums or contributions by the Group as described above.

In no event will a Member be terminated solely on the basis of their physical or mental condition provided they meet all other eligibility requirements set forth in the EOC.

Any Member may appeal a termination decision through KFHPWAO's appeals process.

F. Continuation of Inpatient Services.
A Member who is receiving Covered Services in a hospital on the date of termination shall continue to be eligible for Covered Services while an inpatient for the condition which the Member was hospitalized, until one of the following events occurs:

- According to KFHPWAO clinical criteria, it is no longer Medically Necessary for the Member 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 Member becomes covered under another agreement with a group health plan that provides benefits for the hospitalization.
- The Member becomes enrolled under an agreement with another carrier that provides benefits for the hospitalization.

This provision will not apply if the Member is covered under another agreement that provides benefits for the hospitalization at the time coverage would terminate, except as set forth in this section, or if the Member is eligible for COBRA or USERRA continuation coverage as set forth in Subsection G. below.

G. Continuation of Coverage Options.

1. Continuation Option.
A Member no longer eligible for coverage (except in the event of termination for cause, as set forth in Subsection E.) may continue coverage for a period of up to 3 months subject to notification to and self-payment of premiums to the Group. This provision will not apply if the Member is eligible for the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This continuation option is not available if the Group no longer has active employees or otherwise terminates.

2. Leave of Absence.
While on a Group approved leave of absence, the Subscriber and listed Dependents can continue to be covered provided that:

- They remain eligible for coverage, as set forth in Subsection A.,
- Such leave is in compliance with the Group's established leave of absence policy that is consistently applied to all employees,
- The Group's leave of absence policy is in compliance with the Family and Medical Leave Act when applicable, and
- The Group continues to remit premiums for the Subscriber and Dependents to KFHPWAO.

3. Self-Payments During Labor Disputes.
In the event of suspension or termination of employee compensation due to a strike, lock-out or other labor dispute, a Subscriber may continue uninterrupted coverage through payment of monthly premiums directly to the Group. Coverage may be continued for the lesser of the term of the strike, lock-out or other labor dispute, or for 6 months after the cessation of work.

If coverage under the EOC is no longer available, the Subscriber shall have the opportunity to apply for an individual KFHPWAO group conversion plan or, if applicable, continuation coverage (see Subsection 4. below), or an individual and family plan at the duly approved rates.

The Group is responsible for immediately notifying each affected Subscriber of his/her rights of self-payment under this provision.

4. Continuation Coverage Under Federal Law.
This section applies only to Groups who must offer continuation coverage under the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, or the Uniformed Services Employment and Reemployment Rights Act (USERRA) and only applies to grant continuation of coverage rights to the extent required by federal law. USERRA only applies in certain situations to employees who are leaving employment to serve in the United States Armed Forces.

Upon loss of eligibility, continuation of Group coverage may be available to a Member for a limited time after the Member would otherwise lose eligibility, if required by COBRA. The Group shall inform Members of the COBRA election process and how much the Member will be required to pay directly to the Group.

Continuation coverage under COBRA or USERRA will terminate when a Member becomes covered by Medicare or obtains other group coverage, and as set forth under Subsection E.

5. KFHPWAO Group Conversion Plan.
Members whose eligibility for coverage, including continuation coverage, is terminated for any reason other than cause, as set forth in Subsection E., and who are not eligible for Medicare or covered by another

group health plan, may convert to an individual KFHPWAO group conversion plan. If coverage under the EOC terminates, any Member covered at termination (including spouses and Dependents of a Subscriber who was terminated for cause) may convert to a KFHPWAO group conversion plan, unless he/she is eligible to obtain other group health coverage within 31 days of the termination. Coverage will be retroactive to the date of loss of eligibility.

An application for conversion must be made within 31 days following termination of coverage or within 31 days from the date notice of the termination of coverage is received, whichever is later. A physical examination or statement of health is not required for enrollment in a KFHPWAO group conversion plan.

Persons wishing to purchase KFHPWAO's individual and family coverage should contact KFHPWAO.

VII. Grievances

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

Step 1: The Member should contact the person involved, explain his/her concerns and what he/she would like to have done to resolve the problem. The Member should be specific and make his/her position clear.

