KAISER PERMANENTE®

ANNUAL NOTICE TO HEALTH PLAN SUBSCRIBERS AND PROSPECTS

This document contains information and notices we are required to provide to all health plan subscribers and prospects.

- **ABOUT QUALITY CARE**
- **NOTICE OF PRIVACY PRACTICES**
- **ARBITRATION AGREEMENT/PROCEDURE**
- **UTILIZATION MANAGEMENT**
- **MASTECTOMY-RELATED COVERAGE**

ABOUT QUALITY CARE

Each year, Kaiser Permanente produces a quality summary report that identifies the goals, objectives, and activities we use to improve care and service to members and our community. You can view this report at **kp.org/quality**. If you have questions or would like a printed copy, please contact our Customer Service Center.

Customer Service Center
1-800-966-5955
1-877-447-5990 TTY hearing/speech impaired
Monday–Friday, 8 a.m.–5 p.m.
Saturday, 8 a.m.–noon.

NOTICE OF PRIVACY PRACTICES

We made a change to our Notice of Privacy Practices, effective April 22, 2015. We're required to let you know when we make such changes.

We made the change to reflect changes in state laws and rules related to the confidentiality of health care information. The legislature repealed confidentiality statutes that limited the ability of Hawaii health care providers and health plans to share health information for treatment, payment, and health care operations. The updated state laws and rules allow Hawaii health care providers and health plans, including Kaiser Permanente, to use and disclose health information as permitted by the federal Health Insurance Portability and Accountability Act (HIPAA).

You can view the latest notice at **kp.org/privacy**. If you have questions or would like a printed copy, please contact our Customer Service Center.

ARBITRATION AGREEMENT/PROCEDURE

A. Binding Arbitration

Except as provided below, any and all claims, disputes, or causes of action arising out of or related to this Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration as set forth in this Service Agreement.

1. This includes but is not limited to any claim asserted:

(a) Member or patient, or any other person entitled to bring an action for damages, arising from or related to harm to the Member or patient as permitted by applicable federal or Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this section 8, all family members of the Member or patient who have derivative claims arising from such harm, shall also be deemed “Member Parties” and bound to these arbitration terms;

(b) On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under this Service Agreement, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and

(c) By or against one or more of the following entities or their employees, officers or directors ("Kaiser Permanente Parties"):

- (i) Kaiser Foundation Health Plan, Inc.,
- (ii) Kaiser Foundation Hospitals,
- (iii) Hawaii Permanente Medical Group, Inc.,
- (iv) The Permanente Federation, LLC,
- (v) The Permanente Company, LLC,
- (vi) Any individual or organization that contracts with an organization named in (i), (ii), (iii), (iv) or (v) above to provide medical services to Health Plan Members, when such contract includes a provision requiring arbitration of the claim made.

2. Notwithstanding any provisions to the contrary in this Service Agreement, the following claims shall not be subject to mandatory arbitration:
(a) claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;

(b) actions for appointment of a legal guardian of a person or property subject to probate laws;

(c) purely injunctive orders reasonably necessary to protect Kaiser Permanente’s ability to safely render medical services under this Service Agreement (such as temporary restraining orders, and emergency court orders).

B. Initiating Arbitration

A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties in care of the Health Plan at the address set forth in section VII-J of this Service Agreement. The arbitrators shall have jurisdiction only over persons and entities actually served.

C. Arbitration Proceedings

1. Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute Prevention and Resolution, Inc. ("DPR"). Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30-day period noted above.

2. Within 30 calendar days after notice to Dispute Prevention and Resolution, Inc., the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery of less than $25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The arbitrator(s) will arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.

3. Limited civil discovery shall be permitted only for
   (a) production of documents that are relevant and material,

   (b) taking of brief depositions of treating physicians, expert witnesses, and parties (a corporate party shall designate the person to be deposed on behalf of the corporation) and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and

   (c) independent medical evaluations.

   The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties' rights under this paragraph.

4. Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties.

5. Each party shall bear its own attorney's fees, witness fees, and discovery costs.

6. The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other

parties and a reasonable opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.

7. In claims involving benefits and coverage due under this Service Agreement or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to de novo review.

8. The arbitration award shall be final and binding. The Member Parties and Kaiser Permanente Parties waive their rights to jury or court trial.

9. With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, 9 U.S.C. Chapter 1.

D. General Provisions

All claims based upon the same incident, transaction, or related circumstances regarding the same Member or same patient shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding).

