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Of Attorneys for Plaintiff.

IN THE CIRCUIT COURT OF THE STATE OF OREGON

FOR THE COUNTY OF MULTNOMAH

ALBERT B. AULT, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, an Oregon nonprofit corporation, Defendant.	Case No.: COMPLAINT – Claim For Recovery of Health Insurance Benefits Under 29 USC § 1132 (ERISA) Prayer Amount: $41,598.42 Fee Authority: ORS 21.160(1)(b) ($252) **Subject to Mandatory Arbitration** JURY TRIAL REQUESTED

I.

PARTIES.

1.

Plaintiff Albert B. Ault ("Plaintiff") is a resident of Marion County, Oregon. At all times material to this action, Plaintiff was a beneficiary under a Large Group Traditional Copayment Plan (the "Plan") issued by Defendant to Pioneer Pump, Inc., under Group Number 16010-006, 007.

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2.

Defendant Kaiser Foundation Health Plan of the Northwest ("Kaiser") is an Oregon nonprofit corporation, with its principal place of business in Multnomah County, Oregon.

II.

VENUE AND JURISDICTION.

3.

Venue is proper in Multnomah County Circuit Court pursuant to a term of the Plan requiring any litigation between Kaiser and beneficiaries of the Plan to be filed in Multnomah County.

4.

This action arises under the Employment Retirement and Income Security Act of 1974 ("ERISA"), codified in material part at 29 USC Ch. 18. Pursuant to 28 USC § 1132(e)(1), jurisdiction over this claim is proper in this court.

III.

COMMON ALLEGATIONS.

5.

On or about September 3, 2011, Plaintiff was involved in a motorcycle accident in Burns, Oregon that resulted in multiple severe fractures to his leg. In severe pain and suffering from shock, Plaintiff was taken to Harney County Hospital in Burns, Oregon, where he was given pain medication upon arrival. Upon examining Plaintiff, personnel at Harney County Hospital determined that that facility was not properly equipped to treat Plaintiff's severe injury, and on their own initiative had Plaintiff transported to St. Charles Medical Center in Bend, Oregon, for further treatment. Plaintiff was under the influence of heavy pain medication and was therefore unable to participate in this

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decision. Furthermore, Plaintiff had no family members with him who were able to participate in any health care decisions.

6.

On or about September 4, 2011, Plaintiff was in fact transported to from Harney County Hospital to St. Charles Medical Center in Bend, Oregon. Due to his sedation, Plaintiff has no memory of being admitted to St. Charles Medical Center, nor being consulted about his health insurance or any other health care decisions. St. Charles Medical Center personnel performed surgery on Plaintiff's fractured leg on September 6, 2011. Following this surgery, Plaintiff's pain medication was reduced and Plaintiff began participating in his medical care.

7.

Shortly after becoming lucid following the reduction of his pain medication, on or around September 7, 2011, while still under the care of St. Charles Medical Center, Plaintiff notified Defendant of his hospitalization both at Harney County Hospital and St. Charles Medical Center.

8.

At the time of Plaintiff's accident and subsequent hospitalization, Plaintiff was a beneficiary under a Large Group Traditional Copayment Plan (the "Plan") issued by Defendant to Pioneer Pump, Inc., under Group Number 16010-006, 007, which included the following provision:

> "Post-stabilization care is Services you receive for the acute episode of your Emergency Medical Condition after that condition is clinically stable. ("Clinically stable" means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during your discharge or transfer from the hospital.[)] We cover post-stabilization care only if one of the following is true:
>
> - A Participating Provider or Participating Facility provides the Services.
> - We authorize your receiving the Services from the Non-Participating Provider or Non-Participating Facility before you receive the Services (**or**

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later, if extraordinary circumstances delay your ability to call us but you call us as soon as reasonably possible).