Step 2: If the Member is not satisfied, or if he/she prefers not to talk with the person involved, the Member should call the department head or the manager of the medical center or department where he/she is having a problem. That person will investigate the Member's concerns. Most concerns can be resolved in this way.

Step 3: If the Member is still not satisfied, he/she should call Member Services at 206-630-4636 or toll-free 1-888-901-4636. Most concerns are handled by phone within a few days. In some cases the Member will be asked to write down his/her concerns and state what he/she thinks would be a fair resolution to the problem. An appropriate representative will investigate the Member's concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Member Rights and Responsibilities statement. This process can take up to 30 days to resolve after receipt of the Member's written statement.

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

VIII. Appeals

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

The most current information about your appeals process is available by contacting KFHPWAO's Member Appeal Department at the address or telephone number below.

1. **Initial Appeal**
   If the Member or the Member's legal representative wishes to appeal a KFHPWAO decision to deny, modify, reduce or terminate coverage of or payment for health care services, he/she must submit a request

for an appeal either orally or in writing to KFHPWAO's Member Appeal Department, specifying why he/she disagrees with the decision. The appeal must be submitted within 180 days of the denial notice he/she received. KFHPWAO will notify the Member of its receipt of the request within 72 hours of receiving it. Appeals should be directed to KFHPWAO'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. KFHPWAO will then notify the Member 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 Member's written permission.

For appeals involving experimental or investigational services KFHPWAO will make a decision and communicate the decision to the Member 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 Member's life, health or ability to regain maximum function or subject the Member to severe pain that cannot be managed adequately without the requested care or treatment. The Member can request an expedited/urgent appeal in writing to the above address, or by calling KFHPWAO'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 member 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 member'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 Member may also request an external review at the same time as the internal appeals process if it is an urgent care situation or the Member is in an ongoing course of treatment.

If the Member requests an appeal of a KFHPWAO decision denying benefits for care currently being received, KFHPWAO will continue to provide coverage for the disputed benefit pending the outcome of the appeal. If the KFHPWAO determination stands, the Member 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 Member is not satisfied with the decision regarding medical necessity, medical appropriateness, health care setting, level of care, or if the requested service is not efficacious or otherwise unjustified under evidence-based medical criteria, or if KFHPWAO fails to adhere to the requirements of the appeals process, the Member may request a second level review by an external independent review organization not legally affiliated with or controlled by KFHPWAO. KFHPWAO will notify the Member of the name of the external independent review organization and its contact information. The external independent review organization will accept additional written information for up to 5 business days after it receives the assignment for the appeal. The external independent review will be conducted at no cost to the Member. Once a decision is made through an independent review organization, the decision is final and cannot be appealed through KFHPWAO.

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

IX. Claims

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

If a Member receives a bill for services the Member believes are covered, the Member must, within 90 days of the date of service, or as soon thereafter as reasonably possible, either (1) contact Member Services to make a claim, (2) pay the bill and submit a claim for reimbursement of Covered Services, or (3) For out-of-country claims (Emergency care only) – submit the claim and any associated medical records translated into English at the Member's expense, including the type of service, charges in U.S. Dollars, and proof of travel to KFHPWAO, P.O. Box 34585, Seattle, WA 98124-1585. In no event, except in the absence of legal capacity, shall a claim be accepted later than 1 year from the date of service.

KFHPWAO will generally process claims for benefits within the following timeframes after KFHPWAO 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 KFHPWAO for up to an additional 15 days. Members will be notified in writing of such extension prior to the expiration of the initial timeframe.

X. Coordination of Benefits

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

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

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

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

If the Member is covered by more than one health benefit plan, the Member or the Member's provider should file all the Member's claims with each plan at the same time. If Medicare is the Member's primary plan, Medicare may submit the Member's claims to the Member'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 Members of a Group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

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 Member has health care coverage under more than one plan.

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

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 Member is not an allowable expense.

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

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

2. If a Member is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method,

any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

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

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

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

4. COBRA or State Continuation Coverage. If a Member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the Member as an employee, member, Subscriber or retiree or covering the Member 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 Member as an employee, member, Subscriber or retiree longer is the primary plan and the plan that covered the Member 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 Member 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. KFHPWAO may get the facts it needs from or give them to other

organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the Member claiming benefits. KFHPWAO need not tell, or get the consent of, any Member to do this. Each Member claiming benefits under this plan must give KFHPWAO 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, KFHPWAO 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, KFHPWAO is fully discharged from liability under this plan.