A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is deemed to prohibit any term in this Service Agreement in any particular case, then such term(s) shall be severable in that case and the remainder of this Service Agreement shall not be affected thereby. Class actions and consolidation of parties asserting claims regarding multiple Members or patients are prohibited. The arbitration provisions in this Service Agreement shall supersede those in any prior Service Agreement.

UTILIZATION MANAGEMENT

The medical care and services provided or authorized by a physician are subject to utilization management (UM) review. UM describes the methods we use to ensure you receive the right care at the right time in the right place.

We use the advice and cooperation of practitioners and providers to ensure quality, cost-effective care for members.

If, at any time, you feel you are not receiving coverage for an item or service that you believe is medically necessary, you have the right to make a request for services or supplies you have not received, or to file a claim for payment of charges you've incurred. If you don't agree with our decision regarding your request, you have the right to request an appeal.

For any UM inquiries during regular business hours, please call our Customer Service Center Monday through Friday, 8 a.m. to 5 p.m., or Saturday, 8 a.m. to noon:

1-800-966-5955
1-877-447-5990 (TTY for the hearing/speech impaired)

After regular business hours and holidays:

808-432-7100 (Oahu)
1-800-227-0482 (neighbor islands, toll free)

Language assistance services are provided free of charge for members through an interpreter.

Bilingual Access Line: 808-526-9724

After regular business hours, your message will be forwarded to our UM team and your call will be returned the next business day. You may also fax us at **808-432-7419**.

Pharmaceutical Management Procedures

Pharmacy benefits, including a list of medications on the formulary, locating your nearest pharmacy, the pharmacy exception process, and more can be found on our member website, **kp.org.** For more information on these items, or if you do not have access to the Internet, please contact our Customer Service Center.

External Appeals

If Kaiser Permanente completes the internal appeals process and you continue to disagree with our decision, you still have the right to an external review, as permitted by law. This next step is not conducted by Kaiser Permanente, and there is no charge to you for this review, except for the nominal filing fee described below for external review requests made to the Hawaii Insurance Division. When we notify you of our final internal decision, we will also provide you with detailed information about how and where to file an external appeal.

Expedited appeals are authorized at the internal and external levels if they meet certain criteria. An expedited appeal is authorized and completed within 72 hours whenever processing under the standard 30-day time frame may:

- Seriously jeopardize your life or health.
- Seriously affect your ability to regain maximum functioning.
- Subject you to severe pain that cannot be adequately managed.

Your external review rights

- Members covered by state or county employee plans, certain employee disability or qualified church plans, individual and family (nongroup) plans, or employee health plans subject to ERISA (the Employee Retirement Income Security Act) may request external review with the Hawaii Insurance Division. A member, an appointed representative, or the treating provider may file the request for review. Requests for review must be submitted to the Insurance Division within 130 days after Kaiser Permanente's final decision is received. A $15 filing fee must be included with the request.
- Members who are covered by an employee health plan that is subject to ERISA have the right to bring a civil claim under Section 502(a) of ERISA, in accordance with their plan's Kaiser Permanente Group Medical and Hospital Service Agreement. Prior to pursuing that claim, all required internal reviews must be completed, except as permitted by federal law. If you are not sure whether your

plan is an employee health plan subject to ERISA, speak with your employer or group benefits administrator.

- Federal Employees Health Benefits Program (FEHBP) members may request external review by the U.S. Office of Personnel Management. Members may refer to the FEHBP Brochure for more information.
- QUEST Integration plan members may request external review by the Administrative Appeals Office of the Hawaii Department of Human Services. More information about the process is described in the QUEST Integration Member Handbook.
- External review for Kaiser Permanente Senior Advantage and Kaiser Permanente Medicare Cost members is subject to the process designated by the Medicare program. Members may refer to their respective Evidence of Coverage for more information.

MASTECTOMY-RELATED COVERAGE

Under the Women's Health and Cancer Rights Act of 1998, we are required to annually notify members of our health plan's obligation to provide the following coverage after a mastectomy, as determined in consultation with the attending physician and the patient:

- Reconstruction of the breast(s) on which the mastectomy was performed.
- Surgery and reconstruction of the breast(s) to produce a symmetrical (balanced) appearance.
- Prosthesis (artificial replacement).
- Services for physical complications resulting from the mastectomy.

Coverage is subject to your plan's supplemental charges. If you have any questions, please contact our Customer Service Center.