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-1611-RSL

DECLARATION OF ELEANOR HAMBURGER IN SUPPORT OF PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT RE: RCW 48.43.0128

CONFIDENTIAL Exhibits B, R, S Filed Under Seal Pursuant to Protective Order (Dkt. No. 16)

I, Eleanor Hamburger, declare under penalty of perjury and in accordance with the laws of the State of Washington and the United States that:

1. I am a partner at Sirianni Youtz Spoonemore Hamburger and am one of the attorneys for plaintiffs in this action.

2. Kaiser has not produced in discovery any medical or scientific evidence in support of the Exclusion. No evidence of any clinical review of prescription air-

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conduction hearing aids was produced. No evidence of an analysis that prescription hearing aids are experimental or investigational was produced. Indeed, the only policy related to prescription hearing aids was one written in December 2021 that explained Kaiser's coverage of hearing aids (or lack thereof). That document contained no medical or scientific analysis. Kaiser's key clinical committees: the Medical Policy Committee and the Medical Technology Committee have never reviewed prescription hearing aids.

3. My staff have searched each health plan produced by Kaiser in response to a discovery request for copies of all health plans issued by defendants that contain the Hearing Exclusion. None of the health plans indicate that they are "grandfathered" health plans, as required pursuant to 45 C.F.R. § 147.140(1)(2)(i).

4. On May 30, 2023, I provided opposing counsel with a list of the exhibits that had been marked confidential that I anticipated using in support of this Motion, as well as redacted versions of plaintiffs' medical records cited below. Defense counsel requested that I file a redacted version of the Deposition of Jessica Hamp (*Exh. B*), for pages 47-50 of her testimony, and file Exhibits R and S under seal. Plaintiffs have no objection to filing those documents under seal, and redacted the deposition testimony of Jessica Hamp as requested by Defendants. As was done with Plaintiffs' Motion for Class Certification, Plaintiffs' Placeholder Motion will serve as the motion for all documents marked by either party that are relied upon in briefing regarding the Motion for Partial Summary Judgment.

5. ***Exhibits***. Attached are true and correct copies of the following documents, with underlining where appropriate for the Court's convenience:

Exhibit	Description	Date
A	Excerpts of Kaiser Foundation Health Plan of Washington Options 2020 Access PPO Evidence of Coverage (Dep. Exh. 27, pp. 23-24)	10/01/2020

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Exhibit	Description	Date
B	Excerpts of Deposition of Jessica Hamp, 30(b)(6), pp. 30, 32-51, 62-64, 68-77, 97, 119 (CONFIDENTIAL pp. 47-50_REDACTED)	12/23/2022
C	KPWAC Plan Examples from 2019 to 2022 (KAISER_002281-2298) (Hamp Dep. Exh. 22)	12/23/2022
D	Schmitt Appointment Summaries produced by Allison P. Vega, AuD (VEG 33-36_REDACTED)	11/16, 2016, 12/21/2017
E	O.L. Audiology Clinic Notes produced by Seattle Children's Hospital (SCH 4-7_REDACTED)	09/15/2022
F	Excerpts of Deposition of Andrea Schmitt, pp. 72-73	04/25/2023
G	Excerpts of Deposition of Susan Porter, pp. 28-29, 48-49, 54-58	04/05/2023
H	Defendants' Response to Plaintiffs' Interrogatory No. 12	05/02/2023
I	Substitute House Bill 1870 as signed by Governor Inslee	04/17/2019
J	Screenshot of Kaiser Foundation Health Plan of Washington from Washington Office of the Insurance Commissioner, https://fortress.wa.gov/oic/consumertoolkit/Company/CompanyProfile.aspx?WAOIC=%252BT%2fixfO6iIKQy9CryNrdRA%253D%253D (last visited May 25, 2023)	05/25/2023
K	Screenshot of Kaiser Foundation Health Plan of Washington Options, https://fortress.wa.gov/oic/consumertoolkit/Company/CompanyProfile.aspx?WAOIC=%2f%252BE3t7zOdnC%252BntCmXhSUfA%253D%253D (last visited May 25, 2023)	05/25/2023
L	Screenshot of Kaiser Permanente Washington Clinical Review Criteria, https://wa-provider.kaiserpermanente.org/clinical-review/criteria (last visited May 25, 2023)	2023
M	[Intentionally omitted]	

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Exhibit	Description	Date
N	Kaiser Permanente Health Plan Policy for Cochlear Implants/Hearing Devices, Policy Number: NM-017 (KAISER_001946-1948)	Last revised 10/25/2017
O	Defendants' Responses to Plaintiffs' Interrogatory No. 6 and Request for Production No. 13	10/27/2022
P	SHB 1870 Final Bill Report	04/17/2019
Q	Kaiser Permanente Health Plan Policy – Hearing Aids (KAISER_002279-2280) (Hamp Dep. Exh. 25)	Last revised 12/22/2021
R	Kaiser Permanente Washington Large Group Requirements Relating to Essential Health Benefits (KAISER_003948-3953 CONFIDENTIAL)	Undated
S	Group Health Cooperative MTAC Report, Hybrid Cochlear Implant - Nucleus® Hybrid™ L24 Cochlear Implant System (KAISER_003892-3894 CONFIDENTIAL)	08/17/2015
T	Screenshot of Kaiser Permanente Washington Medical Technology Assessment Committee (MTAC), https://wa-provider.kaiserpermanente.org/clinical-review/mtac (last visited May 25, 2023)	05/25/2023
U	KFHPWAO Explanations of Benefits for O.L. (SCHMITT_001286_REDACTED) (J.L. Dep. Exh. 15)	10/17/2020 05/31/2019

DATED this 1st day of June, 2023, at Seattle, Washington.

/s/Eleanor Hamburger

Eleanor Hamburger (WSBA #26478)
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Attorneys for Plaintiffs

Exhibit A

KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington Options, Inc.

Group Medical Coverage Agreement

Kaiser Foundation Health Plan of Washington Options, Inc. ("KFHPWAO") is a health care service contractor, duly registered under the laws of the State of Washington, furnishing health care coverage on a prepayment basis. The Group identified below wishes to purchase such coverage. This Group Medical Coverage Agreement ("Group Agreement") sets forth the terms under which that coverage will be provided, including the rights and responsibilities of the contracting parties; requirements for enrollment and eligibility; and benefits to which those enrolled under this Group Agreement are entitled.

The Group Medical Coverage Agreement between KFHPWAO and the Group consists of the following:

- Standard Provisions
- Evidence of Coverage

The Richmark Company, #6518800

This Group Agreement will continue in effect until terminated or renewed as herein provided for and is effective October 1, 2020.

Standard Provisions

1. **KFHPWAO agrees to provide benefits as set forth in the attached Evidence of Coverage (EOC) to enrollees of the Group.**

2. **Monthly Premium Payments.**
For the initial term of this Group Agreement, the Group shall submit to KFHPWAO for each Member the monthly premiums set forth in the current Premium Schedule and a verification of enrollment. Payment must be received on or before the due date and is subject to a grace period of 10 days. Premiums are subject to change by KFHPWAO upon 30 days written notice. Premium rates will be revised as a part of the annual renewal process.

   KFHPWAO reserves the right to re-rate this benefit package if the demographic characteristics change by more than 15%.

3. **Dissemination of Information.**
Unless the Group has accepted responsibility to do so, KFHPWAO will disseminate information describing benefits set forth in the EOC attached to this Group Agreement.

4. **Identification Cards.**
KFHPWAO will furnish cards, for identification purposes only, to all Members enrolled under this Group Agreement.

5. **Administration of Group Agreement.**
KFHPWAO may adopt reasonable policies and procedures to help in the administration of this Group Agreement. This may include, but is not limited to, policies or procedures pertaining to benefit entitlement and coverage determinations.

6. **Modification of Group Agreement.**
Except as required by federal and Washington State law, this Group Agreement may not be modified without agreement between both parties.

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

7. **Indemnification.**
KFHPWAO agrees to indemnify and hold the Group harmless against all claims, damages, losses and expenses, including reasonable attorney's fees, arising out of KFHPWAO's failure to perform, negligent performance or willful misconduct of its directors, officers, employees and agents of their express obligations under this Group Agreement.

   The Group agrees to indemnify and hold KFHPWAO harmless against all claims, damages, losses and expenses, including reasonable attorney's fees, arising out of the Group's failure to perform, negligent performances or willful misconduct of its directors, officers, employees and agents of their express obligations under this Group Agreement.

   The indemnifying party shall give the other party prompt notice of any claim covered by this section and provide reasonable assistance (at its expense). The indemnifying party shall have the right and duty to assume the control of the defense thereof with counsel reasonably acceptable to the other party. Either party may take part in the defense at its own expense after the other party assumes the control thereof.

8. **Compliance With Law.**
The Group and KFHPWAO shall comply with all applicable state and federal laws and regulations in performance of this Group Agreement.

This Group Agreement is entered into and governed by the laws of Washington State, except as otherwise pre-empted by ERISA and other federal laws.

9. **Governmental Approval.**
If KFHPWAO has not received any necessary government approval by the date when notice is required under this Group Agreement, KFHPWAO will notify the Group of any changes once governmental approval has been received. KFHPWAO may amend this Group Agreement by giving notice to the Group upon receipt of government approved rates, benefits, limitations, exclusions or other provisions, in which case such rates, benefits, limitations, exclusions or provisions will go into effect as required by the governmental agency. All amendments are deemed accepted by the Group unless the Group gives KFHPWAO written notice of non-acceptance within 30 days after receipt of amendment, in which event this Group Agreement and all rights to services and other benefits terminate the first of the month following 30 days after receipt of non-acceptance.

10. **Grandfathered Health Plans.**
For any coverage identified in an EOC as a "grandfathered health plan" under the Patient Protection and Affordable Care Act (a/k/a the ACA), Group must immediately inform KFHPWAO if this coverage does not meet (or no longer meets) the requirements for grandfathered status including but not limited to any change in its contribution rate to the cost of any grandfathered health plan(s) during the plan year. Group represents that, for any coverage identified as a "grandfathered health plan" in the applicable EOC, Group has not decreased its contribution rate more than five percent (5%) for any rate tier for such grandfathered health plan when compared to the contribution rate in effect on March 23, 2010 for the same plan. Health Plan will rely on Group's representation in issuing and/or continuing any and all grandfathered health plan coverage.

11. **Confidentiality.**
Each party acknowledges that performance of its obligations under this Group Agreement may involve access to and disclosure of data, procedures, materials, lists, systems and information, including medical records, employee benefits information, employee addresses, social security numbers, e-mail addresses, phone numbers and other confidential information regarding the Group's employees (collectively the "information"). The information shall be kept strictly confidential and shall not be disclosed to any third party other than: (i) representatives of the receiving party (as permitted by applicable state and federal law) who have a need to know such information in order to perform the services required of such party pursuant to this Group Agreement, or for the proper management and administration of the receiving party, provided that such representatives are informed of the confidentiality provisions of this Group Agreement and agree to abide by them, (ii) pursuant to court order or (iii) to a designated public official or agency pursuant to the requirements of federal, state or local law, statute, rule or regulation. The disclosing party will provide the other party with prompt notice of any request the disclosing party receives to disclose information pursuant to applicable legal requirements, so that the other party may object to the request and/or seek an appropriate protective order against such request. Each party shall maintain the confidentiality of medical records and confidential patient and employee information as required by applicable law.

12. **HIPAA.**

Definition of Terms. Terms used, but not otherwise defined, in this section shall have the same meaning as those terms have in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Transactions Accepted. KFHPWAO will accept Standard Transactions, pursuant to HIPAA, if the Group elects to transmit such transactions. The Group shall ensure that all Standard Transactions transmitted to KFHPWAO by the Group or the Group's business associates are in compliance with HIPAA standards for electronic transactions. The Group shall indemnify KFHPWAO for any breach of this section by the Group.

13. **Termination of Entire Group Agreement.**
This is a guaranteed renewable Group Agreement and cannot be terminated without the mutual approval of each of the parties, except in the circumstances set forth below.

KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington Options, Inc.

2020 Access PPO
Evidence of Coverage

CA-3962a20,

doctoral-level clinical psychologist, certified addiction medicine specialist), dentist or pharmacist who has the clinical expertise appropriate to the request under review with an unrestricted license may deny coverage based on medical necessity

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

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.
Refer to Section IV. for more information regarding which services KFHPWAO requires Preauthorization. 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.

Exclusions: Dentist's or oral surgeon's fees; dental care, surgery, services and appliances, including: treatment of accidental injury to natural teeth, reconstructive surgery to the jaw in preparation for dental implants, dental implants, 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 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, 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. • 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.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan 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

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. Emergency services include professional services, treatment and supplies, facility costs, outpatient charges for patient observation and medical screening exams required to stabilize a patient. If a Member is admitted as an inpatient directly from an emergency department, any Emergency services Copayment is waived. Coverage is subject to the hospital services Cost Share. Members must notify KFHPWAO by way of the Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Under the PPN option, follow-up care which is a direct result of the Emergency must be received from a Preferred Provider, 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.	After Deductible, Member pays $200 Copayment and 20% Plan Coinsurance	After PPN Deductible, Member pays $200 Copayment and 20% Plan Coinsurance

Hearing Examinations and Hearing Aids	**Preferred Provider Network**	**Out-of-Network**
Hearing exams for hearing loss and evaluation are covered. Cochlear implants or Bone Anchored Hearing Aids (BAHA) when in accordance with KFHPWAO clinical criteria. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** Member pays $35 Copayment	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan

	Enhanced Benefit: Member pays $25 Copayment Annual Deductible and Plan Coinsurance do not apply to office visits, but do apply to all other services, including outpatient surgery	Coinsurance
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 or surgically implanted hearing aids and the surgery and services necessary to implant them except as described above; 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: • Except for patients receiving palliative care services, the Member must be unable to leave home due to a health problem or illness. Unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home. • The 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 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	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance

Outpatient Services	Preferred Provider Network	Out-of-Network
Covered outpatient medical and surgical services in a provider's office, including chronic disease management. See Preventive Services for additional information related to chronic disease management. See Hospital - Inpatient and Outpatient for outpatient hospital medical and surgical services, including ambulatory surgical centers.	Member pays $35 Copayment Enhanced Benefit: Member pays $25 Copayment Annual Deductible and Plan Coinsurance do not apply to office visits, but do apply to all other services, including outpatient surgery	After Deductible, Member pays 40% Plan Coinsurance

Plastic and Reconstructive Surgery	Preferred Provider Network	Out-of-Network
Plastic and reconstructive services: • Correction of a congenital disease or congenital anomaly. • Correction of a Medical Condition following an injury or resulting from surgery which has produced a major effect on the 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 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** Member pays $35 Copayment Annual Deductible and Plan Coinsurance do not apply to office visits, but do apply to all other services, including outpatient surgery	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Cosmetic services including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services		

	apply to office visits, but do apply to all other services, including outpatient surgery **Provider's Office:** Member pays $35 Copayment Enhanced Benefit: Member pays $25 Copayment Annual Deductible and Plan Coinsurance do not apply to office visits, but do apply to all other services, including outpatient surgery	

V. General Exclusions

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

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

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

3. Services or supplies for which no charge is made, or for which a charge would not have been made if the 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

Schmitt et al v. Kaiser Foundation Health Plan of Washington, et al.
USDC (W.D. Wash.), No. 2:17-cv-1611-RSL

CONFIDENTIAL EXHIBIT

Filed Under Seal
Pursuant to Protective Order (Dkt. No. 16)

REDACTED COPY

Exhibit B

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, vs. 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

ZOOM VIDEO DEPOSITION UPON ORAL EXAMINATION

OF

JESSICA HAMP, 30(b)(6)

9:30 a.m.

December 23, 2022

REPORTED BY: Pat Lessard, CCR #2104

that you reviewed a policy for cochlear implants and BAHAs, is that right?

A. Yes. Clinical criteria.

Q. Clinical criteria. And had you reviewed also the clinical criteria for hearing aids?

A. No.

Q. Okay.

A. I believe it's just for cochlear and BAHA.

Q. Okay. And have you reviewed any other medical or scientific documentation prepared by Kaiser to justify the exclusion at issue in this case?

MS. MARISSEAU: Object to the form.

A. No.

Q. (By Ms. Hamburger) And have you talked to any medical expert who has been responsible for the medical and scientific justification of the exclusion at issue in this case?

MS. MARISSEAU: Object to the form.

A. Yes.

Q. (By Ms. Hamburger) Who is that?

A. Susan and Ben.

Q. So it's your understanding that Susan Porter and Ben whatever his name is are the medical or clinical experts responsible for the medical and scientific justification of the exclusion at issue in

A. I don't.

Q. (By Ms. Hamburger) Okay. So sitting here today the only two people you've identified as having knowledge as to the medical or scientific justification for including the exclusions at issue in this case in the Kaiser plans are Susan Porter and Benjamin whose last name we don't know, is that right?

A. Well, there are people within the organization that support our Medical Policy Committee that developed that clinical criteria. So that's the forum that facilitates the development of those.

Amy Nowack is one of those people that support that committee and I've seen some emails from her.

Q. Okay. What is the committee you're referencing?

A. Medical Policy Committee. This is a team of clinical experts that takes into consideration laws, local market, clinical expertise, new developments, science, things like that from our -- even from our Research Institute.

They consider medical policies and develop that in terms of usage and application of our benefits.

Q. And do you know if they have considered or

reviewed coverage for hearing aids and hearing treatment other than cochlear implants and BAHAs?

A. I don't know that.

Q. And how is this committee, Medical Policy Committee, different from the MTC, the Medical Technology Committee?

A. Not very different. They work together. When I think about medical policy they are intended to develop clinical criteria.

So for benefits that require health plan pre-authorization or prior authorization criteria is reviewed to support authorization or denial. But it helps with consistent application of authorization rules.

Whereas MTC is a little bit different. They're more into the research and looking into new technologies and developments in science.

Q. And who supports the MTC?

A. I don't know the doc's name off the top of my head.

Q. Do you know if MTC has reviewed hearing aids and hearing treatments?

A. I don't know that.

Q. All right. I want to take a look at Exhibit 3.

(Marked Deposition Exhibit No. 3.)

A. Okay. I've got it pulled up.

Q. (By Ms. Hamburger) And Interrogatory No. 6 asked for the identification of all of Kaiser's justifications for the exclusions, including but not limited to any objective medical, scientific, evidence-based financial, actuarial or other nondiscriminatory basis for the exclusion.

Do you see that?

A. No. You said Interrogatory 6?

Q. Yes, on page three of Exhibit 3.

A. Okay. I see it.

Q. All right.

A. What is the question?

Q. So the question is did you review this in your preparation for today's testimony?

A. Yes.

Q. Okay. And in this answer to Interrogatory No. 6 did Kaiser identify any medical or scientific justification for the exclusion?

A. Yes.

Q. Please identify where that is.

A. So I think this speaks to our process when it comes to developing any new benefits, our plan design. Anytime we do that we take many things into

consideration starting with regulatory guidance.

And from what I've seen from the regulatory lens most of the conversation that occurred around hearing devices, hearing care, happened with the ACA and when Essential Health Benefits were developed in the state benchmark plan.

Although I have seen that clinical criteria existed before then in the 90s versus ACA in 2010.

But with that our organization from a regulatory perspective had to align to the State Benchmark Plan and that State Benchmark Plan includes coverage of cochlear implants.

Q. So I hear what you're saying and I would call that a regulatory justification for the exclusion rather than a scientific or medical justification.

Do you agree?

MS. MARISSEAU: Counsel, why don't you define what you mean by scientific? Are you meaning just medical science or are you talking about economic science, financial, actuarial? What are you talking about?

Q. (By Ms. Hamburger) Fair enough. I mean medical science.

A. Yeah. And to elaborate on these decisions and plan design cycles I have seen documents as it

related to the development of how to codify cochlear implants.

And within that I've seen some of the experts, some of the medical providers included in those conversations when it comes to how to codify those and what's similar to, what's not similar to.

In my mind that shows that there was some clinical input involved although that predates me.

Q. So let me ask you this. Let me try to get at it in a different way.

A. Yeah.

Q. Does Kaiser believe that hearing aids are experimental?

A. No.

Q. Okay. And Kaiser doesn't take the position that hearing aids are investigational, is that right?

MS. MARISSEAU: I'm going to object to the form because there's probably some hearing aid out there that is investigational.

So are we talking about a specific type?

MS. HAMBURGER: All hearing aids.

MS. MARISSEAU: All hearing aids or any hearing aids, is that your question?

Q. (By Ms. Hamburger) Does Kaiser take the position that it has the exclusion because all hearing

aids are experimental or investigational?

A. No.

Q. Okay. And Kaiser does cover hearing aids when medically necessary in plans that do not have the exclusion, is that right?

A. No. In order to have hearing aid coverage your employer group must purchase a rider indicating that coverage.

Q. In Washington state?

A. Yes. Our plans are issued in Washington state, yes.

Q. Okay. Are you aware that Kaiser provides coverage as part of its general package in other states such as in Oregon?

A. No.

Q. No. Okay.

So when an employer purchases a rider for hearing aids Kaiser makes the determination when those claims come in as to whether the hearing aid meets its Medical Necessity standard, is that right?

A. There is a claims process where, when a member purchases a rider -- I mean when a member purchases a hearing aid. So there's a couple of pathways is what I'm getting to.

There could be a hearing aid that's

prescribed by a provider where that would come through as a claim.

Q. You know what, I'm just going to stop you there because we're going to get to the claims process in a minute. And I appreciate that.

A. Okay.

Q. I'm just trying to be complete. But I'm really trying to drill down on the answer to this topic, you know, which was whether Kaiser has a legal basis or medical or scientific or other justification for including the exclusions in its insured plans and the answer to Interrogatory No. 6.

So let me just kind of reframe the question and focus you back there. Okay?

A. Okay.

Q. I think you've said that Kaiser does not object to hearing aids based upon them being experimental or investigational as an entire category, is that right?

A. Agreed. I've never heard them called experimental or investigational.

Q. Okay. And I think the testimony is that Kaiser will cover hearing aids as medically necessary in the plans where the employer has purchased a rider when the Medical Necessity criteria and financial

criteria are met, is that right?

A. Yes.

Q. Okay. So --

MS. MARISSEAU: Well, I do want to make an objection here because you stopped her from making the distinction between prescribed and non-prescribed.

MS. HAMBURGER: Oh, I didn't intend to do that.

MS. MARISSEAU: That answer then now is not accurate because you cut her off from that.

So if you want her to get more detail on that you should probably ask her.

MS. HAMBURGER: We will get to that.

MS. MARISSEAU: Okay.

Q. (By Ms. Hamburger) But one of the criteria that Kaiser requires under those riders, and in fact was the law until recently, was that the hearing aid had to be prescribed by an appropriate provider, is that right?

A. Yes.

Q. Okay. So I want to have you look again at Exhibit 3, the answer to Interrogatory No. 6.

I think you identified that Kaiser justifies the exclusion because of regulatory reasons.