Right of Recovery.
KFHPWAO 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. KFHPWAO 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 KFHPWAO as set forth in this section. KFHPWAO 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 Preferred Provider renders care to a Member who is eligible for Medicare benefits, and Medicare is deemed to be the primary bill payer under Medicare secondary payer guidelines and regulations, KFHPWAO will seek Medicare reimbursement for all Medicare covered services.

When a Member, who is a Medicare beneficiary and for whom Medicare has been determined to be the primary bill payer under Medicare secondary payer guidelines and regulations, seeks care from Out-of-Network Providers, KFHPWAO has no obligation to provide any benefits except as specifically outlined in the Out-of-Network option under Section IV.

XI. Subrogation and Reimbursement Rights

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

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

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

"Injured Person" under this section means a Member 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 Member including the estate of the Member and, if the Member is a minor, the guardian or parent of the Member. When referred to in this section, "KFHPWAO's Medical Expenses" means the expenses incurred and the value of the benefits provided by KFHPWAO 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, KFHPWAO shall have the right to recover KFHPWAO'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." KFHPWAO shall be subrogated to and may enforce all rights of the Injured Person to the full extent of KFHPWAO's Medical Expenses.

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

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

KFHPWAO'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, KFHPWAO's Medical Expenses are secondary, not primary.

The Injured Person and his/her agents shall cooperate fully with KFHPWAO in its efforts to collect KFHPWAO's Medical Expenses. This cooperation includes, but is not limited to, supplying KFHPWAO 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 KFHPWAO 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 KFHPWAO's right to reimbursement or subrogation as requested by KFHPWAO, and shall inform KFHPWAO of any settlement or other payments relating to the Injured Person's injury. The Injured Person and his/her agents shall permit KFHPWAO, at KFHPWAO'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 his/her agents shall do nothing to prejudice KFHPWAO's subrogation and reimbursement rights. The Injured Person shall promptly notify KFHPWAO of any tentative settlement with a third party and shall not settle a claim without protecting KFHPWAO's interest. The Injured Person shall provide 21 days advance notice to KFHPWAO 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 KFHPWAO in recovery of KFHPWAO's Medical Expenses, and such failure prejudices KFHPWAO's subrogation and/or reimbursement rights, the Injured Person shall be responsible for directly reimbursing KFHPWAO for 100% of KFHPWAO'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 KFHPWAO's right of reimbursement or subrogation, the Injured Person agrees to hold such monies in trust or in a separate identifiable account until KFHPWAO's subrogation and reimbursement rights are fully determined and that KFHPWAO has an equitable lien over such monies to the full extent of KFHPWAO's Medical Expenses and/or the Injured Person agrees to serve as constructive trustee over the monies to the extent of KFHPWAO'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 KFHPWAO's rights of subrogation or reimbursement will be personally liable to KFHPWAO for the amounts so distributed.

If reasonable collections costs have been incurred by an attorney for the Injured Person in connection with obtaining recovery, KFHPWAO will reduce the amount of reimbursement to KFHPWAO by the amount of an equitable apportionment of such collection costs between KFHPWAO and the Injured Person. This reduction will be made only if each of the following conditions has been met: (i) KFHPWAO 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.

implementation of this section shall be deemed a part of claims administration and KFHPWAO shall therefore have discretion to interpret its terms.

XII. Definitions

Allowance	The maximum amount payable by KFHPWAO for certain Covered Services.
Allowed Amount	The amount that is reimbursable to the provider and includes payments by KFHPWAO, the Member, and other third party payers, as applicable. (1) For Preferred Providers: the amount these providers have agreed to accept as payment in full for a service. (2) For Out-of-Network Providers: (a) an amount equal to125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare fee schedule) for facility or physician professional services and 105% of the Medicare fee schedule for non-physician professional services or (b) KFHPWAO's lowest reimbursable amount for the same or similar service from a Preferred Provider if such service is not included in the Medicare fee schedule. There is an exception to the above definition of Allowed Amount for out-of-network services rendered in the emergency department of a hospital. For such services, the Allowed Amount is at least defined as equal to the greatest of (adjusted for in-network cost sharing) the following: (i) the median amount reimbursed for the same or similar service from a Preferred Provider, (ii) the amount generally payable to Out-of-Network Providers (see methodologies above), or (iii) 100% of the Medicare fee schedule. For all Out-of-Network Provider's charges Members shall be required to pay any difference between the charge for services and the Allowed Amount.
Convalescent Care	Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in walking, dressing, bathing, eating, preparation of special diets, and taking medication.
Copayment	The specific dollar amount a Member is required to pay at the time of service for certain Covered Services.
Cost Share	The portion of the cost of Covered Services for which the Member is liable. Cost Share includes Copayments, coinsurances and Deductibles.
Covered Services	The services for which a Member is entitled to coverage in the Evidence of Coverage.
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 KFHPWAO's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.
Deductible	A specific amount a Member is required to pay for certain Covered Services before benefits are payable.