"To request prior authorization for your receiving post-stabilization care from a Non-Participating Provider or Non-Participating Facility, you or someone on your behalf must call us... before you receive the Services **if it is reasonably possible to do so. We understand that extraordinary circumstances can delay your ability to call us, for example if you are unconscious** or if there is no parent or guardian with a young child. In these cases, you must call us as soon as reasonably possible. After we are notified, we will discuss your condition with the Non-Participating Provider. If we decide that the post-stabilization care is Medically Necessary and would be covered if you received it from a Participating Provider or Participating Facility, we will either authorize your receiving the Services from the Non-Participating Provider or Non-Participating Facility, or arrange to have a Participating Provider or Participating Facility (or other designated provider or facility) provide the Services. If we decide to arrange to have a Participating Provider or Participating Facility (or other designated provider or facility), provide the Services, we may authorize special transportation Services that are medically required to get you to the provider or facility. This may include transportation that is otherwise not covered."

Emphasis added.

9.

As noted above, it was not reasonably possible for Plaintiff to call Defendant before receiving services from Harney County Hospital, St. Charles Medical Center, or their associated health care providers, due primarily to the fact that Plaintiff was under the influence of prescribed pain medication that rendered it impossible for him to participate in making health care decisions, let alone operate a telephone. Further, there was no other person who accompanied Plaintiff who was able or authorized to communicate with Defendant on Plaintiff's behalf.

10.

Following his discharge from St. Charles Medical Center on or about September 8, 2011, Plaintiff received follow up care on October 17 and November 7, 2011, from the same providers. Plaintiff was not informed by Defendant, following his post-surgery

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notification to Defendant, that Defendant would refuse to pay for any follow up care that was required as a result of his surgery.

11.

After receiving notifications from St. Charles Medical Center and its associated providers that Defendant had refused to pay any portion of the charges related to Plaintiff's surgery and follow up care, on December 9, 2011, Plaintiff submitted a written request to Defendant requesting that Defendant pay for the services Plaintiff incurred as a result of his motorcycle accident. A true copy of Plaintiff's written request is attached as Exhibit A and incorporated by this reference.

12.

On January 17, 2012, Defendant issued a written denial of Plaintiff's December 9, 2011, request, a true copy of which is attached as Exhibit B and incorporated by this reference. Notably, Exhibit B justifies the denial of Plaintiff's claims based solely on the fact that Plaintiff was "clinically stable" after being treated at Harney County Hospital, and Defendant had not preauthorized Plaintiff's post-stabilization services at St. Charles Medical Center. Exhibit B does include a finding that it was reasonably possible for Plaintiff to seek authorization prior to his being transported to St. Charles Medical Center, nor does Exhibit B explain whether Defendant discussed Plaintiff's condition with St. Charles Medical Center or its associated personnel to determine whether Plaintiff's post-stabilization care was medically necessary and would be covered if Plaintiff had received the care from a Participating Provider or Participating Facility, as required under the Plan provision quoted in paragraph 8 above. In short, Exhibit B's reasoning for denial of Plaintiff's claim fails to deal in any meaningful way with the requirements of the Plan as quoted in paragraph 8 above.

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13.

As a result of Defendant's denial of Plaintiff's claims, Plaintiff has incurred expenses, including late charges, interest, fees and other charges in an amount to be determined at trial, but in no event less than $41,598.42.

IV.

CLAIM FOR RELIEF

Recovery of Health Insurance Benefits Under 29 USC § 1132 (ERISA)

14.

Plaintiff re-alleges paragraphs 1 through 13 above.

15.

Pursuant to 29 USC § 1132(a)(1)(B), Plaintiff is entitled to bring this civil action "to recover benefits due to him under the terms of his plan..." among other things.

16.

In denying Plaintiff's claim for benefits as described above, Defendant has breached the terms of the Plan.

17.

Plaintiff has exhausted his administrative remedies by appealing to Defendant pursuant to the terms of the Plan. Defendant's denial of Plaintiff's appeal was made in bad faith and was an abuse of discretion that was tainted by Defendant's structural conflict of interest in making a coverage decision that was beneficial to Defendant's bottom-line and contrary to the Plan's coverage provisions as set forth in paragraph 8 above.