Is that a fair summary of your earlier

testimony?

MS. MARISSEAU: I'm going to object, Counsel. I don't think it's a fair summary.

But you can answer the question, Jessica.

A. I wouldn't say that's the sole reason, no.

Q. (By Ms. Hamburger) Okay. Not the sole reason but one of the reasons is regulatory, is that right?

A. One of the many.

Q. Okay. And then this answer also talks about adverse selection.

Do you see that on page four at the paragraph starting with the word "second"?

A. Yes.

Q. Okay. And can you describe what adverse selection is?

A. So when we develop plans we have a Product Development team that looks into our local market, amongst other things.

And when they look at the local market they look at our competitors to see what they're offering along with regulations and all the other things we mentioned.

So if we find that maybe a local competitor or if you were to cover something that the other

competitors are not, then that would kind of bring the healthcare industry out of balance adversely, pulling those members or enrollees to one plan versus the other for that imbalance. If that makes sense.

Q. Would it be fair to say that adverse selection is if Kaiser -- in this situation it would be if Kaiser is the only one that is offering hearing aids in the market they would anticipate that people who need hearing aids would flock to the Kaiser plan and cause them to bear the burden of insuring people with hearing loss more disproportionately then the other healthcare providers, is that fair to say?

MS. MARISSEAU: Object to the form and it's been asked and answered.

A. I think that's a fair way to describe it, adverse selection.

MS. MARISSEAU: Counsel, we've been going about an hour.

Can we take a break?

MS. HAMBURGER: Absolutely. Let's go off the record.

THE VIDEOGRAPHER: The time is 10:29 a.m.

We are going off the record.

(Recess.)

THE VIDEOGRAPHER: One moment. It will just

be like five seconds just to get this going.

The time is 10:45 a.m. We're back on the record.

MS. MARISSEAU: Okay. And Ele, before we get going the witness wanted to make a clarification to a prior statement.

A. Thank you, Medora.

A couple of things. So first I have the provider's name, Benjamin Gilhan, G I L H A N.

And then second I wanted to speak a little bit more about your questions as it relates to Medical Necessity reviews for hearing aids. I think we may have used some terms interchangeably between types of policies and criteria.

We have health plan coverage policies as it relates to hearing aids. But when a member has a hearing aid rider and whether they go purchase them on their own regard or they're prescribed, the way the process works is that the claims team is just checking to see if they have that coverage. They're checking to see if they have a hearing aid rider before they reimburse or pay that claim.

They're not sending it to a clinician for a Medical Necessity review.

Q. (By Ms. Hamburger) And why is that?

A. So when they purchase a hearing aid rider it's a dollar allowance amount.

So they may have, you know, a thousand dollars per ear or maybe it's a $3,000 total. It varies depending on what the employer group elects. It could be twelve months, 24 months, 36-month reset.

But that's all our claims team is looking at. They're looking to see if they have that rider and how much money they've used of that allowance and then applying the claim or adjudicating a claim as such.

Q. So does Kaiser consider whether someone has been prescribed the hearing aid when they review those claims?

A. No.

Q. And not in the past?

A. No. Not that I'm aware of.

Q. And you're only speaking as far as Kaiser health plans, Kaiser Foundation Health Plan of Washington, correct?

A. Yes, correct.

Q. And are you aware how Kaiser adjudicates claims for hearing aids in states where hearing aids are part of the Essential Health Benefits?

MS. MARISSEAU: Beyond the scope of the

30(b)(6) deposition.

If you have personal knowledge about what Kaiser might do in other states you can answer.

A. No, I don't.

Q. (By Ms. Hamburger) No, you don't have any knowledge, is that what you meant?

A. No. Our plans are issued for Washington state so I'm not aware of any other state rules or how other carriers administer in other states.

Q. I'm asking how Kaiser administers in other states, not any other carrier.

Are you aware of that?

MS. MARISSEAU: Same objection, beyond the scope of the 30(b)(6).

If you have personal knowledge you can answer.

A. No, I don't.

Q. (By Ms. Hamburger) All right. So anything else you wanted to clarify before we proceed?

A. No. I just wanted to be clear about the process and how that works. There's no clinician intervention when it comes to paying those hearing aid claims.

Q. Fair enough. All right.

Let me ask you this. When Kaiser processes

claims for medical devices under that benefit is there a clinical review of the medical device?

MS. MARISSEAU: Objection, beyond the scope of the 30(b)(6).

You can answer if you know.

A. You're asking about the hearing aid rider specifically?

Q. (By Ms. Hamburger) No. I'm asking about in general benefits when Kaiser covers devices. It has a device benefit, correct?

You know what, let me just put it in front of you. That might make it go faster. Okay.

Actually, you know what, I'm going to just keep going on my track here and we'll get to that in a little bit. All right?

A. Okay.

Q. So I want to continue on with Exhibit 3, and we were on the answer to Interrogatory No. 6 on page four.

A. I have it pulled up.

Q. Are you ready?

A. Yes, I'm ready.

Q. So we had been talking about adverse selection. Do you recall that?

A. Yes.

Q. And so one of the reasons given in the answer to Interrogatory No. 6 for the exclusions is adverse selection, correct?

A. Correct.

Q. And would it be fair to say that that is "Well, the other health plans aren't covering it, so if we covered it we would be subject to adverse selection"?

MS. MARISSEAU: Asked and answered.

You can answer it again.

A. Yes. Yes, that's a high level way of explaining adverse selection.

Q. (By Ms. Hamburger) Okay. And then the next paragraph talks about cost, is that right?

A. Yes.

Q. And why don't you take a moment to review that paragraph on page four and five of Exhibit 3.

A. Okay.

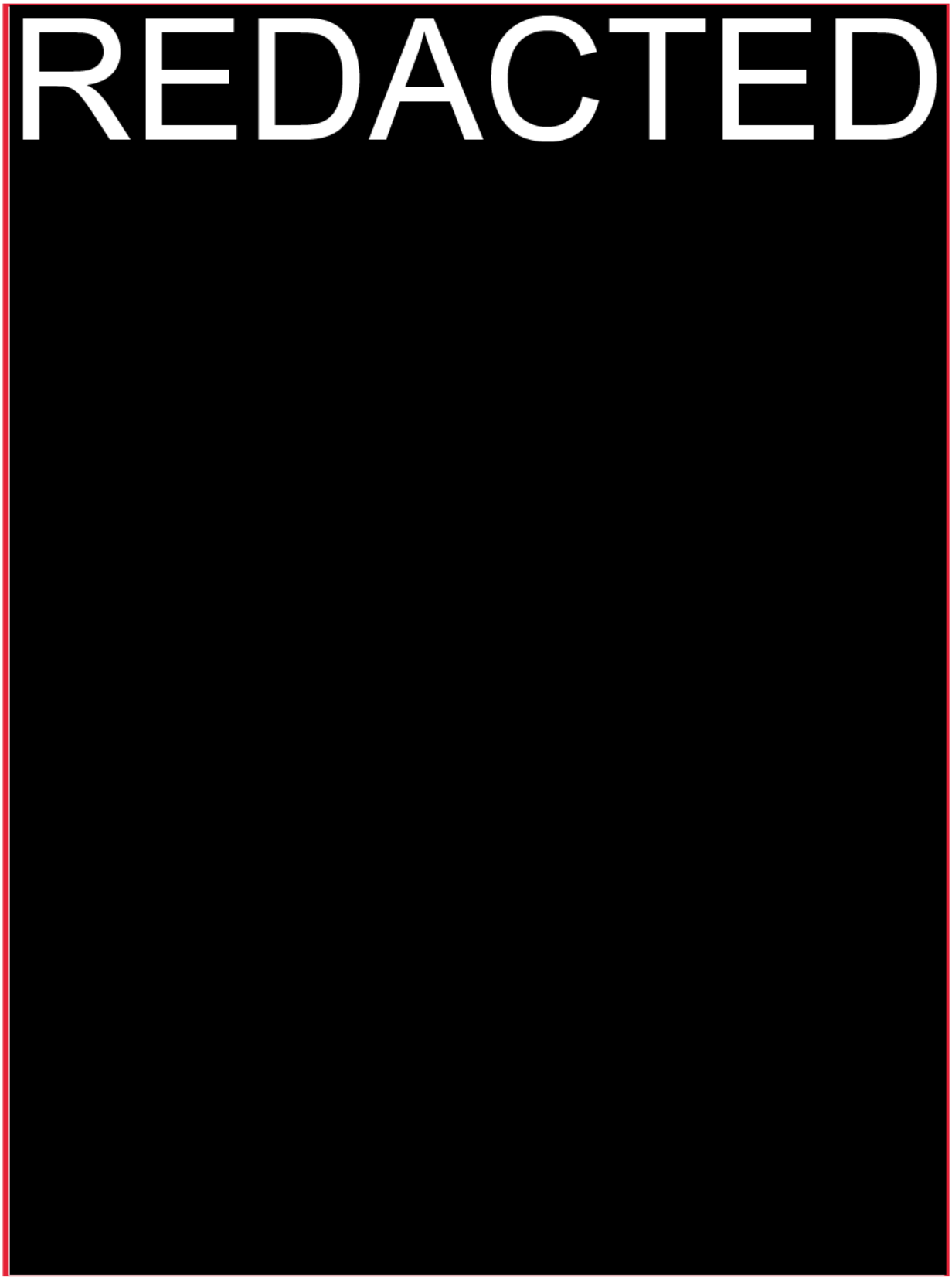
Q. Tell me when you're ready.

A. I'm ready.

Q. Okay. And did you review this paragraph to prepare for today's deposition?

A. Yes, I've seen it.

Q. Okay. And is it fair to say at a high level this paragraph says that the cost of removing the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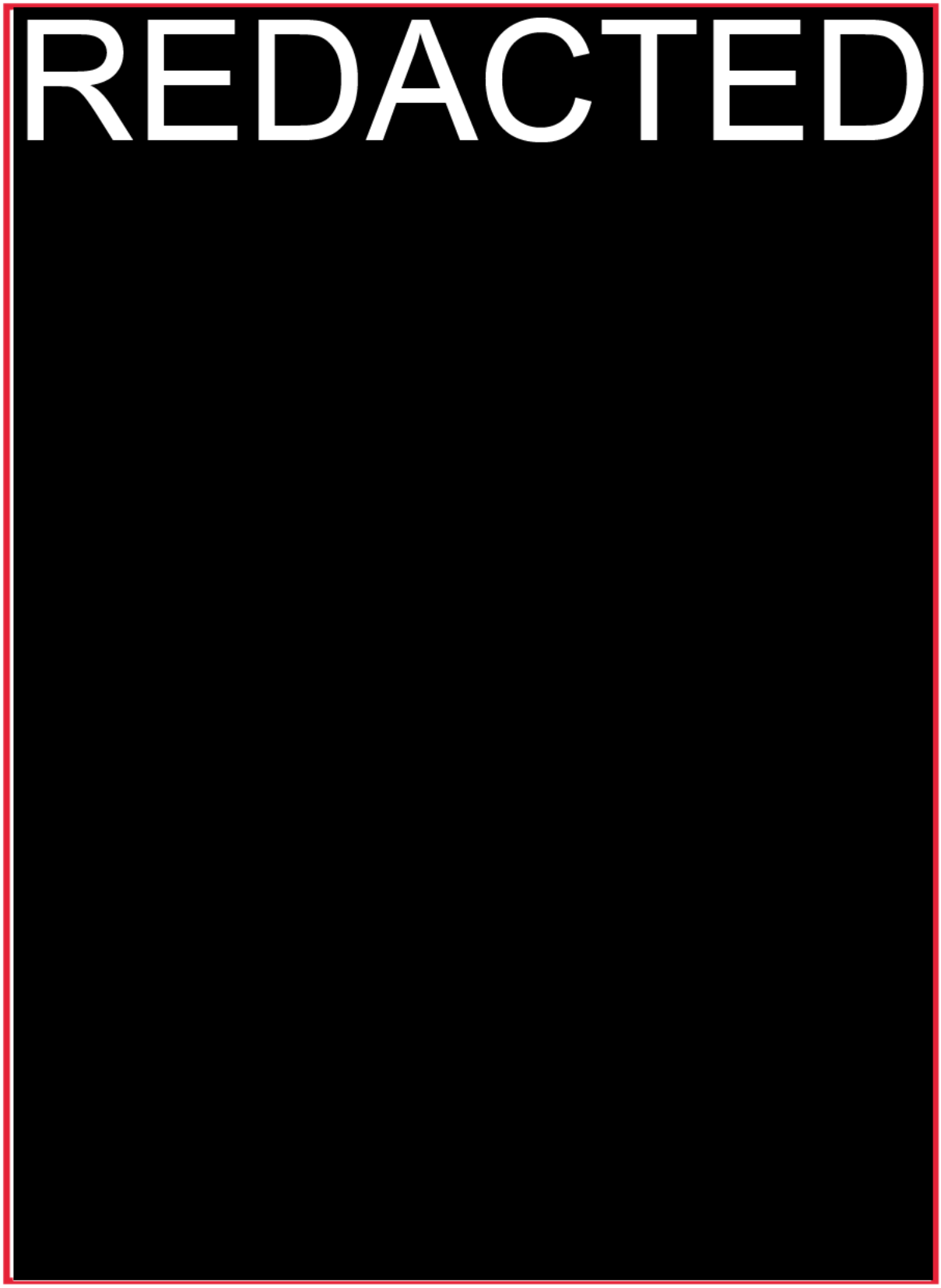
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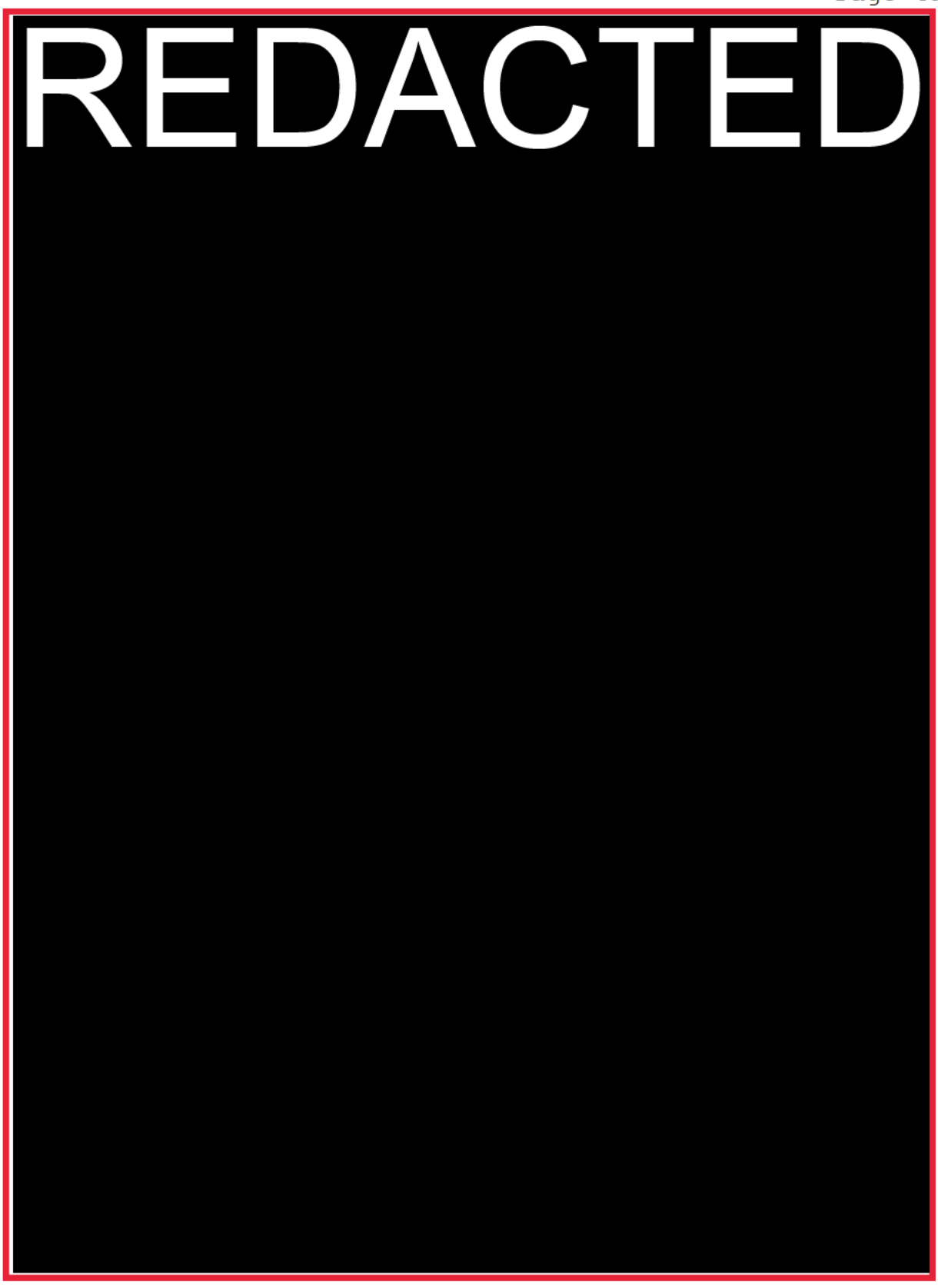
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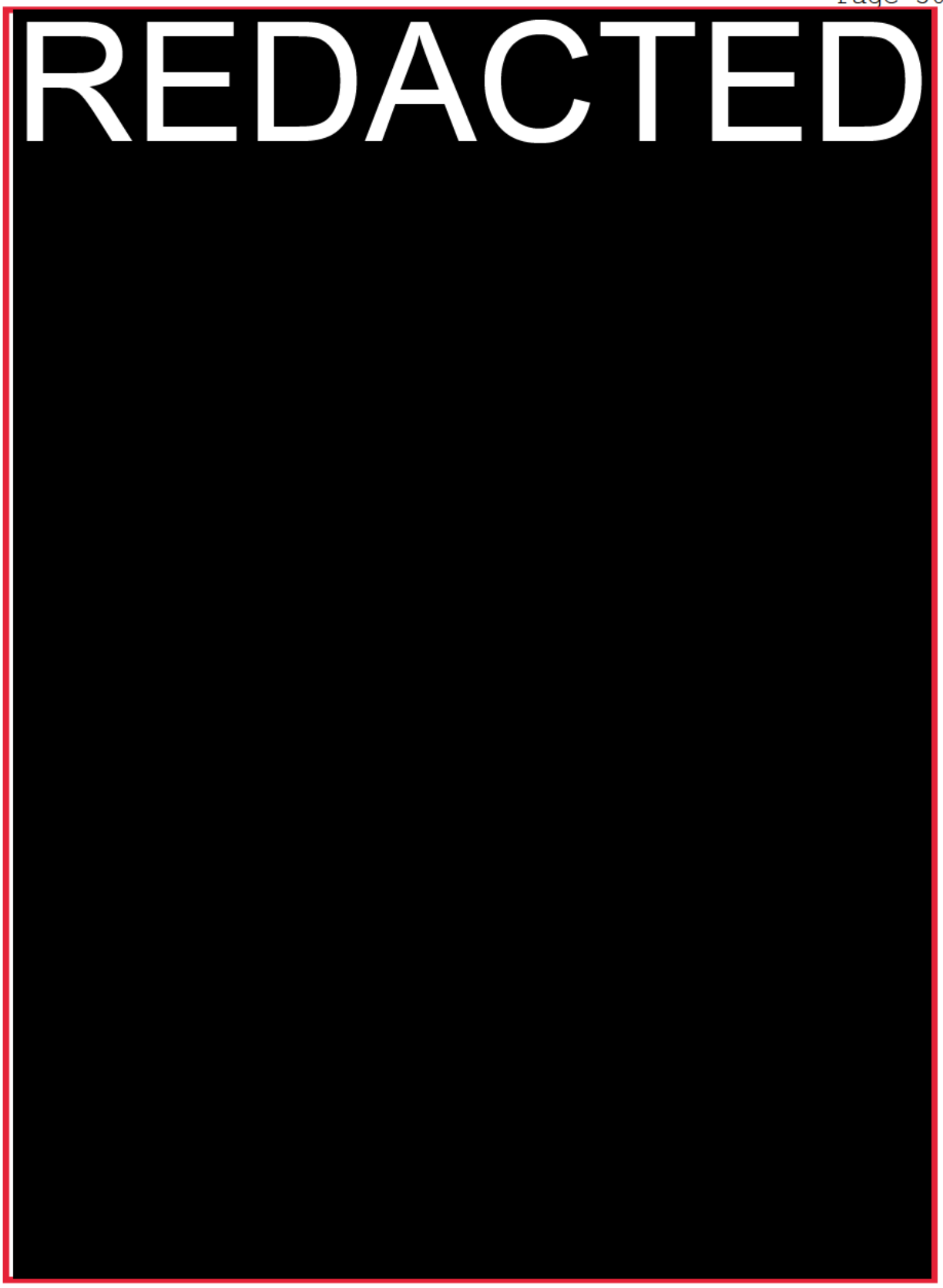
REDACTED

Q. (By Ms. Hamburger) Okay. And there are no other reasons to identify here other than the ones we've discussed, is that right?

MS. MARISSEAU: Object to the form. The document speaks for itself along with all the referenced materials provided.

A. Yeah. It's hard to answer that one because there are so many different variables, so many different things we take into consideration, especially given the length of the dates we've mentioned here back to the 90s.

Q. (By Ms. Hamburger) I'm entitled to ask for all of Kaiser's justifications for the exclusion at issue in this case and Kaiser responded at a high level with four justifications in the answer to Interrogatory No. 6.

Do you agree?

A. Yes, I agree.

Q. Okay. And I think we've talked about that -- well, when you were preparing for this deposition did Kaiser identify at a high level any other justification for the exclusion that does not appear here?

A. No. Not at a high level.

Q. Okay. When a self-funded plan asks Kaiser

Q. Is the Regulatory Review Committee, is it still functioning?

A. Yes. All these committees still exist. They may just have different names with our acquisition.

Q. And does that committee still function to review Kaiser's exclusions to determine ongoing compliance with the Affordable Care Act?

MS. MARISSEAU: Object to the form.

A. I wouldn't say there's a committee. I would say it's more of a process, annual processes that support the evaluation of existing and/or new benefits.

Q. (By Ms. Hamburger) Okay. Do you know when the exclusions at issue in this case first appeared in the Kaiser health plans or that of its predecessors?

A. Oh, gosh. It's been years. I think as far back as we could see was in the 90s.

Q. So I just want to make sure I understand your testimony.

Are you saying that as far as Kaiser knows the exclusion has always been in place and their review only goes back to the 1990s or that it was put in place in the 1990s?

MS. MARISSEAU: I'm going to object to the

form. The question is compound. It asked the witness to go back, I guess, to time immemorial and make a statement about that.