Dependent	Any member of a Subscriber's family who meets all applicable eligibility requirements, is enrolled hereunder and for whom the premium has been paid.
Emergency	The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent lay person acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily function or serious dysfunction of a bodily organ or part, or would place the Member's health, or if the Member is pregnant, the health of her unborn child, in serious jeopardy, or any other situations which would be considered an emergency under applicable federal or state law.
Essential Health Benefits	Benefits set forth under the Patient Protection and Affordable Care Act of 2010, including the categories of ambulatory patient services, Emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.
Evidence of Coverage (EOC)	The statement of benefits, exclusions and other provisions as set forth in the Group medical coverage agreement between KFHPWAO and the Group.
Family Unit	A Subscriber and all his/her Dependents.
Group	An employer, union, welfare trust or bona-fide association which has entered into a Group medical coverage agreement with KFHPWAO.
Hospital Care	Those Medically Necessary services generally provided by acute general hospitals for admitted patients.
Medical Condition	A disease, illness or injury.
Medically Necessary	Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Members will be notified in writing when a determination has been made. Appropriate and clinically necessary services, as determined by KFHPWAO's medical director according to generally accepted principles of good medical practice, which are rendered to a Member for the diagnosis, care or treatment of a Medical Condition and which meet the standards set forth below. In order to be Medically Necessary, services and supplies must meet the following requirements: (a) are not solely for the convenience of the Member, his/her family or the provider of the services or supplies, including exercise equipment and home modifications such as ramps and walkways; (b) are the most appropriate level of service or supply which can be safely provided to the Member; (c) are for the diagnosis or treatment of an actual or existing Medical Condition unless being provided under KFHPWAO's schedule for preventive services; (d) are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions; (e) are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the Member's condition or the quality of health services rendered; (f) as to inpatient care, could not have been provided in a provider's office, the outpatient department of a hospital or a non-residential facility without affecting the Member's condition or quality of health services rendered; (g) are not primarily for research and data accumulation; and (h) are not experimental or investigational. The length and type of the treatment program and the frequency and

	modality of visits covered shall be determined by KFHPWAO's medical director. In addition to being medically necessary, to be covered, services and supplies must be otherwise included as a Covered Service and not excluded from coverage.
Medicare	The federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).
Member	Any enrolled Subscriber or Dependent.
Out-of-Network	Physicians licensed under 18.71 or 18.57 RCW, registered nurses licensed under 18.79 RCW, midwives licensed under 18.79 RCW, naturopaths licensed under 18.36A RCW, acupuncturists licensed under 18.06 RCW, podiatrists licensed under 18.22 RCW or, in the case of non-Washington State providers or out-of-country providers, those providers meeting equivalent licensing and certification requirements established in the territories where the provider's practice is located. For purposes of the EOC, Out-of-Network Providers do not include individuals employed by or under contract with KFHPWAO's Preferred Provider Network or who provide a service or treat Members outside the scope of their licenses.
Out-of-pocket Expenses	Those Cost Shares paid by the Subscriber or Member for Covered Services which are applied to the Out-of-pocket Limit.
Out-of-pocket Limit	The maximum amount of Out-of-pocket Expenses incurred and paid during the calendar year for Covered Services received by the Subscriber and his/her 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 Member is required to pay for Covered Services received.
PPN Facility	A facility (hospital, medical center or health care center) owned or operated by Kaiser Foundation Health Plan of Washington or otherwise designated by KFHPWAO's Preferred Provider Network.
Preauthorization	An approval by KFHPWAO that entitles a Member to receive Covered Services from a specified health care provider. Services shall not exceed the limits of the Preauthorization and are subject to all terms and conditions of the EOC. Benefits do not require Preauthorization, except as noted under Section IV. Members who have a complex or serious medical or psychiatric condition may receive a standing Preauthorization for specialty care provider services.
Preferred Provider	A provider who is employed by Kaiser Foundation Health Plan of Washington or Washington Permanente Medical Group, P.C., or contracted with the Preferred Provider Network to provide primary care services to Members and any other health care professional or provider with whom the Preferred Provider Network has contracted to provide health care services to Members enrolled, 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.
Preferred Provider Network	The participating providers with which KFHPWAO has entered into a written participating provider agreement for the provision of Covered Services.

