2027 RENEWAL PORTFOLIO | WASHINGTON

Changes to 2027 benefits

Washington – HMO HSA – Fully Insured

For more information, please refer to your Summary of Benefits and Coverage.

Large employer group changes for contracts renewing on or after January 1, 2027

This document provides an overview of changes Kaiser Foundation Health Plan of Washington (KFHPWA) is making to the large group HMO HSA health plan offering effective upon a group's 2027 renewal date.

The group may have elected other changes to existing plan design offerings that are not included in this summary, or additional modifications in cost share amounts may occur as a result of changes in employees' plan selection.

The following Evidence of Coverage (EOC) language changes apply to all large group HMO HSA health plans unless otherwise specified.

- **Section II: How Covered Services Work: A: Accessing Care: 1. Receiving Care in Another Service Area (New Language for Accessing Care Section)**

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

Section II: How Covered Services Work: J: Unusual Circumstances (Clarification)

For more information, please refer to your Summary of Benefits and Coverage.

In the event of unusual circumstances such as a major disaster, natural disaster (e.g., earthquake, wildfire, hurricane or tornado), epidemic, pandemic, terrorism, war, riot, civil insurrection, government acts, changes in applicable law, disability of entities providing services to Health Plan, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor dispute ~~military action, civil disorder, labor disputes or similar causes~~, KFHPWA will not be liable for administering coverage beyond the limitations of available personnel and facilities.

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

Additionally, under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest emergency department as described under "Emergency Services" in the "Accessing Care" section, and we will provide coverage and reimbursement as described in that section.

Section II: How Covered Services Work: J: Utilization Management (Clarification)

KFHPWA will not deny coverage retroactively for services ~~with Preauthorization~~ that were Preauthorized and ~~which have~~ already been provided to the Member except in the cases of: (1) an intentional misrepresentation of a material fact by the patient, Member, or provider ~~of services;~~ ,(2) or if coverage ~~was~~ obtained based on inaccurate, false, or misleading information provided on the enrollment application, or ~~for~~ (3) nonpayment of premiums.

Section IV: Benefits Details: Devices, Equipment and Supplies (Benefit Update):

Removing limit language 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.~~

Section IV: Benefits Details: Drugs (Clarification):

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~~ a Member ~~subsequently has~~ experiences a break in creditable prescription drug coverage of 63 continuous days or longer ~~before enrolling in a Part D plan~~ after the Member's initial Medicare enrollment period, Medicare may impose a Part D late enrollment penalty. This penalty is a monthly amount added to the Member's Medicare Part D premium and is based on the length of time the Member was without Medicare Part D or other creditable prescription drug coverage. In most cases, the penalty must be paid for as long as the Member has Medicare Part D coverage.

KFHPWA may notify the Member if a late-enrollment penalty applies and, as a condition of coverage, either the group or KFHPWA may bill the Member directly for the monthly penalty amount. A Member who discontinues coverage must meet eligibility requirements ~~in order~~ to re-enroll.

- **Section IV: Benefits Details: Drugs (Response to OIC request for clarification):**
  Adding the following language:
  - prescription hormone therapy drugs (excluding glucagon-like peptide-1 or glucagon-like peptide-1 agonists such as Ozempic and Wegovy) which are able to be safely stored at room temperature without refrigeration may be allowed up to a 12-month supply. If the prescription hormone is a controlled substance, the prescription will be limited to the maximum fill allowed under state and federal regulations.
  - HIV antiviral drugs approved by the federal food and drug administration. Prior authorization, step therapy and/or utilization management as described below, do not apply.

- **Section IV: Benefits Details: Mental Health and Wellness (OIC request for clarification per OIC objection)**
  Adding Language: Utilization management is not required for the initial evaluation and management visit and up to six treatment visits with a contracting provider in a new episode of care.

- **Section IV: Benefits Details: Non-Emergency Medical Transportation (New Benefit):**

  Adding Benefit Language: Non-Emergency Medical Transportation Services (NEMT Services)
  We cover NEMT Services for travel inside the Service Area provided by Health Plan-designated transportation carriers, such as an ambulette, licensed stretcher/gurney van or wheelchair van. Such NEMT Services are covered only if they are:
  • Ordered by a Physician after obtaining Prior Authorization AND
  • Medically Necessary.

  Exclusion: Other transportation by car, taxi, bus, minivan, and/or any other means (except for emergency ground ambulance or air ambulance as described above).

- **Section IV: Benefits Details: Optical (Clarification):**

  When Medically Necessary for eye pathology, one replacement lens per diseased eye, including following cataract surgery (in lieu of an intraocular lens), is covered once every 12-month period.

- **Section IV: Benefits Details: Optical (Clarification):**
  ~~Note: This benefit is separate from the benefits of the Health Savings Account (HSA) Qualified Health Plan and not subject to the annual Deductible.~~

- **Section IV: Benefits Details: Preventive (Response to OIC Request for clarification):**
  Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force (USPSTF) in effect on June 30, 2025, and as adopted by Washington State.