So those are our objections.

A. Yeah, that's hard to respond to so many years back. But we saw the details from the 90s when it came to clinical criteria with cochlear and BAHAs. Certainly there's been EOC language back through the 90s.

Q. (By Ms. Hamburger) So EOC language reflecting an exclusion has been in place through the 90s?

A. I'm fuzzy on dates because we are consistently working through so many different plan years. But I would say generally "Yes," it's not a new exclusion.

Q. Does Kaiser have any evidence that indicates that it ever covered hearing aids in its base product?

MS. MARISSEAU: I'm going to object. It's outside the scope of the 30(b)(6) and it's unduly burdensome and not likely to lead.

A. Yeah, not that I'm aware of.

Q. (By Ms. Hamburger) So is it fair to say that the best evidence we have is that the exclusions that are at issue in this case have always been in

place at Kaiser or its predecessor here in Washington?

MS. MARISSEAU: Object to the form for the same reasons we objected to this exact question earlier.

A. Yeah. That's hard to answer. You know, if I say if we've always had that I really can't be confident in that. But as far as I've seen, yes.

Q. (By Ms. Hamburger) And you haven't seen any evidence of coverage of hearing aids apart from a rider before the 1990s, is that right?

MS. MARISSEAU: Object to the form. Vague as to what insurance coverages we're talking about.

A. No, I haven't seen any.

Q. (By Ms. Hamburger) Okay. And I think you said in the 1990s there was some discussion about cochlear implants and BAHAs, is that right?

A. Yeah, that was mentioned to the clinical criteria.

Q. Can you just explain what that is?

A. I think the one before the other. But I think in 1995 there was a Cochlear Implant Clinical Criteria Medical Policy created.

And then maybe 2000, early 2000, the BAHA criteria was developed.

Q. And did those early criteria provide for

question.

Q. (By Ms. Hamburger) If a claim comes in for an evaluation of a hearing examination for a hearing aid in a plan with an exclusion that's at issue in this case how does Kaiser process it?

A. So if it's a hearing exam for hearing loss that is covered.

Q. And so are hearing exams for hearing aids covered by Kaiser?

A. Yes. A hearing evaluation for hearing loss.

Now if you needed a fitting or further the hearing aid itself you would need to purchase a rider.

Q. Okay. So the hearing exam is covered but the fitting for the hearing aid is not?

A. Unless you have a rider.

Q. Unless you have a rider.

Can people who buy individual policies buy a rider?

A. No. Those are standard plans that are standardized.

Q. So in the individual market there's no option to buy a rider, is that correct?

A. Correct.

Q. Okay. And what about if an employer is in a small group? Do they have the option to buy a rider?

A. No. Those are standardized plans as well.
Q. So no rider can be purchased in a small group plan, correct?
A. Correct.
Q. And so people in the individual market and small group market have no option for coverage for hearing aids, is that right?
MS. MARISSEAU: Object to the form.
A. I don't know that they have no option. They could go purchase them themselves.
Q. (By Ms. Hamburger) But I said for coverage of hearing aids.
When you pay out of pocket you're not getting coverage, correct?
A. Correct.
Q. So is it fair to say people in the individual and small group market have no option for coverage of hearing aids?
A. I'm pausing because I don't know that there's maybe some other carriers that would cover but not with Kaiser.
Q. Fair enough. Fair enough.
So no option within Kaiser for coverage of hearing aids other than paying for it themselves, is that right?

MS. MARISSEAU: Again, object to the form.

When we're talking about hearing aids we're excluding cochlear implants and we're excluding BAHAs, is that right?

A. Correct, yes.

MS. MARISSEAU: Correct. Okay.

Q. (By Ms. Hamburger) You testified earlier in 1995 there was a coverage policy added for cochlear implants.

MS. MARISSEAU: Objection.

Q. (By Ms. Hamburger) Is that right?

A. Not a coverage policy. Clinical criteria.

Q. Clinical criteria. Okay.

When did Kaiser begin including coverage of cochlear implants in its health plans?

A. I'd say at least that date.

Q. When you say that date, 1995 is what you mean?

A. Yes, correct.

Q. And do you know if cochlear implants were covered in individual and small group plans going back to 1995?

A. Yes, I believe so.

Q. So it was in all individual small group and large group plans?

A. Yes, I believe so for cochlear implants.

Q. Okay. And when was the BAHA coverage added?

A. So clinical criteria was developed in the early 2000s, in 2005 or so. That's not to say we didn't cover it before.

And the same with cochlear. We could have well covered it before but maybe developed criteria to apply it more consistently with a clinical criteria policy.

Q. And was this coverage for BAHA added to all plans in 2005?

A. All fully insured plans, I believe so.

Q. Well, let me ask you did the evidence of -- do you call it the evidence of the fully insured plan itself, is that the Evidence of Coverage or Certificate of Coverage?

A. We've used all the terms but these days we call it the Evidence of Coverage.

Q. Evidence of Coverage.

So when did coverage of BAHAs start showing up in the Evidence of Coverage?

A. I want to say 2010 or so. There are times that we cover something and it just may not be described in the Evidence of Coverage. Those documents would get to be a thousand pages long if we

detailed every single benefit.

Q. So I want to draw your attention to Exhibit 22.

(Marked Deposition Exhibit No. 22.)

A. Okay. I've got it pulled open.

Q. (By Ms. Hamburger) Okay. Can you tell me what this is?

A. So this looks to be snippets from our Evidence of Coverage documents of the hearing aid section.

Q. Okay. And were you involved in preparing this document?

A. My team pulled it, but yes, I coordinated some.

Q. Okay. And in 2019 the coverage at issue in this case discusses cochlear implants or bone anchored hearing aids.

Do you see that?

A. Yes.

Q. And do you know if before 2019 bone anchored hearing aids were explicitly included in the Evidence of Coverage?

MS. MARISSEAU: Asked and answered.

A. Yes, I believe so.

Q. (By Ms. Hamburger) All right. I'm going to

show you some -- I think I'm going to have to do it on the sharing the screen. So tell you what, just give me a minute.

I'm going to share the screen. Can you see this?

A. Yes.

Q. Okay. I'm going to identify this as -- the document starts at Kaiser 0001. It's the first document produced in this case. Let me go back.

MS. MARISSEAU: I'm sorry. Can you go to the first page?

MS. HAMBURGER: Yes.

Q. (By Ms. Hamburger) It's from 2014, is that right?

A. Yes, correct.

Q. Okay. And then I'm skipping down to the hearing examinations and hearing aids section.

Do you see that?

A. I do.

Q. Okay. This is on page 24 of the same document.

A. Uh-huh.

Q. And it says "Covered services for cochlear implants."

Do you see that?

A. Yes.
Q. And it does not include BAHAs, is that right?
A. It looks like it wasn't added yet.
Q. Okay. But the exclusion specifically calls out hearing care, routine hearing examinations, programs or treatments for hearing loss including but not limited to externally worn or surgically implanted hearing aids and the surgery and services necessary to implant them other than for cochlear implants.
Do you see that?
A. Yes.
Q. And that would give the impression that BAHAs are not covered, correct?
MS. MARISSEAU: Object to the form. Calls for a legal conclusion.
A. I see that the clinical criteria is mentioned here so I would say that if a provider determined that a BAHA was necessary then it would be covered.
Q. (By Ms. Hamburger) Where do you see the clinical criteria are mentioned in this section on hearing exams and hearing aids?
A. I'm looking at that first sentence. And my understanding is that these BAHAs are very similar to

cochlear implants.

Q. So it's your understanding that it might be included in cochlear implants?

MS. MARISSEAU: I'm going to object to the form. You're asking this witness to interpret the policy.

MS. HAMBURGER: I asked her to be prepared to talk about this and this is part of what we asked her to be prepared about.

Q. (By Ms. Hamburger) I'm going to scoot down. Here it is in 2016, Individual Family Core HSA Plan.

Do you see that?

A. Yes.

Q. Okay. And this again is produced by Kaiser, it's Kaiser 64. Here's the hearing exam and again it says "Covered services for cochlear implants."

Do you see that?

A. Yes.

Q. It does not mention BAHAs, correct?

A. I do not see mention of BAHAs.

Q. I'm going to scoot down here. This is produced by Kaiser, 793, Flex Bronze 2018.

Is this a 2018 policy?

A. Yes.

Q. And it's switched over to Kaiser Foundation

Health Plan of Washington, right?

A. Yes.

Q. Okay. Now I'm going to go to the exclusion, hearing aid and hearing exams. And again it discusses cochlear implants but not BAHAs.

Do you see that?

A. I do.

Q. And then this exclusion in 2018 still says "Hearing Care. Routine hearing examinations, programs or treatments for hearing loss, including but not limited to externally worn or surgically implanted hearing aids and the surgery and services necessary to implant them other than for cochlear implants."

Do you see that?

MS. MARISSEAU: Wait a minute, Counsel. You didn't read the rest of it.

Q. (By Ms. Hamburger) "And hearing screening tests required under preventive services."

Do you see that?

A. I do.

Q. And so this indicates that everything apart from cochlear implants and hearing screening tests required under preventive services is excluded, is that right?

MS. MARISSEAU: Object to the form.

A. Yes.
Q. (By Ms. Hamburger) Okay. What's a routine hearing exam?
A. From my understanding when it's routine there's no medical need.
Q. So it's different from a diagnostic hearing exam?
A. Yes.
Q. And how do you determine whether there's a medical need for the hearing exam?
A. I think that is a conversation between the patient and provider. If the patient presents and says that they are having some hearing loss or maybe they injured themselves.
Q. I guess my question was from a claims processing perspective how have does Kaiser determine --
A. Oh.
Q. -- whether a hearing examination is routine or diagnostic?
A. Different codes.
Q. And do you know what the different codes are?
A. Not off the top of my head.
Q. Okay. And who would know the difference

A. Yes.

Q. And when a claim comes in for hearing aids in a plan where the exclusions at issue are in place and there's no rider, and the claim is denied, that happens even when the treatment was medically necessary, is that right?

MS. MARISSEAU: Object to the form.

A. Yes. If there's no coverage, their employer group has not elected a rider and it's billed, it's not going to be paid because they do not have the coverage.

Q. (By Ms. Hamburger) Regardless of medical necessity, correct?

A. Correct.

Q. Okay. So let's go to topic 1.(n).

I'm sorry, I forgot one more question on this.

Has this process changed over time in the plans in which there is a hearing aid exclusion and no rider purchased?

MS. MARISSEAU: Object to the form, "this process."

A. Yeah. Are you speaking to the benefit configuration process or claims --

Q. (By Ms. Hamburger) Yeah.

coverage when it comes to routine hearing exams. But then that's the only real difference.

So there are ACA requirements when it comes to covering routine hearing exams and screenings for children.

Q. What is that? What is that difference?

A. We are required to cover preventive routine hearing screening for children.

Q. And will Kaiser cover a hearing exam to fit a hearing aid for a child?

A. If they have a rider, yes.

Q. And if they don't have a rider?

A. No.

Q. Is there a process or policy that Kaiser follows when it decides to exclude a treatment or service?

A. Yes. I would say there are annual processes along with the committees I mentioned earlier.

The annual process happens within the product design and implementation cycle.

Q. And what is that annual process?

A. So it starts off with our product and sales partners kind of combing the market and regulations and other KP markets, the local market as well. Gathering some of the feedback from stakeholders.

Exhibit C

Here are the plan examples from 2019 to 2022:
2019

I&F (non-exchange) KPWAC

Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation and diagnostic testing for cochlear implants are covered only when provided at KFHPWA-approved facilities. Cochlear implants or Bone Anchor Hearing Aids (BAHA) when in accordance with KFHPWA 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 20% Plan Coinsurance **Hospital – Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** Office visits: After Deductible, Member pays $15 Copayment for primary care provider office visits or $40 Copayment for specialty care provider office visits Deductible does not apply to the first 5 office visit claims received per calendar year. All other services, including surgical services: After Deductible, Member pays 20% Plan Coinsurance
Hearing aids including hearing aid examinations.	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	

Small Group KPWAC

Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation and diagnostic testing for cochlear implants are covered only when provided at KFHPWA-approved facilities. Cochlear implants or Bone Anchor Hearing Aids (BAHA) when in accordance with KFHPWA 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 20% Plan Coinsurance **Hospital – Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $15 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 20% Plan Coinsurance
Hearing aids including hearing aid examinations	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 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	

Small Group KPWAO

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 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $30 Copayment for primary care provider office visits or $50 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 20% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $30 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 20% 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
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		

Large Group KPWAC

Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation are covered only when provided at KFHPWA-approved facilities. Cochlear implants or Bone Anchor Hearing Aids (BAHA) when in accordance with KFHPWA clinical criteria. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance <HospInpt-IN> **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment and 20% Plan Coinsurance <HospOutpt-IN> **Outpatient Services:** After Deductible, Member pays $15 Copayment and 20% Plan Coinsurance <OutptSvcs-IN>
Hearing aids including hearing aid examinations.	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 or surgically implanted hearing aids and the surgery and services necessary to implant them except as described above; hearing screening tests required under Preventive Services	

Large Group KPWAO

Hearing Examinations and Hearing Aids	Preferred Provider Network	Out-of-Network
Hearing exams for hearing loss and evaluation are covered. Cochlear implants or Bone Anchor Hearing Aids (BAHA) when in accordance with KFHPWAO clinical criteria. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance <HospInpt-IN> **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance <HospOutpt-IN> **Outpatient Services:** After Deductible, Member pays $10 Copayment and 20% Plan Coinsurance Enhanced Benefit: After Deductible, Member pays $5 Copayment and 20% Plan Coinsurance <OutptSvcs-IN>	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance <HospInpt-OON> **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance <HospOutpt-OON> **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance <OutptSvcs-OON>
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 or surgically implanted hearing aids and the surgery and services necessary to implant them except as described above; hearing screening tests required under Preventive Services		

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I&F (non-exchange) KPWAC

Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation are covered only when provided at KFHPWA-approved facilities. Cochlear implants or Bone Anchor Hearing Aids (BAHA) when in accordance with KFHPWA clinical criteria. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).	**Hospital – Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital – Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** Office visits: After Deductible, Member pays $15 Copayment for primary care provider office visits or $40 Copayment for specialty care provider office visits Deductible does not apply to the first 5 office visit claims received and processed per calendar year. All other services, including surgical services: After Deductible, Member pays 20% Plan Coinsurance
Hearing aids including hearing aid examinations.	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 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	

Small Group KPWAC

Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation are covered only when provided at KFHPWA-approved facilities. Cochlear implants or Bone Anchor Hearing Aids (BAHA) when in accordance with KFHPWA clinical criteria. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).	**Hospital – Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital – Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $15 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 20% Plan Coinsurance
Hearing aids including hearing aid examinations	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 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	

Small Group KPWAO

Hearing Examinations and Hearing Aids	Preferred Provider Network	Out-of-Network
Hearing exams for hearing loss and evaluation. Cochlear implants or Bone Anchor Hearing Aids (BAHA) when in accordance with KFHPWAO clinical criteria. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries). 	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $30 Copayment for primary care provider office visits or $50 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 20% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $30 Copayment for specialty care provider 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
	  Deductible and coinsurance do not apply to primary and specialty care office visits All other services, including surgical services: After Deductible, Member pays 20% 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 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		

Large Group KPWAC

Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation are covered only when provided at KFHPWA-approved facilities. Cochlear implants or Bone Anchored Hearing Aids (BAHA) when in accordance with KFHPWA clinical criteria. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).	**Hospital - Inpatient:** [After Deductible,] Member pays [nothing; $50-$1,000 in $5 increments] Copayment per admission; [nothing; $50-$1,000 in $5 increments] Copayment per day up to [$0-$5,000 in $5 increments] per admission; [$100, $150, $200] Copayment per day up to [$300, $400, $500, $750, $1,000] per [calendar/contract] year [and] [nothing; 5%-50% in 5% increments Plan Coinsurance] <HospInpt-IN> **Hospital - Outpatient:** [After Deductible,] Member pays [nothing; $5-$250 in $5 increments] Copayment [for primary care provider services or [$10-$70 in $5 increments] Copayment for specialty care provider services,] [and] [nothing; 5%-50% in 5% increments Plan Coinsurance] [Annual Deductible does not apply to outpatient services, outpatient hospital surgery and laboratory and radiology services] [Annual Deductible and Plan Coinsurance do not apply to outpatient services, outpatient hospital surgery and laboratory and radiology services] <HospOutpt-IN> **Outpatient Services:** [After Deductible,] Member pays [nothing; $5-$50 in $5 increments] Copayment [for primary care provider services or [$10-$70 in $5 increments] Copayment for specialty care provider
Hearing aids including hearing aid examinations.	[Not covered; Member pays 100% of all charges] {or} [Member pays nothing, limited to an Allowance of [$400 per ear limited to 1 aid per ear during a period of 3 consecutive years; [$1,000, $2,000] maximum per ear during any consecutive 36 month period; $300 maximum per ear during any consecutive 36 month period; $300 maximum per ear limited to 1 aid per ear during a period of 3 consecutive years; $250 maximum during any consecutive 24 month period; $600 maximum per ear limited to 1 aid per ear during a period of 3 consecutive years] After Allowance: Not covered; Member pays 100%

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	of all charges]
Exclusions: [Programs or treatments for hearing loss or hearing care including, but not limited to, externally worn hearing or surgically implanted hearing aids and the surgery and services necessary to implant them except as described above hearing screening tests required under Preventive Services] {or} [Programs or treatments for hearing loss or hearing care associated with externally worn hearing or surgically implanted hearing aids and the surgery and services necessary to implant them except as described above; hearing screening tests required under Preventive Services; replacement costs of hearing aids due to loss, breakage or theft, unless at the time of such replacement the Member is eligible under the benefit Allowance; repairs; replacement parts; replacement batteries; maintenance costs]	

Hearing Examinations and Hearing Aids	Preferred Provider Network	Out-of-Network
Hearing exams for hearing loss and evaluation are covered. Cochlear implants or Bone Anchored Hearing Aids (BAHA) when in accordance with KFHPWAO clinical criteria. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-	**Hospital - Inpatient:** [After Deductible,] Member pays [$100-$200 in $5 increments] Copayment per admission; [$100-$200 in $5 increments]	**Hospital - Inpatient:** After Deductible, Member pays [$100-$200 in $5 increments] Copayment per admission; [$100- $200 in $5 increments]

implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).	Copayment per day up to $300-$1,000 in $5 increments per admission [and] [nothing, 10%-50% in 5% increments Plan Coinsurance] <HospIpt-IN> **Hospital - Outpatient:** [After Deductible,] Member pays [nothing, $10-$50 in $5 increments] Copayment] [for primary care provider visits or [$20-$100 in $5 increments] Copayment for specialty care provider visits,] [and] [nothing, 10%-50% in 5% increments Plan Coinsurance] <HospOutpt-IN> **Outpatient Services:**	Copayment per day up to $300-$1,000 in $5 increments per admission [and] [10%-50% in 5% increments] Plan Coinsurance <HospInpt-OON> **Hospital - Outpatient:** After Deductible, Member pays [10%-50% in 5% increments] Plan Coinsurance <HospOutpt-OON> **Outpatient Services:** After Deductible, Member pays [10%-50% in 5% increments] Plan Coinsurance <OutptSvcs-OON>
	other services, including surgical services. Diagnostic lab/x-ray services covered in full (not subject to annual deductible)] <OutptSvcs-INwEB>	
Hearing aids including hearing aid examinations.	[Not covered; Member pays 100% of all charges] {or} [Member pays nothing, limited to an Allowance of [$400 per ear limited to 1 aid per ear during a period of 3 consecutive years]; [$1,000 maximum per ear during any consecutive 36-month period], [$300 maximum per ear during any consecutive 36-month period]] After Allowance: Not covered; Member pays 100% of all charges]	[Not covered; Member pays 100% of all charges] {or} [Allowance shared with Preferred Provider Network]
Exclusions: [Programs or treatments for hearing loss or hearing care including, but not limited to, externally worn hearing or surgically implanted hearing aids and the surgery and services necessary to implant them except as described above; hearing screening tests required under Preventive Services] {or} [Programs or treatments for hearing loss or hearing care associated with externally worn hearing or surgically implanted hearing aids and the surgery and services necessary to implant them except as described above; hearing screening tests required under Preventive Services; replacement costs of hearing aids due to loss, breakage or theft, unless at the time of such replacement the Member is eligible under the benefit Allowance; repairs; replacement parts; replacement batteries; maintenance costs]		

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I&F (non-exchange) KPWAC

Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation are covered only when provided at KFHPWA-approved facilities. Cochlear implants or Bone Anchored Hearing Aids (BAHA) when in accordance with KFHPWA clinical criteria. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).	**Hospital – Inpatient:** After Deductible, Member pays 30% Plan Coinsurance **Hospital – Outpatient:** After Deductible, Member pays 30% Plan Coinsurance **Outpatient Services:** Office visits: After Deductible, Member pays $20 Copayment for primary care provider office visits or $45 Copayment for specialty care provider office visits Deductible does not apply to the first 5 office visit claims received and processed per calendar year. All other services, including surgical services: After Deductible, Member pays 30% Plan Coinsurance
Hearing aids including hearing aid examinations.	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 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	

Small Group KPWAC

Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation are covered only when provided at KFHPWA-approved facilities. Cochlear implants or Bone Anchored Hearing Aids (BAHA) when in accordance with KFHPWA clinical criteria. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).	**Hospital – Inpatient:** After Deductible, Member pays 25% Plan Coinsurance **Hospital – Outpatient:** After Deductible, Member pays 25% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $15 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 25% Plan Coinsurance
Hearing aids including hearing aid examinations	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 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	

Hearing Examinations and Hearing Aids	Preferred Provider Network	Out-of-Network
Hearing exams for hearing loss and evaluation. Cochlear implants or Bone Anchored Hearing Aids (BAHA)	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan	**Hospital - Inpatient:** After Deductible, Member pays 50% Plan
when in accordance with KFHPWAO clinical criteria. Preauthorization is required. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries). 	Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $30 Copayment for primary care provider office visits or $50 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 20% Plan Coinsurance Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $30 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 20% Plan Coinsurance	Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 50% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 50% 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 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		

Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation are covered	**Hospital - Inpatient:** [After Deductible,] Member