Residential Treatment	A term used to define facility-based treatment, which includes 24 hours per day, 7 days per week rehabilitation. Residential Treatment services are provided in a facility specifically licensed in the state where it practices as a residential treatment center. Residential treatment centers provide active treatment of patients in a controlled environment requiring at least weekly physician visits and offering treatment by a multi-disciplinary team of licensed professionals.
Service Area	Washington counties of Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman and Yakima.
Subscriber	A person employed by or belonging to the Group who meets all applicable eligibility requirements, is enrolled and for whom the premium has been paid.
Urgent Condition	The sudden, unexpected onset of a Medical Condition that is of sufficient severity to require medical treatment within 24 hours of its onset.

APPENDIX B

Prevalence of Hearing Loss by Severity in the United States

Adele M. Goman, PhD, and Frank R. Lin, MD, PhD

Objectives. To estimate the age- and severity-specific prevalence of hearing impairment in the United States.

Methods. We conducted cross-sectional analyses of 2001 through 2010 data from the National Health and Nutrition Examination Survey on 9648 individuals aged 12 years or older. Hearing loss was defined as mild (> 25 dB through 40 dB), moderate (> 40 dB through 60 dB), severe (> 60 dB through 80 dB), or profound (> 80 dB).

Results. An estimated 25.4 million, 10.7 million, 1.8 million, and 0.4 million US residents aged 12 years or older, respectively, have mild, moderate, severe, and profound better-ear hearing loss. Older individuals displayed a higher prevalence of hearing loss and more severe levels of loss. Across most ages, the prevalence was higher among Hispanic and non-Hispanic Whites than among non-Hispanic Blacks and was higher among men than women.

Conclusions. Hearing loss directly affects 23% of Americans aged 12 years or older. The majority of these individuals have mild hearing loss; however, moderate loss is more prevalent than mild loss among individuals aged 80 years or older.

Public Health Implications. Our estimates can inform national public health initiatives on hearing loss and help guide policy recommendations currently being discussed at the Institute of Medicine and the White House. (*Am J Public Health.* 2016;106:1820–1822. doi:10.2105/AJPH.2016.303299)

Current initiatives of the Institute of Medicine[1] and the President's Council of Advisors on Science and Technology[2] are addressing hearing loss as a key public health issue given its potential impact on the cognitive, social, and physical functioning of adults.[3,4] However, existing estimates[5] of hearing loss prevalence are outdated, do not reflect current population estimates, and do not include estimates according to hearing loss severity. Updated information by hearing loss severity is important for informing policy decisions. We sought to estimate the number of people in the United States who have a hearing impairment by severity and age using audiometric data and the most currently available population estimates.

METHODS

We analyzed data from the 2001 to 2010 cycles of the National Health and Nutritional Examination Survey, an ongoing biannual epidemiological survey of a representative sample of the US noninstitutionalized population. Air-conduction pure-tone audiometry tests performed in a sound-attenuating booth (measured in decibel hearing level) were administered to a random half sample of all participants aged 20 to 69 years from 2001 to 2004, all participants aged 70 years or older in the 2005–2006 and 2009–2010 cycles, and all participants aged 12 to 19 years in the 2005–2006, 2007–2008, and 2009–2010 cycles.

The same standardized protocol for audiometric testing was followed in all cycles. Individuals were excluded if threshold data were missing for one ear or there was a difference of more than 10 decibels in a 1-kilohertz retest of the same ear. If participants did not hear the stimulus at the highest level tested (120 dB), a threshold of 125 decibels was assigned, providing a conservative estimate of their hearing and allowing an average threshold to be calculated.