18.

As a result of Defendant's denial of Plaintiff's appeal, Plaintiff has been damaged as set forth in paragraph 13. Plaintiff is entitled to an award of said damages, plus pre

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and post-judgment interest at the rate of 9% per annum running from the date of service(s) until paid.

19.

Pursuant to 29 USC § 1132(g)(1), Plaintiff should be awarded his reasonable attorney fees incurred as a result of Defendant's denial.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for judgment in his favor and against Defendant as follows:

1. For an award of damages in the amount of not less than $41,598.42, plus pre- and post-judgment interest at the rate of 9% per annum running from the date of service(s) until paid;
2. For an award of Plaintiff's reasonable attorney fees, costs and disbursements incurred in this action; and
3. Such further relief the court deems just and equitable.

DATED this 30th day of December, 2014.

By__s/ Kevin J. Jacoby_____
Kevin J. Jacoby, OSB #063783
L.G. Billy Dalto, OSB #130946
Of Attorneys for Plaintiff

Law Office of Connolly & Malstrom
2731 12th Street SE | PO Box 3095
Salem, OR 97302
Ph: (503) 585-2054 | Fax: (503) 584-7037

12-9-11

Dear Kaiser,

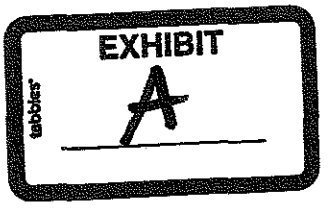
On September 3, 2011 I had a severe accident while riding my motorcycle off paved road on a gravel road outside of Burns Oregon in Harney County. The two men I was with made a splint and rushed me to the hospital in Burns. I was in severe pain and was given pain medication upon arrival in Emergency at Harney County Hospital. I do not remember much of this as I was also in shock. I do remember being on an IV and being told that there was not an orthopedic doctor that could repair my leg that was broken in two places.

The next day an ambulance took me to St. Charles Hospital in Bend. I do not remember checking into admitting, and it was a holiday week end. I do not remember being asked about insurance, but I think they did get my wallet and get my Kaiser card. I was alone, my wife was in Montana. Because there was not an orthopedic doctor available, I had to wait until the holiday week end ended before I was taken into surgery. I do not remember anyone calling Kaiser or asking me about my insurance. My Kaiser Dr. Bradley Romeling had left practice and was working in the hospital from the Lancaster Clinic in Salem. No one called him on my behalf, and I was not aware that someone should have done this. I have never had a severe injury like this, and was on medication the whole time until the surgery was completed.

I am attaching the bills from St. Charles and the Orthopedic Clinic in Bend. My motorcycle insurance covered some of the charges in Burns; and I have not been billed by either the ambulance or the Harney County Hospital.

In light of the circumstances in this emergency I believe that Kaiser should pay for the care I received as a result of this accident.

Albert Ault



January 17, 2012

Patient Name: ALBERT B AULT
Health Record Number: 31037822
Provider: The Center/St. Charles Medical Center

ALBERT AULT
4884 NICKS CT NE
SALEM, OR 97305

Re: Claim Numbers: EB2621178160, EB2975135200, EB2975135220, EB2975135230, 6B3330060130, EB3137012560 and EB3005601610
Dates of Service: September 3, 2011 through September 8, 2011 October 17, 2011 and November 7, 2011
Amount: $38,100.03, $2,508.00, $345.34, $238.45, $1.080.00, $81.70 and $395.00
Date Appeal received by Kaiser Permanente: December 19, 2011

Dear Mr. Ault:

We are writing to give you important information about your request for final appeal (request for internal review) regarding payment for the claim(s) identified above.