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only when provided at KFHPWA-approved facilities. Cochlear implants or Bone Anchored Hearing Aids (BAHA) when in accordance with KFHPWA clinical criteria. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).	pays [nothing; $50-$1,000 in $5 increments] Copayment per admission; [nothing; $50-$1,000 in $5 increments] Copayment per day up to [$0-$5,000 in $5 increments] per admission; [$100, $150, $200 Copayment per day up to [$300, $400, $500, $750, $1,000] per [calendar/contract] year [and] [nothing; 5%-50% in 5% increments Plan Coinsurance]]<HospInpt-IN> **Hospital - Outpatient:** [After Deductible,] Member pays [nothing; $5-$250 in $5 increments] Copayment [for primary care provider services or [$10-$80 in $5 increments] Copayment for specialty care provider services,] [and] [nothing; 5%-50% in 5% increments Plan Coinsurance] [Annual Deductible does not apply to outpatient services, outpatient hospital surgery and laboratory and radiology services] [Annual Deductible and Plan Coinsurance do not apply to outpatient services, outpatient hospital surgery and laboratory and radiology services] [Annual Deductible and Plan Coinsurance do not apply to clinic based visits including surgery, but do apply to all other services.] <HospOutpt-IN> **Outpatient Services:** [After Deductible,] Member pays [nothing; $5-$55 in $5 increments] Copayment
[Hearing aids including hearing aid examinations.] {or} [Hearing aids, fitting and follow-up care.]	[Not covered; Member pays 100% of all charges] {or} [Member pays nothing, limited to [an Allowance of][[$300, $400] per ear limited to 1 aid per ear during a period of 3 consecutive years; [$300, $1,000, $1,500 $2,000; $3,000] maximum [per ear] during any consecutive 36 month period;] $250, $1,500 maximum during any consecutive 24 month period; $600 maximum per ear limited to 1 aid per ear during a period of 3 consecutive years, $800, including repairs, during any consecutive 36 month period]; [$1,000 maximum per ear, per calendar year]; [$1,000 per hearing aid per ear [during any consecutive] [every] 36 month period]. After Allowance: 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 or surgically implanted hearing aids and the surgery and services necessary to implant them except as described above hearing screening tests required under Preventive Services] {or} [Programs or treatments for hearing loss or hearing care associated with externally worn hearing or surgically implanted hearing aids and the surgery and services necessary to implant them except as described above; hearing screening tests required under Preventive Services; replacement costs of hearing aids due to loss, breakage or theft, unless at the time of such replacement the Member is eligible under the benefit Allowance; repairs; replacement parts; replacement batteries; maintenance costs]	

Large Group KPWAO

Hearing Examinations and Hearing Aids	Preferred Provider Network	Out-of-Network
Hearing exams for hearing loss and evaluation are covered. Cochlear implants or Bone Anchored Hearing Aids (BAHA) when in accordance with KFHPWAO clinical criteria. Preauthorization is required. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).	**Hospital - Inpatient:** [After Deductible,] Member pays [$100-$200 in $5 increments] Copayment per admission; [$100-$200 in $5 increments] Copayment per day up to $300-$1,000 in $5 increments per admission [and] [nothing, 10%-50% in 5% increments Plan Coinsurance] <HospIpt-IN> **Hospital - Outpatient:** [After Deductible,] Member pays [nothing, $10-$50 in $5 increments] Copayment] [for primary care provider visits or [$20-$100 in $5 increments] Copayment for specialty care provider visits,] [and] [nothing, 10%-50% in 5% increments Plan Coinsurance] <HospOutpt-IN> **Outpatient Services:** [After Deductible,] Member pays [nothing, $5-$50 in $5 increments]	**Hospital - Inpatient:** After Deductible, Member pays [$100-$200 in $5 increments] Copayment per admission; [$100- $200 in $5 increments] Copayment per day up to $300-$1,000 in $5 increments per admission [and] [10%-50% in 5% increments] Plan Coinsurance <HospInpt-OON> **Hospital - Outpatient:** After Deductible, Member pays [10%-50% in 5% increments] Plan Coinsurance <HospOutpt-OON> **Outpatient Services:** After Deductible, Member pays [10%-50% in 5% increments] Plan Coinsurance <OutptSvcs-OON>

Hearing aids including hearing aid examinations.	[Not covered; Member pays 100% of all charges] {or} [Member pays nothing, limited to an Allowance of [$400 per ear limited to 1 aid per ear during a period of 3 consecutive years]; [$1,000 maximum per ear during any consecutive 36-month period], [$300 maximum per ear during any consecutive 36-month period]]	[Not covered; Member pays 100% of all charges] {or} [Allowance shared with Preferred Provider Network]

	After Allowance: 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 or surgically implanted hearing aids and the surgery and services necessary to implant them except as described above; hearing screening tests required under Preventive Services] {or} [Programs or treatments for hearing loss or hearing care associated with externally worn hearing or surgically implanted hearing aids and the surgery and services necessary to implant them except as described above; hearing screening tests required under Preventive Services; replacement costs of hearing aids due to loss, breakage or theft, unless at the time of such replacement the Member is eligible under the benefit Allowance; repairs; replacement parts; replacement batteries; maintenance costs]		

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I&F (non-exchange) KPWAC

Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation are covered only when provided at KFHPWA-approved facilities. Cochlear implants or Bone Anchored Hearing Aids (BAHA) when in accordance with KFHPWA clinical criteria. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).	**Hospital – Inpatient:** After Deductible, Member pays 30% Plan Coinsurance **Hospital – Outpatient:** After Deductible, Member pays 30% Plan Coinsurance **Outpatient Services:** Office visits: After Deductible, Member pays $20 Copayment for primary care provider office visits or $45 Copayment for specialty care provider office visits Deductible does not apply to the first 5 office visit claims received and processed per calendar year. All other services, including surgical services: After Deductible, Member pays 30% Plan Coinsurance
Hearing aids including hearing aid examinations.	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 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	

Small Group KPWAC

Hearing Examinations and Hearing Aids	
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Small Group KPWAO

Hearing Examinations and Hearing Aids	Preferred Provider Network	Out-of-Network
Hearing exams for hearing loss and evaluation. Cochlear implants or Bone Anchored Hearing Aids (BAHA) when in accordance with KFHPWAO clinical criteria. Preauthorization is required. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries). 	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** Office visits: Member pays $30 Copayment for primary care provider office visits or $50 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 20% 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
	Enhanced Benefit: Office visits: Member pays $10 Copayment for primary care provider office visits or $30 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 20% 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 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		

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Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation are covered only when provided at KFHPWA-approved facilities. Cochlear implants or Bone Anchored Hearing Aids (BAHA) when in accordance with KFHPWA clinical criteria. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).	**Hospital - Inpatient:** After Deductible, Member pays XX% Plan Coinsurance <HospInpt-IN> **Hospital - Outpatient:** After Deductible, Member pays $XX Copayment and XX% Plan Coinsurance <HospOutpt-IN> **Outpatient Services:** After Deductible, Member pays $XX Copayment and XX% Plan Coinsurance <OutptSvcs-IN>
Hearing aids including hearing aid examinations.	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 or surgically implanted hearing aids and the surgery and services necessary to implant them except as described above; hearing screening tests required under Preventive Services	

Large Group KPWAO

Hearing Examinations and Hearing Aids	**Preferred Provider Network**	**Out-of-Network**
Hearing exams for hearing loss and evaluation are covered. Cochlear implants or Bone Anchored Hearing Aids (BAHA) when in accordance with KFHPWAO clinical criteria. Preauthorization is required. Covered services for cochlear implants and BAHA include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance <HospInpt-IN> **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance <HospOutpt-IN> **Outpatient Services:** After Deductible, Member pays $10 Copayment and 20% Plan Coinsurance Enhanced Benefit: After Deductible, Member pays $5 Copayment and 20% Plan Coinsurance <OutptSvcs-IN>	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance <HospInpt-OON> **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance <HospInpt-OON> **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance <OutptSvcs-OON>
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 or surgically implanted hearing aids and the surgery and services necessary to implant them except as described above; hearing screening tests required under Preventive Services		

2023

I&F (non-exchange) KPWAC

Hearing Examinations and Hearing Aids	
Hearing exams for hearing loss and evaluation are covered only when provided at KFHPWA-approved facilities. Cochlear implants or Bone Anchored Hearing System (BAHS) when in accordance with KFHPWA clinical criteria. Covered services for initial cochlear implants and BAHS include diagnostic testing, pre-implant testing, implant surgery, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries). Replacement devices and associated supplies – see Devices, Equipment and Supplies section.	**Hospital – Inpatient**: After Deductible, Member pays 30% Plan Coinsurance **Hospital – Outpatient**: After Deductible, Member pays 30% Plan Coinsurance **Outpatient Services**: Office visits: After Deductible, Member pays $20 Copayment for primary care provider office visits or $45 Copayment for specialty care provider office visits Deductible does not apply to the first 5 office visit claims received and processed per calendar year. All other services, including surgical services: After Deductible, Member pays 30% Plan Coinsurance
Hearing aids including hearing aid examinations.	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 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	

Small Group KPWAC

Hearing Examinations and Hearing Aids	
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Hearing aids including hearing aid examinations	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 or surgically implanted hearing aids, and the surgery and services necessary to	

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Small Group KPWAO

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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 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		

Large Group KPWAC

Hearing Examinations and Hearing Aids	
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CA-1888a23 22

programming and associated supplies (such as transmitter cable, and batteries). Replacement devices and associated supplies – see Devices, Equipment and Supplies Section.	<OutptSvcs-IN>
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Large Group KPWAO

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Exhibit D

Appointment Summary

Patient: Andrea Schmitt [redacted]
Preferred Name:
Time Since Last Purchase: 2.6 years

NOAH

appointment

edit delete

Clinic: **Ascent Olympia II
Provider: Alison Vega
Type: Annual Test
Referral Source: Service
Referral Subcategory:
Referral Name:

Date: 11/23/2016
Time: 10:00 AM
Length: 90 minutes
Status: Completed
Prior Auth. #:
Prior Auth Exp:
Referring Phys:

Notes: annual exam and Demo Halo2
Created: Alison Vega 11/22/2016 12:11 PM
Last Edit: Alison Vega 11/29/2016 1:38 PM

Outcome Notes: Annual hearing exam completed; stable thresholds as compared to last audiogram. Demo of Halo2 RICs. Andrea likes the sound quality. We discussed the advantages of the RIC style and she made a phone call through her phone. I counseled her on the TRULINK application.
She will borrow these devices over the holiday and return the devices next week. She will propose a plan for purchase at her next appointment. AVega, AuD

Alison Vega 11/29/2016 1:38 PM
Edit Log
* All entries will be logged for HIPAA compliance

ICD Indicator: 0

Diagnosis Code:	**A:**	**B:**	**C:**	**D:**
	E:	**F:**	**G:**	**H:**
	I:	**J:**	**K:**	**L:**

Marketing Lists: **Speech Pathology:** No **Tinnitus:** No

appointment companion

None.

patient recall

add

Date	Description

No patient recalls found.

hearing tests

edit

	Left Ear Hearing Loss	Right Ear Hearing Loss
Level:	Level 4 - Moderate	Level 4 - Moderate
Type:	Sensorineural	Sensorineural
Shape:	None	None

	Left Ear Hearing Levels in DBs	Right Ear Hearing Levels in DBs
Levels:	125 250 500 750 1K 1.5K 2K 3K 4K 6K 8K	125 250 500 750 1K 1.5K 2K 3K 4K 6K 8K
Threshold:		
UCL:		
BC:		
IP:		
MCL:		
FF:		

Left Ear Speech Audiometry **Right Ear Speech Audiometry**

Mikayla Graham
Shop Videos Support

print close

Appointment Summary

Patient: Andrea Schmitt [redacted]
Preferred Name:
Time Since Last Purchase: 2.6 years

NOAH

edit delete

appointment

Clinic: **Ascent Olympia II
Provider: Alison Vega
Type: Hearing Aid Evaluation
Referral Source: Service
Referral Subcategory:
Referral Name:

Date: 11/16/2016
Time: 2:00 PM
Length: 30 minutes
Status: Completed
Prior Auth. #:
Prior Auth Exp:
Referring Phys:

Notes: Ms. Schmitt is in Seattle and it is very hard for her to get away from the law office she works at right now. She would like to discuss new technology. Her hearing aid is not broken yet, but she fears that they are getting older and may break soon. She is out of warranty. She has quite a bit of money in her self savings account to spend. Will want to discuss transmission of sounds from certain points. Binaural phones settings are something she is interested in as well. She also has an FM transmission system through Phonak. W: [redacted] C: [redacted] Her work phone is the most reliable to call.- mg

Created: Mikayla Graham 11/15/2016 3:00 PM **Last Edit:** Alison Vega 11/16/2016 7:05 PM

Outcome Notes: Phone conference with Andrea. She is interested in new technology. She has an HSA to use before the close of 2016 and is wondering if she should invest in new hearing aids. Her current technology is 3 years old and functions OK. She has intermittent success with her FM system.
I discussed the option of HALO2 RICs with her. She is not sure that a RIC is a good choice for her active lifestyle. She likes the idea of the binaural phone and ability of HALO2 to be accessible. She understands that it is not compatible with her Phonak FM system.
I recommend that Andrea return for an annual hearing exam and demo of HALO 2. AVega, AuD
Alison Vega 11/16/2016 7:05 PM
Edit Log
* All entries will be logged for HIPAA compliance

ICD Indicator: 0

Diagnosis Code:	**A:**	**B:**	**C:**	**D:**
	E:	**F:**	**G:**	**H:**
	I:	**J:**	**K:**	**L:**

Marketing Lists: **Speech Pathology:** No **Tinnitus:** No

appointment companion

None.

patient recall

add

Date	Description

No patient recalls found.

hearing tests

edit

no tests found

purchases

add

Time Since Last Purchase:2.6 years

close

Author	Date Last Modified	Outcome Notes

VEG 0034

Patient Notes 12/21/2017 7:33 PM

Clinic: **Ascent Olympia II
Address: Ascent Audiology & Hearing
365 Cooper Point Road NW
Olympia,WA,98502-4462

Phone: (360) 704-7900

Patient: Andrea Schmitt
DOB: 1978[redacted]

Patient Notes

Created	Author	Notes
08/21/2017 2:28 PM	April Buchanan	I called PT to schedule her C/C. She is currently living in Seattle but is moving back to Olympia. We set up her C/C for October. She requested to only see Dr. Vega. She explains although Kori was great with her, she doesn't believe that she helped PT with her issues with her hearing aids. AB
03/08/2017 2:13 PM	April Buchanan	PT called in this morning and we schedule her she is having a rough time with her new devices. Right HA works about 20% of the time. It does not matter how new the battery is. She has changed the wax filter. It clicks on and off whenever it feels like it. Streams on and off in both ears on and off. Chime sounds faint at times. AB
02/28/2017 3:37 PM	April Buchanan	24 HR call - No answer, left message. AB
02/28/2017 12:41 PM	April Buchanan	Thank you card sent. AB
02/06/2017 3:13 PM	Mikayla Graham	I called Ms. Schmitt to schedule a time for her to come in to be fit with her ear molds. She is going to wait to schedule the appointment. She might be called for a hearing in Olympia so she would like to wait until she knows what day that is. So far she is doing fine without them. She would prefer to only have to make one trip down here.- mg
02/01/2017 2:19 PM	April Buchanan	Called Ms. Schmitt to schedule fitting with Kori. No answer, left message. Molds are in. $200. Appt for 30mins. AB
02/01/2017 2:18 PM	April Buchanan	Called Ms. Schmitt to schedule fitting with Kori. No answer, left message. AB
12/20/2016 12:21 PM	Mikayla Graham	I called Ms. Schmitt to let her know that I split up her hearing aids into two separate invoices. She did not answer so I left a message.- mg
12/08/2016 3:33 PM	Mikayla Graham	I spoke to Terri E. at Group Health when I called.- mg
12/08/2016 3:32 PM	Mikayla Graham	I looked on OneHelthPort to see if Ms. Schmitt had an insurance benefit. Based on what it said in the benefits booklet, she has a $300/ ear benefit. I called Group Health to see if we needed authorization for this. As of December 1st, we are credentialed with Group Health PPO plans. Ms. Schmitt has a Self-Funded plan. We are not able to use her hearing aid benefit.- mg
08/05/2016 3:11 PM	Mikayla Graham	Andrea came in to purchase 3 cartons of Phonak filters. kr Imported Purchase 1925948: Phonak, ITC, Virto Q90, unknwon model, 04/28/2014 Imported Purchase 1755869: Phonak, ITE, Virto Q90, unknwon model, 03/13/2014 Imported Purchase 1755868: Phonak, ITE, Virto Q90, unknwon model, 03/13/2014
11/05/2015 9:33 AM	Alison Vega	Hearing aids were sent to Starkey by mistake for repair in October. The hearing aids hold a current warranty with Phonak until 2017. The right HA was again mistakenly sent to Starkey for repair; it had Phonak paperwork sent with it, so the right device is being sent back to our clinic and Aleah will send it to Phonak for repair. I authorize shipment to go directly to the patient in Seattle as long as programming is restored and the patient will be able to use it immediately after delivery. AVega, AuD
10/28/2015 5:21 PM	Aleah Fox	Pt. came to pick up repaired HA. The problem was not fixed. The Right HA in the phone program still has the buzzing and popping sound . Called Phonak for and explained to them the issue. They put a courtesy rush NO Charge. Talked to Phillip R. Will call Pt. when HA comes back. AFox
10/19/2015 12:13 PM	Desiree D Neeley	Patient came in and dropped off Right HA not working correctly, telephone setting is not working sounds like static it is still in warranty will have Dr. Vega look at it/ DNeeley
10/19/2015 12:13 PM	Desiree D Neeley	Patient came in and dropped off Right HA not working correctly, telephone setting is not working sounds like static it is still in warranty will have Dr. Vega look at it/ DNeeley
05/18/2015 1:08 PM	Tammy Goldfine	Called Mrs. Schmitt to let her know her repaired.
04/06/2015 10:35 AM	Tammy Goldfine	Called left message for Mrs. Schmitt that her HA is back.
04/01/2015 9:49 AM	Jaclyn Knutson	Pt here to pick up her HA. Dr. Vega nor I could detect any crackling or popping of the HA during separate listening checks. Pt put the HA in today and reported everything was fine in p.1 but when she switched to her phone program there was still crackling and popping. Pt would like the HA sent back to Phonak for another repair. I called Phonak and spoke to Monica in Customer Service. Monica took notes and authorized a N/C rush to repair HA. We will verify that HA is not popping or crackling when it returns. **Tammy, please let me check in HA before you call pt for pick up. JKnutson
03/25/2015 9:42 AM	Tammy Goldfine	Mrs. Schmitt came in to pick up HA but it is still not working. It is making a lite crackling sound more crackling with more noise around. I will talk to Dr Vega about it.

Patient Notes 12/21/2017 7:33 PM

03/23/2015 3:31 PM	Tammy Goldfine	Called Mrs. Schmitt to let her know she can pick it up.
03/16/2015 2:27 PM	Jaclyn Knutson	HA Check. Pt here c/o R HA not working. It will force the L HA program change but there is no amplification or indicators. Could not revive in office. To Phonak for in warranty repair. Please call pt for pick up once repair returns. JKnutson
11/26/2014 9:16 AM	Alison Vega	11/25/14 Andrea continues to complain of a weak right device. I performed a CC and believe it to have internal moisture build up. I recommend manufacturer repair. Andrea is going to take her device with her today and drop it off for repair at a later date. I also recommend that Andrea purchase a renew dryer for maintenance of moisture build up. AVega, AuD
11/05/2014 10:41 AM	Alison Vega	Right device is not amplifying well, yet is still communicating with the left hearing aid. I removed the filter and suctioned the receiver to restore function. I delivered 5 pkgs of filters and 1 box of batteries per warranty. One of the mic covers is missing; I ordered mic covers from Phonak. Andrea will return in 6 mos or sooner if needed for CC. AVega, AUD PLAN: Call/email Andrea when mic covers arrive in office. She does not need an appointment, but is welcome to stop by at her leisure for a quick application of mic covers. AV
07/21/2014 4:45 PM	Alison Vega	Delivered NEW complilot and repaired FM transmitter and MLXi. Andrea verified function in the office and will contact me immediately if she has any issues with connectivity. AVega, AuD
07/01/2014 11:52 AM	Shaughn Woodruff	7/1/14 equipment came back, called pt 11:51 am, left msg to schedule 45 min appt for programming
06/25/2014 10:28 AM	Alison Vega	FM system is intermittent. I called Tech support and it is recommended that I send it in for repair. I am sending the FM zoomlink w/charger as well as the compilot and MLX receiver. I turned off the microphone in bluetooth phone program I deleted the speech in wind program as it does not help at all Call pt for programming (45 min) appt when devices return. AVega, AuD
04/28/2014 11:59 AM	Alison Vega	Fit remake of left ITC. Fit is good. Added speech in wind program 2. Pt delighted. Follow up as needed. AVega, AuD
04/21/2014 1:24 PM	Alison Vega	Remake is the wrong size: #13 battery and large ITE case. Sending back to Phonak for remake AGAIN. NC same day rush. AVega, AuD
04/11/2014 3:04 PM	Alison Vega	3/13/14 Follow up. Push button is difficult for Andrea. I called Phonak and software does not allow for deactivation for one ear button and still have binaural processing. This is disappointing. Andrea will try accommodations with button and return next week. AVega, AuD
03/26/2014 1:28 PM	Alison Vega	Andrea is not happy with button on left device; it switches when using her cell phone. I will order a remake of left device WITHOUT SWITCH Otherwise, hearing is exceptional. P: I will fax order form to Phonak for new left ITE. Scans are on file. Call Andrea when new unit arrives. She needs a 15 min programming appt. AVega, AUD
03/19/2014 8:14 PM	Alison Vega	3/7/14 Andrea here for fitting of Phonak ITE units and FM system. Nikolas is assisting the fitting process today to ensure proper pairing and explanation of Phonak products. Fit to 80% of target. FM system connected and paired successfully. Andrea has a tactronic switch on the devices in order to select her telephone program (acoustic). The button is a little sensitive today (she tripps it easily) but she will try it as is for now. She perceives speech clearly and is delighted with improvement in hearing. She is satisfied with size of device, though wishes it was smaller, understands necessity for size. Andrea is to try these settings for a week and return for follow up. AVega, AUD 10/4/13 Called and left a vm asking Andrea if she would be available to come meet with Dr. Vega and the Widex rep on 10/16 @4pm in regards to the scola fm system. Pt to call back to confirm. MI 3-11-13 Patient called in regarding Hearing aid eval and annual test. She said that she is currently wearing STARKEY HA and seeing a dr in seattle but doesn't want to drive up there all the time. She said that she is having issues with her left hearing aid it seems dead. She said that the last CC she had wax gaurds and mic filters added to right HA and that seems to help with wax build up. She wanted to know if she could get her hearing tested and get her LEFT hearing aid repaired or sent in for repair. I let her know that the dr is going to want to test her hearing check function of current HA and she will go over everything with her. She said that she would like to get her records sent to our office. I let her know that she can fill out request at time of APT. I set her up for apt 3-13-13 at 200 pm. thanked and ended call. spalm.