A 4-frequency (0.5 kHz, 1 kHz, 2 kHz, 4 kHz) pure-tone-average threshold was calculated for each ear. World Health Organization criteria were used to classify the severity of hearing loss in each ear as mild (> 25 dB through 40 dB), moderate (> 40 dB through 60 dB), severe (> 60 dB through 80 dB), or profound (> 80 dB). In instances in which the hearing loss severity classification differed between the 2 ears, bilateral hearing loss severity was based on the better ear (i.e., mild bilateral loss was defined as one ear having mild loss and the other ear having mild or greater loss).

We estimated prevalence of hearing loss by severity over age decades. Overall hearing loss prevalence was estimated according to age decade, gender, and self-reported race/ethnicity (non-Hispanic White, non-Hispanic Black, Hispanic, other; Table A, available as a supplement to the online version of this article at http://www.ajph.org). We used 2015 US population estimates to estimate the number of people with hearing loss.[6] To account for the complex sampling design, we employed sample weights in accordance with National Center for Health Statistics guidelines.[7] Analyses were conducted in Stata version 12 (StataCorp LP, College Station, TX).

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RESULTS

Table 1 displays the prevalence of, and number of individuals with, hearing loss by severity and age. Across the ages of 12 through 79 years, the most prevalent type of hearing loss was mild (> 25 dB through 40 dB). Only in the oldest age bracket (> 80 years) did the prevalence of moderate hearing loss (41% in at least 1 ear, 38% bilateral) exceed that of mild loss (31% in at least 1 ear, 36% bilateral).

We estimate that 6.6 million (2.5%) Americans aged 12 years or older have severe to profound hearing loss in at least 1 ear, with three quarters of these individuals (5.0 million) being older than 60 years. Overall, we estimate that 38.2 million (14.3%) Americans aged 12 years or older have bilateral hearing loss and that 60.7 million (22.7%) have hearing loss in at least 1 ear.

In our sample, the prevalence of hearing loss was higher among older than younger individuals, and, among those aged 40 years or older, the prevalence was significantly higher among men than women ($P < .01$; Table A). The prevalence of hearing loss among Hispanics and non-Hispanic Whites was higher than the prevalence among non-Hispanic Blacks across almost all ages (Table A).

DISCUSSION

In the United States, nearly 1 in 4 individuals aged 12 years or older have hearing loss in at least 1 ear, and 1 in 7 have bilateral hearing loss. Hearing loss is more prevalent among older adults, with two thirds of individuals aged 70 years or older having bilateral hearing loss and almost three quarters having hearing loss in at least 1 ear. Hearing loss is more prevalent among men than women; one third of men aged 40 years or older are estimated to have hearing loss, compared with one fifth of women. In addition, hearing loss is less prevalent among non-Hispanic Black individuals than among individuals from other racial/ethnic groups.

A limitation of our study is that the prevalence estimates for some age and severity subcategories might be imprecise because of the small number of affected individuals in the analytic cohort. However, this limitation would not affect our overall prevalence estimates combining aggregated data across all individuals.

PUBLIC HEALTH IMPLICATIONS

Our study provides current national estimates of the prevalence of, and number of

TABLE 1—Prevalence of and Numbers of Individuals With Hearing Loss, by Age and Severity: National Health and Nutrition Examination Survey, United States, 2001–2010