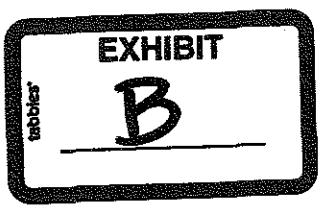
Background Information

In your appeal, you said on September 3, 2011, you had an accident while riding your motorcycle off road and you were taken to Harney County Hospital Emergency Room. You were told there was not an orthopedic surgeon available that could repair your leg. You shared that the next day you were sent by ambulance to St. Charles Medical Center in Bend. You explained that due to the holiday weekend you had to wait for an orthopedic surgeon to perform your surgery. You don't recall anyone asking you about your insurance coverage or contacting Kaiser Permanente and you weren't aware this needed to be done. You believe Kaiser Permanente should pay for the care you received as a result of your accident.

Decision

After careful review of the information that you provided as well as our records relevant to your appeal, your request is denied. We made our decision based on a benefit determination made according to the terms of your coverage.

Your appeal was reviewed by a Senior Appeal Administrator whose findings were presented to our Health Plan Review Committee which consists of a Senior Appeal Administrator and a Regulatory Consultant. These individuals were not involved in the initial decision regarding your claims.



Reason for the Decision

We made our decision for the following reason. Although this is a benefit determination, in consideration of your request, I contacted a Board-Certified Orthopedic Surgeon who is also the Area Chief for the Department of Orthopedic Surgery. After reviewing all your medical records from Harney County Hospital and St. Charles Medical Center, he responded that you had a closed injury (not an open fracture) and you were not emergently transferred from Harney County Hospital to St. Charles Medical Center on the date of injury. You were at St. Charles Medical Center two days before your surgery occurred, which appears to be due to physician availability. In his opinion, you were clinically stable after being treated in the Emergency Room at Harney County Hospital for transfer to a Kaiser Permanente facility for treatment of your condition.

Our records reflect that a third party insurance carrier covered the majority of the services you received at Harney County Hospital and we covered the remaining portion of your emergency services. The medical records from the Emergency Room at Harney County Hospital indicate your primary care provider was with Kaiser Permanente. Upon conclusion of our review, we can find no contractual basis on which to approve your request for payment of the remaining claims from the surgeon's office and St. Charles Medical Center. As indicated on the back of your Kaiser Permanente identification card, in a medical emergency you should call 911 or go to the nearest emergency facility... if you are hospitalized outside the Kaiser Permanente network, you must notify us as soon as possible. Kaiser Permanente was not contacted until after the surgery was performed on September 6, 2011. There was no preauthorization provided for these services or for the follow up care you received on October 17, and November 7, 2011. You remain responsible for these charges.

We are sorry we are unable to approve your request. We hope, however, that this explanation helps you to understand our determination.

You may obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, at not cost to you, by calling Member Relations at 503-813-4480.

Important Information about Your Appeal Rights

You <u>may</u> have the right to request further review of this determination. An explanation of your external review right is enclosed for your convenience.

A copy of your EOC is available upon request at no cost to you. If you would like a copy of your EOC, or if you need assistance in arranging care within Kaiser Permanente, please contact Membership Services from 8 a.m. to 6 p.m., Monday through Friday at 503-813-2000 or 1-800-813-2000; TTY for Oregon and Washington is 1-800-735-2900.

If you have questions regarding this letter, please contact me at 503-813-3605. We appreciate your membership and look forward to serving your future health care needs.

Sincerely,

Linda McVay
Senior Grievance and Appeal Administrator
Member Relations

Enclosures: Oregon Medical Plans External Review Rights; Supporting documentation from the EOC

You may request language assistance by calling 1-800-324-8010.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-324-8010.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-324-8010.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-324-8010.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-324-8010.

EXHIBIT B
PAGE 3

Applicable supporting documentation from the Kaiser Foundation Health Plan of the Northwest Large Group Traditional Copayment Plan Evidence of Coverage

How To Obtain Services

As a Member, you must receive all covered Services from Participating Providers and Participating Facilities inside our Service Area, except as otherwise specifically permitted in this EOC.

We will not directly or indirectly prohibit you from freely contracting at any time to obtain health care Services outside the Plan. However, if you choose to receive Services from Non-Participating Providers and Non-Participating Facilities except as otherwise specifically provided in this EOC, those Services will not be covered under this EOC and you will be responsible for the full price of the Services.