  Immunizations recommended by the ~~Centers for Disease Control's Advisory Committee on Immunization Practices~~ Department of Health. Flu vaccines are also covered when provided by a non-Network Provider.

- **Section IV: Benefits Details: Substance Use Disorder (Response to OIC Request for clarification):**
  Adding Language: Utilization management is not required for the initial evaluation and management visit and up to six treatment visits with a contracting provider in a new episode of care.

- **Section V: General Exclusions (New Language for Exclusion Section):**
  Screenings related to obtaining or maintaining employment

- **Section V: General Exclusions (New Language for Exclusion Section):**
  Surrogacy:

  Services in connection with a surrogacy arrangement, whether traditional or gestational, are excluded, except for otherwise covered Services provided to a Member who is acting as a surrogate.

For more information, please refer to your Summary of Benefits and Coverage.

A surrogacy arrangement is any arrangement in which a woman agrees to become pregnant and relinquish custody of the child or children to another person or persons, whether or not compensation is provided. This includes traditional surrogacy and gestational carriers and applies to pregnancies achieved through artificial insemination, intrauterine insemination, in vitro fertilization, or implantation of a fertilized egg of another person.

For more information, please refer to your Summary of Benefits and Coverage.

If a Member enters into a surrogacy arrangement, they must reimburse us for covered Services they receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services"). The total amount recoverable will not exceed the compensation or other payments payable to the Member or any other payee under the surrogacy arrangement. This provision does not affect a Member's obligation to pay applicable Cost Share.

By accepting surrogacy health services, Members assign to KFHPWA their rights to receive any payments under the surrogacy arrangement, regardless of how those payments are characterized. KFHPWA will have a lien on such payments, including amounts held in escrow, trust, or similar accounts, which will be applied first to satisfy any Member reimbursement obligation. The assignment and lien will not exceed the amount owed to KFHPWA.

Within 30 days of entering a surrogacy arrangement, Members must provide written notice and documentation, including:

- Identification and contact information for all parties to the arrangement;
- Identification and contact information for any escrow agent or trustee;
- Identification and contact information for the intended parents and any insurance covering the child or children; and
- Copies of all contracts or related documents.

Members must also provide any consent, releases, authorizations, or lien forms reasonably requested to enable KFHPWA to enforce our rights. Members may not waive or limit our rights without KFHPWA's prior written consent.

After relinquishment of the child to the legal parents, Members are not responsible for charges for services provided to the child; the legal parents are financially responsible for those Services.

If a Member's estate, parent, guardian, or conservator asserts claims related to the surrogacy arrangement, any recovery is subject to KFHPWA's rights to the same extent as if they had asserted the claim directly. KFHPWA may assign rights under this section.

Notice Address:
Surrogacy Other Party Liability Supervisor
Machinify
PO Box 2000
LaGrange, KY 40031
Phone: 1-855-967-6607

Section VI: Eligibility, Enrollment and Termination: Temporary Coverage for Newborns (Benefit Update):

When a Member gives birth, the newborn is entitled to the benefits set forth in the EOC from birth through ~~3 weeks~~ 31 days of age. All provisions, limitations and exclusions will apply except Subsections F. After ~~3 weeks~~ 31 days of age, no benefits are available unless the newborn child qualifies as a Dependent and is enrolled.

Section IX: Claims (Clarification):

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

- Immediate request situations – within 1 business day.
- Concurrent urgent requests – within 24 hours.
- Urgent care review requests – within 48 hours.
- Non-urgent preservice review requests – within 5 calendar days.
- Post-service clean claim review requests – within 30 calendar days.
- Post-service non-clean claim review requests - within 30 calendar days.
    - Request for additional/missing information are to be submitted to the provider/facility within 21 calendar days of claim receipt.
    - If the provider/facility doesn't provide the additional/missing information within 21 calendar days of receipt of the KFHPWA request, then KFHPWA has 40 calendar days following the date that the carrier receives the requested information.

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

For more information, please refer to your Summary of Benefits and Coverage.

Section IX: Claims (Clarification):

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

Section XII: Definitions: Allowed Amount (Clarification):

The level of benefits which are payable by KFHPWA when expenses are incurred from a non-Network Provider. Expenses are considered an Allowed Amount if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies. Members shall be required to pay any difference between a non-Network Provider's charge for services and the Allowed Amount, except for ground ambulance or air services and Emergency Services, including post stabilization and for ancillary services received from an out of network provider in a network facility. For more information about balance billing protections, please visit: https://healthy.kaiserpermanente.org/washington/support/forms and click on the "Billing forms" link.

Throughout Contract (updates)

Non-material revisions to include grammatical and formatting updates for improved clarity.