Exhibit E

Filed: 9/15/2022 10:14 AM Date of Service: 9/15/2022 8:30 AM Status: Signed
Editor: Howard, Lauren Nicole, AUD,CCC-A (Audiologist)

Audiology Clinic Note

Patient Name: C[redacted] A[redacted] L[redacted]
Patient MRN: [redacted]
Date of Birth: [redacted]2008

Date of Service: 9/15/2022

Encounter Department: Audiology at Seattle Children's Hospital

APPOINTMENT TYPE: Repeat Behavioral Audiologic Evaluation & Hearing Device Follow-Up

HISTORY: C[redacted], 14 y.o. 1 m.o., was seen today for a repeat audiologic evaluation and hearing device follow-up. C[redacted] was most recently seen on 5/31/2022 for an earmold impression(s) appointment. Please refer to previous reports located under the 'Notes' tab in the electronic health record for additional history. C[redacted] was accompanied to today's appointment by her father.

Medical History: C[redacted] 's medical history is significant for bilateral sensorineural hearing loss.

Hearing History: C[redacted] has a history of bilateral sensorineural hearing loss and has worn hearing aids for many years. C[redacted] was most recently seen for an audiologic evaluation on 9/8/2020. At that time, she demonstrated normal hearing sloping to a moderately to severe sensorineural hearing loss in both ears. Please refer to previous report(s) for details.

Amplification History: For the right ear, C[redacted] uses a Phonak Sky M50-PR BTE , which was fit on 10/30/2020 . For the left, C[redacted] uses a Phonak Sky M50-PR BTE , which was fit on 10/30/2020 .

Family Concerns: C[redacted] denied changes in hearing or issues with her hearing aids.

Education: C[redacted] is currently in 9th grade at [redacted] High School in the Seattle School District. She has access to an FM system and ASL interpreter.

Release of Information: A release of information (ROI) was signed by C[redacted]'s father to allow Seattle Children's Audiology to speak directly with school (expiration date: 9/2026).

TEST RESULTS: *Please refer to the audiogram located under the "Procedures" tab in the electronic health record or attached to this report for details of testing and results.*

Otoscopy: For the right and left ears, otoscopy revealed a clear ear canal and the tympanic membrane was visualized.

Tympanometry: A 226 Hz tone was used for testing. For the right and left ears, tympanometry was within normal limits, consistent with normal middle ear function.

Audiologic Evaluation: C[redacted]'s hearing was assessed using Conventional Audiometry (CA) with one examiner present. Responses were established using insert earphones and pulsed pure tones stimuli; responses are indicated on the audiogram. Reliability was judged to be good. For the right ear, air conduction thresholds were obtained at 15-20 dB HL from 250-1000 Hz and at 50-75 from 1500-8000 Hz. For the left ear, air conduction thresholds were obtained at 10-25 dB HL from 250-1000 Hz and at 55-65 from 1500-8000 Hz. Unmasked bone conduction testing suggests a

Seattle Children's Hospital MAIN CAMPUS
4800 Sand Point Way NE
SEATTLE WA 98105

L[redacted], C[redacted] A[redacted]
MRN: 929637, DOB: [redacted]2008, Sex: F
Adm: 9/15/2022, D/C: 9/15/2022

09/15/2022 - Hearing Aid Fitting/Check in Audiology at Seattle Children's Hospital (continued)

Clinical Notes (continued)

hearing loss that is sensorineural in nature. A Speech Reception Threshold (SRT) was obtained at 25 dB HL in the right ear and at 20 dB HL in the left ear using recorded spondees. Word recognition testing was not completed today.

**Note: Compared to last audiologic evaluation dated 9/8/2020, hearing has remained stable in both ears.*

HEARING DEVICE VERIFICATION & PROGRAMMING: *Please refer to verification printouts located under the 'Media' or 'Procedures' tab in the electronic health record for details and results.*

Visual Inspection: A visual inspection of C[redacted]'s hearing device(s) was unremarkable.

Listening Check: A listening check was completed and revealed clear sound.

Data Logging: Data logging confirmed use approximately 12 hours per day.

Earmolds/Retention: C[redacted] came to today's appointment wearing her old earmolds from 2020. She brought her new earmolds from May 2022 to have them fit today. The new earmold(s) appear to fit well and the old earmolds were re-tubed.

Verification: C[redacted]'s hearing aid(s) were evaluated using the Desired Sensation Level (DSL) v 5.0 Child prescriptive fitting method using the Verifit 2 electroacoustic/real ear system. The DSL fitting approach attempts to ensure speech audibility, while avoiding loudness discomfort, by utilizing age and individual ear-specific information to generate targets to set and adjust a child's hearing aids. Targets verified include average gain, soft gain, and maximum power output (MPO). C[redacted]'s device(s) were adjusted to meet DSL fitting targets using the manufacturer software. These results suggest that the hearing aid(s) meet targets from roughly 250-4000 Hz for average gain and soft gain. Please note that meeting targets does not predict audibility of specific sounds for specific individuals, especially at a distance or in the presence of background noise.

EQUIPMENT SUMMARY:

HEARING DEVICE(S)	LEFT	RIGHT
Style	BTE	BTE
Make / Model	Phonak / Sky M50-PR	Phonak / Sky M50-PR
Color	Lave Red	Lava Red
Serial Number	2035N14GR	2035N14GW
Battery Size	NA (rechargeable)	NA (rechargeable)
Battery Door	NA (rechargeable)	NA (rechargeable)
Earhook	Adult yellow filtered	Adult yellow filtered
WARRANTY		
Initial Fit Date	10/30/2020	10/30/2020
Warranty Exp.	12/6/2025	12/6/2025
PROGRAMMING		
Fitting Algorithm	Desired Sensation Level v5 Child	Desired Sensation Level v5 Child
Programming Based On	Audiogram 9/15/2022	Audiogram 9/15/2022
Verification Method / RECD / Measurement Date	in the test box / average RECD /	in the test box / average RECD /
Feedback Analyzer	No	No
SETTINGS		
Programs/Directionality	Startup Program: AutoSense Sky OS 3.0 Startup Directionality: Real Ear Sound (primarily omni directional)	Startup Program: AutoSense Sky OS 3.0 Startup Directionality:Real Ear Sound (primarily omni directional)

09/15/2022 - Hearing Aid Fitting/Check in Audiology at Seattle Children's Hospital (continued)

Clinical Notes (continued)

Indicator Light	disabled	disabled
Program Button	disabled	disabled
Volume Control	disabled	enabled
Frequency Lowering / Cutoff Frequency	enabled	enabled
Roger Direct / SN#	Yes	Yes
EARMOLD(S) / RETENTION	LEFT	RIGHT
Manufacturer	All American	All American
Style	Skeleton	Skeleton
Material	JB-1000	JB-1000
Color	dark blue & green swirl with gold glitter	dark blue & green swirl with gold glitter
Canal Length	medium	medium
Helix Lock	no	no
Venting	large SAV	large SAV
Sound Bore	standard	standard
Tubing	13 Dry with brass tube lock	13 Dry with brass tube lock
Impression Date	5/31/2022	5/31/2022

CONNECTIVITY DEVICES & ACCESSORIES			
Make / Model	Phonak / Partner Mic	/	/
Serial Number	2035NY2F8		
Initial Fit Date	10/30/2020		
Warranty Expiration	10/30/2021		

SUMMARY: C[redacted] returned today for a hearing device follow-up and audiologic re-evaluation appointment. Today's test results are consistent with normal hearing sloping to a moderate to moderately-severe/severe sensorineural hearing loss in both ears. Additionally, tympanometry results are consistent with normal middle ear function, bilaterally. Today's test results were reviewed with C[redacted] and her father. The family was provided a copy of today's results.

RECOMMENDATIONS: Based on today's evaluation, the following recommendations were discussed:

1. Return to the Audiology Clinic in one year to monitor hearing and hearing device status or sooner should concerns arise.
2. C[redacted] should continue full time use (10+ hours per day) of the hearing device(s).
3. Academic accommodations (i.e., preferential/strategic seating, teacher awareness of hearing loss, educational audiology support, potential use of FM/DM equipment) should be considered to allow equal access to instruction. The family is encouraged to discuss these with the education audiologist or special education provider in the district. These accommodations may be addressed in an individualized education plan (IEP) or 504 plan.
4. Use appropriate and well-fitting hearing protection when exposed to loud noises and limit the volume of personal music players.
5. Continue use of good communication strategies including reducing background noise, distance, and reverberation.

It was a pleasure working with C[redacted] and her family in clinic today. Questions or concerns regarding today's evaluation

09/15/2022 - Hearing Aid Fitting/Check in Audiology at Seattle Children's Hospital (continued)

Clinical Notes (continued)

may be directed to my direct line at 206-987-1191, through MyChart, or by calling the Audiology Clinic at 206-987-5173.

Lauren Howard, Au.D., CCC-A
Pediatric Audiologist
Seattle Children's Hospital
(206) 987-1191
lauren.howard@seattlechildrens.org

Electronically signed by Howard, Lauren Nicole, AUD,CCC-A at 9/15/2022 10:14 AM

Procedures

BEHAVIORAL HEARING EVALUATION (Final result)

Electronically signed by: **Interface, Scan In on 09/15/22 0000** Status: **Completed**
Ordering user: Interface, Scan In 09/15/22 0000
Ordering provider: Provider, Scanning
Authorized by: Provider, Scanning
Ordering mode: Standard
Frequency: -
Quantity: 1
Lab status: Final result
Scan on 9/15/2022 9:07 AM (below)

Exhibit F

DEPOSITION UPON ORAL EXAMINATION (VIA ZOOM) OF
ANDREA SCHMITT, APRIL 25, 2023

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WASHINGTON

AT SEATTLE

ANDREA SCHMITT; ELIZABETH MOHUNDRO; 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.	CASE NO. 2:17-cv-1611-RSL

DEPOSITION UPON ORAL EXAMINATION

VIA ZOOM VIDEOCONFERENCING

OF

ANDREA SCHMITT

DATE: Tuesday, April 25, 10:16 A.M.

REPORTED BY: Annamarie C. Spangrud, CCR

bone-anchored hearing aids?

A. No.

Q. Have you ever explored over-the-counter hearing aids?

A. I did ask about that possibility when I was in law school. I had a discussion with somebody at Fifth Avenue Hearing about that. When I was in law school, I didn't have -- you know, I had just a catastrophic health insurance policy and didn't have very much money because I was just paying for school and not working, and I had a pair of hearing aids that were, you know, near the end of their life, and the advice that was given to me was that, with the kind of hearing loss I had, that the technology that was available over-the-counter at the time was not going to be even remotely as good as the old hearing aids that I was still using, and so I, you know, didn't pursue that.

Q. Okay. And just to put our time frame here, the period that you explored this with Fifth Avenue Hearing would have been somewhere between 2004 and 2007; is that correct?

A. Yeah. I mean, I recall being in law school, so --

Q. Have you explored whether over-the-counter hearing aids can be a benefit to you at any later time,

such as any time in the last three years?

A. Only in some general sense that I'm, you know, asking my audiologist what the options are that would be the kind of correction that's going to enable me to do my job and be a mom to little kids, but I haven't asked for, you know, specific information about over-the-counter hearing aids as a specific form of treatment, for example.

Q. Okay. Why haven't you?

A. I mean, a couple of reasons. I think I'm -- I mean, I trust the doctors of audiology that I see and I trust them to give me the range of things that they think are appropriate for me.

I also, you know, didn't have it in mind to push as an option with the understanding that the technologies aren't, you know, as good as what I can get through an audiologist.

Q. How do you know the technologies in 2021 and 2022 are not as good as what you can get through an audiologist?

A. Like I said, I had that idea in mind, and I don't know that for an absolute fact. I'm, you know, not informed about whether that's, in fact, true.

Q. All right.

MS. MARISSEAU: Counsel, what do you want to

Exhibit G

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,	)	
vs.	)	No. 2:17-cv-01611-RSL
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.	)	

ZOOM DEPOSITION UPON ORAL EXAMINATION

OF

SUSAN PORTER

9:30 a.m.

April 5, 2023

REPORTED BY: Pat Lessard, CCR #2104

they still need to be evaluated.

Q. (By Ms. Hamburger) Okay. And what if there is no treatment from a physician or an ENT to address the hearing loss that you identify, what do you do?

A. Well, it depends on the level of the hearing loss. But part of my role and my experience is to counsel the patient regarding, you know, if there is hearing loss what the type of hearing loss is, severity of hearing loss.

And then counsel them on, you know, strategies they can use to, you know, hear in a different variety of different situations. And we may recommend that they look into a hearing aid if they are feeling motivated to do so.

Q. So when do you recommend hearing aids for patients?

A. It really varies. Hearing aids -- in my experience I have recommended hearing aids for patients a lot of times based on the difficulty they are expressing and their interest in, you know, doing something to see if they can improve how they hear in certain situations.

Q. Do you recommend a hearing aid when someone has no identifiable hearing loss on an objective audiogram?

A. I personally don't. However, I am familiar with other providers that may recommend hearing aids for other treatments.

Q. So you personally would not recommend a hearing aid unless there was some objective study that showed some amount of hearing loss, is that right?

A. Yes, that is correct.

Q. Okay. And would you personally recommend a hearing aid for someone who showed on an audiogram that they only had mild hearing loss and who didn't report substantial difficulty with hearing subjectively?

MS. MARISSEAU: Object to the form. Speculation, incomplete hypothetical.

A. I would counsel a patient regarding a variety of different options, listening strategies as well as the option of hearing aids.

But if a patient doesn't perceive that they're having a lot of difficulty then my job is to counsel and just provide and make them aware there are options.

Q. (By Ms. Hamburger) So if the patient did not report difficulty in how they are experiencing their hearing loss and they had mild hearing loss you would counsel them as to different strategies for

Q. But you had to learn at some point that that product was not going to be covered, correct?

A. Yeah. It would have been many years ago when it was brought up -- if a patient asked about the device, then, yeah, we would have referred them to the clinical criteria.

Q. So you think there might be clinical criteria somewhere related to the dental implant?

A. Yes, there may be.

Q. Okay. Did Kaiser ever review the clinical efficacy of hearing aids, externally worn hearing aids?

MS. MARISSEAU: Lack of foundation.

A. I don't know. I'm not part of that review team.

Q. (By Ms. Hamburger) Have you ever seen clinical criteria, a clinical policy that discusses the medical efficacy of hearing aids?

A. No, I don't recall.

Q. Okay. Can hearing aids be clinically effective?

A. I can't comment on that. That's outside of my scope.

Q. You're a licensed audiologist, right?

A. I am.

Q. And you have recommended hearing aids to patients with hearing loss, correct?

A. Correct.

Q. And when you recommend hearing aids to patients with hearing loss it's because you've determined that it's clinically effective for them, right?

A. I've determined that they may receive benefit from it.

Q. Okay. Clinical benefit?

A. Well, subjective benefit.

Q. Subjective benefit.

Do you ever check to see if people's hearing has objectively improved after they've been fitted with hearing aids?

A. We perform a test called a "Real-Ear Measure" to make sure that it is providing amplification based on a formula for their hearing loss.

But other than that it's subjective responses.

Q. Okay. So you do check to see if there is an objective benefit based upon that test to utilizing hearing aids, is that right?

A. No, that's not the case. It's not objective

benefit together with the objective study that shows the amplification is doing what it should be doing?

A. Yes. And sometimes they're also independent. We may see that the hearing aid is doing what it's supposed to be doing and they may not perceive benefit or they may perceive benefit even though the hearing aid is not necessarily performing what we think it should.

Q. Okay. When does an audiologist determine that a Cochlear implant is necessary?

A. So a Cochlear implant is recommended when the hearing loss meets certain criteria for severity between the hearing loss and word understanding and the patient is no longer feeling like they're getting, you know, enough benefit, if they're using hearing aids, from the hearing aids.

Q. Does Kaiser require someone to use and not receive sufficient benefit from a hearing aid before it would consider them for a Cochlear implant?

A. There is clinical criteria that the patient needs to meet through testing that's performed. And some of that testing is performed with the externally worn air conduction hearing aids, you know, in their ears.

Q. So do most people who get Cochlear implants

try hearing aids first?

MS. MARISSEAU: Lack of foundation.

A. I don't personally fit Cochlear implants but I know to meet the criteria the testing needs to be done in what we refer to as the best-aided condition. So typically that involves hearing aids.

Whether they've worn them in the past or whether they're wearing them for the purpose of the test we do have to perform testing with hearing aids.

Q. (By Ms. Hamburger) Okay. And what level of hearing loss is usually required, typically required for a patient to be eligible for a Cochlear implant?

A. There are a few different types of criteria. So in general it is moderately severe to severe or profound.

But that's an average of frequencies or average level across the frequency range, so some patients may have better hearing in certain pitches and worse hearing in other pitches.

Q. Other than -- I think we've discussed BAHAs, or bone-anchored hearing aids, Cochlear implants, Soundbridge, Soundbite and externally worn air conduction hearing aids.

Are there other hearing devices that are typically provided to treat hearing loss?

A. I think there are a variety of amplifying devices that are available such as FM systems, amplifiers like pocket talkers that patients may use or over-the-counter hearing aids.

Q. Okay. But those other devices you're talking about do not have to be prescribed or recommended by a licensed hearing care professional, is that right?

A. Correct. An FM system sometimes is used in conjunction with a hearing aid. But other than that, many of those are available over the counter.

Q. So the universe of devices for hearing loss that are required to be prescribed or recommended by a licensed hearing professional are those five devices: the Cochlear implants, BAHAs, externally worn hearing aids, Soundbridge and Soundbite, is that right?

MS. MARISSEAU: Object to the form.

A. There may be others. There are other types of -- there may be other types of middle ear implants and things that I'm not familiar with.

But the ones I'm most familiar with are Cochlear implant, BAHAs and externally worn air conduction hearing aids.

Q. (By Ms. Hamburger) Okay. And are externally worn air conduction hearing aids used to

treat any other medical conditions other than hearing loss?

A. So some patients may use them to assist in tinnitus or tinnitus or to reduce how much they notice their tinnitus or tinnitus. And sometimes they're recommended for patients with auditory processing disorders.

Q. Does Kaiser cover hearing aids when they are used to treat tinnitus?

A. Well, it's not covered under the base benefit.

Q. Okay. Does Kaiser cover it under the base benefit when it is used to treat auditory processing disorders?

A. No. Not that I'm aware.

Q. Okay. Have you ever prescribed hearing aids for tinnitus or auditory processing disorders?

A. No.

Q. So over the many years that you have been prescribing hearing aids you've never had the occasion to prescribe it for those two conditions?

A. I have -- well, it's been several years since I've fit hearing aids and my recommendation for patients with tinnitus, if they have hearing loss, then maybe they can look into hearing aids.

And they may also notice some benefit for tinnitus but there are other options available for tinnitus as well.

Q. So you've counseled patients when they already have hearing loss and tinnitus that it might have some benefit to their tinnitus, right?

A. Correct.

Q. And other than those two conditions you mentioned are hearing aids used to treat any other medical conditions?

A. Not that I'm aware of.

Q. What about bone-anchored hearing aids, are they used to treat any other medical conditions than hearing loss?

A. Not that I'm aware of.

Q. What about Cochlear implants, are they used to treat any other medical condition than hearing loss?

A. Not that I'm aware of.

Q. Okay. And hearing aids that are not over the counter have to be prescribed or recommended by a licensed hearing professional, is that right?

A. Well, they need to be fit by a licensed hearing professional.

Q. And the hearing professional has to

Exhibit H

The Honorable Robert S. Lasnik

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

ANDREA SCHMITT; ELIZABETH MOHUNDRO; 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.	CASE NO. 2:17-cv-1611 DEFENDANTS' RESPONSES AND OBJECTIONS TO PLAINTIFFS' FOURTH DISCOVERY REQUESTS

Defendants Kaiser Foundation Health Plan of Washington ("KFHPW") and Kaiser Foundation Health Plan of Washington Options, Inc. ("KFHPWO"), collectively "Defendants," respond to Plaintiffs' Fourth Discovery Requests (the "Discovery Requests"), as set forth below.

GENERAL OBJECTIONS

The following general comments and objections are hereby incorporated by this reference into Defendants' answers and responses to each and every Discovery Request.

1. The Discovery Requests are propounded to Kaiser Foundation Health Plan, Inc. ("KFHP"), and purport to require KFHP to respond for and on behalf of any and all of its

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subsidiaries, agents, employees and attorneys. KFHP does not issue health policies and is not a health carrier. Subsidiaries of KFHP include companies who are not named as parties to this suit and do not issue health plans in Washington. Plaintiffs were at times insured under health plans issued by KFHPW and/or KFHPWO. Defendants therefore object to the Discovery Requests as impossibly overbroad and unduly burdensome and not likely to lead to the discovery of admissible evidence.

2. Defendants also object to the Discovery Requests, which by definition call for information or documents that are protected by privilege, including the attorney/client privilege, and work product privilege.

3. Defendants object to the Discovery Requests to the extent they purport to require the disclosure of information or the production of documents that are confidential in nature and/or are protected from discovery by the privacy rights of third parties, with no interest in this proceeding, who do not consent to the disclosure of any responsive information or documents.

4. Defendants object to the Discovery Requests to the extent they call for information or documents in the Plaintiffs' possession, custody or control, or to which the Plaintiffs already have access or equal ability to obtain, or which are a matter of public record.

5. Defendants object to the Discovery Requests to the extent they seek to impose obligations beyond those required by Fed. R. Civ. P. 26.

Nothing in the below answers shall be construed as a waiver of any of specific or general objections, whether or not such objection is reiterated in the answer to any Discovery Request. Defendants reserves the right to assert any such objection to any answer given.

RESPONSES

INTERROGATORY NO. 12: Please identify whether Kaiser's Medical Policy Committee, its Medical Technology Committee or any other Kaiser committee ever reviewed whether non-over-the-counter hearing aids can be medically necessary or should be covered under

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the Kaiser base health plan, including the date of such review, the individuals involved in such review, the data, documents and information considered and the outcome of the review.

ANSWER: Defendants object to this request as vague, overbroad and unduly burdensome, and unlimited in time. Further, Defendants' response below does not include Defendants' insured Medicare Advantage Plans, Federal Employee Health Benefit Plans, or Plans which include hearing aid riders, all of which include coverage for hearing aids. Subject to, and without waiving these objections, Defendants respond as follows:

Yes. Multiple committees and/or teams have considered either medical necessity and/or coverage.