Post-Stabilization Care

Post-stabilization care is Services you receive for the acute episode of your Emergency Medical Condition after that condition is clinically stable. ("Clinically stable" means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during your discharge or transfer from the hospital. We cover post-stabilization care only if one of the following is true:

- ☐ A Participating Provider or Participating Facility provides the Services.
- ☐ We authorize your receiving the Services from the Non-Participating Provider or Non-Participating Facility before you receive the Services (or later, if extraordinary circumstances delay your ability to call us but you call us as soon as reasonably possible).

To request prior authorization for your receiving post-stabilization care from a Non-Participating Provider or Non-Participating Facility, you or someone on your behalf must call us at 503-735-2596 or, toll free at 1-877-813-5993, before you receive the Services if it is reasonably possible to do so.

We understand that extraordinary circumstances can delay your ability to call us, for example if you are unconscious or if there is no parent or guardian with a young child. In these cases, you must call us as soon as reasonably possible.

After we are notified, we will discuss your condition with the Non-Participating Provider. If we decide that the post-stabilization care is Medically Necessary and would be covered if you received it from a Participating Provider or Participating Facility, we will either authorize your receiving the Services from the Non-Participating Provider or Non-Participating Facility, or arrange to have a Participating Provider or Participating Facility (or other designated provider or facility) provide the Services. If we decide to arrange to have a Participating Provider or Participating Facility (or other designated provider or facility), provide the Services, we may authorize special transportation Services that are medically required to get you to the provider or facility. This may include transportation that is otherwise not covered.

EXHIBIT B
PAGE 4

Referrals to Non-Participating Providers and Non-Participating Facilities

If your Participating Physician decides that you require Services not available from Participating Providers or Participating Facilities, he or she will recommend to Medical Group and Company that you be referred to a Non-Participating Provider or Non-Participating Facility inside or outside our Service Area. If the Medical Group's assigned Participating Provider determines that the Services are Medically Necessary and are not available from a Participating Provider or Participating Facility and Company determines that the Services are covered Services, Company will authorize your referral to a Non-Participating Provider or Non-Participating Facility for the covered Services. The Copayments and Coinsurance for these approved referral Services are the same as those required for Services provided by a Participating Provider. You will need written authorization in advance in order for the Services to be covered. If Company authorizes the Services, you will receive a written "Authorization for Outside Medical Care" approved referral to the Non-Participating Provider, and only Services that are listed on the written referral will be covered, subject to any benefit limitations and exclusions applicable to these Services.

OREGON MEDICAL PLANS EXTERNAL REVIEW RIGHTS

The following information explains the process for requesting an external review of our decision denying your appeal.

You may request language assistance by calling 1-800-324-8010.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-324-8010.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-324-8010.
CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-324-8010.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-324-8010.

You may have the right to request an external review of our appeal decision. External reviews are conducted through Independent Review Organizations (IROs) that are not associated with Kaiser Foundation Health Plan of the Northwest. To request an external review, please send your request for review in writing by mail or fax to:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 503-813-3985

You may also contact the Oregon Division of Insurance; see the "Help with Your Appeal" section.

We must receive your request within 180 days of your receiving the notice of our appeal decision. Please note that we will count the 180 days starting 5 business days from the date of the notice to allow for delivery time, unless you can prove that you received the notice after that 5 business day period.

Along with your written request for an external review, we must receive your signed and written authorization to disclose your protected health information, which may include the medical records that are relevant to the external review. Your request for an external review will not be complete until we receive the completed authorization.

You must exhaust all internal appeals before you may file a request for external review unless we have failed to comply with federal requirements regarding our internal claims and appeals procedures.