Hearing Loss Category and Age, y	Prevalence, % (95% CI)					Number With Hearing Loss (Millions)				
	Mild	Moderate	Severe	Profound	Overall	Mild	Moderate	Severe	Profound	Overall
Bilateral[a]										
12–19 y	0.14 (0.04, 0.24)	0.03[b] (0.00, 0.06)	. . .[c]	0.00[b] (0.00, 0.01)	0.18 (0.07, 0.28)	0.05	0.01	. . .[c]	<0.01	0.06
20–29 y	0.34[b] (0.00, 0.88)	0.07[b] (0.00, 0.20)	. . .[c]	. . .[c]	0.42[b] (0.00, 0.97)	0.15	0.03	. . .[c]	. . .[c]	0.18
30–39 y	1.01[b] (0.18, 1.84)	0.55[b] (0.00, 1.21)	0.08[b] (0.00, 0.25)	. . .[c]	1.64 (0.23, 3.06)	0.41	0.23	0.03	. . .[c]	0.68
40–49 y	6.05 (3.71, 8.40)	0.48[b] (0.00, 1.01)	. . .[c]	. . .[c]	6.53 (4.19, 8.88)	2.46	0.20	. . .[c]	. . .[c]	2.65
50–59 y	10.48 (7.34, 13.62)	2.13 (0.79, 3.46)	0.35[b] (0.00, 0.78)	0.34[b] (0.00, 0.99)	13.29 (9.76, 16.81)	4.57	0.93	0.15	0.15	5.80
60–69 y	19.94 (15.03, 24.84)	5.85 (3.53, 8.17)	0.76[b] (0.00, 1.70)	0.25[b] (0.00, 0.75)	26.80 (22.25, 31.35)	6.92	2.03	0.27	0.09	9.31
70–79 y	35.62 (31.03, 40.22)	15.83 (13.63, 18.04)	2.86 (1.60, 4.12)	0.30[b] (0.02, 0.59)	54.62 (49.27, 59.97)	6.84	3.04	0.55	0.06	10.49
≥80 y	36.02 (32.03, 40.01)	37.92 (33.40, 42.44)	6.97 (4.94, 9.01)	0.56[b] (0.01, 1.10)	81.47 (78.12, 84.82)	3.98	4.19	0.77	0.06	9.01
Total						25.39	10.66	1.77	0.35	38.17
Loss in at least 1 ear (unilateral and bilateral)										
12–19 y	1.18 (0.77, 1.59)	0.46 (0.18, 0.74)	0.31 (0.11, 0.51)	0.01[b] (0.00, 0.03)	1.96 (1.39, 2.54)	0.39	0.15	0.10	< 0.01	0.65
20–29 y	2.32 (0.92, 3.72)	0.62[b] (0.00, 1.75)	0.02[b] (0.00, 0.05)	0.26[b] (0.00, 0.65)	3.22 (1.38, 5.07)	1.02	0.28	0.01	0.11	1.42
30–39 y	3.50 (1.91, 5.09)	1.38 (0.15, 2.62)	0.30[b] (0.00, 0.76)	0.25[b] (0.00, 0.63)	5.43 (3.28, 7.58)	1.44	0.57	0.12	0.10	2.23
40–49 y	10.02 (7.41, 12.64)	2.00 (1.01, 3.00)	0.86[b] (0.00, 1.88)	0.06[b] (0.00, 0.19)	12.95 (9.85, 16.04)	4.07	0.81	0.35	0.03	5.25
50–59 y	21.30 (16.57, 26.02)	5.49 (3.35, 7.63)	0.82[b] (0.06, 1.57)	1.08[b] (0.06, 2.10)	28.69 (23.63, 33.74)	9.30	2.40	0.36	0.47	12.52
60–69 y	29.38 (24.46, 34.29)	12.12[b] (8.62, 15.62)	2.06 (0.61, 3.51)	1.30[b] (0.29, 2.31)	44.86 (40.79, 48.92)	10.20	4.21	0.72	0.45	15.58
70–79 y	37.51 (33.10, 41.92)	21.14 (17.88, 24.40)	7.47 (5.75, 9.19)	2.04 (1.06, 3.01)	68.15 (62.78, 73.53)	7.21	4.06	1.43	0.39	13.09
≥80 y	31.42 (26.75, 36.08)	40.83 (36.42, 45.24)	13.80 (11.13, 16.47)	4.24 (2.49, 5.99)	90.29 (87.20, 93.39)	3.47	4.51	1.53	0.47	9.98
Total						37.10	16.99	4.61	2.03	60.73

Note. CI = confidence interval. Hearing loss was defined as a pure-tone average (at 0.5, 1, 2, and 4 kHz) of above 25 dB hearing level. The sample size was n = 9648.

[a]Severity of bilateral loss is based on the better ear.

[b]The unweighted number of individuals in the category is < 10.

[c]No individuals with this hearing loss severity level were observed in the sample.

individuals with, hearing loss in the United States by severity and age. These estimates can inform ongoing national public health initiatives on hearing loss and can help guide policy recommendations currently being discussed at the Institute of Medicine and the White House. AJPH

CONTRIBUTORS

Both of the authors contributed to study concept and design, analysis and interpretation of data, and the drafting of the article.

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HUMAN PARTICIPANT PROTECTION

No protocol approval was needed for this study because no human participants were involved.

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