In addition to Bone Anchored Hearing Aids, for which documents and information were previously provided, the Medical Technical Advisory Committee (MTAC) received a request to review a hybrid cochlear implant with an external air conduction hearing aid, requested by Dr. Susan Porter and Kurt Schendel, RN on April 8, 2015, and MTAC reviewed the request on August 17, 2015, by Quinn Jenkins, MPH and Dr. Kenneth Deem, M.D. MTAC reviewed sound therapy maskers for the management of tinnitus in adults on June 17, 2013, reviewed by Quinn Jenkins, MPH and Dr. Dennis Elonka. MTAC reviewed the "Soundbite Prosthetic Hearing System" on December 15, 2014, reviewed by Quinn Jenkins, MPH and Dr. Dennis Elonka. In 2013-2014, the Large Group Reform Response Team (RRT) evaluated whether hearing services (including air conduction hearing aids) were Essential Health Benefits under the law, and subsequently re-reviewed. See documents produced in response to RFP no. 22. Annually, the base benefit plan (which includes the hearing care exclusion) offered on the Washington State Health Benefit Exchange (WAHBE) is evaluated to determine if it meets the requirements for Qualified Health Plan certification by the Washington State Health Benefit Exchange. This effort is undertaken by the Kaiser Foundation Health Plan of Washington Filing and Certification team, currently managed by Jill McMahon, who has managed the team for plan years 2018-2023. In addition, annually, the Health Plan Services and Administration department has submitted the base benefit

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plan, which includes the hearing care exclusion, to the Washington Office of the Insurance Commissioner, for approval, in compliance with the OIC's analyst checklist and other legal requirements. The deposition of Jessica Hamp, 30(b)(6) witness, contains details on this process, along with the ongoing benefit review (including the hearing care exclusion) performed by the Health Policy Committee, as described by Ms. Hamp in the deposition.

REQUEST FOR PRODUCTION NO. 22: Please produce for inspection and copying all documents relating to, relied upon or reviewed as part of creating Kaiser's response to Interrogatory No. 12.

RESPONSE: Defendants incorporate objections to Interrogatory No. 12 as fully set forth herein. Subject to, and without waiving any objection, Defendants are producing herewith CONFIDENTIAL KAISER_003796-3815; CONFIDENTIAL KAISER_003876-3916; CONFIDENTIAL KAISER_003923-3937; CONFIDENTIAL KAISER_003938-3941; CONFIDENTIAL KAISER_003970; CONFIDENTIAL KAISER_004010-4019; CONFIDENTIAL KAISER_003917-3922; CONFIDENTIAL KAISER_003973-4009; KAISER_003816-3875 in response to this request. Additionally, please see documents previously produced, including without limitation:

KAISER_001860- KAISER_001862

CONFIDENTIAL KAISER_2056- KAISER_002061

KAISER_002064- KAISER_002067

KAISER_002073- KAISER_002076

This response may be supplemented as discovery is ongoing.

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DATED this 2nd day of May, 2023.

KARR TUTTLE CAMPBELL

s/Medora A. Marisseau

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Attorneys for the Defendants

Exhibit I

CERTIFICATION OF ENROLLMENT

SUBSTITUTE HOUSE BILL 1870

Chapter 33, Laws of 2019

66th Legislature
2019 Regular Session

FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT--STATE LAW

EFFECTIVE DATE: April 17, 2019

Passed by the House April 1, 2019
Yeas 56 Nays 37

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate March 27, 2019
Yeas 28 Nays 17

CYRUS HABIB

President of the Senate

Approved April 17, 2019 12:36 PM

JAY INSLEE

Governor of the State of Washington

CERTIFICATE

I, Bernard Dean, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SUBSTITUTE HOUSE BILL 1870** as passed by House of Representatives and the Senate on the dates hereon set forth.

BERNARD DEAN

Chief Clerk

FILED

April 18, 2019

Secretary of State
State of Washington

SUBSTITUTE HOUSE BILL 1870

AS AMENDED BY THE SENATE

Passed Legislature - 2019 Regular Session

State of Washington 66th Legislature 2019 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Davis, Cody, Ryu, Jinkins, Dolan, Senn, Bergquist, Peterson, Thai, Valdez, Morgan, Robinson, Goodman, Kilduff, Fey, Pollet, Appleton, Orwall, Mead, Kirby, Kloba, Gregerson, Fitzgibbon, Stanford, and Tharinger)

READ FIRST TIME 02/22/19.

AN ACT Relating to making state law consistent with selected federal consumer protections in the patient protection and affordable care act; amending RCW 48.43.005, 48.43.012, 48.21.270, 48.44.380, 48.46.460, 48.43.715, and 48.43.0122; adding new sections to chapter 48.43 RCW; adding a new section to chapter 43.71 RCW; repealing RCW 48.43.015, 48.43.017, 48.43.018, and 48.43.025; prescribing penalties; and declaring an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

PART I
DEFINITIONS

Sec. 1. RCW 48.43.005 and 2016 c 65 s 2 are each amended to read as follows:

Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Adjusted community rate" means the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities.

(2) "Adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(3) "Applicant" means a person who applies for enrollment in an individual health plan as the subscriber or an enrollee, or the dependent or spouse of a subscriber or enrollee.

(4) "Basic health plan" means the plan described under chapter 70.47 RCW, as revised from time to time.

(5) "Basic health plan model plan" means a health plan as required in RCW 70.47.060(2)(e).

(6) "Basic health plan services" means that schedule of covered health services, including the description of how those benefits are to be administered, that are required to be delivered to an enrollee under the basic health plan, as revised from time to time.

(7) "Board" means the governing board of the Washington health benefit exchange established in chapter 43.71 RCW.

(8)(a) For grandfathered health benefit plans issued before January 1, 2014, and renewed thereafter, "catastrophic health plan" means:

(i) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand seven hundred fifty dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand five hundred dollars, both amounts to be adjusted annually by the insurance commissioner; and

(ii) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand five hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least six

thousand dollars, both amounts to be adjusted annually by the insurance commissioner.

(b) In July 2008, and in each July thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for a preceding twelve months, as determined by the United States department of labor. For a plan year beginning in 2014, the out-of-pocket limits must be adjusted as specified in section 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount shall apply on the following January 1st.

(c) For health benefit plans issued on or after January 1, 2014, "catastrophic health plan" means:

(i) A health benefit plan that meets the definition of catastrophic plan set forth in section 1302(e) of P.L. 111-148 of 2010, as amended; or

(ii) A health benefit plan offered outside the exchange marketplace that requires a calendar year deductible or out-of-pocket expenses under the plan, other than for premiums, for covered benefits, that meets or exceeds the commissioner's annual adjustment under (b) of this subsection.

(9) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

(10) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(11) "Covered person" or "enrollee" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

(12) "Dependent" means, at a minimum, the enrollee's legal spouse and dependent children who qualify for coverage under the enrollee's health benefit plan.

(13) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect

the absence of immediate medical attention to result in a condition (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

(14) "Emergency services" means a medical screening examination, as required under section 1867 of the social security act (42 U.S.C. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. 1395dd(e)(3)).

(15) "Employee" has the same meaning given to the term, as of January 1, 2008, under section 3(6) of the federal employee retirement income security act of 1974.

(16) "Enrollee point-of-service cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(17) "Exchange" means the Washington health benefit exchange established under chapter 43.71 RCW.

(18) "Final external review decision" means a determination by an independent review organization at the conclusion of an external review.

(19) "Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a health plan or carrier at the completion of the internal appeals process, or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the exhaustion rules described in RCW 48.43.530 and 48.43.535.

(20) "Grandfathered health plan" means a group health plan or an individual health plan that under section 1251 of the patient protection and affordable care act, P.L. 111-148 (2010) and as amended by the health care and education reconciliation act, P.L.

111-152 (2010) is not subject to subtitles A or C of the act as amended.

(21) "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.

(22) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

(23) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(24) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(25) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the patient protection and affordable care act (P.L. 111-148).

(26) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide,

arrange, reimburse, or pay for health care services except the following:

(a) Long-term care insurance governed by chapter 48.84 or 48.83 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Coverage supplemental to the coverage provided under chapter 55, Title 10, United States Code;

(d) Limited health care services offered by limited health care service contractors in accordance with RCW 48.44.035;

(e) Disability income;

(f) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(g) Workers' compensation coverage;

(h) Accident only coverage;

(i) Specified disease or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered as an independent, noncoordinated benefit;

(j) Employer-sponsored self-funded health plans;

(k) Dental only and vision only coverage;

(l) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner; and

(m) Civilian health and medical program for the veterans affairs administration (CHAMPVA).

(27) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(28) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

(29) "Open enrollment" means a period of time as defined in rule to be held at the same time each year, during which applicants may enroll in a carrier's individual health benefit plan without being

subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(30) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

(31) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(32) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

(33) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least one but no more than fifty employees, during the previous calendar year and employed at least one employee on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor who is covered as a group of one must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived at least seventy-five percent of his or her income from a trade or business through which the

individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year.

(34) "Special enrollment" means a defined period of time of not less than thirty-one days, triggered by a specific qualifying event experienced by the applicant, during which applicants may enroll in the carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(35) "Standard health questionnaire" means the standard health questionnaire designated under chapter 48.41 RCW.

(36) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.

(37) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

(38) "Essential health benefit categories" means:

(a) Ambulatory patient services;

(b) Emergency services;

(c) Hospitalization;

(d) Maternity and newborn care;

(e) Mental health and substance use disorder services, including behavioral health treatment;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and chronic disease management; and

(j) Pediatric services, including oral and vision care.

PART II

GUARANTEED ISSUE AND ELIGIBILITY

Sec. 2. RCW 48.43.012 and 2011 c 315 s 3 are each amended to read as follows:

(1) No carrier may reject an individual for an individual or group health benefit plan based upon preexisting conditions of the individual ((~~except as provided in RCW 48.43.018~~)).

(2) No carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions ((~~except as provided in this section~~)) including, but not limited to, preexisting condition exclusions or waiting periods.

(3) ((~~For an individual health benefit plan originally issued on or after March 23, 2000, preexisting condition waiting periods imposed upon a person enrolling in an individual health benefit plan shall be no more than nine months for a preexisting condition for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months prior to the effective date of the plan. No carrier may impose a preexisting condition waiting period on an individual health benefit plan issued to an eligible individual as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)).~~

~~(4) Individual health benefit plan preexisting condition waiting periods shall not apply to prenatal care services.~~

~~(5)~~)) No carrier may avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. A new or changed rate classification will be deemed an attempt to avoid the provisions of this section if the new or changed classification would substantially discourage applications for coverage from individuals who are higher than average health risks. These provisions apply only to individuals who are Washington residents.

((~~(6) For any person under age nineteen applying for coverage as allowed by RCW 48.43.0122(1) or enrolled in a health benefit plan~~

~~subject to sections 1201 and 10103 of the patient protection and affordable care act (P.L. 111-148) that is not a grandfathered health plan in the individual market, a carrier must not impose a preexisting condition exclusion or waiting period or other limitations on benefits or enrollment due to a preexisting condition.~~))

(4) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act.

NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43 RCW to read as follows:

(1) A health carrier or health plan may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(a) Health status;

(b) Medical condition, including both physical and mental illnesses;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including conditions arising out of acts of domestic violence;

(h) Disability; or

(i) Any other health status-related factor determined appropriate by the commissioner.

(2) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act.

Sec. 4. RCW 48.21.270 and 2011 c 314 s 2 are each amended to read as follows:

(1) An insurer shall not require proof of insurability as a condition for issuance of the conversion policy.

(2) A conversion policy may not contain an exclusion for preexisting conditions for any applicant ((~~who is under age nineteen. For policies issued to those age nineteen and older, an exclusion for a preexisting condition is permitted only to the extent that a waiting period for a preexisting condition has not been satisfied under the group policy~~)).

(3) An insurer must offer at least three policy benefit plans that comply with the following:

(a) A major medical plan with a five thousand dollar deductible per person;

(b) A comprehensive medical plan with a five hundred dollar deductible per person; and

(c) A basic medical plan with a one thousand dollar deductible per person.

(4) The insurance commissioner may revise the deductible amounts in subsection (3) of this section from time to time to reflect changing health care costs.

(5) The insurance commissioner shall adopt rules to establish minimum benefit standards for conversion policies.

(6) The commissioner shall adopt rules to establish specific standards for conversion policy provisions. These rules may include but are not limited to:

(a) Terms of renewability;

(b) Nonduplication of coverage;

(c) Benefit limitations, exceptions, and reductions; and

(d) Definitions of terms.

Sec. 5. RCW 48.44.380 and 2011 c 314 s 7 are each amended to read as follows:

(1) A health care service contractor shall not require proof of insurability as a condition for issuance of the conversion contract.

(2) A conversion contract may not contain an exclusion for preexisting conditions for any applicant ((~~who is under age nineteen. For policies issued to those age nineteen and older, an exclusion for a preexisting condition is permitted only to the extent that a waiting period for a preexisting condition has not been satisfied under the group contract~~)).

(3) A health care service contractor must offer at least three contract benefit plans that comply with the following:

(a) A major medical plan with a five thousand dollar deductible per person;

(b) A comprehensive medical plan with a five hundred dollar deductible per person; and

(c) A basic medical plan with a one thousand dollar deductible per person.

(4) The insurance commissioner may revise the deductible amounts in subsection (3) of this section from time to time to reflect changing health care costs.

(5) The insurance commissioner shall adopt rules to establish minimum benefit standards for conversion contracts.

(6) The commissioner shall adopt rules to establish specific standards for conversion contract provisions. These rules may include but are not limited to:

(a) Terms of renewability;

(b) Nonduplication of coverage;

(c) Benefit limitations, exceptions, and reductions; and

(d) Definitions of terms.

Sec. 6. RCW 48.46.460 and 2011 c 314 s 9 are each amended to read as follows:

(1) A health maintenance organization must offer a conversion agreement for comprehensive health care services and shall not require proof of insurability as a condition for issuance of the conversion agreement.

(2) A conversion agreement may not contain an exclusion for preexisting conditions for an applicant ((~~who is under age nineteen. For policies issued to those age nineteen and older, an exclusion for a preexisting condition is permitted only to the extent that a waiting period for a preexisting condition has not been satisfied under the group agreement~~)).

(3) A conversion agreement need not provide benefits identical to those provided under the group agreement. The conversion agreement may contain provisions requiring the person covered by the conversion agreement to pay reasonable deductibles and copayments, except for preventive service benefits as defined in 45 C.F.R. 147.130 (2010), implementing sections 2701 through 2763, 2791, and 2792 of the public health service act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

(4) The insurance commissioner shall adopt rules to establish minimum benefit standards for conversion agreements.

(5) The commissioner shall adopt rules to establish specific standards for conversion agreement provisions. These rules may include but are not limited to:

(a) Terms of renewability;

(b) Nonduplication of coverage;

(c) Benefit limitations, exceptions, and reductions; and

(d) Definitions of terms.

NEW SECTION. **Sec. 7.** The following acts or parts of acts are each repealed:

(1) RCW 48.43.015 (Health benefit plans—Preexisting conditions) and 2012 c 64 s 2, 2004 c 192 s 5, 2001 c 196 s 7, 2000 c 80 s 3, 2000 c 79 s 20, & 1995 c 265 s 5;

(2) RCW 48.43.017 (Organ transplant benefit waiting periods—Prior creditable coverage) and 2009 c 82 s 2;

(3) RCW 48.43.018 (Requirement to complete the standard health questionnaire—Exemptions—Results) and 2012 c 211 s 16, 2012 c 64 s 1, 2010 c 277 s 1, & 2009 c 42 s 1; and

(4) RCW 48.43.025 (Group health benefit plans—Preexisting conditions) and 2001 c 196 s 9, 2000 c 79 s 23, & 1995 c 265 s 6.

PART III
PROHIBITING UNFAIR RESCISSIONS

NEW SECTION. **Sec. 8.** A new section is added to chapter 48.43 RCW to read as follows:

(1) A health plan or health carrier offering group or individual coverage may not rescind such coverage with respect to an enrollee once the enrollee is covered under the plan or coverage involved, except that this section does not apply to a covered person who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. The plan or coverage may not be canceled except as permitted under RCW 48.43.035 or 48.43.038.

(2) The commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on

January 1, 2017, implementing the patient protection and affordable care act.

PART IV
ESSENTIAL HEALTH BENEFITS

Sec. 9. RCW 48.43.715 and 2013 c 325 s 1 are each amended to read as follows:

(1) ((~~Consistent with federal law,~~)) The commissioner, in consultation with the board and the health care authority, shall, by rule, select the largest small group plan in the state by enrollment as the benchmark plan for the individual and small group market for purposes of establishing the essential health benefits in Washington state ((~~under P.L. 111-148 of 2010, as amended~~)).

(2) If the essential health benefits benchmark plan for the individual and small group market does not include all of the ten essential health benefits categories ((~~specified by section 1302 of P.L. 111-148, as amended~~)), the commissioner, in consultation with the board and the health care authority, shall, by rule, supplement the benchmark plan benefits as needed ((~~to meet the minimum requirements of section 1302~~)).

(3) ((~~A~~)) All individual and small group health plans ((~~required to offer~~)) must cover the ten essential health benefits categories, other than a health plan offered through the federal basic health program, a grandfathered health plan, or medicaid((~~, under P.L. 111-148 of 2010, as amended,~~)). Such a health plan may not be offered in the state unless the commissioner finds that it is substantially equal to the benchmark plan. When making this determination, the commissioner:

(a) Must ensure that the plan covers the ten essential health benefits categories ((~~specified in section 1302 of P.L. 111-148 of 2010, as amended~~));

(b) May consider whether the health plan has a benefit design that would create a risk of biased selection based on health status and whether the health plan contains meaningful scope and level of benefits in each of the ten essential health benefits categories ((~~specified by section 1302 of P.L. 111-148 of 2010, as amended~~));

(c) Notwithstanding ((~~the foregoing~~)) (a) and (b) of this subsection, for benefit years beginning January 1, 2015, ((~~and only to the extent permitted by federal law and guidance,~~)) must establish

by rule the review and approval requirements and procedures for pediatric oral services when offered in stand-alone dental plans in the nongrandfathered individual and small group markets outside of the exchange; and

(d) ((~~Unless prohibited by federal law and guidance,~~)) Must allow health carriers to also offer pediatric oral services within the health benefit plan in the nongrandfathered individual and small group markets outside of the exchange.

(4) Beginning December 15, 2012, and every year thereafter, the commissioner shall submit to the legislature a list of state-mandated health benefits, the enforcement of which will result in federally imposed costs to the state related to the plans sold through the exchange because the benefits are not included in the essential health benefits designated under federal law. The list must include the anticipated costs to the state of each state-mandated health benefit on the list and any statutory changes needed if funds are not appropriated to defray the state costs for the listed mandate. The commissioner may enforce a mandate on the list for the entire market only if funds are appropriated in an omnibus appropriations act specifically to pay the state portion of the identified costs.

PART V
COST SHARING

NEW SECTION. **Sec. 10.** A new section is added to chapter 48.43 RCW to read as follows:

(1) For plan years beginning in 2020, the cost sharing incurred under a health plan for the essential health benefits may not exceed the following amounts:

(a) For self-only coverage:

(i) The amount required under federal law for the calendar year; or

(ii) If there are no cost-sharing requirements under federal law, eight thousand two hundred dollars increased by the premium adjustment percentage for the calendar year.

(b) For coverage other than self-only coverage:

(i) The amount required under federal law for the calendar year; or

(ii) If there are no cost-sharing requirements under federal law, sixteen thousand four hundred dollars increased by the premium adjustment percentage for the calendar year.

(2) Regardless of whether an enrollee is covered by a self-only plan or a plan that is other than self-only, the enrollee's cost sharing for the essential health benefits may not exceed the self-only annual limitation on cost sharing.

(3) For purposes of this section, "the premium adjustment percentage for the calendar year" means the percentage, if any, by which the average per capita premium for health insurance in Washington for the preceding year, as estimated by the commissioner no later than April 1st of such preceding year, exceeds such average per capita premium for 2020 as determined by the commissioner.

(4) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act.

PART VI

OPEN ENROLLMENT PERIODS

Sec. 11. RCW 48.43.0122 and 2011 c 315 s 4 are each amended to read as follows:

(1) The commissioner shall adopt rules establishing and implementing requirements for the open enrollment periods and special enrollment periods that carriers must follow for individual health benefit plans ((~~and enrollment of persons under age nineteen~~)).

(2) The commissioner shall monitor the sale of individual health benefit plans and if a carrier refuses to sell guaranteed issue policies to persons ((~~under age nineteen~~)) in compliance with rules adopted by the commissioner pursuant to subsection (1) of this section, the commissioner may levy fines or suspend or revoke a certificate of authority as provided in chapter 48.05 RCW.

PART VII

LIFETIME LIMITS

NEW SECTION. **Sec. 12.** A new section is added to chapter 48.43 RCW to read as follows:

A health carrier may not impose annual or lifetime dollar limits on an essential health benefit, other than those permitted as reference-based limitations under rules adopted by the commissioner.

PART VIII

EXPLANATION OF COVERAGE

NEW SECTION. **Sec. 13.** A new section is added to chapter 48.43 RCW to read as follows:

(1) The commissioner shall develop standards for use by a health carrier offering individual or group coverage, in compiling and providing to applicants and enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan. In developing the standards, the commissioner must use the standards developed under 42 U.S.C. Sec. 300gg-15 in use on the effective date of this section.

(2) The standards must provide for the following:

(a) The standards must ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed four pages in length and does not include print smaller than twelve-point font.

(b) The standards must ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

(c) The standards must ensure that the summary of benefits and coverage includes:

(i) Uniform definitions of standard insurance and medical terms, consistent with the standard definitions developed under this section, so that consumers may compare health insurance coverage and understand the terms of coverage, or exceptions to such coverage;

(ii) A description of the coverage, including cost sharing for:

(A) The essential health benefits; and

(B) Other benefits identified by the commissioner;

(iii) The exceptions, reductions, and limitations on coverage;

(iv) The cost-sharing provisions, including deductible, coinsurance, and copayment obligations;

(v) The renewability and continuation of coverage provisions;

(vi) A coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic

medical conditions and related cost sharing. The scenarios must be based on recognized clinical practice guidelines;

(vii) A statement of whether the plan:

(A) Provides minimum essential coverage under 26 U.S.C. Sec. 5000A(f); and

(B) Ensures that the plan share of the total allowed costs of benefits provided under the plan is no less than sixty percent of the costs;

(viii) A statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and

(ix) A contact number for the consumer to call with additional questions and a web site where a copy of the actual individual coverage policy or group certificate of coverage may be reviewed and obtained.

(3) The commissioner shall periodically review and update the standards developed under this section.

(4) A health carrier must provide a summary of benefits and coverage explanation to:

(a) An applicant at the time of application;

(b) An enrollee prior to the time of enrollment or reenrollment, as applicable; and

(c) A policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

(5) A health carrier may provide the summary of benefits and coverage either in paper or electronically.

(6) If a health carrier makes any material modification in any of the terms of the plan that is not reflected in the most recently provided summary of benefits and coverage, the carrier shall provide notice of the modification to enrollees no later than sixty days prior to the date on which the modification will become effective.

(7) A health carrier that fails to provide the information required under this section is subject to a fine of no more than one thousand dollars for each failure. A failure with respect to each enrollee constitutes a separate offense for purposes of this subsection.