External Review

If you are dissatisfied with our decision regarding your appeal, you have the right to request an external review of our decision by an Independent Review Organization (IRO) if our decision

involves medical judgment. For example, you have the right to an external review of an adverse decision that is based on any of the following:

- Whether a course or plan of treatment is medically necessary.
- Whether a course or plan of treatment is experimental, or investigational.
- Whether a course or plan of treatment is an active course of treatment for purposes of continuity of care when a Participating Provider's contract with us is terminated.
- Whether a course of plan of treatment is delivered in an appropriate health care setting and with the appropriate level of care.

The Director of the Oregon Department of Consumer and Business Services shall appoint an IRO. When this appointment is made, we will forward your relevant medical records and other relevant materials to the IRO not later than 5 business days after the appointment of the IRO. You will also receive notice of the IRO's appointment and, if you wish to submit additional information to the IRO, you must transmit that additional information to the IRO no later than 5 business days after receiving your notice of the IRO's appointment.

The IRO should issue a decision no later than 30 days after our receipt of your request for external review.

If you request a review of our denial of your appeal, we will continue to provide coverage for the services in question pending the outcome of external review. If we prevail in external review (the IRO determines that our decision should be followed), you may be responsible for paying full price for the services and items you received during the review period. Even if you or we decide to pursue other remedies under applicable state or federal law, we must provide services, including making payment on a claim, if the final external review decision reverses our denial of your appeal. If we intend to seek judicial review of the external review decision, the payment and/or benefits must continue until there is a judicial decision changing the final determination.

We won't impose fees as part of the external review process.

Appointment of a Representative

You have the right to be represented in the external review process by anyone you choose, including an attorney, but representation is not required. If you would like to have someone act on your behalf during the external review, you must appoint an authorized representative in writing. Please contact Membership Services at 1-800-813-2000, Monday through Friday, 8 a.m. to 6 p.m., to request the necessary forms.

You must pay the cost of anyone you hire to represent or help you.

Your Claim and/or Appeal File

If you want to review the information that we have collected regarding your claim for this service, you may request, and we will provide without charge, copies of all relevant documents, records and

other information. Separately, you have the right to request any diagnostic and treatment codes and their meanings that may be subject of your claim. To make a request, you should contact the Member Relations Department Monday through Friday, 8 a.m. to 5 p.m., at 503-813-4480.

You may send us additional information including comments, documents, or additional medical records which you believe supports your claim. If we had asked for additional information before and you did not provide it, we would still like to have that additional information for our review. Please send or fax all your additional information to:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 503-813-3985

Expedited External Review

You may request an expedited review from the IRO if (1) our adverse benefit determination concerns an admission, the availability of care, a continued stay, or a health care service for a medical condition for which you have received emergency services but have not been discharged from the facility; or (2) a provider with an established clinical relationship to you certifies in writing and provides supporting documentation that the ordinary time frame for external review would seriously jeopardize your life or health, or your ability to regain maximum function. Services already received are not eligible for an expedited external review.

If the IRO provides an expedited external review, a decision should be rendered no later than 3 days after the receipt of your request for an external review.

Your Claim After External Review

You may have certain additional rights if you remain dissatisfied after you have exhausted all levels of review, including external review, if it is available. If you are enrolled through a plan this is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court. The Consumer Protection Unit of the Oregon Division of Insurance (listed below) should be able to help you understand any further review rights available to you.

Help with Your Appeal

You have the right to seek assistance from the Consumer Protection Unit at the Oregon Division of Insurance. Contact them by mail, telephone, over the internet, or by email;

Oregon Division of Insurance
Consumer Protection Unit
P.O. Box 14480
Salem, OR 97309-0405
503-947-7984 or 1-888-877-4894
www.insurance.oregon.gov/consumer/consumer.html
cp.ins@state.or.us

Further Assistance from Kaiser Permanente

Should you have any questions regarding your internal appeal rights or external review rights, please contact the Member Relations Department at 503-813-4480 or Membership Services at 1-800-813-2000 and ask for Member Relations, Monday through Friday, 8 a.m. to 5 p.m. (TTY 1-800-735-2900). You can also log on to kp.org and email us.

EXHIBIT B
PAGE 9