(8) The commissioner shall, by rule, provide for the development of standards for the definitions of terms used in health insurance coverage, including the following:

(a) Insurance-related terms, including premium; deductible; coinsurance; copayment; out-of-pocket limit; preferred provider; nonpreferred provider; out-of-network copayments; usual, customary, and reasonable fees; excluded services; grievance; appeals; and any other terms the commissioner determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage; and

(b) Medical terms, including hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and any other terms the commissioner determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits or exceptions to those benefits.

(9) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act.

PART IX

WAITING PERIODS FOR GROUP COVERAGE

NEW SECTION. **Sec. 14.** A new section is added to chapter 48.43 RCW to read as follows:

(1) A group health plan and a health carrier offering group health coverage may not apply any waiting period that exceeds ninety days.

(2) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act.

PART X

PROHIBITING ISSUER AND HEALTH PLAN DISCRIMINATION

NEW SECTION. **Sec. 15.** A new section is added to chapter 48.43 RCW to read as follows:

(1) A health carrier offering a nongrandfathered health plan in the individual or small group market may not:

(a) In its benefit design or implementation of its benefit design, discriminate against individuals because of their age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions; and

(b) With respect to the health plan, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

(2) Nothing in this section may be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques.

(3) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act.

NEW SECTION. **Sec. 16.** A new section is added to chapter 43.71 RCW to read as follows:

(1) For qualified health plans, an issue offering a qualified health plan may not employ marketing practices or benefit designs that have the effect of discouraging enrollment in the plan by individuals with significant health needs.

(2) Unless preempted by federal law, the commissioner shall adopt any rules necessary to implement this section, consistent with federal rules and guidance in effect on January 1, 2017, implementing the patient protection and affordable care act.

NEW SECTION. **Sec. 17.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately.

Passed by the House April 1, 2019.
Passed by the Senate March 27, 2019.
Approved by the Governor April 17, 2019.
Filed in Office of Secretary of State April 18, 2019.

--- END ---

Exhibit J

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KAISER FOUNDATION HEALTH PLAN OF WASHIN

Change History | Licensing | Appointments | Complaints | Independent Reviews | Orders | Network Access Reports | Financial State

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General information

Name: KAISER FOUNDATION HEALTH PLAN OF WASHINGTON
Corporate family group: KAISER FOUNDATION GRP
Organization type: HEALTH MAINTENANCE ORGANIZATION
Doing Business As (DBA): Unavailable

WAOIC: 554
NAIC: 95672

Status: Active
Admitted date: 04/07/1976
Ownership type: NON-PROFIT

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Contact information

Registered address
601 UNION ST SUITE 3100
SEATTLE, WA 98101

Telephone
888-901-4636

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has information and tips to help you understand current insurance issues.

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KAISER FOUNDATION HEALTH PLAN OF WASHINGTON OI

Change History | Licensing | Appointments | Complaints | Independent Reviews | Orders | Network Access Reports | Financial Statemer

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General information

Name: KAISER FOUNDATION HEALTH PLAN OF WASHINGTON OPTIONS INC
Corporate family group: KAISER FOUNDATION GRP
Organization type: HEALTH CARE SERVICE CONTRACTOR
Doing Business As (DBA): Unavailable

WAOIC: 76461
NAIC: 47055

Status: Active
Admitted date: 10/23/1990
Ownership type: STOCK

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Contact informatio

Registered address
601 UNION ST SUITE 3100
SEATTLE, WA 98101

Telephone
888-901-4636

Company change history

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Before you buy, check out the insurance company's financial rating.

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Exhibit L

Clinical review criteria

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A B C D E F G H I J K L M N O P R S T U V W X

Coverage provided by Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente).

Kaiser Permanente Clinical Review Criteria are developed to assist in administering plan benefits. These criteria neither offer medical advice nor guarantee coverage. For information concerning whether a specific service or benefit is covered, please refer to the patient's medical coverage agreement, the Provider Manual, your Provider contract, or call the Kaiser Permanente Provider Assistance Unit at 1-888-767-4670. Kaiser Permanente reserves the exclusive right to modify, revoke, suspend or change any or all of these review criteria, at Kaiser Permanente's sole discretion, at any time.

By viewing these criteria, you acknowledge that you understand and accept the following:

- These Kaiser Permanente Clinical Review Criteria are technical and written to assist medical personnel in making coverage determinations. They are not medical advice, nor are they intended to influence the practitioner or alter his/her duty in any way to exercise his/her independent professional judgment in the care of members.
- The Kaiser Permanente Clinical Review Criteria are developed to identify eligibility for coverage when the patient's coverage contract includes the service/device.
- It should not be assumed that a patient meeting the criteria has coverage for the service/device. Please check the patient's coverage contract for specific exclusions or limitations.
- The criteria developed for use by Kaiser Permanente are based on the best available clinical evidence and regionally or nationally accepted standards.
- All Kaiser Permanente Clinical Review Criteria are reviewed annually. However, they are regularly updated and subject to change without notice. Service requests for a member are reviewed using the most current criteria.
- Kaiser Permanente has included the results of reviews conducted by the Medical Technology Assessment Committee and the Pharmacy & Therapeutics Committee. These committees, using evidence-based standards, review new technologies and treatments for medical efficacy. By including these reviews on this site, you will find that not all services listed in the directory are covered, and therefore some do not have approved criteria. Please carefully check the coverage and criteria sections under each of the topics.
- Members and practitioners have the right to appeal coverage decisions. If the Kaiser Permanente medical director or his/her designee determines that a service is not covered, a notice will be issued to both the member and the practitioner. In addition to outlining the rationale for the denial, the notice will contain instructions for appealing the decision.

If you have questions, call the Kaiser Permanente Provider Assistance Unit at 1-888-767-4670. For more information about how Kaiser Permanente applies the criteria, see Utilization Review.

Provider Manual

More resources

Summary of Medical Policy Changes (PDF)

Preauthorization Code Check

Notice

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc., provide these Clinical Review Criteria for internal use by their members and health care providers. The Clinical Review Criteria only apply to Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. Use of the Clinical Review Criteria or any Kaiser Permanente entity name, logo, trade name, trademark, or service mark for marketing or publicity purposes, including on any website, or in any press release or promotional material, is strictly prohibited

Contact a Department

Contact Us

Other KP region contacts
Other KP region provider sites

Provider Assistance Unit

For status updates or issues with claims and referrals

1-888-767-4670

Medical offices

Medical center hours and locations
Holiday closures and hours

[Intentionally omitted]

Exhibit M

Exhibit N

KAISER PERMANENTE®

Health Plan Policy
Non-Medicare Policies

Cochlear Implants/Hearing Devices	**Policy Number:**	NM-017
	Adopted:	06/01/1997
	Last Revised:	10/25/2017
	Last Reviewed:	

PURPOSE:

EXPLANATION:

To ensure consistent administration of Kaiser Foundation Health Plan of Washington (KFHPWA)/Kaiser Foundation Health Plan of Washington Options, Inc. (KFHPWAO) coverage for cochlear implants and hearing devices.

POLICY:

DESCRIPTION:

Cochlear Implants

A cochlear implant is an electronic device that can enable patients with severe to profound hearing loss to perceive sound. Cochlear implants have two main parts:

1. An internal device that is implanted under the skin behind the ear, and
2. A speech processor that is worn or carried (externally) by the individual.

Osseointegrated Implants (Bone-Anchored Hearing Aid)

Devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer. These are covered as a prosthetic when hearing aids are medically inappropriate or cannot be used due to:

1. Congenital malformations
2. Chronic disease,
3. Severe sensorineural hearing loss, or
4. Surgery

PROCEDURES:

IMPLEMENTING THE BENEFITS AND COVERAGE POLICY

These procedures provide additional information related to the Benefits and Coverage Policy, but are separate and distinct from that policy. Benefits and Coverage Leadership retains discretion in implementing these procedures and can change them at any time, with or without notice.

GUIDELINES:

Cochlear Implants

Cochlear implants, including implant surgery, pre-implant testing, post-implant follow-up, speech therapy, programming and associated supplies (transmitter cable, batteries, etc.) are covered at the medical benefit when Clinical Criteria is met.

Some plans may choose to apply the Devices, Equipment and Supplies benefit for the cochlear implant device and supplies. Check the plan document to confirm the benefit.

Replacement/Repair Cochlear Implants

A cochlear implant includes external components (i.e., a speech processor, a microphone headset and an audio input selector). The life expectancy of a typical processor is between 5-7 years. Before replacement is approved the member must have a durable medical or cochlear implant benefit and the device must no longer be on warrantee or part of a replacement recall. Replacement (L8619) of a cochlear implant and/or its external components is considered for coverage when:

1. The existing device cannot be repaired or when replacement is required because a change in the member's condition makes the present unit non-functional and;
2. Improvement is expected with a replacement unit;
3. A separate assessment is required for recommended accessories and upgrades for a cochlear implant. The member's current condition, the member's capabilities with his/her current cochlear implant, and the member's capabilities of the upgrade or accessory will be considered in determining whether the upgrade or accessory offers clinically significant benefits to the member
4. The evaluation must be conducted by a participating otolaryngologist.

Upgrade Cochlear Implants

Cochlear implant upgrades are only covered when the current device is no longer functioning and the replacement criteria (as stated above) are met.

Bone Anchored Hearing Aids (BAHA)

For most plans, Bone Anchored Hearing Aids (BAHA), including testing, surgery, fitting, follow-up, speech therapy and programming are covered at the medical benefit when Clinical Criteria is met. BAHA replacement hardware will be covered under the plan's prosthetic devices benefit. Check the DE rider to confirm the benefit.

Evaluation and diagnostic testing are covered even when results reveal the patient is not a candidate. Any tests available at Kaiser Permanente (KP) (e.g. tympanometry, computer tomography, etc.) must be provided at KP.

Associated supplies are covered when device criteria has been met.

EXCLUSIONS:

N/A

APPLICABILITY:

Unless specifically identified as excluded, this policy applies to:
• Kaiser Foundation Health Plan of Washington (KFHPWA)
• Kaiser Foundation Health Plan of Washington Options, Inc. (KFHPWAO)
• Commercial

For Self-Funded plans, refer to the plan document.

SCOPE:

This policy is intended to support consistent benefit application for Kaiser members.

RESPONSIBILITIES:

Benefits and Coverage is responsible for the interpretation of regulations and guidelines as it relates to policy level coverage determinations. Policies are reviewed on a regular basis to ensure accurate information.

DEFINITIONS:

N/A

REFERENCES:

N/A

Authorized HPA Authority: Director of Benefits and Coverage
Designated Content Expert: Benefit Interpretation Coordinator

Related Policies, Documents and References:

Clinical Criteria	Referenced Documents
Clinical Criteria?	Referenced Documents

Documents which refer to this document:

Exhibit O

The Honorable Robert S. Lasnik

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

ANDREA SCHMITT; *et al.*, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN OF WASHINGTON; *et al.*, Defendants.	CASE NO. 2:17-cv-1611-RSL DEFENDANTS' RESPONSES TO PLAINTIFFS' SECOND DISCOVERY REQUESTS TO KAISER FOUNDATION HEALTH PLAN, INC.

Defendants Kaiser Foundation Health Plan of Washington ("KFHPW") and Kaiser Foundation Health Plan of Washington Options, Inc. ("KFHPWO"), collectively "Defendants," respond to Plaintiffs' Second Discovery Requests (the "Discovery Requests"), as set forth below.

GENERAL OBJECTIONS

The following general comments and objections are hereby incorporated by this reference into Defendants' answers and responses to each and every Discovery Request.

1. The Discovery Requests are propounded to Kaiser Foundation Health Plan, Inc. ("KFHP"), and purport to require KFHP to respond for and on behalf of any and all of its subsidiaries, agents, employees and attorneys. KFHP does not issue health policies and is not a health carrier. Subsidiaries of KFHP include companies who are not named as parties to this suit

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Request. Defendants reserves the right to assert any such objection to any answer given.

I. INTERROGATORIES

INTERROGATORY NO. 6: Please identify any and all of Kaiser's justifications for the Hearing Loss Exclusion, including but not limited to, any objective medical, scientific, evidence-based, financial, actuarial, or other non-discriminatory basis for Kaiser's administration of the Hearing Loss Exclusion.

ANSWER: Defendants object to Interrogatory No. 6 as an improper compound interrogatory, as it requests information on the "justification for the Hearing Loss Exclusion" and the "non-discriminatory basis for Kaiser's administration of the Hearing Loss Exclusion." Defendants further object to Interrogatory No. 6 as it is vague and ambiguous with respect to what Plaintiffs contend constitutes "Kaiser's administration of the Hearing Loss Exclusion." Defendants also object to Plaintiffs' request to the extent their characterization of the so-called "Hearing Loss Exclusion" ignores that Defendants have long covered cochlear implants (to treat severe to profound hearing loss) and bone anchored hearing aids. Notwithstanding these objections, and subject to them, Defendants respond as follows:

Defendants' health plans are administered in accordance with the plan documents, without reference to members' race, age, gender, or disability status. In addition, Defendants specifically advise members of their non-discrimination policy: For example:

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

Consideration for benefit coverage in Defendants' health plans for the specific class of hearing aids at issue in Plaintiffs' Fourth Amended Complaint is evaluated on the same bases as other services. There are numerous factors and inputs that go into determining what services to include for coverage under a health plan, none of which relate to a person's disability status. First

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is whether coverage is required by regulators or applicable law. No regulator or applicable law has ever required this class of hearing aids to be covered. Washington's Essential Health Benefit regulations expressly stated that this class of hearing aids was not required to be covered, reaffirming Defendants' long held understanding that coverage was not required. WAC 284-43-5640(b)(vii). This is the same for frames and lenses for eye glasses for adults, adult dental care, routine foot care in the absence of diabetes, and therapeutic shoe inserts, for example. Complying with regulatory rules which do not require coverage for this type of hearing aid is a legitimate non-discriminatory basis for the exclusion.

Second are considerations relating to the market, from both a competition standpoint and an adverse selection standpoint. The largest provider of healthcare in the United States is Medicare. Medicare statutorily excludes coverage for hearing aids, including fittings and hearing exams with the intended purpose of prescribing hearing aids, along with eye glasses. 42 U.S.C. § 1395y(a)(7). Defendants generally consider and apply Medicare's coverage positions in evaluating benefits and following Medicare's coverage position with respect to this type of hearing aid is a legitimate non-discriminatory basis for the exclusion. The commercial marketplace also is considered and Defendants keep informed about what services competitors are offering that are beyond those required by law. The fact that Regence BlueShield is also being sued by Plaintiffs' counsel to require coverage of this same type of hearing aid demonstrates the lack of a competitive insurance market for this coverage, which would lead to adverse selection. Keeping in step with the health insurance marketplace in its treatment of this type of hearing aid is a legitimate non-discriminatory basis for the exclusion.

Third, cost is a consideration. Defendants' health plans are designed to make health care affordable and keep premiums, coinsurance, copayments, deductibles, out-of-pocket maximums and other costs at a minimum, while also providing coverage for all services required by law. To provide more choice, Defendants offer fully insured group plans the option to purchase a rider to cover the specific hearing aid coverage Plaintiffs seek. This gives members and plan sponsors the

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flexibility to choose coverage for hearing aids and related services and treatments while obligating them to pay premiums for such coverage, or to forego that additional expense. As is common with vision plans as a stand-alone option, the rider allows employers and groups to select the best coverage for their individual financial and medical needs, while addressing the cost and market considerations. As far as can be determined, the hearing aid rider was first offered in 1998. Actuarial pricing estimates that if hearing aids were covered with a maximum benefit amount of $2,500 *in a market that mandated such coverage for all health plans,* premiums would rise annually by $48.52 for every member for individual policies;$47.81/member for large groups; and $43.10/member for small groups; for an aggregate increase of over $22,400,000.00 or even higher depending on the benefit maximum. If hearing aids were being offered in a market environment that did not require the coverage, the above costs would be significantly higher due to adverse selection. In an era of rising health insurance costs, offering riders for groups who want this type of hearing aid coverage, while excluding the coverage to maintain affordability for those who do not, is a legitimate non-discriminatory basis.

Fourth, requests from internal stakeholders, including healthcare providers, are considered. While coverage for bone anchored hearing aids and cochlear implants was sponsored by provider and other internal stakeholders, there has been no similar promotion of coverage for the air conduction type of hearing aids sought by Plaintiffs. This is based on the above three factors, as well as the fact that hearing aids, like eye glasses, have been considered an "optional" benefit in the United States, and the patient acceptance rate and the high rates of under-utilization or non-utilization of hearing aids by patients who have been fitted with hearing aids indicate that there are significant factors unrelated to insurance coverage that impact patients' regular use of hearing aids.

INTERROGATORY NO. 7: Please identify the total number of insureds, by plan year, enrolled in Washington state-regulated Kaiser insured plans that contained or contain the Hearing Loss Exclusion, starting on October 31, 2013 through to the present.

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II. REQUESTS FOR PRODUCTION

REQUEST FOR PRODUCTION NO. 13: Please produce for inspection and copying all documents relating to, relied upon or reviewed as part of creating Kaiser's response to Interrogatory No. 6.

RESPONSE: Objection. This request seeks attorney work product privileged and confidential attorney client communications. Without waiving its objections, see the following documents attached or previously produced:

- The plan documents previously produced at KAISER_000001 – KAISER_001773.
- The Washington Essential Health Benefits for Washington's benchmark plan ("EHB") found at WAC 284-43-5640 and Confidential Kaiser 001969-1977
- "ESSENTIAL HEALTH BENEFITS: BENCHMARK PLAN COMPARISON 2021 AND LATER" published by Cigna, which is publicly available at: https://www.cigna.com/static/www-cigna-com/docs/employers-brokers/insights/informed-on-reform/top-11-ehb-by-state.pdf.
- E.S. v. Regence lawsuit
- Competitor coverage and/or exclusion for this type of hearing aids. See https://www.insurance.wa.gov/health-care-and-disability-filings.
- Analyst checklist (current version attached). See also https://www.insurance.wa.gov/speed-market-tools-health-coverage-analysts.
- Medical criteria for Bone Anchored Hearing Aids and Cochlear Implants (previously produced at Confidential Kaiser 002056-02084);
- Actuarial data regarding hearing aid impact (this is being provided under the Protective Order)
- Studies relating to use of air conduction hearing aids for perceived hearing loss, see e.g. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3665209/.

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RESPONSE: Kaiser objects to Request for Production No. 19 on the grounds that it is vague, overly broad, unduly burdensome, not reasonably calculated to lead to the discovery of admissible evidence, and confusing since 45 C.F.R. §92.5 does not apply to any assurances. To the extent this request is intended to seek information about applications for federal financial assistance and related assurances, by entities principally engaged in the business of providing healthcare, which the regulations confirm does not include entities principally engaged in the business of providing health insurance, such as Defendants (pursuant to 45 C.F.R. §92.3 and §92.4), Defendants do not have responsive documentation.

Dated this 27th day of October, 2022,

KARR TUTTLE CAMPBELL

/s/ Medora A. Marisseau
Medora A. Marisseau (WSBA #23114)
Mark A. Bailey (WSBA #26337)
Joshua M. Howard (WSBA #52189)
Attorneys for Defendants

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Exhibit P

FINAL BILL REPORT
SHB 1870

C 33 L 19
Synopsis as Enacted

Brief Description: Making state law consistent with selected federal consumer protections in the patient protection and affordable care act.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Davis, Cody, Ryu, Jinkins, Dolan, Senn, Bergquist, Peterson, Thai, Valdez, Morgan, Robinson, Goodman, Kilduff, Fey, Pollet, Appleton, Orwall, Mead, Kirby, Kloba, Gregerson, Fitzgibbon, Stanford and Tharinger).

House Committee on Health Care & Wellness
Senate Committee on Health & Long Term Care

Background:

Enacted in 2010, the federal Patient Protection and Affordable Care Act (ACA) contained a variety of provisions related to private health insurance coverage, including guaranteed issue and eligibility, open enrollment periods, limitations on rescissions, essential health benefits, out-of-pocket maximums, annual or lifetime limit prohibitions, uniform explanation of coverage requirements, maximum waiting periods for group coverage, and discrimination prohibitions.

The ACA preempts state laws that prevent its application. Washington law includes some provisions that conflict with the ACA and are therefore not enforced. Additionally, state law includes provisions implementing the ACA, although some of the provisions of the ACA are not addressed in state law.

I. Guaranteed Issue and Eligibility.

A. Federal Law.

The ACA requires most health insurers to accept every employer or individual who applies for coverage. Health carriers are prohibited from imposing pre-existing condition exclusions or waiting periods. Health carriers are also prohibited from establishing eligibility rules based on:

- health status;
- medical condition;

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability;
- disability; or
- any other health status-related factor determined appropriate by the Secretary of Health and Human Services (Secretary).

B. State Law.

State law includes provisions relating to guaranteed issue and pre-existing conditions that are not enforced because of the ACA. For example, state law requires an individual to complete the standard health questionnaire prior to purchasing an individual market health insurance plan. Based on the results of the questionnaire, the person may be denied individual market coverage, in which case he or she is eligible to purchase coverage from the Washington State Health Insurance Pool. State law also includes provisions allowing for pre-existing condition waiting periods, except for persons under the age of 19.

II. Open Enrollment Periods.

A. Federal Law.

The ACA allows health carriers to restrict enrollment in health plans to open or special enrollment periods. Open enrollment periods occur once per year. A person who misses open enrollment may enroll in a health plan during a special enrollment period upon the occurrence of a life event such as losing health coverage or the birth of a child.

B. State Law.

The Insurance Commissioner (Commissioner) is required to establish open enrollment periods for persons under the age of 19. The Commissioner may levy fines against a carrier that refuses to sell guaranteed issue policies to persons under the age of 19.

III. Rescissions.

A. Federal Law.

The ACA prohibits health carriers from retroactively rescinding coverage except in cases involving fraud or material misrepresentation.

B. State Law.

State law does not prohibit rescissions. However, the reasons for which a carrier may cancel coverage are limited to nonpayment of premium, violations of the published policies of the carrier, Medicare eligibility, failure to pay cost-sharing, fraud, material breach of contract, or changes in state or federal law.

IV. Essential Health Benefits.

A. Federal Law.

The ACA requires most individual and small group market health plans to cover 10 categories of essential health benefits:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder treatment, 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.

To determine the specific services covered within each category, federal rules allow states to choose a benchmark plan and to supplement that plan to ensure it covers all 10 categories.

B. State Law.

State law designates the largest small group plan in the state as the benchmark plan. Consistent with federal law, the Commissioner must supplement the benchmark plan to ensure that all 10 categories of essential health benefits are included.

V. Out-of-Pocket Maximums.

A. Federal Law.

The ACA imposes a maximum for the out-of-pocket costs associated with the essential health benefits an enrollee must pay per plan year. The Secretary sets the maximum for individual and family coverage. The Secretary may adjust the amounts based on increases in premiums for the previous calendar year. Federal rules prohibit a person's out-of-pocket maximum from exceeding the limit for self-only coverage, regardless of whether he or she is enrolled in self-only or family coverage.

B. State Law.

State law does not address the federal out-of-pocket maximums.

VI. Lifetime Limits.

A. Federal Law.

The ACA prohibits health plans from imposing annual or lifetime limits on an essential health benefit for a particular beneficiary.

B. State Law.

Rules adopted by the Commissioner prohibit a health carrier from imposing annual or lifetime limits on an essential health benefit, other than those permitted as reference-based limitations.

VII. Explanation of Coverage.

A. Federal Law.

Under the ACA, a health carrier must provide a summary of benefits and coverage explanation (SBCE), either in paper or electronically, to:

- an applicant at the time of application;
- an enrollee prior to the time of enrollment or re-enrollment; and
- a policyholder or certificate holder at the time of issuance.

The ACA requires the Secretary to develop standards for health carriers to use when providing a SBCE to applicants, enrollees, and policyholders. The standards must require that the SBCE is presented in a uniform format of four pages or less in at least 12-point font, is culturally and linguistically appropriate and uses terms understandable by the average enrollee, and includes:

- uniform definitions that allow consumers to compare coverage and understand the terms of coverage;
- a description of the coverage; reductions, limitations, and exceptions on coverage; cost-sharing provisions; and renewability and continuation of coverage provisions;
- a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing;
- a statement of whether the plan provides minimum essential coverage under federal law and ensures that the plan share of total allowed costs is no less than 60 percent of the costs;
- a statement that the outline is a summary and that the coverage document itself should be consulted to determine the governing contractual provisions; and
- a contact number for the consumer to call with additional questions and a website where a copy of the actual individual coverage policy or group certificate of coverage may be reviewed and obtained.

The Secretary must periodically review and update the standards.

If a health carrier makes any material modification in any of the terms of the plan that is not reflected in the most recent SBCE, it must provide notice of the modification no less than 60 days prior to the date the modification becomes effective.

A health carrier that fails to provide the required information is subject to a fine of no more than $1,000 for each failure. A failure for each enrollee constitutes a separate offense.

The Secretary must develop standards for definitions of terms to be used on health insurance coverage, including insurance-related terms and medical terms.

B. State Law.

There are no state requirements regarding the SBCE.

VIII. Waiting Periods for Group Coverage.

A. Federal Law.

A health carrier may not apply a waiting period for group coverage that exceeds 90 days.

B. State Law.

State law does not address waiting periods for group coverage.

IX. Non-Discrimination.

A. Federal Law.

The ACA prohibits a health carrier from making coverage decisions, determining reimbursement amounts, establishing incentive programs, or designing benefits in a way that discriminates against individuals because of their age, disability, or life expectancy. Similarly, health carriers are required to ensure that essential health benefits are not subject to denial based on age, life expectancy, disability, degree of medical dependency, or quality of life. Qualified health plans are prohibited from employing marketing practices or benefit designs that have the effect of discouraging enrollment in the plan by individuals with significant health needs.

B. State Law.

State law prohibits discrimination in insurance transactions based on sex, marital status, sexual orientation, race, creed, color, national origin, or the presence of any sensory, mental, or physical disability or the use of a trained dog guide or service animal. Health care service contractors are prohibited from discriminating on the basis of race, religion, national origin, or the presence of any sensory, mental, or physical handicap. Health maintenance organizations are prohibited from discriminating on the bases of any sensory, mental, or physical handicap. This does not prohibit a health care service contractor or health maintenance organization from limiting or denying coverage when a person does not meet essential eligibility requirements because of a medical condition.

Summary:

I. Guaranteed Issue and Eligibility.

A health carrier is prohibited from rejecting an applicant based on a pre-existing condition. Similarly, a health carrier may not deny, exclude, or otherwise limit coverage for an

individual's pre-existing condition, including pre-existing condition exclusions or waiting periods. Provisions relating to pre-existing condition exclusions and waiting periods and the standard health questionnaire are eliminated.

A health carrier may not establish eligibility rules based on:
- health status;
- medical condition;
- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability;
- disability; or
- any other health status-related factor determined appropriate by the Commissioner.

II. Open Enrollment Periods.

The Commissioner's requirement to establish open enrollment periods is expanded to include all persons, instead of only persons under the age of 19. The Commissioner may levy fines against a carrier that refuses to sell guaranteed issue policies to any person, instead of only persons under the age of 19.

III. Rescissions.

A health plan or health carrier may not rescind coverage for an enrollee once the enrollee is covered under the plan, except in situations involving fraud or material misrepresentation.

IV. Essential Health Benefits.

The 10 essential health benefit categories are defined to include:
- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder treatment, 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.

References to federal law are eliminated in provisions relating to selecting and supplementing of the state benchmark plan.

V. Out-of-Pocket Maximums.

For plan years beginning in 2020, the cost-sharing incurred under a health plan for the essential health benefits may not exceed the amount required under federal law for the calendar year. If there are no cost-sharing requirements under federal law, the cost sharing may not exceed $8,200 for self-only coverage and $16,400 for family coverage, increased by the premium adjustment percentage for the calendar year. An enrollee's cost-sharing may not exceed the self-only limit regardless of whether he or she is enrolled in self-only or family coverage.

The premium adjustment percentage for the calendar year is the percentage, if any, by which the average per capita premium for health insurance in Washington for the previous year exceeds the average per capita premium for 2020 as determined by the Commissioner.

VI. Lifetime Limits.

A health carrier may not impose annual or lifetime limits on an essential health benefit, other than those permitted as reference-based limitations under rules adopted by the Commissioner.

VII. Explanation of Coverage.

A health carrier must provide a summary of benefits and coverage explanation (SBCE), either in paper or electronically, to:

- an applicant at the time of application;
- an enrollee prior to the time of enrollment or re-enrollment; and
- a policyholder certificate holder at the time of issuance.

The Commissioner must develop standards for health carriers to use when providing a SBCE to applicants, enrollees, and policyholders. The standards must require that the SBCE is presented in a uniform format of four pages or less in at least 12-point font, is culturally and linguistically appropriate, and uses terms understandable by the average enrollee, and includes:

- uniform definitions that allow consumers to compare coverage and understand the terms of coverage;
- a description of the coverage; reductions, and exceptions on coverage; cost-sharing provisions; and renewability and continuation of coverage provisions;
- a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing;
- a statement of whether the plan provides minimum essential coverage under federal law and ensures that the plan share of total allowed costs is no less than 60 percent of the costs;
- a statement that the outline is a summary and that the coverage document itself should be consulted to determine the governing contractual provisions; and
- a contact number for the consumer to call with additional questions and a website where a copy of the actual individual coverage policy or group certificate of coverage may be reviewed and obtained.

The Commissioner must use the current federal SBCE standards when developing the state standards. The Commissioner must periodically review and update the standards. If a health

carrier makes any material modification in any of the terms of the plan that is not reflected in the most recent SBCE, it must provide notice of the modification no less than 60 days prior to the date the modification becomes effective.

A health carrier that fails to provide the required information is subject to a fine of no more than $1,000 for each failure. A failure for each enrollee constitutes a separate offense.

The Commissioner must develop standards for definitions of terms to be used on health insurance coverage, including insurance-related terms and medical terms.

VIII. Waiting Periods for Group Coverage.

A group health plan and a health carrier offering group coverage may not apply any waiting period that exceeds 90 days.

IX. Non-Discrimination.

A health carrier offering a non-grandfathered health plan in the individual or small group market may not, in its benefit design or implementation of its benefit design, discriminate against individuals because of age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Such a health carrier may not, with respect to the health plan, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. This does not prevent a health carrier from appropriately using reasonable medical management techniques.

X. Rulemaking.

Unless preempted by federal law, the Commissioner must adopt any rules necessary to implement the provisions relating to guaranteed issue and eligibility, open enrollment periods, limitations on rescissions, essential health benefits, out-of-pocket maximums, prohibiting annual or lifetime limits, uniform explanation of coverage requirements, maximum waiting periods for group coverage, and discrimination prohibitions. The rules must be consistent with federal rules and guidance in effect on January 1, 2017, implementing the Patient Protection and Affordable Care Act.

Votes on Final Passage:

House	56	38	
Senate	28	17	(Senate amended)
House	56	35	(House concurred)

Effective: April 17, 2019

Exhibit Q

KAISER PERMANENTE®

Health Plan Policy

Non-Medicare Policies

Hearing Aids	Policy Number:	NM - 106
	Adopted:	10/01/1981
	Last Revised:	12/22/2021

PURPOSE:

EXPLANATION:

To ensure consistent administration of the Kaiser Foundation Health Plan of Washington (KFHPWA)/Kaiser Foundation Health Plan of Washington Options, Inc. (KFHPWAO) Evidence of Coverage (EOC) provisions regarding external hearing aid coverage.

POLICY

DESCRIPTION:

Hearing exams/test and evaluation, not related to hearing aids, is a base benefit and subject to applicable cost shares. See the EOC for details.

Hearing aids, including hearing aid examinations/evaluation and fittings, are not a base benefit. Large groups can purchase a hearing aid (HA) rider to include hearing aid coverage.

For information regarding cochlear implants or bone anchored hearing aids (BAHA)/ bone anchored hearing systems (BAHS), see the Cochlear Implants/Implanted Hearing Devices - NM-017 policy.

PROCEDURES:

IMPLEMENTING THE BENEFITS ADMINISTRATION POLICY

These procedures provide additional information related to the Benefits Administration Policy but are separate and distinct from that policy. Benefits Administration Leadership retains discretion in implementing these procedures and can change them at any time, with or without notice.

GUIDELINES:

Plans that include hearing aid coverage typically have a dollar allowance (the most KFHPWA/KFHPWAO will pay) and will be tracked using the period of time specified in the EOC/rider.

- If the EOC states "per year" or "calendar year" the benefit resets January 1st of each year.
- If the EOC states "every 12 months/24 months/36 months/3 consecutive years..." the benefit is tracked for the applicable time frame, starting from the last usage date.

Some HA riders may apply annual deductible and plan coinsurance in addition to a hearing aid dollar allowance or maximum. KFHPWA/KFHPWAO payment, after the deductible is met, will not exceed the dollar allowance or maximum, per the EOC. HSA plans are required to apply annual deductible to hearing aids.

Effective 01/01/2022, plans/HA riders will no longer have separate age limitation benefits for hearing aids.

EXCLUSIONS:

- Replacement costs of hearing aids due to loss, breakage, or theft, unless at the time of such replacement the member is eligible under the benefit.
- Repairs, replacement parts, replacement batteries and maintenance costs are typically excluded. See EOC and riders.

APPLICABILITY:

Unless specifically identified as excluded, this policy applies to:
• Kaiser Foundation Health Plan of Washington (KFHPWA)
• Kaiser Foundation Health Plan of Washington Options, Inc. (KFHPWAO)
• Commercial
• Self-Funded ○ Content found in this policy applies unless the Self-Funded plan document and/or riders state otherwise.

SCOPE:

This policy is intended to support consistent benefit application for Kaiser members.

RESPONSIBILITIES:

Benefits Administration is responsible for interpretation of regulations and guidelines as it relates to policy level coverage determinations. Policies are reviewed on a regular basis to ensure accurate information.

DEFINITIONS:

N/A

REFERENCES:

RCW 48.43.0128

Authorized HPSA Authority: Director of Benefits Administration

Designated Content Expert: Benefit Interpretation Coordinator

KAISER PERMANENTE®

Health Plan Policy

Non-Medicare Policies

Hearing Aids	Policy Number:	NM - 106
	Adopted:	10/01/1981
	Last Revised:	12/22/2021

PURPOSE:

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DEFINITIONS:

N/A

REFERENCES:

RCW 48.43.0128

Authorized HPSA Authority: Director of Benefits Administration

Designated Content Expert: Benefit Interpretation Coordinator

KAISER PERMANENTE®

Health Plan Policy

Non-Medicare Policies

Hearing Aids	Policy Number:	NM - 106
	Adopted:	12/22/2021
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APPLICABILITY:

Unless specifically identified as excluded, this policy applies to:
• Kaiser Foundation Health Plan of Washington (KFHPWA)
• Kaiser Foundation Health Plan of Washington Options, Inc. (KFHPWAO)
• Commercial
• Self-Funded ○ Content found in this policy applies unless the Self-Funded plan document and/or riders state otherwise.

SCOPE:

This policy is intended to support consistent benefit application for Kaiser members.

RESPONSIBILITIES:

Benefits Administration is responsible for interpretation of regulations and guidelines as it relates to policy level coverage determinations. Policies are reviewed on a regular basis to ensure accurate information.

DEFINITIONS:

N/A

REFERENCES:

RCW 48.43.0128

Authorized HPSA Authority: Director of Benefits Administration

Designated Content Expert: Benefit Interpretation Coordinator

Schmitt et al v. Kaiser Foundation Health Plan of Washington, et al.
USDC (W.D. Wash.), No. 2:17-cv-1611-RSL

CONFIDENTIAL EXHIBIT

Filed Under Seal
Pursuant to Protective Order (Dkt. No. 16)

Exhibit R

Schmitt et al v. Kaiser Foundation Health Plan of Washington, et al.
USDC (W.D. Wash.), No. 2:17-cv-1611-RSL

CONFIDENTIAL EXHIBIT

Filed Under Seal
Pursuant to Protective Order (Dkt. No. 16)

Exhibit S

Exhibit T

Medical Technology Assessment Committee

The Medical Technology Assessment Committee (MTAC) is responsible for systematically evaluating new medical technologies, new applications of existing technologies, and new uses of existing pharmaceuticals using an evidence-based process. Technologies include diagnostic tests, procedures, treatments, and devices for both medical and behavioral health that have implications for patient coverage.

MTAC includes a consumer representative, clinical leaders, epidemiologists, and representatives from specialty services, pharmacy and therapeutics, the legal department, clinical review and appeals, and community networks. The committee also seeks input from specialists and professionals relevant to the topic under review.

For current technologies under review or for supporting evidence on a prior decision, contact your Provider Services or Health Plan consultant.

Contact a Department

Contact Us

Other KP region contacts
Other KP region provider sites

Provider Assistance Unit

For status updates or issues with claims and referrals

1-888-767-4670

Medical offices

Medical center hours and locations
Holiday closures and hours

Exhibit U

KAISER PERMANENTE®

Kaiser Foundation Health Plan
of Washington Options, Inc.
Member Services
P.O. Box 34590 Seattle, WA 98124-1590

Explanation of Benefits

PLEASE SAVE THIS DOCUMENT FOR YOUR RECORDS AND TAX PURPOSES.

Important Plan Information

Print Date: 10/17/2020

[redacted] E. L[redacted]
[redacted]
SEATTLE WA [redacted]

Dear Subscriber:

THIS IS NOT A BILL. This is an itemized summary of services that outlines provider charges, payments, and claims decisions based on your coverage contract.

If you are responsible for any amount as noted in the Payment Summary, you may receive a separate statement. Thank you.

CLAIM SUMMARY

Patient:	O[redacted] A. L[redacted]
Member ID:	[redacted]9394
Subscriber:	J[redacted] E. L[redacted]
Group:	RICHMARK LABEL
Group Number:	6518800
Provider:	SEATTLE CHILDREN'S HOSPITAL
Provider Acct. No.:	H1221149400
Claim Number:	2026012445000
Diagnosis Code:	H903 Hearing loss from nerve or inner ear damage

PAYMENT SUMMARY (This is NOT a bill)

Total charges for this claim:	$	1323.80
Total KP allowed charges:	$	426.44
Total deductible:	$	426.44
Total coinsurance:	$	0.00
Total copay:	$	0.00
Other Insurance Paid:	$	0.00
KP Paid from COB Savings:	$	0.00
Your total responsibility:	$	1141.04
KP paid:	$	0.00

CLAIM DETAILS

Date of Service	Service Description	Service Code	Mod	Provider Billed	Plan Allowed	Plan Paid	Patient Responsibility	Note
09/08/20	Medical supplies or	0270		$ 131.80	$ 0.00	$ 0.00	$ 131.80	071 3029
09/08/20	Medical supplies or	0270		$ 131.80	$ 0.00	$ 0.00	$ 131.80	071 3029
09/08/20	Hearing (audiology)	0470		$ 443.80	$ 310.66	$ 0.00	$ 310.66	3016
09/08/20	Hearing (audiology)	0470		$ 165.40	$ 115.78	$ 0.00	$ 115.78	3016
09/08/20	Hearing (audiology)	0470		$ 451.00	$ 0.00	$ 0.00	$ 451.00	071 3029
		TOTALS		$ 1323.80	$ 426.44	$ 0.00	$ 1141.04	

BENEFIT SUMMARY 01/01/2020 - 12/31/2020

		Annual Amount Individual	Annual Amount Family	Applied this Claim Individual	Applied this Claim Family	Amount to Date Individual	Amount to Date Family
In Network:	Annual Deductible	$ 1500.00	$ 4500.00	$ 426.44	$ 426.44	$ 461.89	$ 667.30
	Out-of-Pocket Limit	$ 3500.00	$10500.00	$ 426.44	$ 426.44	$ 515.75	$ 725.29
Out of Network:	Annual Deductible	$ 3000.00	$ 9000.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
	Out-of-Pocket Limit	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Pharmacy:	Out-of-Pocket Limit	$ 0.00		$ 0.00		$ 0.00	
Life Time Maximum:		$ 0.00		$ 0.00		$ 0.00	

Questions? Please call 206-630-4636, or 1-888-901-4636 (TTY/TDD: 1-800-833-6384), or you may submit your questions to the E-mail link at **www.kp.org/wa/memberservices.** **Please see back of page for appeals information.**

CLKOSY

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KAISER PERMANENTE®

Kaiser Foundation Health Plan
of Washington Options, Inc.
Member Services
P.O. Box 34590 Seattle, WA 98124-1590

Explanation of Benefits

PLEASE SAVE THIS DOCUMENT FOR YOUR RECORDS AND TAX PURPOSES.

Important Plan Information

Page No.: 1 of 1
Print Date: 05/31/2019

[redacted] E. [redacted]
[redacted]
SEATTLE WA [redacted]

Dear Subscriber:

THIS IS NOT A BILL. This is an itemized summary of services that outlines provider charges, payments, and claims decisions based on your coverage contract.

If you are responsible for any amount as noted in the Payment Summary, you may receive a separate statement. Thank you.

CLAIM SUMMARY

Patient:	O[redacted] A. L[redacted]
Member ID:	[redacted]9394
Subscriber:	J[redacted] E. L[redacted]
Group:	RICHMARK LABEL
Group Number:	6518800
Provider:	SEATTLE CHILDREN'S HOSPITAL
Provider Acct. No.:	H1011146700
Claim Number:	[redacted]3000
Diagnosis Code:	H903 Hearing loss from nerve or inner ear damage

PAYMENT SUMMARY (This is NOT a bill)

Total charges for this claim:	$	1195.20
Total KP allowed charges:	$	409.99
Total deductible:	$	409.99
Total coinsurance:	$	0.00
Total copay:	$	0.00
Other Insurance Paid:	$	0.00
KP Paid from COB Savings:	$	0.00
Your total responsibility:	$	1019.49
KP paid:	$	0.00

CLAIM DETAILS

te of Service	Service Description	Service Code	Mod	Provider Billed	Plan Allowed	Plan Paid	Patient Responsibility	Note
04/30/19	Medical supplies or	0270		$ 126.70	$ 0.00	$ 0.00	$ 126.70	071 3029
04/30/19	Medical supplies or	0270		$ 126.70	$ 0.00	$ 0.00	$ 126.70	071 3029
04/30/19	Hearing (audiology)	0470		$ 426.70	$ 298.69	$ 0.00	$ 298.69	3016
04/30/19	Hearing (audiology)	0470		$ 159.00	$ 111.30	$ 0.00	$ 111.30	3016
04/30/19	Hearing (audiology)	0470		$ 356.10	$ 0.00	$ 0.00	$ 356.10	071 3029
	TOTALS			$ 1195.20	$ 409.99	$ 0.00	$ 1019.49	

Notes:
071 - THE SERVICE REPORTED IS NOT A COVERED SERVICE UNDER YOUR CONTRACT
3029 - SEE "GENERAL EXCLUSIONS" SECTION OF YOUR BENEFITS BOOKLET.
3016 - SEE "HOSPITAL-INPATIENT AND OUTPATIENT" IN THE BENEFITS DETAILS SEC YOUR BENEFITS BOOKLET.

BENEFIT SUMMARY 01/01/2019 - 12/31/2019

		Annual Amount Individual	Annual Amount Family	Applied this Claim Individual	Applied this Claim Family	Amount to Date Individual	Amount to Date Family
In Network:	Annual Deductible	$ 1500.00	$ 4500.00	$ 409.99	$ 409.99	$ 409.99	$ 409.99
	Out-of-Pocket Limit	$ 3500.00	$10500.00	$ 409.99	$ 409.99	$ 409.99	$ 409.99
of Network:	Annual Deductible	$ 3000.00	$ 9000.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
	Out-of-Pocket Limit	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Pharmacy:	Out-of-Pocket Limit	$ 0.00		$ 0.00		$ 0.00	
Life Time Maximum:		$ 0.00		$ 0.00		$ 0.00	

Questions? Please call 206-630-4636, or 1-888-901-4636 (TTY/TDD: 1-800-833-6384), or you may submit your questions to the E-mail link at **www.kp.org/wa/memberservices.** **Please see back of page for appeals information.**

CLKOSY

If you have questions concerning your benefits and coverage decisions, please call toll-free 1-888-901-4636 (TTY WA Relay: 1-800-833-6388). Para obtener asistencia en español, llame al 1-888-901-4636.

Appeals Process for Coverage Denials

If you wish to appeal a decision, you must submit a request for appeal within 180 days of this notice, specifying why you disagree with the decision. Kaiser Foundation Health Plan of Washington ('Kaiser Permanente') will notify you of its determination or request written permission for an extension of time within 30 days of receipt of the request for appeal. You may submit your appeal request by mail, fax, or phone to Kaiser Permanente. A written request for appeal should include copies of your medical record, physicians' letters and any other printed material related to your request.

Kaiser Permanente
Member Appeals
P.O. Box 34593
Seattle, WA 98124-1593
Toll-Free: 1-866-458-5479
Fax: 206-630-1859

If you are not satisfied with the initial decision on appeal or if Kaiser Permanente fails to grant or reject the request for review within the required timeframe, you may request another review of the decision.

For more details on additional levels of review, please refer to your Certificate of Coverage or contact Member Appeals.

If your health plan is governed by ERISA (most employment related health plans, other than those sponsored by governmental entities or churches - ask your employer about your plan) you have the right to file a lawsuit under section 502(a) of ERISA to recover benefits due to you under the plan at any point after completion of the initial appeals process.

For questions about your appeal rights, this notice, or for assistance, you can contact:

Kaiser Permanente
Member Services
Phone: 1-888-901-4636